

# Historically Marginalized Populations Engagement Toolkit

FOR HEALTHCARE SYSTEMS & PROVIDERS



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

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# Historically Marginalized Populations Engagement Toolkit for Healthcare Systems & Providers

This toolkit is a project of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Historically Marginalized Populations (HMP) Workgroup. The group is comprised of over 75 individuals from the following agencies and organizations:

- NC Office of Minority Health and Health Disparities
- Governor’s Council on Hispanic/Latino Affairs
- Governor’s Indian Affairs Commission
- Advocacy Organizations
- Community-based Organizations
- Academic Institutions
- Healthcare Providers
- County Health Departments and Agencies
- Various Divisions within DHHS

NCDHHS would like to thank the various organizations, state and county agencies, and individuals who contributed their time, expertise and feedback.

For questions or comments, contact the NC Office of Minority Health and Health Disparities staff at 919-707-5040 or [NCMinorityHealth@dhhs.nc.gov](mailto:NCMinorityHealth@dhhs.nc.gov).

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# EXECUTIVE SUMMARY

Health inequities and disparities among historically marginalized populations (HMP) in the United States and North Carolina existed long before COVID-19, however the pandemic has spotlighted these glaring problems.

This toolkit is intended as a guide for NC healthcare systems and providers to help ensure HMP are appropriately engaged in all aspects of public health and healthcare delivery – from planning to evaluation, whether emergency preparedness and response efforts or everyday programs and services.

## The toolkit is organized to provide:

- 1) A framework for embedding health equity into organizational infrastructure for long-term reduction in health disparities and improved health outcomes beyond the pandemic.
  - **SECTION I** provides a brief overview of health equity, including the general defining characteristics of a historically marginalized population, an explanation of equity versus equality, and the significance of engaging HMP in all phases of program and service delivery.
  - **SECTION II** recommends organizations establish an HMP Advisory Group to inform the planning, implementation and evaluation of programs and services. Promising practices and example strategies are provided to help guide the development of an effective advisory group. Providers can adopt and/or adapt these strategies based on local needs and organizational capacity.
- 2) Health equity considerations and strategies specific to COVID-19 response efforts.
  - **SECTION III** describes key considerations and barriers to successful vaccine adoption and equitable distribution among HMP and provides example strategies to address them. Recognizing that population demographics, determinants of health and other factors vary across the state, providers should adopt and/or adapt these strategies based on local context.
- 3) Resources (**APPENDIX**) to support health equity infrastructure development and COVID-19 response efforts.

# PREAMBLE

## PUBLIC HEALTH CORE VALUES

Public health professionals and anyone who serves the public are connected and grounded by a shared set of core values. These values underscore all that we do, and while they do not have simple definitions, there are key aspects of each value that are strongly related to principles of health equity.

**Professionalism and Trust:** The effectiveness of public health depends upon **public trust gained** through decisions based on the highest ethical, scientific, and professional standards. Public health gains public trust because its practices are **informed by evidence** and an **ethical framework** to drive decision making.

**Health and Safety:** Public health practitioners have an ethical responsibility to **prevent, minimize, and mitigate** health harms and to **promote and protect** public safety, health, and well-being.

**Health Justice and Equity:** Public health practitioners have an ethical obligation to **promote equitable distribution of burdens, benefits, and opportunities for health**. Health justice and equity also extend to ensuring that public health activities **do not exacerbate health inequities**.

**Interdependence and Solidarity:** Public health practitioners have an ethical obligation to **foster positive — and mitigate negative — relationships among individuals and societies** in ways that protect and promote the flourishing of communities.

**Human Rights and Civil Liberties:** The effective and ethical practice of public health depends upon **social and cultural conditions of respect** for personal autonomy, self-determination, privacy, and the absence of domination.

**Inclusivity and Engagement:** Preventing adverse health outcomes and protecting and promoting the flourishing of individuals and societies requires informed public decision-making **processes that engage affected individuals and communities**.

# SECTION I

## HEALTH EQUITY

Understanding the root causes of population marginalization and consequently the definition of an historically marginalized population (HMP) are critical precursors to understanding the importance of and need for HMP engagement throughout all phases of public health and healthcare delivery.

**Racism** is one of the more pervasive root causes of health inequities in the United States. Structural Violence is a manifestation of racism that is helpful for understanding how the histories of violence, neglect and oppression seen in many aspects of American society are connected and how they have manifested in present-day health disparities.

### Structural Violence

Social arrangements that put individuals and populations in harm's way

- They are structural because they are embedded in the political and economic organization of society
- They are violent because they cause injury to people



“The United States has grappled with a history of racism, and this year we have seen the pervasive injustices built into our system come out in a new way with the COVID-19 pandemic — but they’ve always been there, this is nothing new. The inequalities and inequities in our healthcare system are a reflection of the systemic racism we see in a lot of sectors.

We need to use our time, resources and influence to change the way healthcare is delivered and all services across the board, because it’s not just healthcare that impacts someone’s overall health. There’s so much more and they’re all interconnected — your ability to get a good education, a job, where you live and your zip code we know are important to your ability to live a long and healthy life. We have to look beyond the healthcare sector as we think about these issues.”

– NCDHHS Secretary Mandy Cohen, BCBS of North Carolina Black History Month Townhall 2/25/21

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLoS Med*, 3(10), e449. Accessed 2/9/2021 at [www.ncbi.nlm.nih.gov/pmc/articles/PMC1621099/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621099/)

Nuriddin, A., Mooney, G., & White, A. I. (2020). Reckoning with histories of medical

## SECTION I HEALTH EQUITY

While race and ethnicity have been and continue to be the basis for much of the discrimination and oppression seen throughout society, they are not the only defining characteristics of a historically marginalized population.

Several other communities have also endured longstanding and well documented structural marginalization, and it is important to also acknowledge, engage and consider their unique needs as we strive for health equity.

These communities include, but are not limited to, individuals with disabilities, the LGBTQ+ community, homeless populations, rural communities, and refugee and immigrant populations.

A historically marginalized population is therefore defined as a population that has historically and systematically been denied access to services, resources and power relationships, which has resulted in poor outcomes across the spectrum. They are often identified based on their race, ethnicity, socioeconomic status, geography, religion, language, sexual identity and disability status.

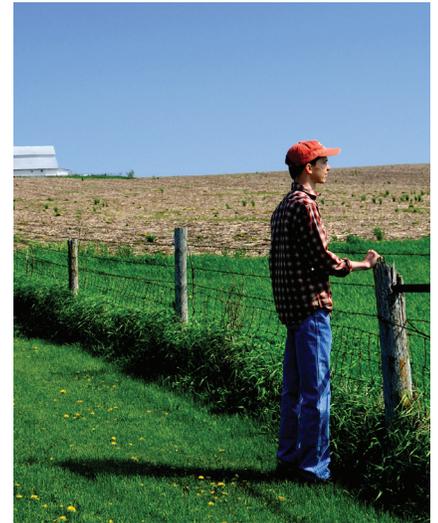
### Historically Marginalized Populations

Individuals, groups, and communities that have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression.

Long standing and well documented structural marginalization has resulted in poor outcomes - health, social, political, economic and overall increased vulnerability to harm.

Historically Marginalized Populations are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status:

- African American/Black
- American Indian
- Immigrant
- Disability
- LGBTQ+
- Veterans
- Latinx/Hispanic
- Asian American
- Refugee
- Homeless
- Rural
- And others...



# SECTION I HEALTH EQUITY

The **intersectionality** of historically marginalized populations and determinants of health is another important concept to understand. Health equity efforts require that HMP be considered not only for their identifying group (i.e., by race, ethnicity, religion, etc.) but for how their community may also be impacted by high rates of poverty, food insecurity, or other known determinants of health. Individuals may also belong to more than one historically marginalized population. For example, Hispanics with disabilities or American Indians living in rural areas.

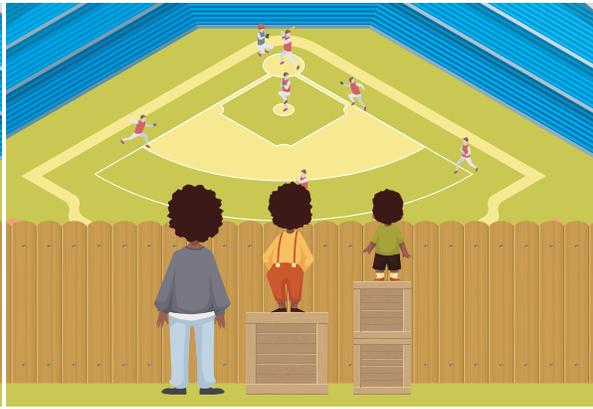
Recognizing how intersectionality compounds the challenges HMP routinely experience will help healthcare systems and providers effectively plan and implement programs and services for these communities.



# SECTION I HEALTH EQUITY

The concept of equity, and therefore health equity, is often misunderstood and confused with equality. This popular graphic illustrates and explains the difference between the two terms and also introduces the concepts of liberation, or justice, and inclusion.

## EQUALITY ≠ EQUITY

	
<b>EQUALITY</b>	<b>EQUITY</b>
The assumption is that the <b>playing field is level, and everyone benefits from the same resources.</b> This is equal treatment.	The reality is that the playing field is not level, and <b>everyone benefits only if they receive the resources they need.</b> This is equitable treatment.
	
<b>LIBERATION</b>	<b>INCLUSION</b>
Everyone has a fair chance without resources or accommodations because <b>the cause(s) of the inequity was addressed.</b> The systemic barrier was removed.	Everyone has a fair chance not only because the systemic barrier was removed, but because they were also <b>involved in the process.</b> This is inclusion.

Adapted from Craig Froehle, PhD - University of Cincinnati, Interaction Institute for Social Change and Center for Story-Based Strategy

### Speed and Equity: Balancing the Scales

How healthcare systems and providers plan for and respond to public health emergencies and general healthcare issues has implications for the populations served. While the inclination may be to quickly find solutions to resolve problems and meet people's needs, a hurried approach to public health and healthcare delivery is likely to overlook key steps and considerations. Health equity is often a casualty of this approach and historically marginalized communities are the most negatively impacted.



- There is a longstanding and growing concern among HMP that they are not a priority.
- Intentional and consistent engagement and inclusion of HMP are necessary in all aspects of public health and healthcare delivery.
- Healthcare systems and providers must earn HMP trust and be willing to meet people where they are.

### COVID-19 Example

North Carolina and vaccine providers faced tremendous pressure as the federal government indicated vaccine allocations might be reduced for states that still had large amounts of supply on hand. NC DHHS leadership acknowledges the conflict this created by prioritizing speed of vaccine distribution over equity of distribution.

**“Speed is critical, but we are also emphasizing equity.”**

– Governor Roy Cooper, Press Release 2/9/21

- Equity must be embedded into all phases of vaccine distribution and other COVID-19 response efforts, including testing and contact tracing.
- Vaccine distribution must meet or exceed county HMP demographics.

# SECTION II

## TIPS FOR SUCCESSFUL HMP ENGAGEMENT

**Achieving health equity requires investing in and directing disproportionate resources, including human resources, to historically marginalized populations.** NCDHHS recognized this early during the pandemic and established an HMP Workgroup to provide recommendations for effective HMP engagement in all aspects of the pandemic response.

The HMP Workgroup has been vital to ensuring health equity is a driving force behind state-level decisions and recommends healthcare systems and providers establish similar advisory groups at the local or regional level.

### RECOMMENDATION

**Healthcare systems and providers should establish an HMP Advisory Group within their organization.**

The purpose of this action is to engage community stakeholders to form strategic partnerships to bring about collective impact and improve health equity. Establishing HMP engagement efforts at a local level confers many benefits:

- **Connecting more directly** to HMP than state level efforts
- Potentially **building on existing local groups or initiatives** that focus on HMP (i.e., Healthy Communities program, Community Health Assessment activities, CLAS initiatives)
- **Building local infrastructure** for improved response to future public health emergencies and general healthcare issues

## SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT

The promising practices that follow are intended as a **guide to establishing an effective HMP Advisory Group**. Over the next several pages, each practice is broken down with example strategies, tips and key recommendations for success. The examples presented are those currently used by the NC DHHS HMP Workgroup and local health departments and do not represent an all-inclusive list of best practices or strategies. Providers should consider local needs and organizational infrastructure and capacity, and adopt or adapt these strategies accordingly.

### PROMISING PRACTICES

Prepare		Foster Environment of Equity
Identify		Identify Health Equity Lead(s)
		Identify HMP Representatives
Organize		Establish Operating Structure
		Establish Accountability
		Develop Communications Plan
Collaborate		Connect with State



**PROMISING PRACTICE:**  
Foster Environment of Equity within the organization.

#### Key Recommendations:

- Assess hiring practices and processes
  - Look at your employee demographics
  - Hire for cultural contribution, not fit
- Assess employee retention
  - At your onboarding process
  - Establish mentoring for new employees, particularly those from underrepresented groups
- Require all employees to participate in annual racial equity and health equity training
- Develop a process for open, continuous feedback from staff, where people feel safe to voice opinions and share ideas without fear of retribution or retaliation

## SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



### PROMISING PRACTICE:

Identify Health Equity Lead(s) within the organization to lead the group.

#### Key Recommendations:

- Be mindful and intentional about advisory group leadership. HMP should not only be represented within the group, but also in the leadership of the group.

#### State Example: HMP Workgroup roles & responsibilities

Team Lead	Lead & set agenda, follow-up on action items, facilitate group discussion and execution of work; communicate with other HMP subgroups and Deputy Director
Champion	Act as a liaison between NCDHHS-level response and HMP group, attending meetings and noting action items to be brought back to HMP group
Goal Lead	Act as lead for an HMP group goal and its related activities, timeline and metrics; determine if activities are being completed and reflected in metrics
SME	Serve as subject matter expert/resource representing a community or population; create content and assist in deliverables related to group's guiding principles

#### Local Examples: HMP Advisory Group roles & responsibilities

Identify the staff member(s) most passionate and knowledgeable about health equity. If no one is available in-house, consider hiring someone with the necessary characteristics and skills.

One person is likely to assume multiple roles and responsibilities within the group.

## SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



### PROMISING PRACTICE:

Identify HMP Representatives from the community to participate in the group.

#### Key Recommendations:

- Advisory Group composition may be unique to each county. However, in addition to African American and LatinX/Hispanic, please ensure representation from state recognized American Indian tribes, Asian American, disability and LGBTQ+ communities, where applicable.

#### State Example

NCDHHS HMP Workgroup originally assembled with HMP representation from DHHS staff only. Using the HMP definition, the group assessed its membership for representation gaps. Connections both internal and external to NCDHHS were then used to help fill these gaps.

#### Local Examples

At a minimum, identify and connect with local faith-based leaders! They are trusted, well connected to the community and typically ready to partner.

Know before you need! Must know (or find out) key HMP leaders in community *before* a problem occurs and maintain relationships after the problem is resolved.

HMP engagement does not necessarily require a single convened group *within* the organization but could also be achieved through consistent representation at HMP community organizations.

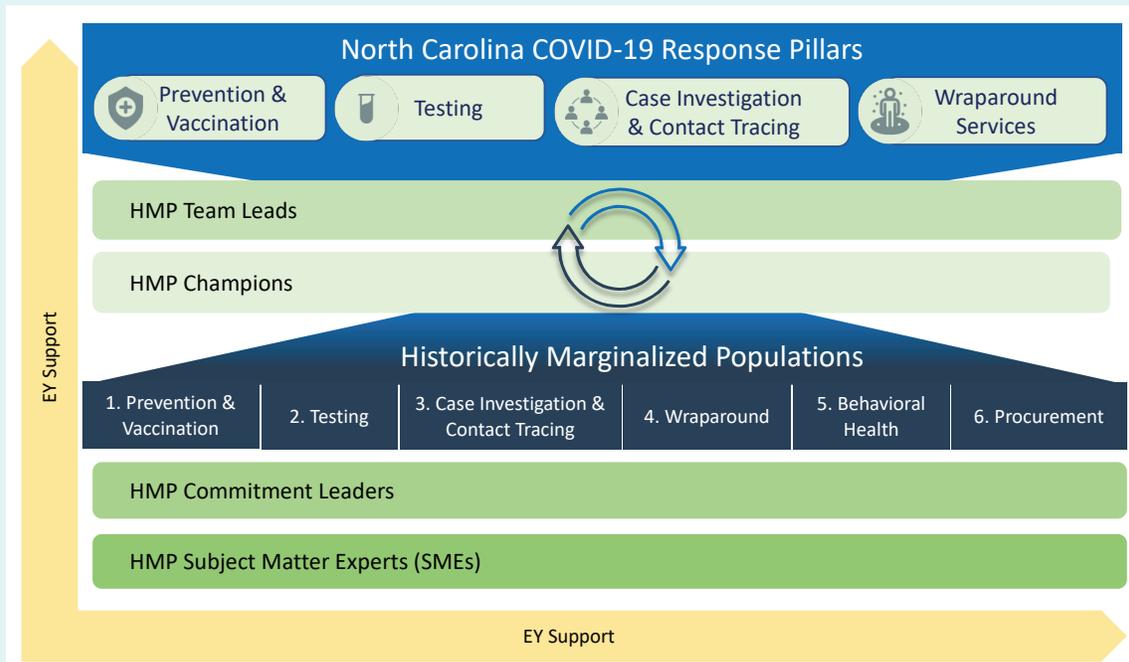
# SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



## PROMISING PRACTICE:

**Establish Operating Structure to efficiently manage the work of the group.**

**State Example:** COVID-19 HMP Operating Structure with 6 HMP sub-workgroups



## Local Examples

### EQUITY TEAM WITHIN ORGANIZATION

Team assesses all health department activities for equity

No distinct sub-workgroups

Team represents the organization at various HMP community organization meetings

Equity teams also within other county and city departments (i.e., public safety, incident command center, joint information center, mayor's office) with which to partner

### EQUITY COALITION EXTERNAL TO ORGANIZATION

Organization staff participate in multi-agency coalition to address issues among vulnerable populations in the county

Taskforces/subgroups within the coalition focus on specific topics or issues

# SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



## PROMISING PRACTICE:

Establish Accountability by setting goals and objectives for the work of the group.

### State Example: Goals & Strategies\*

#### Commitments to achieve HMP vision and mission

1. Prevention	2. Testing	3. Contact Tracing	4. Wraparound Services	5. Behavioral Health	6. Procurement
<ul style="list-style-type: none"> <li>• Create Prevention Messaging: Ensure messaging for prevention is relatable to HMPs and consistent.</li> <li>• Engage Resources: Develop initiatives to broadly engage communities with prevention messaging.</li> <li>• Aid in Vaccine Distribution: Provide resources where needed to successfully engage the various at-risk communities when a vaccine is ready for distribution.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide SARS-CoV-2 Testing: Provide accessible and affordable testing for historically marginalized populations with a data driven and culturally appropriate approach.</li> <li>• Gather information to inform Policy: Be the eyes and ears as to how to funnel up information to the correct stakeholders and policymakers.</li> <li>• Engage HMP Stakeholders: Create an open and inclusive process to engage HMP stakeholders in the design of testing strategies and policies.</li> <li>• Disseminate resources: Provide and disseminate resources and information about COVID testing related policy and initiatives developed by DHHS.</li> </ul>	<ul style="list-style-type: none"> <li>• Outreach to Positive Cases: Provide contact tracing to those who have tested positive with COVID-19 with a data driven approach.</li> <li>• Build Trust and Equity: Engage community leaders to allow intake forms and</li> </ul>	<ul style="list-style-type: none"> <li>• Outreach to Positive Cases: Contact all those who have tested positive to confirm they can safely and successfully isolate for a two-week period</li> <li>• Engage Resources: For those who do not have a safe place</li> </ul>	<ul style="list-style-type: none"> <li>• Raise awareness of BH resources for HMPs: Raise awareness (BH+ schools, PSAs for HMPs, crisis lines, etc.) and provide education to HMP populations.</li> <li>• Crisis and Early Intervention: Mitigate</li> </ul>	<ul style="list-style-type: none"> <li>• Increase Procurement with HMP: Enhance procurement opportunities for minority led and operated entities serving the Historically Marginalized Populations impacted by COVID-19.</li> <li>• Assess current Procurement</li> </ul>

#### Workstream 1: Prevention – Commitments & Tactics

Team Leads: Shaneka Grimes & Jacquelyn Clymore

Purpose Statement: Reach 80% historically marginalized populations in North Carolina to provide access to education and prevention methods.

Commitments	Tactics	Success Criteria
<p><b>1. Prevention Messaging</b></p> <p>Ensure messaging for prevention is relatable to HMPs and consistent.</p>	<p>1. Create or identify public facing culturally, linguistically and developmentally competent content in multiple languages using a variety of venues/platforms to communicate and engage Historically Marginalized Populations (TV, radio, newspaper, website, social media, virtual townhalls, etc.).</p> <p>2. Assess and advise DHHS on content, appearance and dissemination of prevention and vaccination-related information.</p>	<ul style="list-style-type: none"> <li>• All health departments and 50% of state agencies should promote COVID-19 prevention messages</li> <li>• Vaccination rate at least 15% should be achieved for HMPs</li> <li>• Work to engage 50% of community partners within communities of color to be a mask distribution site</li> </ul>
<p><b>2. Engage Resources</b></p> <p>Develop initiatives to broadly engage communities with prevention messaging.</p>	<p>1. Identify and cultivate relationships with community stakeholders and influencers representing Historically Marginalized Populations, including reimbursement for their time and assistance, to help create, disseminate and appraise culturally relevant messages with Historically Marginalized Populations that will support prevention messaging tactics.</p> <p>2. Assess Historically Marginalized Populations needs and interests related to COVID responses at state and local levels and make policy recommendations based upon findings.</p> <p>3. Expand virtual and telehealth services and uptake for chronic disease management and prevention (i.e., smoking cessation, stress management, etc.)</p>	
<p><b>3. Aid in Vaccine Distribution</b></p> <p>Provide resources where needed to successfully engage the various at-risk communities when a vaccine is ready for distribution.</p>	<p>1. Advise NC DHHS strategy and approach to vaccine distribution to ensure HMPs are prioritized.</p> <p>2. Assist in the development of a stakeholder engagement and communication plan for when a vaccine is ready for distribution.</p> <p>3. Review HMP Annex in NC's COVID Vaccine Plan and plan action steps once approved.</p>	



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### Local Examples: Goals & Strategies

Partner with faith-based organizations to implement programs and services in HMP communities

Work with county or organization's Communications Office on appropriate, tailored messaging for different communities

Equitable access to services:

- Reserve set number of appointments for HMPs. Equity team members go into HMP communities to educate, inform and compile list of individuals wanting services.
- Use Community Health Workers (CHW) to identify HMP individuals wanting services and pre-schedule them for appointments. List returned to provider organization for scheduling.

\*See Appendix C for example Activities & Accomplishments from the six state HMP sub-workgroups.

## SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



### **PROMISING PRACTICE:**

**Develop Communication Plan to ensure early, transparent, consistent and frequent communication with the local HMP communities.**

### **Key Recommendations:**

- Develop a process for open, continuous feedback from the community, where people feel safe and empowered to voice concerns and share ideas that improve health equity efforts and outcomes.

#### **State Example**

Regularly updating online resources and dashboards with custom Spanish and other translation options

Presenting educational presentations to community leaders & organizations

Hosting townhall/fireside chat sessions with NC DHHS & trusted community leaders

#### **Local Examples**

Posting weekly online summaries about how health issues are impacting HMP communities

Hosting radio spots and Facebook Live events promoting health programs and services

Visiting churches for discussions with the community

Soliciting feedback from HMP community on organization's communication/outreach efforts

Having the right messenger for your audience!

## SECTION II TIPS FOR SUCCESSFUL HMP ENGAGEMENT



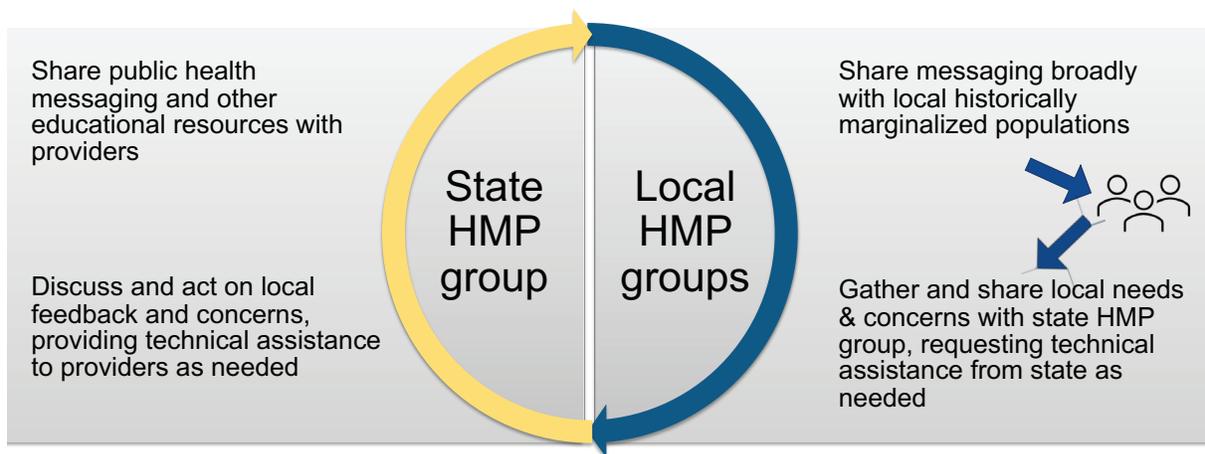
### PROMISING PRACTICE:

**Connect with State HMP Workgroup for helpful resources, assistance engaging local HMP and to share local success stories and strategies.**

### Communication and Support:

#### BETWEEN LOCAL HEALTH EQUITY LEADS AND STATE:

- Request technical assistance on local concerns or challenges
- Share new resources to support local HMP engagement
- Provide local feedback on state resources
- Facilitate sharing of local and state best practices among providers



\*See Appendix E for state HMP Workgroup contact information.

# SECTION III

## COVID-19 VACCINATION ADOPTION & DISTRIBUTION

The goal of the North Carolina COVID-19 Vaccination Plan is to immunize every person living in the state who wants to receive the vaccine. Because historically marginalized populations make up a large proportion of the state population, the plan is guided by six equity-based principles.

**40%**  
of North Carolinians  
from racial & ethnic  
minority groups

### GUIDING PRINCIPLES



All North Carolinians have equitable access to vaccines.



Vaccine planning and distribution is inclusive and draws upon the experience and expertise of leaders from historically marginalized populations.



Transparent, accurate and frequent public communication is essential to building trust.



Data is used to promote equity, track progress and guide decision-making.



Appropriate stewardship of resources and continuous evaluation and improvement drive successful implementation.



Strategies are informed by key stakeholders, including the COVID-19 Vaccine Advisory Committee convened by the NC Institute of Medicine and the NCDHHS Historically Marginalized Populations Workgroup.

This section of the toolkit includes a comprehensive overview of potential barriers to vaccine adoption and equitable distribution among HMP and example strategies and activities to address them. These strategies align with the six guiding principles of the Vaccination Plan. Healthcare systems and providers can tailor strategies and activities based on local demographics, resources and needs.

## SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

NCDHHS leveraged research to inform messaging and communications strategies with a focus on historically marginalized populations. Research results were also intended to help public health officials respect where people are on COVID-19 vaccination, while moving them toward actions that will save lives.

A November 2020 survey of 1,900 North Carolinians revealed 40% of residents were uncertain or unlikely to get the COVID-19 vaccine, even if it were approved by the Food and Drug Administration and available for free. Survey results were weighted to reflect actual population distributions by race, ethnicity, gender and age.

Top 10 Reasons for Vaccine Hesitancy Among respondents uncertain or unlikely to get the vaccine			More commonly reported
1	Vaccine is too new and has not been tested enough	76%	Female, Age 25+
2	Concerned about potential side effects	70%	Female, African American/ Black, Age 25+
3	Want to first know more about how well it works	68%	Female, College+ education, Urban
4	Do not want to be the first to try a new vaccine	60%	Female, Healthcare workers, College+ education, Age 25+
5	Not sure it will work/be effective	45%	Healthcare workers
6	Afraid of getting COVID-19 from the vaccine	35%	African American/Black, HS or less education, Lower income
7	Do not trust the FDA or other federal government agencies responsible for approving the vaccine	34%	African American/Black
8	Not worried about getting the illness, the risk is low	18%	Male
9	Do not like needles/getting shots	15%	
10	Have already had COVID-19 so do not need a vaccine	6%	Under age 45



### Successful strategies for increasing vaccine adoption among HMP...

- are supported by trusted community members to overcome fear and mistrust.
- are built with HMP input & collaboration that is culturally appropriate.
- build confidence that COVID-19 vaccines are for them, safe & effective, accessible and affordable.
- avoid blaming or shaming HMP for their mistrust of healthcare, government or vaccines.
- address necessary beliefs and assurances.



### Prerequisite Beliefs & Assurances

#### Healthcare systems, providers and HMP must believe

- Vaccination is important for everyone
- COVID-19 vaccines are safe and effective
- We all take responsibility for our own health and that of others

#### Healthcare systems and providers must ensure

- Vaccination is affordable and available through trusted sources

Example strategies and activities to address each prerequisite belief and assurance are presented on the next few pages. Providers may adopt and/or adapt these strategies and activities based on local context.

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

## BELIEF: Vaccination is Important for Everyone

### Potential Barriers

Some HMP may think the COVID-19 vaccine is not for them:

- I am not at risk
- Vaccination is not necessary
- The vaccine is for someone else

Historical mistreatment of HMP has resulted in mistrust of government, healthcare and other institutions:

- What are you really trying to do to me?
- I am not a guinea pig

Other local barriers...

### Example Strategies

Use culturally & linguistically appropriate education on the importance, safety and effectiveness of COVID-19 vaccination for everyone, with a special focus on HMP.

Disseminate Vaccine 101 collateral widely so that it is readily available to potentially interested parties (professionals, lay leaders, politicians, other organizations, etc.).

Other local strategies...

### Example Activities

<p>Create and distribute “backgrounders” about the vaccines and the development and distribution process in a simple, concise, and accurate format:</p> <ul style="list-style-type: none"> <li>• In different languages</li> <li>• At different literacy levels</li> <li>• For different cultures</li> </ul>	<p>Budget for:</p> <ul style="list-style-type: none"> <li>• Bilingual support on site or remotely.</li> <li>• Auxiliary communication aids for individuals with disabilities (ie ASL interpreters, TDD).</li> </ul>	<p>Promote town halls and focus groups in a COVID-19 safe environment (ie webinars for face-to-face and on the ground engagement).</p>	<p>Invite community health worker representatives to help develop educational materials and outreach efforts. <b>Funding these resources is key.</b></p>	<p>Consider funding and placing community health workers in community-based organizations to engage HMP. <b>Funding these resources is key.</b></p>
<p>Create a plan to showcase long-term scalable change, not a short-term adhoc crisis response department.</p>	<p>Go beyond traditional places to engage with HMP (i.e., schools, pharmacies, grocery stores).</p>	<p>Showcase vaccine transparency - be clear about benefits, risks, side effects and cost of vaccine; who will be receiving the vaccine first and why; develop clear educational materials.</p>	<p>Earn trust and credibility with HMP by creating services for the community to address needs beyond vaccination (ie behavioral health, job connections).</p>	<p>Other local activities...</p>

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

## BELIEF: Vaccination is Safe and Effective

### Potential Barriers

Historical mistreatment of HMP has resulted in mistrust of government, healthcare and other institutions:

- What are you really trying to do to me?
- I am not a Guinea pig

Misinformation and myths create fear and confusion and impede acceptance of new vaccines:

- I'm afraid that the vaccine is not safe for me and people like me

Other local barriers...

### Example Strategies

Use culturally & linguistically appropriate education on the importance, safety and effectiveness of COVID-19 vaccination for everyone, with a special focus on HMP.

Use community advisory committees to:

- Compile advice on how to encourage folk to get vaccinated
- Decide on locations where vaccinations would be best conducted
- Endorse importance, safety and effectiveness of vaccine

Use HMP influencers to:

- Encourage adoption
- Endorse importance and safety

Other local strategies...

### Example Activities

Involve HMP in creation of vaccine “backgrounders” that:

- Are simple, concise, accurate and at appropriate language & literacy levels.
- Are transparent about potential adverse events such as sickness, disability, hospitalization or death.
- Show diversity in clinical trials.

Share PSAs through a variety of media.

Use trusted sources in collaboration with state and local officials to address fears of deportation among immigrants.

Consider funding and placing community health workers in community-based organizations to engage HMP. **Funding these resources is key.**

Engage key stakeholders (ie community health workers, faith-based leaders) to disseminate materials.

Utilize committees and groups created by the community.

Engage HBCU and PWI scholars to become advisors in the development of communications and community engagement plans.

Engage HMP scholars to help affirm proposed materials.

Make sure community outreach teams reflect the population they seek to engage.

Create pathways for community members to provide feedback.

Create infrastructure to support communities after COVID-19.

Other local activities...

## SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

### BELIEF: We All Take Responsibility for Our Own Health & That of Others

#### Potential Barriers

Systemic discrimination, inequities, and disparities impede ability to achieve health goals for self, family and others.

Low self-efficacy – disbelief that I am or can act to be responsible for my own health.

My health is someone else’s responsibility:

- Powerful people determine my health, for better or worse.
- The state is responsible for my health.

Fatalism – it does not matter what I do, I have no control over what happens to me; whatever will be, will be.

Other local barriers...

#### Example Strategies

Using trusted community leaders, healthcare providers, lay health workers, religious organizations, schools, etc., empower HMP to:

- Combat ambivalence and inertia.
- Overcome fear & helplessness.
- Take control of one’s health, for self and others.

Leverage vaccine acceptance by one family member across the rest of the family and those they influence.

Other local strategies...

#### Example Activities

Socialize that one can take responsibility, even if limited, one step at a time for self, family members and others through modeling and examples of HMP influencers at the community or neighborhood level.

Develop ways for HMP individuals who have been vaccinated to encourage others who have not yet been vaccinated.

Enlist community groups, religious organizations, schools, etc., to help HMP recognize they can be successful in the pursuit of health (ie prevent COVID-19).

Other local activities...

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

## ASSURANCE: Vaccination is Available and Affordable

### Potential Barriers

- HMP may not know or believe that COVID-19 vaccines are to be provided at no cost to them.
- May be surprised or confused about any vaccine administration fees.
- Organizations/locations that are trusted by HMP do not have access to proper vaccine storage, sufficient doses or personnel to serve as vaccination sites.
- Vaccination sites may not be open when HMP are off work or other duties.
- Those who receive only one dose of two-dose vaccines may be under protected.
- Other local barriers...

### Example Strategies

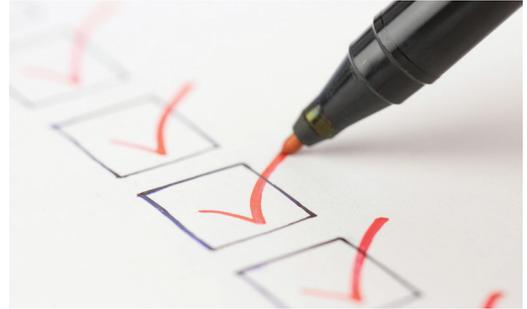
- Ensure vaccines are available:
  - Administer at trusted sites within or easily accessible to HMP communities.
  - Include administration during non-traditional hours.
  - Include proper safeguards for authenticity & storage.
- Ensure vaccination personnel are:
  - Readily available.
  - Trained – technically and culturally.
  - Compensated.
  - Feel prepared and safe.
- Vaccine and administration are affordable or free:
  - Clear, simple and inclusive processes for covering cost/ reimbursement.
- Track those receiving vaccine to:
  - Facilitate receipt of second dose where required.
  - Encourage those who may fail to return as scheduled.
- Other local strategies...

### Example Activities

<p>Involve HMP and healthcare providers, healthcare systems, community health centers, national and local pharmacies and other organizations in vaccine distribution:</p> <ul style="list-style-type: none"> <li>• Support healthcare providers to distribute vaccine in timely manner, follow protocols, and track patients with minimal disruption to their practices, overhead and liability.</li> <li>• Solicit qualified volunteers to assist.</li> </ul>	<p>Make readily available listings of HMP-trusted sites where vaccination can be completed without cost and no or minimal administration fee.</p>	<p>Implement and monitor statewide or local tracking systems for those receiving one of a planned two dose series.</p>	<p>Develop vaccine cost-related collateral (i.e., cost breakdown, FAQs) to share with patients, providers, payers, etc.:</p> <ul style="list-style-type: none"> <li>• May include vaccine cost, administration fees, co-pays, overhead, etc. and how these costs are accounted for through state or federal subsidies.</li> <li>• Sharing this with patients will increase their trust and mitigate surprise billing issues.</li> </ul>
<p>Engage trusted community health workers and Peer Support Specialists as communication linkages between those who lack faith in traditional system.</p>	<p>Engage HMP physicians to disseminate materials to all levels of patients (publicly and privately insured, uninsured)</p>		<p>Other local activities...</p>

### Similar to vaccine adoption, successful strategies for equitable vaccine distribution among HMP...

- are supported by trusted community members.
- are built with HMP input & collaboration that is culturally appropriate.
- ensure access.



### Barriers to Equitable Vaccine Distribution

- Transportation access
- Technology access
- Physical access
- Insufficient outreach
- Communication access
- Information access
- Prioritization challenges

The next several pages present suggested strategies to address these barriers. Again, providers may adopt and/or adapt these strategies based on local context.

One resource available to support many of the suggested strategies is the [Database of Organizations Interested in Hosting or Supporting Vaccine Events](#) located on the NC DHHS COVID-19 website. The organizations listed are able to contribute venues, volunteers, equipment and/or other resources. The list is updated in real-time. Healthcare providers should proactively connect with these organizations to support equitable vaccine distribution.

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 <b>Transportation Access</b>	<ul style="list-style-type: none"> <li>• Mobile vaccination clinics</li> <li>• Large vaccine events specifically targeting HMP communities, held in highly accessible locations</li> <li>• Partner with faith-based and community-based organizations desiring to host and recruit HMP for vaccine events</li> <li>• Engage CHWs and Home Health Agency staff to address accessibility challenges</li> <li>• Host vaccine events on public transit routes when possible</li> <li>• No limitations based on jurisdiction</li> <li>• Promote transportation assistance available through <a href="#">local transit agencies</a></li> </ul>
 Communication Access	
 Technology Access	
 Information Access	
 Physical Access	
 Prioritization Concerns	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Provide materials and auxiliary aids for effective communication (i.e., Spanish resources, qualified language and ASL interpreters, TDD)               <ul style="list-style-type: none"> <li>- <a href="#">Effective Communication with Individuals that Have Hearing Loss in Vaccination Settings Training Video</a></li> <li>- <a href="#">How to Communicate with Your Deaf, Hard of Hearing, or DeafBlind Patient Factsheet</a></li> <li>- <a href="#">Contact a Regional Center for Deaf and Hard of Hearing for consultation, information and referral, outreach and training</a></li> <li>- <a href="#">Clear Mask Resource List</a></li> </ul> </li> <li>• Engage CHWs, Home Health Agency staff, and disability advocacy organizations to address accessibility challenges</li> <li>• Vaccine Navigators               <ul style="list-style-type: none"> <li>- Pending model whereby CHWs are trained specifically on Vaccine 101 and accessing vaccine providers.</li> </ul> </li> <li>• Assess vaccination clinic sites to ensure accessibility for individuals with disabilities. Refer to:               <ul style="list-style-type: none"> <li>- <a href="#">NCDHHS COVID-19 Vaccination Site Accessibility Checklist (English; Spanish)</a></li> <li>- <a href="#">Accessibility at Drive-Thru Medical Sites</a></li> </ul> </li> </ul>
 <b>Communication Access</b>	
 Technology Access	
 Information Access	
 Physical Access	
 Prioritization Concerns	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Engage CHWs and Home Health Agency staff to address accessibility challenges</li> <li>• Vaccine Navigators             <ul style="list-style-type: none"> <li>- Pending model whereby CHWs are trained specifically on Vaccine 101 and accessing vaccine providers.</li> </ul> </li> </ul>
 Communication Access	
 <b>Technology Access</b>	
 Information Access	
 Physical Access	
 Prioritization Concerns	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Work with faith-based and community-based organizations to share accurate and timely information</li> <li>• Partner with faith-based and community-based organizations desiring to host and recruit HMP for vaccine events</li> <li>• Engage CHWs and Home Health Agency staff to address accessibility challenges</li> <li>• Vaccine Navigators               <ul style="list-style-type: none"> <li>- Pending model whereby CHWs are trained specifically on Vaccine 101 and accessing vaccine providers.</li> </ul> </li> <li>• Public reporting, including demographics</li> <li>• No limitations based on lack of personal identification</li> </ul>
 Communication Access	
 Technology Access	
 <b>Information Access</b>	
 Physical Access	
 Prioritization Concerns	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Assess vaccination clinic sites to ensure accessibility for individuals with disabilities. Refer to:               <ul style="list-style-type: none"> <li>- <a href="#">NCDHHS COVID-19 Vaccination Site Accessibility Checklist (English; Spanish)</a></li> <li>- <a href="#">Accessibility at Drive-Thru Medical Sites</a></li> </ul> </li> <li>• Engage disability advocacy organizations, CHWs and Home Health Agency staff to address</li> </ul>
 Communication Access	
 Technology Access	
 Information Access	
 <b>Physical Access</b>	
 Prioritization Concerns	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Reserve a block of appointments specifically for members of HMP               <ul style="list-style-type: none"> <li>- Engage CHWs, care managers, churches and other community partners to fill reserved slots with HMP members</li> </ul> </li> <li>• Utilize extended hours outside of 9am-5pm and weekend appointments</li> </ul> <p>Note: Refer to <a href="#">COVID-19 Vaccine Provider Guidance</a> for the current vaccine allocation methodology.</p>
 Communication Access	
 Technology Access	
 Information Access	
 Physical Access	
 <b>Prioritization Concerns</b>	
 Insufficient Outreach & Targeted Efforts	

# SECTION III COVID-19 VACCINE ADOPTION & DISTRIBUTION

Barriers to Equitable Vaccine Distribution & Access	Strategies to Address Barriers
 Transportation Access	<ul style="list-style-type: none"> <li>• Mobile vaccination clinics</li> <li>• Large vaccine events specifically targeting HMP communities, located in highly accessible locations</li> <li>• Partner with faith-based and community-based organizations desiring to host and recruit HMP for vaccine events</li> <li>• Reserve a block of appointments specifically for members of HMP               <ul style="list-style-type: none"> <li>- Engage CHWs, care managers, churches and other community partners to fill reserved slots</li> </ul> </li> </ul>
 Communication Access	
 Technology Access	
 Information Access	
 Physical Access	
 Prioritization Concerns	
 <b>Insufficient Outreach &amp; Targeted Efforts</b>	

# APPENDIX A

## Training Resources

### HEALTH EQUITY TRAINING & RESOURCES

Available training and resources cover health equity, determinants of health and provide population-specific overviews to highlight the complex intersection of historical trauma, HMP identity and determinants of health.

Contact the NC Office of Minority Health and Health Disparities at 919-707-5040 or [NCMinorityHealth@dhhs.nc.gov](mailto:NCMinorityHealth@dhhs.nc.gov) for more information.

### COVID-19 VACCINE 101 (updated regularly)

The quicker we can get reliable information to those who want a COVID-19 vaccine and those who are hesitant, the faster we can gain control over this pandemic and get back to the people and places we love. This training will help you communicate the safety and effectiveness of approved COVID-19 vaccines and help people find their spot to take their shot.

Contact a State HMP Workgroup member if interested in being trained to use the slide deck or to connect a local community-based organization with a trainer. See contact list in Appendix E.

# APPENDIX B

## NC COVID-19 Vaccination Plan

**HMP ANNEX:** The HMP Annex of the NC COVID-19 Vaccination Plan provides a statewide overview of historically marginalized populations in NC and the recommended considerations for effective engagement in each operational phase of vaccination. It is an example of how health equity was embedded in a public health response effort.



### Annex (A-2): External Relations (Historically Marginalized Populations)

#### Purpose, Scope, and Situation Overview Purpose

To recommend effective strategies and important considerations in order to reach historically marginalized populations (HMPs) with the COVID-19 vaccination.

#### Scope

HMPs in this annex include African Americans, LatinX people, federal- and state-recognized American Indian tribes, Asian Americans, immigrants (regardless of legal status), refugees, LGBTQ+, and people with disabilities.

North Carolina leaders will include state-recognized American Indian tribal leaders and organizations in vaccine rollout planning efforts. Indian Health Service (IHS) will provide vaccination services to the Eastern Band of the Cherokee Indians (EBCI); health/medical facilities will need to work with state authorities to receive vaccination for state-recognized tribes. North Carolina will reach out to the eight non-federally recognized tribes to ensure access to vaccination services, since these groups will not be served by IHS.

#### Situation Overview

**LOCATION:** Statewide considerations for reaching these populations will differ for those in large areas (Charlotte, Raleigh, etc.) vs. the most rural areas where access to any medical care is severely limited.

**DEMOGRAPHIC:** North Carolina HMPs have experienced significant disparities in COVID-19 diagnoses and deaths. At the beginning of the pandemic, African American populations were experiencing disproportionate rates of infections and deaths.

- African Americans make up 22% of the North Carolina population; however, as of April 2020, African Americans accounted for 38% of confirmed and probable COVID-19 cases and 40% of COVID-19 related deaths. Since that time, the disparity in rates of infection has improved and as of October 14, 2020, African Americans account for 23% of cases. However, disparity in deaths, while improved, has continued, with African Americans comprising 30% of COVID-19-related deaths.

## APPENDIX B

- LatinX people are 9.8% of the North Carolina population. Earlier in the pandemic, the LatinX population made up 40% of lab-confirmed COVID-19 cases. While it has improved, significant disparity in infection rates still exists with LatinX populations accounting for 32% of confirmed and probable cases and 9% of COVID-19-related deaths in North Carolina, as of October 14, 2020.
- Alaskan/Native Americans (non-Hispanic) are 1.2% of North Carolina's population; they are 2% of North Carolina COVID-19 cases, and 1% of North Carolina COVID-19-related deaths (as of October 14, 2020).
- Asian Americans/Pacific Islanders (non-Hispanic) are 3.3% of North Carolina's population; they are 2% of North Carolina COVID-19 cases, and 1% of North Carolina COVID-19-related deaths (October 14, 2020).
- All other HMPs are currently captured together: they are 4% of North Carolina COVID-19 cases, and 2.2% of North Carolina COVID-19-related deaths.

Historically Marginalized Populations are more likely to be low-income, primarily uninsured or under-insured, and rural, thus also experiencing structural barriers around transportation, access to medical care and medical homes, and access to social supports. All these barriers put HMPs at higher risk for COVID-19 infection and adverse clinical outcomes due to lack of care.

All of this speaks to the critical importance of prioritization of HMPs in vaccine distribution. Although we do not list race or ethnicity groups as the sole criteria for prioritization, the prioritization of groups by risk of exposure and chronic conditions promotes equity. Historically marginalized populations are disproportionately represented among the prioritized high-risk populations, frontline and high-density occupational setting workforce, and congregate living settings. For example, nationally, African Americans and Latinx people comprise over 40% of long-term care workers. In North Carolina, 51% of homeless people and 52% of incarcerated people are African American. Ninety-nine percent of farmworkers are of Latinx ethnicity.

Farmworkers are critical infrastructure workers and most live in congregate housing. Further, prioritizing essential workers promotes equity. According to a Kaiser Family Foundation survey (May 2020), "Compared to others who are currently employed (most of whom are presumably able to do their jobs from home), essential workers working outside the home are more likely to be Black (15% vs 5%) and have a household income of less than \$40,000 (31% vs 19%)."

However, despite being at higher risk of infection or severe complications of COVID-19, studies and surveys across the U.S. and in North Carolina have clearly shown that there is considerable COVID-19 vaccine hesitancy among HMPs.

A September 2020 WRAL/Survey USA poll found:

- Few North Carolinians (23%) are willing to be vaccinated as soon as a COVID-19 vaccine is released, with black (9%), female (13%), and rural North Carolinians (17%) the least likely.
- There is considerable uncertainty, particularly among black (19%) and rural (21%) North Carolinians who say they are not sure when they would likely get a vaccine.
- A September 2020 poll by Suffolk University/USA Today Network has similar findings:
  - 21% of all North Carolinians, 18% of female North Carolinians, and 7% of black North Carolinians would take a vaccine as soon as they could.
  - 24% of all North Carolinians and 30% of black North Carolinians would not take the vaccine.

The vaccination approach is informed by the historical mistrust of government and the medical establishment, created by centuries of abuse of black and brown people. Due to this history, it will be critical to provide consistent, accurate, and clear information about COVID-19 vaccination and find methods to build trust in communities of historically marginalized people. Special consideration for HMPs must be made, inclusive of outreach, communication, trust, prioritization of these populations when vaccine becomes available, and vaccine accessibility for these populations.

### Concept of Operations

#### A. PHASE 0: PLANNING

##### 1. Build trust:

- a. Explicitly acknowledge the past wrongs perpetuated by governments and healthcare institutions against HMPs in medical settings.
  - i. Based on recommendations from HMP advisors, create a PSA with leading North Carolina government leaders (e.g., State Health Director, Secretary of Health and Human Services) speaking to a trusted HMP medical leader, together in video and print.
  - ii. Partner with the NC Chapter of the National Medical Association (Old North State Medical Society).
- b. Work with Community Health Workers and the Communications team to develop communication plans and messaging.
- c. Be guided by research in understanding barriers, values, and motivations for vaccine uptake across different populations.
  - i. Hold focus groups to gain input regarding effective messaging to gain trust.
- d. Engage trusted community leaders and sources to promote trust.
  - i. Utilize HMP workstreams and External Advisory Committee to identify and invite speakers to host webinars and town hall meetings, utilizing faith-based organizations (FBOs) and others, as necessary.
- e. Lead with transparency with early, frequent, and consistent communication about process and plans.
- f. Enlist and inform community health workers (CHWs) and trusted community leaders to carefully explain key messages described in the communications annex, including:
  - i. What vaccines are and how they work.
  - ii. How vaccines are being tested and approved:
    - How the COVID-19 trials are similar to regular trials (e.g., what processes have changed with Operation Warp Speed and what implications exist).
    - What risks are currently known and how they are outweighed by the benefits, particularly for HMPs who have been critically and disproportionately affected by COVID-19.
    - Describe known adverse reactions and side effects.
    - Include patients that are recovering from COVID to offer personal testimony on the serious potential consequences of the virus and to promote vaccination.
  - iii. How the vaccine will be distributed once available (e.g., the purpose of vaccine administration tracking logs).

2. Build capacity to educate HMPs about COVID-19 vaccine and assist in distributing vaccine to HMPs:
  - a. Work with community health workers, community-based organizations (CBOs), faith-based organizations (FBOs), and leaders to identify and operationalize methods to disseminate vaccine information. Methods will include distributing flyers, sending mass emails, and discussing key messages during virtual meetings or services.
  - b. Educate and update agencies and partners (e.g., General Assembly, academic institutions, cultural advocacy groups) about vaccine, tracking, and trial results within the HMP community.
3. Create messaging: Create or identify public-facing culturally and linguistically competent content in multiple languages using a variety of venues/platforms to communicate and engage HMPs (TV, radio, newspaper, website, social media, virtual townhalls, etc.), ensuring it is inclusive and accessible to those with disabilities.
  - Develop and test messaging with community partners via established focus groups for African Americans, LatinX, Native Americans, Asian Americans, refugees, immigrants, LGBTQ+, and people with disabilities.
  - Develop a cadre of social media influencers to counter misinformation about the vaccine on Facebook, Instagram, and Twitter.
  - Seek photos, video, and personal testimony of HMP leaders, celebrities, and other trusted messengers receiving vaccine as early adopters.
  - Develop a communications and operational plan to respond to a patient having an adverse response to a vaccine to counter negative media and potential resistance.
4. Partner with local health departments (LHDs) and HMP-serving agencies on vaccine planning:
  - a. Identify and invite local HMP-serving organizations and LHDs to convene local workgroups (CBOs, FBOs, etc.) to determine the best way to build trust, add capacity, and deliver vaccine locally. Methods will include holding focus groups, conducting PSAs, and developing other collateral materials for use on social media and other communication venues.
  - b. The established local work groups will help identify vaccine sites for mobile distribution to prioritized populations where HMPs have been clearly identified as both essential workers and as being at great risk for COVID-19 exposure, including but not limited to meat plant and farm workers, community health workers, and cleaning staff and cafeteria workers in hospitals caring for COVID-19 patients. Mobile distribution will be especially critical in rural areas.

### B. PHASE 1: IMPLEMENTATION

1. Release statewide messaging appropriate to each phase of distribution to address trust and vaccine safety, including but not limited to the following organizations/agencies to disseminate to their members:
  - a. Faith-based organizations
  - b. The National Panhellenic Council
  - c. Refugee-serving organizations or organizations that serve historically marginalized communities
  - d. Public and private school-age children in top relevant languages
  - e. Public-serving locations (e.g., driving schools or DMV, post office, voter registration, etc.)

- f. Advocacy organizations (e.g., NAACP, Equality North Carolina, North Carolina Asian Americans Together, etc.)
  - g. Farmworker Advocacy Network
  - h. North Carolina Native American tribal organizations (as referenced by UNC American Indian Center and the North Carolina Commission of Indian Affairs)
  - i. Others, including common businesses that have traditionally served as trusted places of communication and influence such as barber shops, hair salons, and nail salons
2. Mirror/leverage best practices and community partnerships used in North Carolina's Community testing and High priority And Marginalized Populations (CHAMP) testing effort that successfully increased COVID-19 testing among HMPs to bring COVID-19 vaccine to the same geographic areas and populations.
  3. Ensure providers who serve HMPs (e.g., members of Old North State Medical Society) are registered as vaccine providers for early vaccination phases via outreach from professional societies, health systems, targeted emails, and other forms of communication.
    - a. LHDs, community health centers, free and charitable clinics, occupational health providers that serve front-line workers and other agencies
    - b. Stand up identified mobile locations for HMPs in pre-identified areas
    - c. Work with church medical auxiliaries to host vaccination events for members and the community

### C. PHASE 2: ADJUSTMENT

1. As the COVID-19 vaccine becomes more readily available, continue to disseminate messaging regarding phases in vaccine distribution using the modes of communication discussed in Planning.
2. Utilize HMP workgroups to identify sites for community-based mass vaccination clinics that are accessible, convenient, and trusted by HMPs.
3. Continue to phase in access for children in Phase 3, assuming vaccines are approved for those populations.

### D. PHASE 3: TRANSITION

1. As the vaccine becomes routinely available for all groups, develop new campaign of messaging that is culturally relevant, and developmentally and linguistically appropriate, like the annual flu campaign.
  - a. DHHS Communications will work directly with HMP workstreams and community partners to continue public awareness of the availability of the COVID-19 vaccine using established and informal platforms and work groups.
  - b. Reach out to community to create PSAs in multiple languages, with messages delivered by native speakers.

## Organization and Assignment of Responsibilities

### A. ORGANIZATION

#### 1. HMP:

a. DHHS will partner with LatinX, Native American, African American, and refugee organizations to raise vaccine awareness statewide by disseminating information. Organizations will be responsible for disseminating updated information throughout their constituency. Examples of organizations are included below but are not limited to:

- i. Local health departments: North Carolina Association of Local Health Directors
- ii. Faith-based organizations (e.g., North Carolina General Baptist State Convention, AME Zion)
- iii. AMEXCAN
- iv. NAACP
- v. Farmworker Advocacy Network (FAN)
- vi. NC Growers Association
- vii. Agricultural Cooperative Extension
- viii. Blueberry Assoc of NC, NC Sweet Potato Commission
- ix. NC Christmas Tree Association
- x. Agromedicine Institute
- xi. Refugee Community Partners
- xii. Asian Americans Together (NCAAT)
- xiii. Equality NC
- xiv. North Carolina Commission of Indian Affairs and/or the UNC American Indian Center
- xv. North Carolina Council on Disabilities and/or The Arc of North Carolina
- xvi. Panhellenic Council
- xvii. Refugee-serving organizations
- xviii. Schools (public and private)
- xix. Old North State Medical Society

### B. COMMUNICATIONS

As described in Planning: All public-facing communications must be culturally and linguistically competent content in multiple languages using a variety of venues/platforms to communicate and engage HMPs (TV, radio, newspaper, website, social media, virtual townhalls, etc.), ensuring they are inclusive and accessible to those with disabilities. HMP workstreams will be included at beginning of communication planning in an advisory capacity, including engagement of partners listed above and existing groups in the state.

*External Relations (HMP) SME – Minority Health and Health Disparities*

# APPENDIX C

## State HMP Workgroup Activities & Accomplishments

This section presents some of the goals, activities and accomplishments that the six state HMP sub-workgroups used to hold themselves and the state accountable to health equity. These are examples of the type of goals and activities a local HMP Advisory Group may adopt, adapt and/or add to for local health equity efforts.

Covering end of August 2020 through December 2020

### HMP Accomplishments: Prevention (WS1)

#### Advising Vaccine Communications and Outreach to Focus on HMPs

How did WS1 influence the NC COVID-19 Vaccination plan and related communications?



- Development of an HMP annex within the NC COVID-19 Vaccination Plan
- Reviewing and providing feedback on key vaccine resources and communications, such as the Vaccine 101 Deck

#### Dissemination and Promotion of COVID-19 Prevention Guidance

How did WS1 promote Prevention guidance developed by NC DHHS?



- Assistance with development and promotion of Get Behind the Mask PSA videos in 14 languages
- Working with Prevention Pillar to brainstorm dissemination methods for the Private Social Gathering and Get-togethers guidance

#### Driving Increased Availability of Face Masks and PPE for HMPs

How did WS1 enable increased face mask and PPE distribution to HMPs?



- Continuous engagement and provision of PPE to HMP organizations (i.e., NC Farmworkers Program, LatinX outreach vendors, African American outreach vendors, Refugee Resettlement Agencies)

#### Additional List of Accomplishments:

##### Engagement & Communications:

- ▶ Presented to Local Health Departments (LHD) Executives to discuss LHD engagement with HMPs, considering potential communication channels and feedback loops between NCDHHS HMP and LHDs
- ▶ Connecting with UNC/Duke physicians heading vaccine trial work and members of IQVIA to engage them via our HMP Standup
- ▶ Private social gathering guidance shared with the National Pan-Hellenic Council of Greater Raleigh and multiple LatinX groups (i.e., Boricuas en NC, Wakandan Queens, La Cuarentena NC)
- ▶ Promotion of Thanksgiving and Holiday Prevention guidance

##### Advising Vaccination and Prevention Pillar Communication Efforts and Decisions:

- ▶ Participation in ongoing Vaccination meetings, such as CVMS Sprint planning discussions to assist with prioritization of Spanish translation
- ▶ Leveraged HMP standup to obtain team insights for overcoming barriers to HMP involvement in clinical trials
- ▶ Identified potential budgetary/funding needs for vaccine planning, such as translation & interpretation costs
- ▶ Identified and added LatinX faith-based organizations to master listing being assembled by Prevention team for faith leaders tool kit rollout
- ▶ Identified and provided a list of cultural celebrations to the Prevention Pillar, for consideration regarding dissemination and communication of social gathering guidance
- ▶ Recommended that information from the Vaccine 101 deck be broken-down into digestible social media messaging that can be disseminated by HMP workgroup
- ▶ Creation of *Community Organization Resources* flyer and email template to facilitate outreach to partners in red (priority) counties, promoting free PPE and dissemination of COVID-19 informational resources

Covering end of August 2020 through December 2020

## HMP Accomplishments: Testing (WS2)

### Advising the NC COVID-19 Testing Response

How did WS2 **advise testing efforts** as part of the NC COVID-19 Response?



- Development of Barriers to High Test Volumes Slide Deck and COVID-19 Testing Site Accessibility Checklist
- Signage recommendations for testing sites

### Driving Partnerships & Cross-Workstream Synergies

How did WS2 **promote engagement with external partners and community-based organizations** for testing?



- Engagement of partners, such as Union Baptist, The Good Shephard and La Semilla, for testing events
- Sharing NC DHHS COVID-19 guidance and resources with partners and testing vendors

### Promoting a Data-Driven Approach

How did WS2 enable the **use of data for insights and decision-making**?



- Ongoing feedback on interactive vendor testing dashboards
- Completion of CBO demographic analysis for priority counties

### Additional List of Accomplishments:

#### Engagement to Support Testing:

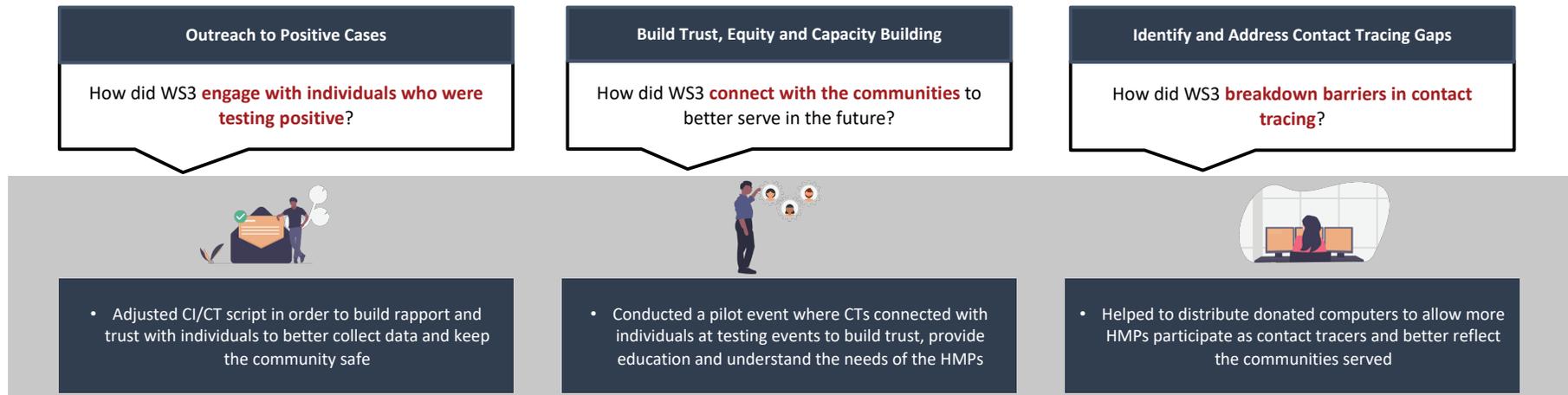
- ▶ Partnered with UNC Chapel Hill's Research Outreach Prevention Education (ROPE) team to assist with DHHS testing promotion and education for Thanksgiving Surge Testing
- ▶ Connected with Carolina Business Alliance for testing event support
- ▶ Partnered with LATIN-19 and Duke Bass Connections Mobile testing team to connect with CBOs, and provide testing event organization and support
- ▶ Worked with UPOH and contacts with ties to Elizabeth City State University to foster potential support for testing events
- ▶ Informed LGBTQ centers of free COVID testing opportunities and how to get connected for COVID testing partnerships (via LHD or DHHS)
- ▶ Held meeting with Positive Wellness Alliance to discuss whether we can leverage their services to include testing, contact tracing, wraparound services and behavioral health
- ▶ Onsite participation at La Semilla testing event, providing COVID-19 education and assisting with the provisioning of PPE and food to HMPs
- ▶ Collaborative efforts with Contact Tracing and CHWs to promote NC DHHS resources and collateral at testing events

#### Advising Testing Pillar Efforts and Decisions:

- ▶ Open communication with NC DHHS leaders, providing transparent community feedback and flagging challenges
- ▶ Met with Optum and StarMed to discuss CBO engagement and to emphasize the importance of (1) weekend & evening testing availability and (2) faster turnaround times
- ▶ Provided recommendations for updates to the Secret Shopper Survey
- ▶ Collaborated with Testing Pillar on potential farmworker testing pilots
- ▶ Attended Coffee Corner with NCFHP outreach workers to obtain testing insights from those working "on the ground"
- ▶ Partnered with retail associations for holiday surge testing, advising testing site location decisions in order to reach HMPs

Covering end of August 2020 through December 2020

## HMP Accomplishments: **Contact Tracing (WS3)**



### Additional List of Accomplishments:

#### Data Driven:

- ▶ Generated data-driven insights by confirming that race/ethnicity data is broken out into program-level metrics
- ▶ Advised updates to the COVID-19 Community Team Outreach (CCTO) tool to assure data and reporting includes both unreached
- ▶ Shared race/ethnicity data during community communications and engagements

#### Aligning Technology:

- ▶ Assisted in securing internet access for HMP Case Investigators (CIs) /Contact Tracers (CTs)
- ▶ Provide licensing fee relief to CCTO for HMP communities

#### Building Trust and Community Support:

- ▶ Building trust and community support through feedback session with farmworkers/growers to leverage existing ground leaders to introduce contact tracers and build trusted relationships as well better coordinate timing to reach farmworker populations
- ▶ Ensured HMP representation on LatinX, AA/Black, and Faith-based engagement calls in order to build trust and community support through these connections and relationships

#### HBCU Engagement:

- ▶ Incorporating equity in strategic development by leveraging Historically Black Colleges and Universities (HBCUs) for feedback in exposure notification development
- ▶ Outreach to HBCUs to promote SlowCovidNC exposure notification app toolkit
- ▶ Recruited additional HBCUs through direct relationship building
- ▶ Addressed HBCUs concerns around current bandwidth for contact tracing efforts and data concerns by decreasing admin burden with the tool
- ▶ Successfully bringing on four (4) additional HBCUs

#### HMP Communications:

- ▶ Provide HMP lens to contact tracing collateral including a scenario infographic, a contact tracing overview and contacts worksheet and update to "Be the One" which targets black and brown audiences to "Be the One to Answer the Call"
- ▶ Consolidated collateral on contact tracing for distribution at testing events
- ▶ Created SlowCOVID app banners for promotion at HBCU-based testing events

Covering end of August 2020 through December 2020

## HMP Accomplishments: **Wraparound Services (WS4)**

### Outreach to Positive Cases

How did WS4 **apply cultural and linguistic sensitivity** to work toward equitable outreach?



- Identified Spanish-language gap and assisted the drive to translate in NCCare360 tool & training materials to better reflect communities served
- Assisted in promoting the hiring of bilingual speakers to assist with training CHWs

### Engage & Connect Resources

How did WS4 support CHWs in their work and HMP communities **through cross-workstream collaboration**?



- Shared informational content on behavioral health resources in training playbook to support CHWs
- Support services food drives to include distribution of PPE and holiday guidance

### Assist in Completing Isolation

What did WS4 do to connect at the program-level to **broaden reach**?



- Input into strategic decision-making for coordination of COVID relief to expand reach
- Developed non-congregate sheltering (NCS) webinar focusing on rural populations and other webinars and training in Spanish and English

### Additional List of Accomplishments:

#### Data Driven:

- ▶ Provided feedback on the non-congregate sheltering (NCS) survey to understand the statewide status of NCS programs, inclusive of potential barriers and support needs

#### Population-specific Pursuit of Health Equity:

- ▶ Determine NCS strategy prioritization for HMP and farmworker communities including how to assess individuals before entering state and entering the work space

#### Increasing Access:

- ▶ Promoted telehealth as primary care option that is covered by updating comms for Support Services Program (SSP)
- ▶ Hired additional call center navigators to answer NC211 calls and to support counties not covered via the Community Health Worker (CHW) program
- ▶ Assisted in securing additional funding to continue support services into end of year
- ▶ Assessment of remaining gaps as it pertains to program-level Wraparound moving into 2021

#### Community Outreach:

- ▶ Provided context around historically marginalized populations and on the CHW, SSP and NCS programs
- ▶ Provided technical assistance and offered financial resources & support across all counties on NCS and Wraparound Services

#### Culturally sensitive application to materials:

- ▶ Improved social needs assessment aspects in CI/CT script
- ▶ Helped in creating guidance on how to set up non-congregate sheltering as well shared contacts for resources
- ▶ Identifying next steps for audio and visually impaired support for the CHW program

#### Cross Workstream Collaboration:

- ▶ Cross-collaboration partnerships to bring CHWs to testing events to promote support services and offerings
- ▶ Introduced crossover training opportunities for case investigation, contact tracing and community health work at a CHW vendor meeting

#### Support for CHWs:

- ▶ Raised challenges for HMPs and questions to be discussed at the monthly CHW and Support Services Meeting to influence vendor management such as confirming PPE safety procedures for CHW and provisioning of PPE to residents

Covering end of August 2020 through December 2020

## HMP Accomplishments: Behavioral Health (WS5)

### Increasing Accessibility to Resources

How did WS5 ensure that marginalized communities had **access to additional resources**?



- Gathered various resources for Intellectual and Developmental Disabilities (I/DD) communities and overall Mental Health Resources (including, substance-abuse, local organizations, etc.) to publish on the DHHS site

### Increasing Peer Support in Communities

What did WS5's **partnership with United Partners of Health (UPOH)** accomplish?



- Through the UPOH Partnership, DHHS was able to address unmet healthcare needs of historically marginalized communities
- UPOH added 25 peer support specialists to the existing community

### Engaging HMP Communities

How did WS5 make sure **we are reaching those** in need of mental health resources?



- Through engagement with UPOH mobile sites and CHAMP 2.0 Testing Sites, Behavioral Health engaged with different HMP communities to broaden their scope

### Additional List of Accomplishments:

#### Youth Engagement:

- ▶ Creation of text message-based Hope4NC line to increase youth user-base
- ▶ Development of online chat-based Hope4NC line to increase youth user-base
- ▶ Collection of community-partners that target youths for partnership

#### Expansion of Inclusion:

- ▶ Inclusion of Sexual Orientation and Gender Identity (SOGI) questions in intake process for FQHCs

#### Partnerships and Collaboration:

- ▶ Increased collaboration and developed partnership with Camino
- ▶ Developed faith-leaders roundtable conversations to better execute on-ground engagement

#### Campaigns and Resources:

- ▶ Published "Hope is on the Line" Campaign, along with specifically targeting advertisements to youth viewers
- ▶ Distributed Behavioral Health collateral at UPOH Mobile Food Sites to drive engagement

Covering end of August 2020 through December 2020

## HMP Accomplishments: **Procurement (WS6)**

### Increasing Accessibility to Resources

How did WS6 **socialize department resources** available to community business organizations?



- Creation of Procurement Toolkit that consolidated resources for the application processes, available resources, and trainings for community organizations looking to get funding



### RISKS

- ▶ Procurement lacks a co-lead that poses a risk to the transition of the 2021+ period
- ▶ Procurement workstream lacks participation and momentum

# APPENDIX D

## Communications Toolkit

### ONLINE RESOURCES (regularly updated)

The NCDHHS Communications Toolkit and Video Library provide a variety COVID-19 materials that can be readily shared with the local community.

[Video Library](#)

[Custom Spanish language website & resources](#)

[Bilingual flyers, postcards, FAQs & Social media graphics](#)

The collage displays various communication materials from the NCDHHS COVID-19 toolkit. It includes screenshots of the 'Video Library' section, a Spanish language website titled '¡VACÚNATE!' with the text 'PROTÉGETE A TI Y A LOS DEMÁS', and several bilingual flyers and social media graphics. One flyer says 'When you get your COVID-19 vaccine, your PRIVACY and PERSONAL information are PROTECTED at all times.' Another says 'Friday Facts COVID-19 Vaccine' and 'Yes, and it is safe. The vaccine works to protect against future infection.' A large graphic at the bottom says 'PROTECT YOURSELF, FAMILY AND COMMUNITY. Get a safe, effective and free COVID-19 vaccine.'

# APPENDIX E

## State HMP Workgroup Contacts

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NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**