

**Impacts of COVID-19 in New York's Capital Region:
A View from the Local Community on the Socioemotional Experience of the Pandemic**

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Abstract

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. This study examined the impact of the COVID-19 pandemic and subsequent shutdowns on the Black/African American community in the City of Albany. The present report focuses on the socioemotional impact of the COVID-19 pandemic, grouping data from a Qualtrics survey (N = 238) and interview accounts (N = 25) into three areas: (1) the impact on work and consequently on food and housing security; (2) anxieties directly connected with the virus itself; and (3) self-reports of respondents' mental health and the socioemotional impact on their children. The concluding recommendations are grounded in interview responses, survey results, and the assessment of the data by the Albany Minority Health Task Force in the context of their knowledge of the local community.

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 of New York State, specifically in the City of Albany. Particular emphasis was placed on documenting any disparities in impacts on Black and African American communities (B/AA), as they were consistently being identified as disproportionately affected by COVID-19. With the active participation of the Albany Minority Health Task Force (AMHTF) – a group of professionals from the Albany community concerned with the health of Communities of Color within the Capital Region, an interdisciplinary study team including faculty and doctoral students disseminated a comprehensive survey ($N= 239$) cataloging healthcare utilization, social relationships, demographics, job and living conditions, technology access, information-seeking, and impact of COVID-19; and conducted 25 follow-up interviews with survey participants. This report focuses on findings related to the socioemotional impact of the pandemic and their implications.

Background and Rationale

Reports since April 2020 have consistently identified COVID-19 as disproportionately affecting Black and Hispanic communities in the US, following well documented patterns of health disparities in the US (Artiga 2020). A great deal of national attention understandably focused on the devastating impact of COVID-19 in the greater New York area, especially among its Communities of Color.

There are many reasons for the disparities, and each one may point to a potential target for intervention and for improvement. Specifically, B/AA communities may be excessively exposed to COVID-19 through employment in public facing occupations and reliance on public transportation, and Black individuals are more likely to have one or more of comorbidities for COVID-19 fatality (Barranco, Holtgrave and Rosenberg 2020). 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 (Bennett, Olatosi, and Probst 2008). Health inequities in smaller cities and rural areas differ from those in large cities in other important ways as well (Singh and Siahpush 2014; Rural Health Information Hub, n.d.). In addition, in larger urban areas, African Americans and Hispanics represent a higher proportion of the population. Blacks and Hispanics comprise only 21% of the population in New York State outside of New York City, compared to 51% 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 impact of the pandemic (Mays, Mamaril, and Timsina 2016).

These factors are exacerbated by the communication gap in these geographic regions. 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 B/AAs and Hispanics less likely to be online than non-Hispanic whites (Perrin and Atskae 2021). 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, Golden, and Scott 2014).

In summary, numerous factors impact the health and well-being of persons with low incomes and the B/AA and other minority 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.

Study Goals and Design

This community-engaged research project was undertaken by 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.¹

The overarching purpose of this study is to describe the impact of the COVID-19 pandemic on the social, emotional, and economic well being of residents of the City of Albany, and to assess possible disparities in these domains. The results of the survey were intended help make local community voices heard, and support efforts to advocate for resources and policies aimed at disease prevention while improving access to care. This study, while focused on Black communities in Albany, New York, also contributes to answering national questions about why there are disparities in COVID-19 incidence and outcomes. It also contributes to answering how these disparities may be shaped by a mid-size city context with some policies already in place to address health disparities (for example, accessible walk-up COVID-19 testing within historically underserved, predominantly Black neighborhoods). A full report on this collaborative project, including the final recommendations, was distributed to officials in city and county governments, in the hope that it would help inform decisions about distribution of resources from the American Rescue Plan.

Our research questions serve to organize the description and analysis, focusing on possible disparities by race (as a social category only) between B/AA residents and all other racial identities (Others):

1. What were the economic impacts of the pandemic, specifically in housing and food insecurity, access to government support (unemployment benefits and stimulus checks), and changes in employment, and did they differ by race?
2. What COVID-19-related preventative behaviors did participants undertake and did they differ by race?
3. How great were perceptions of risks associated with COVID-19 and COVID-19-related anxiety, and did they differ by race?
4. What were respondents' perceptions of self and family (including children) physical and mental health, and did they differ by race?

Research Procedures: Data Collection

This collaborative community engaged project has two data collection components, a survey administered through the Qualtrics platform, and follow-up interviews with 25 survey respondents. All survey questions were developed in collaboration with the AMHTF and researchers from the University at Albany, primarily between the months of April and July of 2020, thus reflecting greatest concerns during that period. Survey development was an iterative process in which researchers identified validated scales related to concepts highlighted by the community, and selected items that were then shared with the AMHTF for further feedback.² Major areas addressed by survey questions included demographics (housing, cohabitants, employment, health status, age, gender, race, ethnicity), experiences of COVID-19 and precautionary measures, income impact, concerns about children, community connections, information access, ability to access healthcare, food and housing security.³ The survey was pilot-tested among twenty graduate students before launching.

The survey was administered between December 7th, 2020 and January 29th, 2021. Respondents were initially recruited through community organizations that serve under-resourced residents. Individuals who visited websites of community organizations or who received information from those organizations were presented with an invitation to take the survey, either online or by telephone interview (in-person recruitment and survey administration was prohibited by the University IRB in the pandemic environment). The survey was available in English and Burmese. The on-line survey required approximately thirty minutes to complete. The first 100 respondents received a \$25 gift card to compensate for their time and effort. From December 7th, 2020 through January 20th, 2021, 275 responses were recorded. On January 21st, Facebook advertising was added, aimed at residents of specific zip codes in the City of Albany that are home to the city's most vulnerable populations, and 211 additional responses were received through January 29th, 2021. A total of 478 responses were recorded. The open, online format of the survey allowed parties outside of the City of Albany to take the 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% and with responses that indicated the participant resided in an Albany neighborhood. After application of the validation algorithm, 239 valid responses remained. One participant who did not report racial or ethnic identity data was removed from this analysis, resulting in an analytic sample of 238 participants.

In addition to the data gathered through the survey instrument, follow-up semi-structured interviews were conducted with 25 survey participants selected by the research team from among individuals 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. Consistent with the overall aims of the study, these participants were predominantly B/AA, and selected 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, 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) and satisfaction with public response to COVID-19 at the federal, state, and local levels.⁴

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.

Research Procedures: Data Analysis

Statistical Methods

In addition to descriptive statistics, we conducted tests of differences in relevant survey responses between categories of B/AA and all other racial identities (race is used here as a social category with no biological meaning) designated "Others." As Hispanic is not a racial category, persons self-identifying as Hispanic could also self-identify as white, B/AA, or any other racial category. Student's t-tests or Welch t-tests were applied to ordinal and continuous data, depending on whether groups had significantly different variances based on a Levene's test. Chi-square tests were applied to categorical data. As a supplementary analysis to account for possible socioeconomic factors, we conducted multiple linear regression models with racial categories (B/AA vs others), home ownership (owned vs. Not owned), and employment status (full-time employment vs. not fully employed with those ineligible for work excluded). Standardized beta coefficients are presented in tables. Traditional measures of socioeconomic status were not included in the survey as being too invasive and discouraging of participation, so home ownership and full-time employment status are used as surrogate measures. Regression models were applied to all binary and ordinal variables of interest, with any not applicable responses (ex: "don't know" or not needing the services referenced) excluded. Given the importance of socioeconomic factors on many of these variables, we note significant associations between home ownership and employment status with dependent variables in the regression models.

Significant differences were determined as $p < 0.05$. All results expressed as percentages are the percentage of persons answering that question. Findings from interviews are presented in the text together with the statistical findings they pertain to.

Qualitative Data Analysis

Our analytic process for the 25 interview transcripts began with "index coding" (Deterding and Waters 2018) of the entire body of interviews using the NVivo qualitative data analysis program. Coding used 17 major content areas identified by the first author as being consonant with the main topics addressed by the interview guide and that accounted for the content of responses that participants produced. The topical categories most relevant to the research questions that guide the analysis reported on here were, accessibility of goods and services, government supports, housing (in)security, impact on children, preventive measures and risk management, fear of COVID-19 and personal connection to COVID-19, impact on work, and recommendations for future public response to COVID-19. Using NVivo to extract all coded references to these index codes, and guided by Owen's (1984) principles of recurrence (of meaning), repetition (of key phrases), and forcefulness (of expression), summary sentiments were formulated, and exemplar quotes were selected for inclusion in the results presented here.

Results

Sample Characteristics

The survey sample consists of 137 women and 96 men, as well as 2.1% of participants identifying as an other or non-binary gender (Table 1). Ninety-two self-identify as B/AA; 120 as white; 11 as American Indian/African American; 11 as Native Hawaiian or Pacific Islander; 7 as Asian and 9 as “other”. Forty-one self-identify as Hispanic. The average age of respondents is 34.7 years.

Compared to the demographic profile of the City of Albany (U.S. Census Bureau 2019), we oversampled non-white city residents (Table 1). B/AAs, American Indians/Alaskan Natives, 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%).

Table 1
Sample versus City of Albany Demographic Profile

| | Sample (%) | City of Albany (%) |
|----------------------------------|------------|------------------------|
| Race and ethnicity: | | |
| B/AA | 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 | * |
| Hispanic | 17.7 | 10.1 |
| Gender: | | |
| Male | 40.3 | 46.9 |
| Female | 57.6 | 53.1 |
| Other/non-binary | 2.1 | no City of Albany data |

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 respondents (42%) live in a single-family home that they own, with 25% living in a rented single-family home. Next most common was a rented or owned condo or apartment in a multi-unit building (18%). Eighty-one respondents live with children (34%). Most (53%) are employed full time (30 hours/week or more) with the next largest category (17%) being employed part time. In all tests of differences on demographic variables, B/AA respondents were not significantly different from Others, including differences in owning vs. renting housing ($p=0.454$), except for mean age of B/AA respondents significantly higher than Others' mean age (Table 2).

Table 2

| | Other (N=146) | B/AA (N=92) | p-value |
|--|---------------|-------------|--------------------|
| Gender | | | 0.602 ¹ |
| Woman | 84 (57.5%) | 53 (57.6%) | |
| Man | 60 (41.1%) | 36 (39.1%) | |
| Other | 2 (1.4%) | 3 (3.3%) | |
| Age (years) | | | 0.036 ² |
| Mean±SD | 33.4±10.8 | 36.8±12.3 | |
| Hispanic or Latinx | | | 0.765 ¹ |
| Yes | 24 (17.1%) | 17 (18.7%) | |
| No | 116 (82.9%) | 74 (81.3%) | |
| Language preferred for health information | | | 0.166 ¹ |
| English | 143 (97.9%) | 92 (100.0%) | |
| Spanish | 3 (2.1%) | 0 (0.0%) | |
| Housing type | | | 0.731 ¹ |
| Single family home or apartment - own | 63 (43.4%) | 37 (40.2%) | |
| Two family home own | 6 (4.1%) | 3 (3.3%) | |
| Apartment/condo in a multi-unit building own | 2 (1.4%) | 0 (0.0%) | |
| Single family home or apartment - rented | 35 (24.1%) | 24 (26.1%) | |
| Two family home rented | 12 (8.3%) | 9 (9.8%) | |
| Apartment/condo in a multi-unit building rented | 24 (16.6%) | 16 (17.4%) | |
| Other | 3 (2.1%) | 3 (3.3%) | |
| Have children at home | 43 (29.5%) | 38 (41.3%) | 0.579 ⁴ |
| Current employment status | | | 0.346 ¹ |
| Unemployed | 28 (19.2%) | 11 (12.0%) | |
| Employed ≥ 30 hours/week | 78 (53.4%) | 48 (52.2%) | |
| Employed < 30 hours/week | 21 (14.4%) | 19 (20.7%) | |
| Unable to work | 3 (2.1%) | 3 (3.3%) | |
| Retired | 3 (2.1%) | 6 (6.5%) | |
| Student with no additional job | 3 (2.1%) | 1 (1.1%) | |
| Student with additional paid job | 10 (6.8%) | 4 (4.3%) | |
| Current employment sector | | | 0.188 ¹ |
| Education | 25 (22.9%) | 11 (15.5%) | |
| Health care | 17 (15.6%) | 14 (19.7%) | |
| Grocery store | 9 (8.3%) | 17 (23.9%) | |
| Food service | 12 (11.0%) | 5 (7.0%) | |
| Other | 46 (42.2%) | 24 (33.8%) | |

Cell entries are count (%) or mean±SD. Counts may not add up to total n for category due to missing responses or not applicable questions. Percentages are based on total valid responses for that category. Ordinal scores are indicated with (#) next to the response option.

¹Pearson's Chi-squared test, ²Welch t-test, ³t-test with equal variances assumed, ⁴Chi-squared test for given probabilities, ⁵In regression models, home ownership significantly associated with

variable, ⁶In regression models, employment status significantly associated with variable.

Interviewees were predominantly female (n = 22) because of the small number of males (n = 3) who expressed interest in participating. With respect to race/ethnicity (as reflected in their original survey responses), 15 interviewees self-identified as B/AA, 5 as white, 1 as Asian, 2 as biracial/multiracial, and 2 as not recorded. Ages ranged from 21 to 74 with a mean of 43.5 years. With respect to occupational status, 4 were retired, 12 employed thirty-plus hours per week, 2 employed less than thirty 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 following results, drawing on data from the Qualtrics survey and the interview accounts, are grouped into three areas: (1) the impact on work and consequently on food and housing security; (2) anxieties directly connected with the virus itself; and (3) self-reports of respondents' mental health and the socioemotional impact on their children.

Impact of the Pandemic on Work and Life Necessities (Food/Shelter)

Income reduction from complete job loss or reduced hours has been a well documented effect of the pandemic, disproportionately impacting Communities of Color across the U.S., and contributing considerable stress to these individuals' mental health (Donnelly and Farina 2021). Moreover, this economic insecurity contributes to cascading impacts on food and housing insecurity and associated mental health effects (Fitzpatrick, Harris and Drawve 2020). Consistent with this national picture, and with reports on COVID-19 mental health impact in New York State more specifically (New York State Health Foundation 2021), only 10% of respondents' work was not affected by COVID-19 between mid-March and the end of May, and 16% lost their job (Table 3). More commonly they had their hours reduced (32%). Some (11%) were required to work more hours, and another 27% changed to work from home.

B/AA participants significantly differed from Others on whether COVID-19 had impacted their work. More B/AAs reported having their work hours reduced and being required to work more, while a lower proportion of B/AA respondents reported their work changing to work-from-home. Of all respondents who lost their job, 62% worked in retail, customer service and/or food service.

B/AAs also significantly differed from Others on whether they were able to claim unemployment benefits, with fewer B/AAs able to claim regular unemployment benefits with the additional \$600 COVID-19 relief payment. Correspondingly, more B/AAs were able to claim regular unemployment benefits without the supplemental payment compared to all others.

Most 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 of B/AA and non-B/AA receiving stimulus checks or deposits. 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). One participant expressed frustration stating, "And the stimulus check in particular bothered me just because I wasn't actually eligible for it despite the fact that I totally should've been because I pay my own taxes."

Economic insecurity can contribute to food and housing insecurity, though the pandemic also created food insecurities separate from the ability to pay. Forty-three percent of respondents reported it had been difficult to get food for oneself and their families due to COVID-19, and this proportion did not differ significantly between B/AAs and Others. B/AA respondents did not differ from Others in reporting concern about being able to afford and obtain healthy food for oneself or family for the next month. In regression models, home ownership was significantly associated with more difficulty getting food and more concern about obtaining healthy food for the next month ($\beta = -0.161$ and $\beta = -0.168$) and not being fully employed with more difficulty getting food ($\beta = -0.226$), suggesting that socioeconomic status was a more significant contributor to food insecurity than race.

Table 3

| | Other (N=146) | B/AA (N=92) | p-value | Regression β (p-value) |
|--|------------------|----------------|--------------------|---------------------------------|
| Impact on employment mid-March to end of May 2020 | | | 0.003 ¹ | |
| I lost my job | 26 (18.4%) | 9 (10.8%) | | |
| My hours were reduced | 39 (27.7%) | 33 (39.8%) | | |
| I was required to work more hours | 12 (8.5%) | 12 (14.5%) | | |
| My work changed to work-from-home rather than going to a physical location | 49 (34.8%) | 12 (14.5%) | | |
| There was no change in my work | 10 (7.1%) | 13 (15.7%) | | |
| Other | 5 (3.5%) | 4 (4.8%) | | |
| Able to claim unemployment benefits | | | 0.033 ¹ | |
| Yes, I was able to claim regular unemployment plus the additional \$600 from the COVID-19 relief | 33 (49.3%) | 16 (33.3%) | | |
| Yes, I was able to claim regular unemployment only | 11 (16.4%) | 18 (37.5%) | | |
| No, I was not able to claim any unemployment benefits | 23 (34.3%) | 14 (29.2%) | | |
| Received stimulus check (or direct deposit) from the government | | | 0.397 ¹ | 0.082 (0.245) ⁶ |
| Yes | 79 (54.5%) | 55 (59.8%) | | |
| Not yet | 49 (33.8%) | 30 (32.6%) | | |
| Not eligible | 13 (9.0%) | 7 (7.6%) | | |
| I don't know or I prefer not to answer | 4 (2.8%) | 0 (0.0%) | | |
| Difficult to get food for self or family due to COVID-19 | | | 0.637 ¹ | -0.054 (0.46) ^{5,6} |
| Yes | 59 (44.0%) | 33 (40.7%) | | |
| No | 75 (56.0%) | 48 (59.3%) | | |

| | | | | |
|---|------------|------------|----------------------|---------------------------------|
| Concern about being able to afford and obtain healthy food for self and/or family for the next month | | | | -0.069 (0.35) ⁵ |
| Extremely concerned (1) | 34 (25.4%) | 14 (17.5%) | | |
| Somewhat concerned (2) | 41 (30.6%) | 27 (33.8%) | | |
| A little concerned (3) | 29 (21.6%) | 15 (18.8%) | | |
| Not at all concerned (4) | 30 (22.4%) | 24 (30.0%) | | |
| Mean±SD | 2.41±1.10 | 2.61±1.10 | 0.194 ³ | |
| Worry about losing housing in the next few months | | | | -0.248 (<0.001) ⁵ |
| Extremely worried (1) | 33 (24.8%) | 5 (6.3%) | | |
| Somewhat worried (2) | 29 (21.8%) | 13 (16.5%) | | |
| A little worried (3) | 31 (23.3%) | 26 (32.9%) | | |
| Not at all worried (4) | 40 (30.1%) | 35 (44.3%) | | |
| Mean±SD | 2.59±1.16 | 3.15±0.92 | < 0.001 ² | |

Refer to Table 2 for footnotes key.

Interview responses indicated that reasons for difficulty getting food may be due to inaccessible locations of grocery stores and food pantries, concern about safety in groceries, as well as multiple financial responsibilities that escalated during COVID-19. One interviewee observed a lack of access to food in their immediate area: “You would have to take two or three buses to get there. And there always seems to be a delay in effect like with getting food when they be passing it out. I don’t remember one ever being in our immediate area actually,” while another noted the trade off between affording food versus paying for childcare: “I’m spending the money that we do have on childcare to the extent where I don’t really have anything else for food.”

Interviewees also reported a financial impact in terms of spending more on food than pre-pandemic, sometimes as a result of children being home for all meals (and finding school-supplied take-away food unacceptable), and sometimes through having additional family members added to their household who had been displaced from their housing. Interviewees also reported perceptions of higher prices: “I mean, everything got way more expensive, so I had to get another job that paid more money so I could still afford like groceries.”

Most respondents (65%) were worried about losing their housing, which has been identified as an important consequence of job loss or insecurity and in turn linked to psychological stress (Donnelly and Farina 2021). Interview responses suggested that worries about losing housing were due to reduced work hours or losing one’s job. As one interview participant distressingly stated, “I can’t work no more. I can’t pay my rent on time like I used to.” B/AA respondents were significantly less worried about losing housing in the next few months, even after accounting for employment status and home ownership. In the regression model, homeowners were significantly more worried about losing their housing ($\beta=-0.170$), compared with those in non-owner-resided properties, accounting for race and employment.

Direct and Indirect Experience of COVID-19: Pandemic Anxieties

Fears associated with becoming infected with the virus and fears raised through direct and indirect experience of COVID-19 have been widely linked to psychological distress (e.g., McGinty et al. 2020). Twenty percent of B/AAs reported having experienced symptoms of COVID-19, whereas 27% of non-B/AAs had, a non-significant difference (Table 4). However, almost all interviewees reported knowing multiple individuals who had contracted the virus and consistently expressed being emotionally impacted by the news of diagnosis. One interviewee told a story of how COVID-19 impacted the mother of a friend: “She’s not on oxygen right now, so that’s good, but she’s very weak and she really can’t do a lot. She was a big cook, and with being in the kitchen all the time, she really can’t stand for long periods of time to be able to do that. So, that’s been sad.” Many interviewees knew individuals who had not recovered, and expressed grief compounded with a sense of unfairness: “I get a phone call, and my first cousin who’s in New Jersey had COVID, and she’s dead. And we’re the same age, and it’s not fair.” Interviewees expressed their anxieties over the uncertainty of getting sick: “It’s kind of scary because you never know who has it,” and spoke of exacerbated pre-existing mental health problems: “I suffer from anxiety without the pandemic. So, it just takes my anxiety into high gear, and I’m very paranoid, and very, very cautious, very just scared.” Some interviewees had been infected themselves, with one participant reporting having such severe kidney damage that she now required regular dialysis, and its emotional, as well as physical toll: “It’s difficult because everything is brand-new to me. So I cry. I cry. . . . I cry every night before I go to bed because it’s difficult.”

Additional anxieties were reported in connection with perceptions of risks posed by community members’ failure to observe recommended precautionary behaviors. Ninety-four percent of respondents said they wear a mask or face covering when they leave home, with no significant differences between B/AA and Others. However, many interview participants expressed concern about what they observed as widespread failure on the part of individuals in their immediate neighborhood to observe physical distancing recommendations, and especially recommendations related to masking. One interviewee noted, “You definitely see a lot of young people without them [masks]. I think they think they’re invincible or something. And I’ve seen older people also [not wearing masks]. Even like at the bus stops.” Participants described feeling that others in their community did not, and continued not to, take recommendations seriously: “But people even now, you go in the corner store, people don’t have masks on. People are all up on my kids. Like what happened to the six feet? Like nobody’s respecting other people’s personal space and stuff, which is why I try to stay in the house.”

The discrepancy between these reports and what the survey data suggests about protective behaviors may point to a self-selection bias on the part of study participants such that those who agreed to participate in interviews may be more concerned with the impact of the pandemic than others in their communities and have a desire to speak out. There were no significant differences between B/AAs and Others in the perceived severity or perceived personal risk of COVID-19, even accounting for socioeconomic status in regression models. However, home ownership was associated with greater perceived severity and personal risk ($\beta=-0.275$ and $\beta=0.184$) and full-time employment with greater personal risk of COVID-19 ($\beta=-0.150$). Interviewees, though, expressed their concerns about the virus in powerful terms, talking about being “scared to death to be outside,” and “being in panic of being out around people” because of what they perceived as the lack of concern on the part of other community

members: “I really think a lot of these people around here think that they’re invincible or that it’s not real because when it was summertime, they were just having barbecues and all kinds of out in the street, packed up on each other, and it would make me so angry.”

Most persons had been tested (81%), with no significant differences between B/AAs and Others. Home owners were significantly more likely to be tested than non-home owners ($\beta = -0.154$). Most people were tested at the University at Albany drive-through (56%), followed by the Whitney M. Young, Jr. Health Center walk-in site (14%), and neighborhood mobile sites (7%), but 23% were tested at other types of locations (e.g., community care clinics, urgent cares, hospitals, pharmacies, at work). A notable, though not significantly different, larger percentage of B/AA respondents were tested at other locations and a smaller percentage at the University at Albany drive-through site compared to Others. Interviewees reported testing was readily accessible to them and their families.

Table 4

| | Other (N=145) | B/AA (N=92) | p-value | Regression β (p-value) |
|--|------------------|----------------|--------------------|---------------------------------|
| Experienced symptoms of COVID-19 in past few months | | | 0.198 ¹ | -0.058 (0.416) |
| Yes | 39 (26.9%) | 18 (19.6%) | | |
| No | 106 (73.1%) | 74 (80.4%) | | |
| Wear a mask/face covering outside the home | | | 0.097 ¹ | 0.138 (0.053) |
| Yes | 132 (91.0%) | 90 (97.8%) | | |
| No | 10 (6.9%) | 2 (2.2%) | | |
| Yes, depending on the situation | 3 (2.1%) | 0 (0.0%) | | |
| Perceived Severity of COVID-19 (1=strongly disagree, 5=strongly agree) | 4.14±0.88 | 4.08±0.97 | 0.596 ³ | -0.011 (0.88) ⁵ |
| Personal Risk of COVID-19 (1=strongly disagree, 5=strongly agree) | 3.40±0.96 | 3.48±1.04 | 0.529 ³ | -0.028 (0.69) ^{5,6} |
| Received COVID-19 testing | | | 0.961 ¹ | 0.030 (0.672) ⁵ |
| Yes | 117 (80.7%) | 74 (80.4%) | | |
| No | 28 (19.3%) | 18 (19.6%) | | |
| COVID-19 testing site used | | | 0.054 ¹ | |
| UAlbany drive-through testing site | 73 (62.4%) | 33 (44.6%) | | |
| Whitney Young walk-in site | 15 (12.8%) | 12 (16.2%) | | |
| Neighborhood mobile walk-up site | 9 (7.7%) | 5 (6.8%) | | |
| Other, please specify | 20 (17.1%) | 24 (32.4%) | | |

Refer to Table 2 for footnotes key.

Health and Well-being

Study participants were also asked to report on the impact of the pandemic on their own mental health and well-being and that of their children, and their ability to access health care services. Regarding access to health care services for non-COVID-19 health concerns since mid-March 2020, overall, 28% of respondents disagreed that they had difficulty, while 43% strongly or somewhat agreed that they had difficulty. There were no differences between B/AAs and Others, even accounting for socioeconomic status (Table 5). A slight majority of respondents (51%) delayed or decided not to seek healthcare services because of concerns about COVID-19, which was not significantly different between B/AAs and Others, even when participants who did not need to go to a doctor’s office or medical clinic were excluded ($p=0.713$). B/AA respondents were significantly less likely to report difficulty accessing mental health care when excluding those who did not need to access mental health care during this time ($p=0.020$), though this was not significant after accounting for socioeconomic status (not being employed full-time was significantly associated with more difficulty accessing mental health care, $\beta=-0.182$). Both groups reported a similar percentage of not needing mental health care (32% of Black/-American respondents and 29% of all others). 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, for example: “I’m concerned about probably just that I don’t fall deeper into depression. You know what I mean? . . . I don’t wanna do that. So, I’m concerned that this is affecting me to a point where I just become unable to just function like normal.” The discrepancy between the quantitative and qualitative data regarding seeking and finding mental health care may be attributable to self selection into the interview cohort, such that those indicating willingness to speak to the interviewers may have been strongly motivated by a desire to voice concerns with different aspects of the pandemic’s impacts on them. It could also be due, though, to participants in the larger survey sample simply not knowing where to begin the process of seeking services, particularly in the context of the pandemic restrictions, and thus not even attempting it.

| | Other (N=140) | B/AA (N=84) | p-value | Regression β (p-value) |
|---|------------------|-------------|--------------------|---------------------------------|
| Difficulty accessing healthcare services for non-COVID-19 related health concerns since mid-March. | | | 0.469 ¹ | -0.011 (0.887) |
| Strongly disagree (1) | 14 (10.0%) | 7 (8.3%) | | |
| Somewhat disagree (2) | 25 (17.9%) | 17 (20.2%) | | |
| Neither agree nor disagree (3) | 32 (22.9%) | 13 (15.5%) | | |
| Somewhat agree (4) | 42 (30.0%) | 35 (41.7%) | | |
| Strongly agree (5) | 14 (10.0%) | 6 (7.1%) | | |
| I have not needed to access healthcare services for non-COVID- | 13 (9.3%) | 6 (7.1%) | | |

| | | | | |
|---|------------|------------|--------------------|-----------------------------|
| 19 related health concerns since mid-March | | | | |
| Mean±SD, excluding those who did not need to access healthcare | 3.13±1.18 | 3.21±1.14 | 0.672 ³ | |
| Delayed or decided not to go to the doctor's office or medical clinic because of concerns about COVID-19 | | | 0.148 ¹ | 0.009 (0.906) |
| Yes (1) | 70 (50.0%) | 44 (52.4%) | | |
| No (2) | 50 (35.7%) | 35 (41.7%) | | |
| I have not needed to go to the doctor's office or medical clinic for any reason | 20 (14.3%) | 5 (6.0%) | | |
| Difficulty accessing mental health care and appointments since mid-March | | | 0.061 ¹ | -0.147 (0.079) ⁶ |
| Yes (1) | 52 (37.4%) | 19 (22.6%) | | |
| No (2) | 47 (33.8%) | 38 (45.2%) | | |
| I have not needed to access mental health care or appointments during this time | 40 (28.8%) | 27 (32.1%) | | |

Refer to Table 2 for footnotes key.

Respondents were asked about the frequency of their feelings over the past four weeks (Table 6). B/AA respondents were significantly less frequently nervous or downhearted and blue compared to Others, even accounting for socioeconomic status. There were no significant differences in frequency of feeling calm and peaceful, happy, or so down in the dumps that nothing could cheer them up. In the multivariate analyses, homeownership was significantly associated with less frequent feelings of nervousness. Being employed less than full-time was associated with more frequently feeling downhearted and blue ($\beta=-0.162$) and less frequently feeling happy ($\beta=0.181$).

Table 6

| | Other (N=139) | B/AA (N=83) | p-value | Regression β (p-value) |
|--|------------------|----------------|--------------------|---------------------------------|
| Frequency of feeling very nervous in the past 4 weeks (1=all of the time, 6=none of the time) | 3.31±1.35 | 3.83±1.43 | 0.007 ³ | -0.166 (0.020) ⁵ |
| Frequency of feeling calm and peaceful in the past 4 weeks (1=all of the time, 6=none of the time) | 3.78±1.21 | 3.85±1.44 | 0.728 ² | -0.052 (0.479) |
| Frequency of feeling downhearted and blue in the past 4 weeks | 3.62±1.26 | 4.05±1.23 | 0.014 ³ | -0.209 (0.004) ⁶ |

| | | | | |
|--|------------|------------|----------------------|--------------------------------|
| (1=all of the time, 6=none of the time) | | | | |
| Frequency of feeling happy in the past 4 weeks | 3.57±1.12 | 3.55±1.31 | 0.932 ³ | 0.027 (0.714) ⁶ |
| (1=all of the time, 6=none of the time) | | | | |
| Frequency of feeling so down in the dumps that nothing could cheer you up in the past 4 weeks | 4.48±1.07 | 4.24±1.53 | 0.222 ² | 0.117 (0.110) |
| (1=all of the time, 6=none of the time) | | | | |
| Was there ever a time when you would have gotten better medical care if you had belonged to a different race or ethnic group? | | | 0.156 ¹ | 0.076 (0.298) |
| Yes | 38 (27.1%) | 33 (39.3%) | | |
| No | 77 (55.0%) | 34 (40.5%) | | |
| Don't know | 21 (15.0%) | 13 (15.5%) | | |
| Refuse to answer | 4 (2.9%) | 4 (4.8%) | | |
| Over the past 6 months, how frequently have you experienced racism or racial discrimination? | | | | -0.203 (0.004) ⁶ |
| Never (1) | 63 (43.8%) | 17 (20.0%) | | |
| Rarely (2) | 24 (16.7%) | 15 (17.6%) | | |
| Sometimes (3) | 33 (22.9%) | 34 (40.0%) | | |
| Often (4) | 23 (16.0%) | 17 (20.0%) | | |
| Always (5) | 1 (0.7%) | 2 (2.4%) | | |
| Mean±SD | 2.13±1.17 | 2.67±1.08 | < 0.001 ² | |

Refer to Table 2 for footnotes key.

Interviewees' accounts did not reflect these survey findings, but did highlight other feelings, commonly reporting that they felt "scared," "isolated," and "disconnected," sometimes shading over into anger: "It's tiring. That – my life has changed a lot. And I'm really tired of it. And I'm angry. I'm very angry." This variation between the quantitative and qualitative data may reflect the difference between the opportunity for literally voicing one's feelings to an interested listener compared with a more impersonal online survey.

While survey responses did not reflect significantly more negative emotional states on the part of B/AA respondents using the items above, they did reflect a significantly greater experience of racism. A greater proportion of B/AA participants reported that there was a time when they would have received better medical care if they had belonged to a different race or ethnic group compared to Others, which was a significant difference when participants responding "don't know" or "refuse to answer" were excluded ($p=0.031$). B/AA participants also reported experiencing racism or racial discrimination significantly more frequently than Others, even after accounting for socioeconomic status. Not being employed full-time was also associated with reports of more frequent racism ($\beta=0.173$).

Although interviewees were not explicitly asked about their experiences with racism, interviewees expressed an awareness of COVID-19's disparate impact on Black/African-

Americans, with participants expressing their perception that their race increased their risk of both mortality, “No, I don’t think I can avoid getting it. I mean, one, I’m African American, so we have the highest risk of dying from it, so that worries me the utmost,” and poor treatment by state and local officials: “Listen to Black people, Black and Brown people in general, because we know what we need, and they don’t seem to know, and they don’t seem to care because people keep dying.” One interview participant expressed worry over her child’s health outcome due to her race: “My child is a Black child, and at baseline, they have poor outcomes just due to systemic racism outside of the pandemic, and so then you throw this on as well; it just makes it more likely to not receive the care she is deserving of.”

Respondents largely felt that the effect of COVID-19 on children’s well-being was predominantly negative (Table 7). Of the respondents with children, 72% reported that it had affected their child’s emotions very or somewhat negatively, with no statistically significant difference between B/AA respondents and Others. A majority (69%) reported that COVID-19 had affected their child’s schoolwork 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 was no significant difference between B/AA and Others in the impact of COVID-19 on their child’s schoolwork. The impact of COVID-19 on child’s social activities including exercise were reported as significantly less negative among B/AA respondents compared to Others, though still an overall negative impact, even after accounting for socioeconomic status. In multivariate analyses, home ownership was associated with more negative impacts on child’s schoolwork and emotions ($\beta=-0.343$, $\beta=-0.215$), and full-time employment with less negative impacts on child’s social activities and emotions ($\beta=0.329$, $\beta=0.292$).

Table 7

| | Other (N=43) | B/AA (N=38) | p-value | Regression β (p-value) |
|---|-----------------|-----------------|--------------------|---------------------------------|
| Impact of COVID-19 and distance learning on child’s school work | | | | 0.00 (1.00) ⁵ |
| Very negatively (1) | 18 (41.9%) | 10 (27.0%) | | |
| Somewhat negatively (2) | 13 (30.2%) | 14 (37.8%) | | |
| Not at all (3) | 2 (4.7%) | 5 (13.5%) | | |
| Somewhat positively (4) | 9 (20.9%) | 6 (16.2%) | | |
| Very positively (5) | 1 (2.3%) | 2 (5.4%) | | |
| Mean \pm SD | 2.12 \pm 1.24 | 2.35 \pm 1.21 | 0.394 ³ | |
| Impact of COVID-19 on child’s social activities, including physical exercise | | | | -0.184 (0.01) ⁶ |
| Very negatively (1) | 23 (53.5%) | 14 (36.8%) | | |
| Somewhat negatively (2) | 11 (25.6%) | 9 (23.7%) | | |
| Not at all (3) | 6 (14.0%) | 6 (15.8%) | | |
| Somewhat positively (4) | 2 (4.7%) | 7 (18.4%) | | |
| Very positively (5) | 1 (2.3%) | 2 (5.3%) | | |
| Mean \pm SD | 1.77 \pm 1.02 | 2.32 \pm 1.30 | 0.037 ³ | |

| | | | | |
|---|------------|------------|--------------------|---------------------------------|
| Impact of COVID-19 on child's emotions | | | | -0.108 (0.34) ^{5,6} |
| Very negatively (1) | 18 (41.9%) | 10 (26.3%) | | |
| Somewhat negatively (2) | 15 (34.9%) | 15 (39.5%) | | |
| Not at all (3) | 5 (11.6%) | 5 (13.2%) | | |
| Somewhat positively (4) | 3 (7.0%) | 6 (15.8%) | | |
| Very positively (5) | 2 (4.7%) | 2 (5.3%) | | |
| Mean±SD | 1.98±1.12 | 2.34±1.19 | 0.160 ³ | |

Refer to Table 2 for footnotes key.

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: “It’s problematic because the teachers are not available as if they were in person. My kids get anxiety looking at homework because there’s so much work and they can’t keep up” and “Nobody was prepared. They were just giving my kids packets and packets of work that they had expected them to get done. It was bad. I never did homeschool with my kids before. So, we were all over the place.” Parents also described particular difficulties for children with disabilities, stresses for children with asthma in complying with masking recommendations, and disruptions to accessing school-based mental health services for their children: “You have to stay in the house. I have two kids. It just put a whole mental effect on them. They can’t go outside with their friends. They can’t hang out.” One participant, an educator, observed, “I’ve had two students this year who became homeless in the last month. One of them disappeared for three weeks. They were trying to find a new place to live. They were trying to find a place that had internet access. . . . So many of the kids that I work with are struggling with things like anxiety and depression and behavioral challenges. They really need the social interaction.”

Discussion: Implications and Recommendations

In summary, the most notable differences, in terms of statistical significance in quantitative data related to socioemotional impact of the pandemic, in which B/AAs differ from non-B/AAs include:

- Being more likely to have their work hours reduced or to be required to more hours, and less likely to have their work change to work-from-home
- Being less likely to be able to claim additional COVID-19 unemployment benefits and more likely to claim regular unemployment benefits only
- Having less worry about losing their housing
- Not having difficulty as frequently in accessing mental health care
- Feeling very nervous or downhearted and blue less frequently
- Experiencing racism or racial discrimination more frequently
- Feeling they would have received better medical care at some point if they were a different race
- Assessing the impact of COVID-19 on their child’s social activities as less negative

There were also notable, though non-significant differences between B/AA respondents and all other respondents, with a larger proportion of B/AAs wearing a mask outside of the home, a smaller proportion using the University at Albany COVID-19 testing site, and a larger proportion having no difficulty accessing mental health care. There was no significant difference in food insecurity in our sample, though the proportion of respondents reporting this overall is high. There was also no significant difference in perceived severity of COVID-19 and risk, with concern uniformly high across all respondents. In addition, comparable levels of difficulty in seeking health care services were reported between B/AAs and all others. Compounding other stressors was a significantly higher frequency of experiencing racism among B/AA participants.

While race was not consistently predictive of a disproportionate socioemotional impact of the pandemic across the categories of dependent variables analyzed, we note that in some instances, the socioeconomic status indicators of home ownership and employment were predictive, with our sample displaying a higher level of home ownership than residents of the City of Albany in general. This high level of home ownership across B/AA respondents and Others may contribute to socioeconomic indicators being more predictive of stress than race is for our sample. Moreover, while the more negative overall picture of the socioemotional impact of the pandemic conveyed by the qualitative data may be ascribed to the self-selection bias discussed earlier, the stress and in some cases even anguish conveyed by the interviewees is undeniable. Stressors related to employment likely contribute to concerns about housing and food insecurity and to anxiety and depression. This is consistent with the increasing attention that work is being given by public health scholars as a major contributor to health disparities, for a variety of reasons that lie outside of OSHA concerns (Ahonen et al. 2018), as well as research on the deleterious health impacts of precarious work (Sverke, Hellgren, and Näswall 2002; Lewchuk, Clarke, and de Wolff 2008).

Fear of the virus was another source of stress, together with isolation, disconnection, and uncertainty for the future, with the qualitative data in participants' own voices helping to paint a vivid picture of the impacts. As one interviewee put it, "It's affected my life. I don't wanna say the purpose of life, but everything is just stagnant right now. It's like every day is the same, and you have no control over this. You're just stuck." And another even more succinctly: "It's sad. It sucks, how our life is." And another very poignantly, "I may wanna be out more, and now I kind of miss being places I haven't even really been to." Many of these feelings are widely reported in the media coverage of individuals' response to the pandemic, regardless of race or socioeconomic standing, but the risks to the mental health within Communities of Color, who are already laboring under an allostatic load that greatly exceeds whites, is arguably substantially greater (Guidi et al. 2021).

Also of concern is the mistrust of fellow community members reported by many interviewees. The diminishment caused by the pandemic of so-called "weak ties," the casual communication between neighbors as they go about their daily routines, and which has been identified as a source of social cohesion (Yamamoto and Jo 2018) may have contributed to this, together with the relative absence of good news in the local media (Yamamoto 2018). This is concerning because of the importance that being part of a neighborhood network, including not only neighbors but community organizations and local media, has been demonstrated to play in the development of communicative social capital and in turn collective efficacy, which

ultimately contributes to accessing health resources (Matsaganis 2015; Matsaganis and Wilkin 2015; Seo and Matsaganis 2013).

At the same time, it is important to bear in mind that the findings reported here reflect a particular point in time: December 2020 through January 2021, in the depths of a northeastern US winter, a post-Thanksgiving holiday COVID-19 surge, and before vaccination rollout was underway in any substantial manner. Moreover, while many interviewees professed not feeling connected to local organizations, and 31% of survey participants reported not feeling strongly connected to any organization, others were resourcefully using social media to connect with friends and neighbors to organize mutual aid efforts.

When interviewees were asked what they would most like public officials to know about the experience of the pandemic for them and their local communities, they identified several areas where improvements could be made. The following recommendations are grounded in these responses, the survey results, and the assessment of the data by the Albany Minority Health Task Force in the context of their knowledge of the local community. Quotes from interview participants are provided (in italics) to present the concerns of community members in their own voices.

- ***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.*
- ***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, the Task Force recommends 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.*
- ***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 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 make Communities of Color in Albany vulnerable and 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 among 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.

The results of our study demonstrate the importance of local conditions, for example with respect to home ownership and employment, in understanding the impact of a public health emergency like the COVID-19 pandemic across racial groups. Moreover, the comparison of qualitative and quantitative data results also allows us to see important within-group variations in experiences. Together, these results affirm the importance of community-engaged, place-based research to inform policy development, especially local policies on allocation of federal resources.

Notes

¹ 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.

² Items for the survey instrument were selected and adapted from the following scales through collaborative consultation between the academic researchers and the community members of the Albany Minority Health Task Force. Not all of the items from scales listed below are presented in this report. Further information can be obtained from the corresponding author.

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³ The complete 96-item survey is available at https://scholarsarchive.library.albany.edu/cgi/viewcontent.cgi?filename=0&article=1008&context=covid_mhd_nys_white_papers&type=additional.

⁴ The interview protocol is available at https://scholarsarchive.library.albany.edu/cgi/viewcontent.cgi?filename=1&article=1008&context=covid_mhd_nys_white_papers&type=additional

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