

Understanding and eliminating minority health disparities in a 21st-century pandemic: A White Paper Collection

Differential Impacts of COVID-19 in New York State: Understanding and eliminating minority health disparities in a 21st-century pandemic

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## Capital Region Collaborative Community Survey Project to Document Disparate Impacts of COVID-19

The Albany Minority Health Task Force

Lawrence Schell *University at Albany, State University of New York*, [lmschell@albany.edu](mailto:lmschell@albany.edu)

Annis Golden *University at Albany, State University of New York*, [agolden@albany.edu](mailto:agolden@albany.edu)

Alex Pieterse *University at Albany, State University of New York*, [apieterse@albany.edu](mailto:apieterse@albany.edu)

Archana Krishnan *University at Albany, State University of New York*, [akrishnan@albany.edu](mailto:akrishnan@albany.edu)

*See next page for additional authors*

*Please contact the following author for an updated version of this work prior to citing it:*

Lawrence Schell

 Part of the Community Health Commons and the Diseases Commons  
University at Albany, State University of New York

[lmschell@albany.edu](mailto:lmschell@albany.edu)

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In April 2020, the University at Albany was asked by Gov. Andrew Cuomo to research why communities of color in New York have been disproportionately impacted by COVID-19. The goal of this research, carried out in partnership with the New York State Department of Health and Northwell Health, is to add to the existing well of knowledge about health disparities in New York State by identifying the environmental, socioeconomic and occupational factors that explain why COVID-19 has disproportionately harmed Black and Hispanic New Yorkers and to propose practical intervention strategies to eliminate these disparities and save lives.

For additional information about this project please see: [www.albany.edu/mhd](http://www.albany.edu/mhd) or contact Theresa Pardo, Special Assistant to the President and Project Director for this initiative at [tpardo@ctg.albany.edu](mailto:tpardo@ctg.albany.edu).

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**Authors**

The Albany Minority Health Task Force, Lawrence Schell, Annis Golden, Alex Pieterse, Archana Krishnan, Masahiro Yamamoto, Elizabeth Holdsworth, Pallavi Khurana, Olivia Mata, Amy Williams, and Hnin Wai Lwin Myo

***Capital Region Collaborative Community Survey Project  
to Document Disparate Impacts of COVID-19***

**Research Team:**

Albany Minority Health Task Force

Lawrence Schell, Distinguished Professor, Departments of Anthropology and Epidemiology

Annis Golden, Associate Professor, Department of Communication

Alex Pieterse, Associate Professor, Department of Counseling Psychology

Archana Krishnan, Assistant Professor, Department of Communication

Masahiro Yamamoto, Associate Professor, Department of Communication

Elizabeth Holdsworth, Ph.D. Candidate, Department of Anthropology

Pallavi Khurana, Doctoral Student, Department of Communication

Olivia Mata, Doctoral Student, Department of Communication

Amy Williams, Doctoral Candidate, Department of Communication

Hnin Wai Lwin Myo, Health Disparities Research Training Fellow, Doctoral Candidate, Department of  
Epidemiology and Biostatistics

## Abstract

The Capital Region Collaborative Community Survey project was undertaken in December 2020-January 2021 to document the social, economic and health impacts of COVID-19 on residents in the Capital Region, particularly in the city of Albany with an emphasis on the impacts on Black and African American (B/AA) communities (n=239). Key findings included B/AA participants reported experiencing general racism or racial discrimination significantly more than other racial groups as did Hispanics. The pandemic impacted employment of Capital Region residents significantly as half of the respondents either lost their jobs or had their hours reduced. B/AA individuals were more likely than others to have both their work hours reduced and increased, which aligns with their status as frontline workers in healthcare, food service, groceries and transportation. B/AA were more concerned about losing housing in the near future. Of respondents with children (n=80) 71% reported that the pandemic had affected their child's emotions very or somewhat negatively with similar percentages reporting that it had affected their child's school work and child's social activities very or somewhat negatively. There were no differences between B/AA and Others (members of all other respondent groups combined) in these domains.

Reported high rates of regular mask-wearing and vaccine intent were promising, although 19% of B/AA individuals were extremely or somewhat unlikely to receive a vaccine vs only 11.8% of Others. Vaccine safety was the most frequent reason for hesitancy among B/AA respondents. Even though the internet and social media were common sources of information, they were not deemed as trustworthy as doctors, state and federal health organizations, and community clinics. Internet access was very high in this sample of Albany residents.

The authors recommend 1) More transparency in communication from public officials; 2) More localization in the distribution of resources – including food, testing, and vaccination; 3) Expansion of community based mental health services and funding of research to determine if there are barriers to

obtaining a primary care provider or physician outside of a lack of health insurance: 4) Funding of research into how individuals access the internet and their online information-seeking behaviors, including barriers to information seeking; 5) Supports to address food insecurity (caused by suspension of subsidized school breakfasts and lunches, and low-quality substitutions; and/or having additional family members in households who had been displaced from their housing), and housing insecurity (e.g., rent support); and 6) Supports for children suffering from isolation, lack of physical activity, and supports for parents to assist children with online learning, including guidance and recommendations on how to best support their child's emotional stability, mental health, and coping strategies.

## Background and Rationale

Reports since April 2020 have consistently identified COVID-19 as disproportionately affecting Black and Hispanic communities in the US, following the common pattern of health disparities in the US. A great deal of national attention has understandably focused on the devastating impact of COVID-19 in the greater New York area, especially among its Communities of Color. Black residents of New York City (NYC) represent 22% of the population but 27% of the fatalities due to COVID-19 for a ratio of deaths to population of 1.27. However, the impact in upstate New York has been even worse according to New York State Department of Health statistics (n.d). At the time of this writing, February 23, 2021, Black residents of NYS outside NYC comprise 13 percent of COVID-19 related fatalities yet are only 9 percent of the population. They are 1.44 times more likely to die of COVID-19 than their representation in the population, far higher than the ratio in New York City. Considering the white population outside of New York City; it constitutes 71 percent of COVID-19 fatalities and yet are 74 percent of the overall population for a ratio of 0.96.

There are many reasons for these disparities, and each one may point to a potential target for intervention and for improvement. Specifically, Black communities may be excessively exposed to COVID-19 and Black individuals are more likely to have one or more of the top 10 comorbidities for COVID-19 fatality (hypertension, diabetes, hyperlipidemia, dementia, coronary artery disease, renal disease, COPD, atrial fibrillation, cancer, or stroke). While these factors may be shared across upstate and downstate settings there are additional factors that are specific to the upstate setting.

Rural areas and small postindustrial cities have higher rates of poverty and unemployment, and more uninsured compared with urban areas (Bennet et al., n.d.). Health inequities in smaller cities and rural areas differ from those in large cities in important ways (Singh, et al., 2014; Rural Health Disparities, n.d.). In larger urban areas, African Americans and Hispanics represent a higher proportion of the population. Blacks and Hispanics comprise only 21 percent of the population in New York State

outside of New York City, compared to 51 percent in New York City. Larger populations make possible greater economies of scale that improve the ability to serve these communities. Consequently, rural areas and smaller cities are less likely to have multisector population health activities, fewer service agencies serving families living in poverty and fewer health-focused nonprofits and minority-serving nonprofits, which provide resources to blunt the pandemic (Mays, et al., 2016).

These situations are exacerbated by the communication gap in these areas. Small cities and rural areas in the Capital Region of New York, like much of upstate New York, have dispersed media. Local radio stations reach rural and small towns, but populations living in these areas are two times as likely as those in urban and suburban areas to never use the internet, with Blacks and Hispanics less likely to be online than non-Hispanic whites (Anderson et al., 2019). Even for those with access, users may find internet resources to be not culturally relevant, and digital literacy may be low. Much online information on available health resources is geared towards metropolitan areas (Bodie, et al., 2008); contributing to individuals in smaller cities and rural areas relying more on informal interpersonal channels of communications, such as health providers, family, and church leaders for health information (Matsaganis, et al., 2015).

An additional factor to consider in upstate New York is the digital divide. The recent COVID-19 pandemic has hastened social systems' dependence on technology, and in the process revealed the stark gap between technology "haves" and "have-nots". A recent survey among 1,000 New Yorkers revealed that low-income and African Americans households had access to only one technology device and a third reported having inadequate internet access (EmblemHealth, 2020). In addition to addressing the traditional divide in technology access, the pandemic has underlined the need to address the gap between "haves" and "lesser-haves". This includes not just granting basic access to technology but expanded access, free or affordable internet access, and digital literacy programs to engage non-adopters with an increasingly ICT society.

In summary, numerous factors impact the health and well-being of persons with low incomes and the Black and Brown residents of New York State outside of New York City. To mitigate the impact of the COVID-19 pandemic it is essential to understand the actions of these factors and their consequences for health and well-being in order to formulate policies that will effectively eliminate COVID-19 disparities.

### **Goals and Design**

This community-engaged research project was undertaken by a team of University at Albany researchers in collaboration with the Albany Minority Health Task Force (AMHTF). The AMHTF is an assemblage of professionals from the Albany community who are concerned with the health status of Communities of Color within the Capital Region. Since 2005 the AMHTF has collaborated with faculty from the University at Albany to facilitate research that reflects the concerns of the local community. The members, who meet on a monthly basis, represent only themselves rather than any employers, agencies or institutions they may be associated with. The AMHTF seeks to identify health issues in Communities of Color from the perspective of its members, encourage research in the community by University at Albany faculty with methods that are scientifically rigorous, culturally appropriate, and that benefits the needs of the communities, and aid in the dissemination of that research to the community. While the AMHTF is affiliated with Center for the Elimination of Minority Health Disparities at the University at Albany, the views of the task force do not necessarily represent those of the University.

This study aims to identify the major sources of COVID-19 exposure, and gaps in resources for underserved, primarily Black communities and neighborhoods in Albany, in order to immediately advocate for the most effective policies and resources to be distributed to these communities, both to ameliorate the effects of COVID-19 on communities and to prevent effects in the future. This study,



while focused on Black communities in Albany, will also contribute to answering national questions about why there are disparities in COVID-19 incidence and outcomes. It will also contribute to answering how these disparities may be shaped by a mid-size city context with some policies in place to address health disparities already (for example, Albany did institute walk-up, fairly-accessible COVID-19 testing within historically underserved, predominantly Black neighborhoods).

The overarching purpose of this survey is to document the disparate health, social, emotional, and economic impacts of COVID-19 in vulnerable communities in the Capital Region. The results of the survey will help to make community voices heard, and support efforts to advocate for resources and policies aimed at prevention and access to care. This evidence can serve as a basis for advocating for resources and policy changes to address these disparate impacts and prevent them in the future. The specific purposes are to:

- Identify particular areas of concern and challenges in coping with the pandemic within a local community context.
- Identify local conditions that increase risk of exposure.
- Identify barriers to enacting protective measures (including social distancing, and the ability to access accurate and relevant health information) and to accessing healthcare services (including testing).
- Identify media and communication technology use patterns and preferred sources of health information about COVID-19.
- Recommend allocation of resources based on evidence and documentation obtained from the survey.

## **Methods**

The project has two components. The first is a survey using the Qualtrics platform. All survey questions were developed in collaboration with the Albany Minority Health Task Force (AMHTF) and researchers from the University at Albany. The survey was developed primarily between the months of April and July of 2020 and reflect concerns in that period. The survey questions and topics are drawn from several existing surveys aimed to assess attitudes, behavior and values of respondents. In, addition, questions were added to focus on particular issues of concern to the community. This was an iterative process in which researchers identified validated scales related to concepts highlighted by the community, and these were further shared with the community for further feedback. After the instrument was developed, it was pilot-tested among 20 graduate students between June and July of 2020.

The survey was administered between December 7<sup>th</sup>, 2020 and January 29<sup>th</sup>, 2021. The survey respondents were recruited through community organizations that serve under-resourced residents and through Facebook advertising aimed at residents of specific zip codes in the city of Albany. Members of the Albany community who visited websites of community organizations or who received information from those organizations were presented with an invitation to take the survey as in-person recruitment was prohibited in the pandemic environment. Those considering the survey could complete it online or by telephone interview. The survey was available in English and Burmese. The on-line survey required approximately 30 minutes to complete. The first 100 respondents received a \$25 gift card to compensate for their time and effort.

From a launch on December 7<sup>th</sup>, 2020 that lasted through January 20<sup>th</sup>, 2021, 275 responses were recorded. On January 21<sup>st</sup>, a participant recruitment campaign was started to include Facebook advertising, where 211 additional responses were received until January 29<sup>th</sup>, 2021. A total of 478 responses were recorded. The open, online format of the survey allowed for parties outside of the city of Albany to take our survey. To ensure that analysis was performed on survey responses taken by city

residents, we applied a validation algorithm to include only those surveys with completion rates of at least 50% with responses that indicated the participant resided in an Albany neighborhood. After application of the validation algorithm, 239 valid responses remained.

In addition to the data gathered through the survey instrument, follow-up semi-structured interviews were conducted with 25 survey participants who had indicated willingness to be contacted for this purpose. An additional \$25 gift card was provided to individuals who participated in follow-up interviews. From among the individuals who volunteered to participate in the follow-up interview, the research team selected 25 individuals who were predominantly Black/African American, consistent with the overall aims of the study, and with as much diversity as possible with respect to age, gender, employment status, and family responsibilities. All interviews were conducted by telephone or online, digitally recorded and professionally transcribed, and imported into the NVivo qualitative data management program for analysis. Interviews averaged 42 minutes in length. The goal of this qualitative data collection was: 1) to provide context and detail to help interpret the results of the survey, supplemented with selected explanatory/descriptive quotes, and 2) for qualitative analysis of common themes regarding COVID-19 impacts generated by the participants themselves, and which might not be captured in the researcher designed survey questions. Interviewees were asked to comment on changes in their daily activities, social relationships, and feelings of well-being; extent of their worries about COVID-19, perceptions of fellow community members' response to COVID-19 risk, changes to work, financial impact, community coping strategies, impact on children (if they lived with children), satisfaction with public response to COVID-19 at the federal, state, and local levels.

Interviewees were predominantly female (n=22) because of the small number of males who expressed interest in participating (n=3). With respect to race/ethnicity (as reflected in their original survey responses), 15 interviewees self-identified as Black/African American, 5 as White, 1 Asian, 2 bi/multiracial, and 2 not recorded. Their age ranged from 21 to 74 with a mean of 43.5 years. With

respect to occupational status, 4 were retired, 12 employed 30-plus hours per week, 2 employed less than 30 hours, 3 were unemployed, and 2 reported being unable to work. The most common employment sector reported was education (n=6), followed by healthcare (n=2), grocery store (n=1), and a variety of “others (n=6). Six participants (all female) reported having children living at home.

The survey and the interview protocols were approved by the Institutional Review Board of the University at Albany and by the Albany Minority Health Task Force.

All results expressed as percentages are the percentage of persons answering that question. Findings from interviews are integrated with the statistical analyses. A summary of recommendations from interview participants as well as from members of the Albany Minority Health Task Force is presented on pages 19-23. When sample sizes allowed, responses among “race” categories (race is used here as a social category with no biological meaning) are compared with t-tests and chi square tests. As Hispanic is not a race category, persons self-identifying as Hispanic could also self-identify as White or Black/African American or any other race category. Hispanic persons are compared to those not self-identifying as such.

## **Results**

The valid sample consists of 137 women and 96 men, as well as 2.1% of other genders. Ninety-two self-identify as Black/African American; 120 as White; 11 as American Indian/African American; 11 as Native Hawaiian or Pacific Island; 7 as Asian and 9 as Other. Forty-one self-identify as Hispanic. The average age of respondents is 34.7 years (Table 1).

Compared to the demographic profile of the city of Albany available from the U.S. Census for July 1, 2019 (U.S. Census Bureau, 2019) which reports race categories as one race with no mixed-race categories (e.g., White alone and Black/African American alone), the participation has developed oversampling of non-White city residents (table 1). Black/African Americans (B/AA), American Indians and Native Hawaiian/Pacific Islanders together comprise 47.7% of respondents compared to 29.2 in the

city itself. Likewise, the percentage of Hispanic identifying respondents is 1.75 times the percentage in the city. The sample does include a lower percentage of Asians (2.9% vs. 6.9%).

	Sample %	City of Albany %
Black/African American	38.5	28.9
White	50.2	55.0
American Indian/Alaskan Native	4.6	0.2
Native Hawaiian/Pacific Islander	4.6	0.0
Asian	2.9	6.9
Other race	3.8	
Male gender	40.3	46.9
Female gender	57.6	53.1
Other gender	2.1	
Hispanic	17.7	10.1
Owner occupied housing	46.9	37.5

Respondents were more often homeowners compared to the percentage of residents reported to own their own homes in the city, according to Census data (U.S. Census Bureau, 2019), whether that home is a single-family house, a two-family house or an apartment or condo. Most people 42% live in a single-family home that they own with 25% living in a rented single-family home. Next most common was a condo or apartment in a multi-unit building. Thirty-three respondents live with children. Most (53%) are employed full time (30 hours/week or more) with the next largest category (17%) being employed part time. There were no significant differences between B/AA and Others (i.e., all other respondents combined) with respect to unemployment at  $\chi^2 (7) = 11.83, p > .05$ , nor were there any differences between Hispanics and non-Hispanics ( $\chi^2 (7) = 6.54, p = 0.48$ ).

## Work

Only 10% of respondents' work was not affected by COVID-19 between mid-March and the end of May, and 16% lost their job. More commonly they had their hours reduced (32%). Some, 11%, were required to work more hours and another 10% changed to work from home. Some B/AAs were more likely to have had both their work hours reduced while others were required to work more hours ( $\chi^2 (5) = 24.88, p < 0.001$ ). Twenty-eight percent of Hispanics lost their job vs. 13% of non-Hispanics. Nineteen percent of Hispanics reported no change in their work vs. 11% of non-Hispanics. When comparing Hispanics to non-Hispanics, they did not differ in terms of changes to their employment. Of those who lost their job, 62% worked in retail, customer service or/and food service.

Of people who lost their job ( $n=116$ ), 16 of 48 Black people (33%) were able to claim regular unemployment benefits as well as the additional \$600 unemployment benefit supplement whereas 50% of non-B/AA were able to do so. Eighteen of 48 B/AA (38%) were able to claim regular unemployment but not the supplement compared to 11 of 68 of non-B/AA (16%). Most importantly 29% of B/AA were not able to claim any unemployment benefit (regular or supplemental) vs. 33% of non-B/AA, a difference that is statistically significant at  $\chi^2 (7) = 7.2, p = 0.03$ , but the difference between claiming any unemployment and none was not ( $t = 0.529$ ). Hispanics and non-Hispanics who lost their jobs did not differ in the proportion who were able to claim unemployment of any kind. Overall, of 237 respondents, 57% had received the government stimulus check, 8% were not eligible and 33% had not yet received the stimulus. There was no statistically significant difference in the proportion B/AA and non-B/AA receiving stimulus checks or deposits. However, Hispanics and non-Hispanics did differ in receiving stimulus checks, 45% vs 55% ( $\chi^2 (3) = 11.0, p = 0.012$ ). Some interview participants, who were predominantly B/AA, who did not receive stimulus payments reported confusion about their eligibility (i.e., thinking they were eligible, but not receiving a payment for reasons that were unclear to them).

Of those who worked at a job site outside of their home from mid-March to end of May, 24.7% were provided with all necessary PPE by their employer and another 45% were supplied with some PPE. Ten percent were supplied with none. Hispanics and non-Hispanics did not differ in being supplied with PPE ( $\chi^2 (3) = 2.2, p = 0.54$ ).

### **The Experience of COVID-19, Including Difficulties with Necessities**

Of 237 respondents, 20% of B/AA reported having experienced symptoms of COVID-19, whereas 27% of non-B/AA had. The group with the highest percentage reporting some symptoms of COVID-19 was Hispanics (35%) while 22% of non-Hispanics reported having some symptoms. The difference between B/AA and non-B/AA was suggestive but was not a statistically significant ( $t = 1.32, p = 0.19$ ) as was the difference between Hispanics and non-Hispanics ( $\chi^2 (1) = 3.3, p = 0.71$ ).

Several effects of COVID-19 were queried. Ninety-three percent of all respondents said they wear a mask or face covering when they leave home. There were no significant differences between B/AA and others, nor between Hispanics and non-Hispanics. However, many interview participants expressed concern about what they observed as widespread failure on the part of individuals in their immediate neighborhood to observe masking and physical distancing recommendations. The discrepancy between these reports and what the survey data suggests may point to a self-selection bias on the part of study participants such that they may be more concerned with the impact of the pandemic than others in their communities. There were no significant differences between B/AA and others in the perceived severity of COVID-19. Likewise, there were no significant differences between B/AA and others in perceived personal risk of getting COVID-19. Most persons had been tested (80.6%) and there also were no significant differences between B/AA and others in the rate of testing. Most people were tested at the UAlbany drive-through (55.5%), followed by the Whitney M. Young, Jr., walk-in site (14.1%), and neighborhood mobile sites (7.3%) but 23% were tested at other types of locations (community care clinic, urgent care, hospital, pharmacy, at work, etc.). Interviewees reported testing

was readily accessible to them and their families. Health literacy, measured on a 5-point scale did not differ between B/AA and others. However, the average health literacy score of Hispanics (3.4) was significantly lower ( $t = 2.6, p = 0.025$ ) than non-Hispanics (3.8).

Several questions assessed access to basic necessities. Forty-three percent admitted that it has been difficult to get food for oneself and their families due to COVID-19 and this proportion did not differ significantly between Black/African Americans and others. Hispanics and non-Hispanics also did not differ in this regard. Forty-seven percent admitted to being somewhat or extremely concerned about being able to afford and obtain healthy food for their families. Interviewees also reported a financial impact in terms of spending more money on food than pre-pandemic, as a result of children being home for all meals (and finding school-supplied take-away food unacceptable), and in some cases having additional family members added to their household who had been displaced from their housing. Over 50% of respondents were concerned about losing their housing. There was a significant difference in concern about keeping housing. Black/African Americans averaged 3.14 ( $SD = 0.93$ ) on a 5-point scale of concern about losing housing in the next few months compared to 2.61, ( $SD = 1.16$ ) for other racial groups ( $t = 3.58, p < 0.001$ ). Hispanics and non-Hispanics differed. Only 17% of Hispanics were not concerned about losing housing whereas 40% of non-Hispanics were not concerned, a significant difference ( $\chi^2 (3) = 9.1, p = 0.03$ ).

### **Health and Well-being, including Children**

Respondents were managing a variety of health conditions. Hypertension was reported most often, followed by other (mental health, cancer, allergies) followed by diabetes and asthma. The effect of COVID-19 on children was assessed also. The effects of COVID-19 were largely negative. Of the respondents with children ( $n = 80$ ), 71% reported that it had affected their child's emotions very or somewhat negatively (no difference between groups); 68.4% reported that that it had affected their child's school work very or somewhat negatively; and 70% reported that that it had affected their child's



social activities including physical activities very or somewhat negatively. There were no differences between Blacks/African-Americans and Others in effects in these domains. Interviewees with children mostly voiced negative impacts of online learning, though a few reported that some of their children actually preferred staying home. More commonly, however, interviewees reported difficulties for their children in keeping up with homework and particular difficulties for children with disabilities. In addition, parents reported stresses for children with asthma in complying with masking recommendations and disruptions to accessing school-based mental health services for their children.

Over 60% of respondents had health insurance. B/AA were significantly more likely to have health insurance than Others. Overall, 46% had a primary care physician who is seen regularly while 41% do not. Fifty-one percent of Whites had a primary care physician and 10% were not sure while 47% of non-Whites did but only 3% were not sure which was a significant difference.

Regarding access to health care services for non-COVID-19 health concerns since mid-March 2021, overall, 28% of respondents disagreed that they had difficulty, while 50% strongly or somewhat agreed that they had difficulty. There were no differences between B/AA and Others. Difficulty in seeking mental health care was reported by 21% of B/AA while 38% of Others did so, which was a significant difference. Both groups reported the same percentage of not needing mental health care. On the other hand, in the interview accounts (from a predominantly B/AA cohort), mental health surfaced as a strong concern for self and others. Some interviewees reported the isolation imposed by pandemic restrictions exacerbated previous problems with depression and lack of adequate mental health services, or lack of knowledge about where to obtain mental health services.

Respondents were asked about their feelings over the past four weeks. Among Whites, 54% felt “very nervous” all the time, most of the time, or a good bit of the time, while for Non-Whites 41% did not, which was a significant difference. On the other hand, when comparing B/AA to non-B/AA, only 29% of the former reported feeling very nervous all the time, most of the time, or some of the time,

whereas 57% of Others reported those feelings, a statistically significant difference. Feelings of “down in the dumps” varied also; 12% of Whites reported this feeling all the time, most of the time or some of the time whereas 27% of non-Whites did. The frequency of feeling “calm and peaceful” did not differ between B/AA and Other, nor did the frequency of feeling “downhearted and blue”, nor feeling “happy”. A significant difference between B/AA and Others was found for the frequency of “feeling so down in the dumps that nothing could cheer you up”: 25.5% of B/AA respondents reported feeling all the time, most of the time, or a good bit of the time, while only 17% of Others reported that feeling so frequently.

### **Trust, Confidence, and Vaccination**

Overall, trust in doctors was moderate, averaging 3.54 on a 5-point scale; there was no difference between B/AA and Others. Respondents trusted doctors more than any other source but only slightly. Trust in state government health agencies was nearly the same (3.52) followed by trust in federal government health agencies (3.45). Substantially less trusted were online media (2.82) and least of all, religious institutions (2.62). Of B/AA, 35% trust federal health agencies while 56% of Others do, a significant difference. Sixty-five percent of B/AA respondents trust religious organizations entirely, a lot or somewhat while 54% of Others do, a significant difference.

Respondents were asked if they heard a lot of conflicting information and were not able to make sense of it. Fifty-six percent of B/AA agreed and 45% of Others did also. This was not a significant difference. Self-reported health literacy scores on a 5-point scale did not differ between Blacks (3.8) and Others (3.7) but did differ between Hispanics (3.4) and non-Hispanics (3.8).

Eighty percent of respondents felt quite or extremely confident in filling out medical forms and there was no difference between Whites and non-Whites in this regard. While 31.7% of all respondents said they would have gotten better medical care if they had belonged to a different race or ethnic group, there was not a significant difference between B/AA and Others. Despite these similarities, B/AA

reported experiencing racism or racial discrimination generally (on a 5-point scale;  $\bar{X} = 2.6$ ,  $SD = 1.08$ ) more than other racial groups ( $\bar{X} = 2.2$ ,  $SD = 1.18$ ); the difference being highly significant ( $t = 2.72$ ,  $p < 0.01$ ). Likewise, 78% of Hispanics reported experiencing racism sometimes, often or always vs. 41% of non-Hispanics, a highly significant difference ( $\chi^2 (4) = 27.3$ ,  $p < 0.001$ ).

The planned likelihood of receiving the COVID-19 vaccine was very high among all respondents: 73.8% said that they were somewhat or extremely likely to receive the vaccine and only 14.5% said they were somewhat or extremely unlikely to receive the vaccine. Using a 5-point scale for likeliness of receiving a vaccine with 5 being extremely likely, Hispanics averaged 3.92 slightly higher than non-Hispanics but not significantly different. However, there was a significant difference between B/AA and Others in vaccine receptivity. B/AA respondents score 3.59 while Others scored 3.99 which was a statistically significant difference ( $t = 2.37$ ,  $p = 0.018$ ). The reasons for not receiving a vaccine differed also although the numbers are quite small. Of 13 B/AA hesitant or resisting a vaccine, only 1 stated it was due to doubts of the vaccine's efficacy whereas among the Others, 10 of 16 stated that reason. On the other hand, 9 of the 13 B/AA gave the reason for resisting the vaccine that they doubted its safety whereas among the 16 in the Other group, only 2 doubted its safety. This was a significant difference ( $\chi^2 (5) = 13.99$ ,  $p = 0.016$ ). Among Hispanics, only three persons answered this question and of those, concern for side effects was the most frequent reason.

Among the interviewees, while some participants welcomed the possibility of receiving the vaccine, others were hesitant though rarely absolutely rejecting the possibility, taking more of a wait and see attitude than refusal. Interestingly, when asked whether they thought getting the vaccine would change their lives and the constraints on activities they currently face, many, even those who expressed intention to get the vaccine, said no – pointing to the possibility of an unexploited avenue for messaging. It has been observed in the press that the effectiveness and usefulness of the vaccines has been undersold by the public health authorities, with too much emphasis placed on what you can't do

after being fully vaccinated and not enough on how it will change your life for the better. This has changed somewhat since the interviews were conducted, with new messaging as of the week of April 5 regarding travel recommendations for fully vaccinated individuals.

In terms of content and channels for messaging in relation to objections/fears about the vaccine, the sources where interview participants report obtaining their information about COVID-19 are potentially instructive. Interviewees voiced similar concerns to those reported by survey respondents as a whole. Fears include reactions to the vaccine, that it is not sufficiently vetted, given the relative speed with which the vaccines were developed, and that they are being used as “guinea pigs” for this – in their view – unproven intervention. Although the survey results reported doctors as the most trusted sources of information about the vaccines and whether it would be safe for them personally, none of the participants reported the intention to actively seek medical advice about the safety of the vaccine, suggesting that such conversations might only take place in the context of medical appointments for other purposes, which in turn means that medical professionals should be advised to make this a part of all visits, much as inquiries about influenza vaccines (have you received your flu shot this year?) are now. In addition, though, proactive outreach by healthcare systems to encourage enrolled patients to obtain vaccines could be helpful (e.g., as St. Peters Healthcare system is doing with their text messaging campaign).

Interview participants reported a strong reliance on and trust in local information, such as news conferences from the Albany County Executive Dan McCoy and Albany County Health Commissioner Elizabeth Whelan, and local television news, whether accessed on air or via the internet on smart phones. Participants also reported strong influence by family members, particularly when those family members had a connection to healthcare, suggesting a role for family members in messaging (e.g., “spread the word – if you’ve been vaccinated, talk with your friends and family members”).

### **Technology Use and Information-Seeking**

With respect to technology access and use, 95% of respondents had access to the internet. Of these, a majority accessed the internet from their own homes (84.8%) and fewer respondents accessed the internet at the homes of friends/family/neighbors (4.3%), community room in apartment building (4.3%), public places with free wi-fi (3.3%) and the library (1.4%). When asked about the impact of the pandemic on their internet access, only a third (34.9%) indicated that their internet access had not been impacted at all. 40% said that their access had been impacted a little or somewhat, and nearly a quarter of the sample (24.8%) said that their internet access had been impacted severely or entirely. While there were no significant differences between B/AA and others in this respect, it begs the question as to why we see such high numbers with internet disruption. Interview results suggest that possibly, the disruption referenced in the survey responses was due to increased costs for upgraded broadband connections required by new work-from-home arrangements and online education for children. Some respondents complained of the strain that this represented for household budgets that were already strained by the need to purchase additional cleaning supplies and masks, in addition to larger grocery bills, as referenced earlier.

When participants were asked to indicate the various reasons they accessed the internet, sending/receiving email ( $\bar{X} = 3.67$ ;  $SD = 1.05$ ), using social media ( $\bar{X} = 3.65$ ;  $SD = 1.02$ ), searching for general information ( $\bar{X} = 3.64$ ;  $SD = 0.96$ ), reading news ( $\bar{X} = 3.57$ ;  $SD = 0.95$ ), and entertainment were the most frequent uses. Of all the health-related uses of the internet, searching for COVID-19 information was the most common use ( $\bar{X} = 3.46$ ;  $SD = 0.99$ ). Overall, the internet was the most common source of COVID-19 information, used by 46.9% of the respondents. This was followed closely by government health organizations (44.4%), television (39.7%), social media (37.7%), friends/family (36.4%). Only a fifth of respondents said that their doctors or community clinics were their primary source of COVID-19 information. Interestingly, however, doctors ( $\bar{X} = 3.54$ ,  $SD = 0.97$ ) were perceived as the most trustworthy source of COVID-19 information on a 5-point scale followed by state health

agencies ( $\bar{X} = 3.52$ ,  $SD = 1.04$ ), federal health agencies ( $\bar{X} = 3.45$ ,  $SD = 1.02$ ) and ( $\bar{X} = 3.40$ ,  $SD = 1.04$ ) community care clinics. Friends/family and social media which were two of the most common sources of COVID-19 information were also judged to be the least trustworthy with low averages of 2.92 ( $SD=1.02$ ) and 2.82 ( $SD=1.05$ ) respectively. When asked about preferred sources of information about COVID-19 vaccines, nearly half of the participants indicated that they would prefer to get this information from their doctors (46.0%) or government health organizations (46.4%). A third (33.1%) indicated that community clinics would be their preferred source and 25.5% indicated the internet as their preferred source for COVID-19 information.

### Recommendations

The following recommendations are grounded in survey results, interview responses, and the assessment of the data by the Albany Minority Health Task Force. The Albany Minority Health Task Force recommends:

- **More transparency in communication from public officials:** Participants felt that information related to the spread of COVID-19, testing and its availability, and vaccines was not shared as widely and expeditiously as it could have been. This means ensuring that NYS entities and agencies that provide direct public health services follow state guidelines and requirements for translating documents, forms, and instructions, including ensuring that physicians have language-appropriate public health information that is assessable in all media forms. This may be achieved by targeting and tailoring public health information and developing culturally inclusive public service messaging in all media for Communities of Color to address vaccine and testing hesitancy and skepticism surrounding efficacy, safety, and ease of access. Messaging should include reminders to the public about their normalized health behavior surrounding other virus-borne diseases controlled in the population or have been eliminated because of vaccines. (e.g., polio, chickenpox, tetanus, shingles, MMR, etc.).

- *As soon as they know, just put the information out there to make people be aware, keep the public – you know, knowledgeable of whatever information we need to protect ourselves, and that’s really all. . . . I feel like people might’ve been sitting on the information a little too long before it became public knowledge. . . . So, I just feel like if it was something that happened, or it was known about prior to March or prior to 2020, coming into 2020, then the public should’ve been aware of it.*
- *Spread the truth, keep it very clear, consistent, have people who know what they’re talking about address it, so a politician should not be talking about the prognosis of the disease because unless that politician is a doctor; that is the only way.*
- ***More localization in the distribution of resources – including food, testing, and vaccination:***  
 Community members without cars, and fearful of public transportation, found it difficult to access these resources. Localization includes reducing the financial impacts and barriers to access related to obtaining PPE, home-testing kits, and other recommended and needed resources addressing at-home safety. Additionally, more funding for research into the relationship between obtaining and utilizing public health services that include vaccinations, testing, or other health supports and the impact of limitations associated with transportation/access to public transportation.
  - *We had to like basically pretty much travel outside the neighborhood to gain access to some of the things that was offered. . . . I think when they have these food drives, I think they should spread them out more like one week one community get it and the next week the other community.*
- ***Expansion of community based mental health services and funding research to determine if there are barriers to obtaining a primary care provider or physician outside of a lack of health insurance:***  
 Participants reported heightened levels of depression, anxiety, and fear and losing access to their mental health support systems.

- *I think they really need to focus on the psychological part, how mentally it affects a lot of people, and then you deal with that accordingly. You know? A lot of people don't understand about depression or they don't know about mental health. They just won't be able to understand.*
- ***Funding research into how individuals access the internet and their online information-seeking behaviors, including barriers to information:*** Respondents reported significant loss and limitations of internet access that could be correlated to several factors, including the monthly cost of cell phone and internet service (financial barriers), low bandwidths, and high-speed broadband being unavailable or too costly. The use of cell phones in obtaining information via the internet can often pose limitations in terms of ability to obtain, moreover complete, documents and forms that would include the location of vaccination sites and the scheduling of vaccination appointments. Participants reported that children learning at home and parents working from home expanded the need for high-speed broadband internet service, which comes with a higher price tag, creating hardship for families with increased expenses in other areas (e.g., cleaning and disinfectant supplies; masks; groceries).
  - *I have access to the internet through Spectrum. I have to have it because of my job and also the kids' school. . . . I used to be able to have the cheap \$20.00 internet, but because I had to work from home and work off a VPN, I had to go to the \$100.00 one.*
- ***Supports to address food insecurity (caused by suspension of subsidized school breakfasts and lunches, and low-quality substitutions; having additional family members in households who had been displaced from their housing), housing insecurity (rent support):***
  - *I think they should do something with the food stamp threshold. My sister, yeah, she works. She doesn't make that much money because she has to pay all her bills. She makes too much money and that's not totally true. So, she can't get food stamps. So, I feel like if you can*



*adjust the limits for food stamps due to the pandemic or whatever case may be or maybe it's for right now just cut those guidelines because people are spending more. Or not even spending more. Just people don't have it.*

- ***Supports for children suffering from isolation, lack of physical activity, and supports for parents to assist children with online learning and ensuring that local government and public health entities provide support, resources, and strategies to parents/guardians who need to participate in their children's online public-school education, including guidance and recommendations to best support their child's emotional stability, mental health, and coping strategies:*** Parents and guardians may find recommendations provided by NYS personally supportive. Additionally, while such decisions like opening schools may be political and must be informed by science, representation by members of impacted, most at-risk communities in the decision making bodies is essential.
  - *I wish there was some kind of more programs. I know you can't be like with COVID a lot. She was going to a program, she has some emotional issues, that she was going to. But because of COVID, it stopped. She would go to it once or twice a week.*
  - *I think some kids might need a little bit of guidance counseling or something on campus because the transition is hard. It's something they've never experienced.*

The Task Force has indicated that for recommendations to enact lasting positive change in addressing health disparities in Communities of Color, all remedies must take a community resilience approach to enable citizens to survive all future health emergencies. This includes examining and reforming all policies that keep Communities of Color in Albany vulnerable and to ensure recommendations are not temporary resolutions or remedies.

The Task Force suggests that these ends are achieved by (a) Conducting periodic comprehensive community assessments to help identify and reinforce factors that can improve health outcomes,

particularly for Communities of Color- both before and after a pandemic, natural disaster, or other health crises; and (b) Creating alliances with existing community partners, community-based organizations, elected officials, planners, health agencies, health institutions, and academic institutions in order to enable action in remedying existing and emerging health disparities in currently vulnerable communities.

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