COVID-19 has taken a disparate toll on vulnerable populations in Massachusetts. Low income communities, people of color, and those with disabilities are disproportionately affected. The health and economic impacts threaten to further exacerbate already existing disparities as the economy reopens.

This forum discussed the disparate impacts of COVID on vulnerable populations, including Black and Hispanic populations, and what steps physicians can take, as clinicians and as advocates, to help their patients.

Faculty:

Monica Bharel, MD, MPH, is the Commissioner of the Massachusetts Department of Public Health, appointed in February of 2015. She has led the state’s public health response to the COVID-19 crisis and served on the Governor’s Reopening Advisory Board. Previously, she served as the Chief Medical Officer of Boston Health Care for the Homeless Program, the largest nonprofit health care organization for homeless individuals in the country.

Dr. Bharel has served on the faculty of Boston University Medical School, Harvard Medical School and Harvard School of Public Health. She was previously at Massachusetts General Hospital and Boston Medical Center. She has practiced general internal medicine for over 20 years in neighborhood health centers, city hospitals, the Veterans Administration, university hospitals and nonprofit organizations.

Mary T. Bassett, MD, MPH, is director of the François-Xavier Bagnoud Center for Health and Human Rights. From 2014 to ’18, Dr. Bassett served as the Commissioner of the New York City Department of Health and Mental Hygiene where she worked to address the structural racism at the root of the city’s health gaps between whites and communities of color. Dr. Bassett served on the Massachusetts Department of Public Health COVID-19 Health Equity Advisory Group convened by commissioner Bharel.

Moderator: Simone Wildes, MD Doctor Wildes is an Infectious Disease Specialist at South Shore Health and serves in a number of roles here at the Massachusetts Medical Society including as Chair of our Committee on Diversity, Vice Chair of the Committee on Public Health, and as a member of our board of trustees, and the
Committee on Membership. Dr. Wildes also serves as the Massachusetts Department of Public Health COVID-19 Health Equity Advisory Group.

Commissioner Bharel discussed COVID-19 in terms of social determinants of health and health equity. She reviewed the course of the virus in Massachusetts beginning in February to today, when Massachusetts has the lowest transmission rate of any state in the country.

The overarching mission of the state Department of Public Health has been to promote wellness and health equity for all people in Massachusetts, supported by attention to three pillars: data, determinants and disparities.

Looking at stratified data revealed the biggest disparity in the Commonwealth, one of the healthiest states in the nation, in diseases and health impacts was along racial and ethnic lines.

In 2017, the DPH identified conditions where, based on our data, came up to the areas where we could have the largest impact by going upstream from the actual medical diagnosis. And you can see here, it's mental health wellness, homelessness, and housing stability, substance-use disorder, and preventable chronic disease. These issues all come up again as we talk about COVID-19.

The Department of Public Health came up with a frame that had to do with having a strategic vision, and changing the culture at the DPH, including through racial equity training and increasing our leadership in that area.

As we frame our work in COVID-19 and beyond, thinking about the social determinants, let’s ourselves to go even beyond that and thinking about the social inequities and the institutional inequities. Finding where we might have unconscious bias or ways that we do procurements of programming or policies. Or thinking about how do we educate our children in schools? and what is the role of class, race, ethnicity and so on in the way we interact with our patients?

This is really a time for us to think of our patients across this entire spectrum and use the power of our voice. There’s so much respect for what a physician has to say about their patient, about these issues, about policies we have in place. And so many of the policies were made a long time ago.

When we study and understand the historic implications and the impact of things like redlining and housing, you can trace that now to patients we're caring for and the impact it's had. hose policies were put in place by people just like us. And it's people like us who can change this and improve and enhance that as well.

Specifically with regard to COVID-19 and some of the data at the state level: when the state started collecting data, most of our categories related to COVID-19 look at individuals who test positive, were they hospitalized or not, and deaths related to COVID-19. Race and ethnicity reported to the state and into testing labs, commercial labs, was very poor— a lot of missing data.
Recently, data has much improved, but still, there’s 34% missing. But the data shows disparities in rates. Current data shows that black non-Hispanics and Hispanics have much higher rates of being positive for COVID than their white non-Hispanic counterparts.

The 10 communities with the highest rates of COVID-19—nine of those communities have greater than 50% of residents who are people of color. Looking at hospitalizations. The rate of hospitalization for black non-Hispanics and Hispanics is 2.4 and 1.6 times higher respective to their white non-Hispanic counterparts, so a greater number of cases, and greater rates of hospitalization.

Finally, looking at age-adjusted death rates by race and ethnicity, there are higher rates of death related to individuals who are black non-Hispanic and Hispanic.

The MDPH Health Equity Advisory Group, which both Dr. Wildes and Dr. Bassett were unbelievable contributors to, discussed how to share this data in new ways. DPH will continue to stratify the data more, and will be looking to collect much more detailed information in a qualitative way from individuals in order to guide understanding of education needs, employment, basic needs, risk, etc.

As we discuss these disparities, and realize it goes back to institutional racism, we can recognize the power and respect that Mass Medical Society and the members of Mass Medical Society have. Black Lives Matter—racism is a public health issue—clinicians can take time to educate ourselves and understand what we can do.

**Steps physicians can take include:**

Documenting some of these important factors: race and ethnicity and other demographic information, and social determinants of health, including occupation—which is now required to be reported. COVID19 has shown us how important one's job is to one's health.

Thinking about our patients in the full context, and referring them to appropriate support services

Understanding ourselves and our own biases and how racial inequities may be impacting both ourselves and our patients.

And advocating for equitable policies at any level that you can.

**Resources:**

[www.mass.gov/covid19](http://www.mass.gov/covid19) has data and links to the Health Equity Advisory Group report.

[www.mass.gov/gettested](http://www.mass.gov/gettested) for where patients can go to get tested.

211 phone number for basic questions and resources for patients.

**Mary Bassett, MD, MPH**

Dr. Bassett discussed racial equity differences in COVID mortality, noting there were also many dimensions of marginalization and exclusion. There’s no more foundational divide in the United States than its divisions
based on race, ethnicity, which have been with us from the beginning of, even before, our founding as a nation.

The first COVID death nationally was reported just four months ago at the end of February. We're now approaching 130,000 deaths. The racial and ethnic disparities in COVID mortality emerged very early. And just at the end of March, Milwaukee reported that of just 15 patients who died statewide, eight who died in Milwaukee were all African-American. And that was followed by numbers of local jurisdictions, cities, reporting excess black and Latino mortality, and also reports from the Navajo Nation of excess mortality. And then some states followed, Louisiana, Illinois, Massachusetts, Connecticut, many others.

The CDC, our federal public health agency, was not reporting data by race/ethnicity, only by gender. National data reporting on age-specific mortality just became by race, still not available by gender, just became available about a month ago.

The risk of death goes up with age. So if you have a very old population, then a higher mortality rate would be expected. So when you age adjust, there are marked differences in mortality with more than 3½ fold excess mortality as compared to Whites among Blacks, the 2.6 for Latinos, all nonwhite groups in the United States—Asians 1.7, and American Indian, Alaska natives, these are the census categories—20% higher than whites. And the way to put this in plain English is, after adjusting for age, Blacks are 3.6 times more likely than Whites to die of COVID-19.

But that doesn't tell us at what age people are dying. For Black Americans, throughout life at all ages, the mortality rates are higher. But there's a bulging out of mortality among younger adults here.

And the same is true for Latinos. And the mortality data on American Indians and Alaska natives, you'll see here, the mortality is lower. It's probably just not very good data.

So this is that graph turned into risk ratios as compared to whites by race ethnicity. The age-standardized mortality rate for blacks was 3.6. But when broken out by 10-year age groups, the mortality risk for Blacks relative to Whites is nine-fold higher. Higher in all age groups and from young adulthood through midlife, nine-fold higher for 35- to 44-year-olds, Latinos nearly eight-fold higher, American Indians, Alaska natives eight-fold higher.

There is an excess risk for all groups that are not white, including Asians and Pacific Islanders. But the most extreme relative excess mortality rates are seen in Blacks, Latinos, and indigenous people.

In plain language, among adults between the ages of 35 and 44, Blacks are nine times more likely than whites to die of COVID-19. And another way of capturing this, because everybody who dies young has been deprived of years of life that they would be expected to have, is by using a measure called "years of potential life lost".

And in this case, the cut point that we used was 65 years. And the reason for using that cut point is that 65 is a number that people understand-- well, at least it used to be-- as the age at which many people would think about retiring, the age at which you become eligible for Medicare. So it's just arbitrary.
But we picked that. And I think everybody agrees that, if you die before you're 65, you've died too young. So here is one way of looking at it, that in the short period of time between February and the end of May, Blacks lost nearly 46,000 years of life.

So another way to do this measure is also to compare it. Blacks lost nearly seven times as many years of life before the age of 65 as whites, Latinos over five times, American Indians, Alaska natives four, and so on.

The bulk of deaths due to COVID occurred in older people for all groups. For all groups, at least 80% of deaths are among people who are 65 or older. But when we look only at the age-standardized mortality rates, which is a legitimate way to look at mortality, we lose the information about the extreme disparity in risk of death among young and middle-aged adults.

What does this mean? For clinicians, be aware that younger people of color still have a disproportionate risk of having fatal disease. But the idea that a younger person is going to have a much easier time of it isn't quite as true among younger people of color.

And then understanding the reasons why this excess risk exists in, particularly, Blacks, Latinos and indigenous people. And here are some. One often mentioned, is the high rates of other chronic disease, meaning obesity, diabetes, heart disease, asthma, other chronic lung disease.

Another may be failure to follow public health advice, but this doesn’t always mean personal failure, making a bad decision. It may be impossible to follow public health advice. On the Navajo Nation, for example, 30% of households reported they have no running water. So the idea of having handwashing be a mainstay of personal protection is kind of cruel advice when people don't have running water.

And the third reason, to be explored more, is the difference in exposure to the novel coronavirus, particularly exposure at work. The number of people who were deemed as essential workers is large, 40% of the workforce. The Governor's list of essential occupations goes on for several pages, single spaced.

A large and disproportionate share of these frontline workers are people of color. Only 30% of people can work from home. And the proportion of black and Latino workers who can work from home is much smaller than that.

So these young people are working-age people who likely have been exposed as they continued working. They may have had the choice to stay home. But it wasn't a real choice because they couldn't stay home and earn a living.

In New York City, ¾ of frontline workers are people of color. 82% of cleaning services are people of color as are transit workers. Our failure as a society to protect these frontline workers just as we looked after health care workers not particularly effectively, at least initially, this group of workers was really largely neglected.

The premature mortality among these groups is 20% to 30% higher.

Questions:
Please address the different challenges in COVID-19 equity outside of the Boston region. What are the strong tools to improve public health and care in those areas?

The state looks at all 351 cities and towns, and reports in great detail where cases are positive and how the disease looks across our state. See [www.mass.gov/COVID](http://www.mass.gov/COVID).

The most important work is what's done at the local level—the local boards of health, the local community outreach programs, the local health care systems.

This is a pandemic of our lifetime. And the local boards of health have stepped up in ways that have been unbelievable. Here, in Massachusetts, each and every city and town has their own local board of health that works with the municipality. And the state can provide guidance, but does not oversee them. They can make local decisions. And the MDPH supports them. For example, during the COVID-19, the state has put out millions of dollars to help them work together and have more resources as one example.

How are we preventing disease in congregate situations such as prisons, nursing homes, homeless shelters, or group housing?

One of the highest risk groups we've seen, speaking specifically about congregate settings, is individuals living in long-term care facilities. And it's where we see in Massachusetts, devastatingly, about 60% of our deaths. In the state’s daily report, information is stratified by age.

The average age of individuals who test positive is in their 50s. The average age of individuals who are hospitalized is in their 60s. And the average age of individuals who pass away from COVID and die from COVID is 82.

So we know that age is a risk factor, not only for illness but also for death. In our long-term care settings, we've seen devastating amount of disease. The state has worked very closely with our long-term care facilities to do multiple things: providing more PPE at the time of the surge--there was actually a federal supply to all long-term care facilities of PPE. Working very closely with them to have the National Guard go in and do testing of both patients and staff members. We've done an incredible amount of work in infectious disease control. And now, there’s a schedule of regular testing within the long-term care as well, so cases can be quickly quarantined.

Could you discuss the role of data in responding to the virus? And what does it take to get more complete data, nationally and here in Massachusetts?

Massachusetts has really shown what's possible. The improvement in its absence of race ethnicity data is really remarkable. It's been about a month that you've gotten double the capture of race specific data.

Nationally, it's still not looking that good. The data that are reported by the Centers for Disease Control, particularly for cases, which is based on tests, is under half of tests have had race ethnicity data. So the way to do it, frankly, is leadership. Regulation is important.

But unfortunately, there are many regulations which are not enforced.
There’s also the question of what can we do at the state level versus the individual level? COVID-19 is new. But the issues we’re talking about related to the social determinants are not new.

COVID-19 has shone a spotlight on it. It is our job as physicians at every level, wherever we are in the system, to do what we can. The place that the state obtains the information on someone’s race and ethnicity is from the lab form.

There are some labs that send that information in electronically. But some are still paper. And the majority of the time, those were blank.

At the state level, one of the biggest obstacles what about essential workers? Who’s at risk? A lot of that is related to not having the information at hand. So we are working very hard to improve not only our electronic systems of capturing the information, but also how we then take in that information in a way that we could push back out.

And this is work that has to have persistence and has to continue-- it’s a daily effort. The work at the MDPH is around viewing our work through this racial equity lens and looking at our policies, programming, grants that we put out and making sure and ensuring we’re looking at it through that lens. But it's all based on having the information in the first place. One of the things I really look forward to working with Mass Medical Society about is how to make that easier to capture that information as well.

For anybody who's filling out forms, the hope is that, when you see what we learn from these data, you understand why it's so important to complete these forms. Clinical practice is definitely overburdened by forms and paperwork. The hope of the electronic record is yet, in my view, to be fully realized.

One would hope that you could pull this information from electronic records, for example, and populate all the forms that go out. But that just hasn’t been possible so far. So the data really matter. Please, please help with it.

What can physicians do now as clinicians or as advocates to protect vulnerable population?

Dr. Bassett: People who are physicians continue to have a certain status and prestige. So lending our voices to the importance of eliminating these disparities, making very clear that there's nothing natural about them, that we can't accept them if we believe in equality and fairness. That's important.

And that is really not to be minimized. Additionally, of course, there are all the actions that we take as individual clinicians. But I want to end, really, with the important voice that physicians have, which organizations like the Massachusetts Medical Society has, in speaking out about how it's possible to ensure that everyone has an equal chance for a long and healthy life.

Commissioner Bharel: I really do believe that each one of us has a responsibility to speak for those who don’t have their capacity to raise their own voice.

And I will add another area, which is such a powerful role to play in terms of educating and assisting our patients in understanding this new disease. Just imagine, we didn’t even have this disease several months ago.
And just like you were all trying to keep up with the new information and really pointing our patients towards trusted sources of information, we update our mass.gov site every day with new information as we learn it.

So sending them to a trusted source is really helping us with talking about face coverings or face masks, when people are outside talking about the distancing. There's this thing people talk about related to quarantine fatigue. And I know people are tired. And I know it's hard to do all of these measures.

We don't have fancy machines or procedures to help our patients with COVID-19. It's these basic things that will work. There was just something in Health Affairs modeling, if we all wore face masks and kept distancing, there would be a 50% reduction in deaths.

So even as our numbers come down in Massachusetts, it's really important to remember and remind our patients that the pandemic is not over. And there are steps each one of us can take that will help keep our numbers low.

And finally, if you're pediatricians or family medicine folks who work with children, especially the older children as we work really hard to get them back to school, just helping them start to get used to wearing masks so that-- because that will be our new reality for a while