PHI Dialogue4Health Webinar
COVID-19 and Its Impact on Communities of Color
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>> Kathy Piazza: Welcome to COVID-19 and the Impact on Communities of Color: Our Nation's Inequities Exposed. My name is Kathy Piazza. I'm running in Dialogue4Health web forum with my colleague, Murlean Tucker. Thank you to our partner for today's event, Trust for America's Health.
Audio for this web forum is through your computer speakers or headphones. Just click the telephone icon located at the bottom of your screen for additional ways to connect.
Realtime captions for today is provided by Karen from Home Team Captions. For captions, click the Multimedia Viewer under the circle with three dots at the bottom of your screen. Next, on the right side of your screen, locate the link in the captioning panel that says show/hide header.
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Please share your thoughts and questions about today's presentation by typing them in the Q&A box and we'll answer as many of them as we can. Open the Q&A panel by clicking the circle with three dots at the bottom of your screen.
In the Q&A panel on the right side of your screen, select "all panelists" in the dropdown menu so that your question gets sent to the right place.
Now, it is my pleasure to introduce Dr. J. Nadine Gracia, the moderator of this event. Dr. Gracia is the Executive Vice President and Chief Operating Officer at Trust for America's Health, TFAH. She has extensive leadership and management experience in federal government, professional associations, and academia. Prior to joining TFAH, Dr. Gracia served in the Obama Administration as the Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health at the U.S. Department of Health and Human Services. In that capacity, she directed departmental policies and programs to end health disparities and advance health equity.
Welcome to the microphone, Dr. Gracia!
>> Nadine Gracia: Thank you very much, Kathy, and thank you to everyone in the audience for joining us today for our web forum. Let me welcome you to our fourth webinar in the series focused on the implications and impact of the COVID-19 pandemic. Today's webinar entitled COVID-19 and the Impact on Communities of Color: Our Nation's Inequities Exposed, is focusing on an important and serious issue that has garnered much national attention.
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On behalf of Trust for America's Health, I am so pleased to moderate this important discussion. Trust for America's Health is a nonprofit, nonpartisan, public health policy research and advocacy organization based in Washington, D.C.

We recommend policies to advance an-based public health system that is ready to meet the challenges of the 21st century. Undoubtedly the COVID-19 pandemic is one of these great challenges.

At Trust for America's Health, we envision a nation that values the health and wellbeing of all, and where prevention and health equity are foundational to policymaking at all levels of society.

In our first three webinars, we addressed one, the importance of paid sick leave in stopping the spread of the pandemic.

Secondly we hosted a webinar on protecting older adults from the harms of social isolation.

Thirdly, we hosted a webinar on how the pandemic is complicating current gaps in mental health care.

If you weren't able to tune in for any of these first three webinars, the recordings are available both at the Dialogue4Health website as well as Trust for America's Health website in our COVID-19 resources portal. Our website is TFAH.org.

So now let's turn to today's webinar. COVID-19 and the Impact on Communities of Color: Our Nation's Inequities Exposed.

We have certainly seen disparities in past public health emergencies. For many years at Trust for America's Health, we have focused attention on the importance of a strong and effective public health emergency preparedness system. For the past nearly two decades, TFAH has published an annual report called ready or not, protecting the public health's from diseases, disasters, and bio-terrorism. We provide an assessment of policy actions to ensure that everyone's health is protected during such events.

In our policy recommends we prioritize promoting health equity and preparedness, building thriving communities and the need to address underlying social, economic, and health disparities that impact how communities experience disasters and public health crises and how quickly communities can recover.

To do so requires leadership. It requires multi-sector engagement. It requires meaningful and authentic engagement of communities. And it requires sustained investment and resources.

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In the COVID-19 response, we have been engaged in advocacy to Congress and the administration for emergency funding to states and localities to address the immediate public health crisis. We are calling for data disaggregation to identify the populations at greatest risk for illness and death from COVID-19. We are urging that federal resources be directed to communities disproportionately impacted to ensure that resources are meeting communities that are in need.

While we are raising attention to these immediate and pressing issues, we are also focusing on long-term solutions. Calling for increased and sustained investment in public health infrastructure and public health approaches to advance equity and address the social determinants of health.

COVID-19 certainly is an unprecedented and devastating pandemic for our nation and the world. The likes of which has not been experienced in a century.

Prior to the COVID-19 pandemic, communities of color already faced inequitable opportunities for health and wellbeing. Racial and ethnic disparities have persisted across generations.

Next slide.

Now the COVID-19 pandemic is starkly exposing these long-standing inequities. I'm sure many of us can recall the days of the early reports of the tragically higher rates of deaths among blacks in a few cities and counties across the country. We have seen it in cities and counties such as Chicago, Illinois; and Milwaukee County, Wisconsin; and states such as Louisiana, Michigan and North Carolina. Those reports have only increased since that time and include the LatinX, Native Hawaiian, Asian American, and Pacific Islander communities. These disproportionate impacts of COVID-19 are not happening in isolation. This he are consequential economic impacts on individuals, families and workers of color as well as minority owned businesses. All of which affect the health and prosperity of communities of color.

And we must never forget that these are not simply statistics. They are people. They are family members, friends, neighbors, front line and essential workers and loved ones.

So there is an urgent need to accelerate equity in this pandemic response.

Our objectives for today's webinar are to highlight the disproportionate impact the outbreak is having on communities of color. With these distinguished experts to delve into both the immediate and ongoing efforts that are needed as well as long-term recommendations to end these structural inequities.

With that background, let's get started.

It is truly my pleasure to introduce our esteemed panel of experts. First, Dr. David Williams. Dr. Williams is the Florence and Laura Norman professor of public health and chair of the Department of social and behavioral sciences at the Harvard T.H. Chan school of public health. He is also a professor of African and African-American studies at Harvard University. He is preeminent scholar and an internationally recognized authority on social influences on health and his research has enhanced our understanding of the ways in which race, socioeconomic status, stress, racism, health behavior and religious involvement can affect physical and mental health. The everyday discrimination scale that he developed is the most widely used measure of discrimination in health studies.

He was elected to the national academy of medicine in 2001 and just last week Dr. Williams was elected to the Robert Wood Johnson foundation Board of Trustees.

Next is Kathy Ko Chin. She is the President and Chief Executive Officer of the Asian and Pacific Islander American Health Forum, a national health justice organization which influences policy, mobilizes communities and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians and Pacific Islanders Pacific Islanders. Ms. Ko Chin is a renowned voice for the Asian American community and served on the President's advisory commission on Asian Americans and Pacific Islanders during the Obama Administration.

She has served on a number of Advisory Committees including the national academy of social insurance, academy study panel, studying Medicaid as a critical lever in building a culture of health.

Our third panelist is Danyelle Solomon, who is vice-president of Race and Ethnicity Policy at the Center for American Progress. Her work focuses on structural reforms to improve outcomes for people of color in our economic, social, and civic systems.

Her work has been focused on policies that close the racial wealth gap, protect voting rights, ensure police accountability, and move the conversation beyond diversity to equity and inclusion.

Prior to joining the Center for American Progress, Ms. Solomon worked at the Brennan Center for Justice, the White House Office of National Drug Control Policy and the United States Senate as counsel to Senator Benjamin Carden.

The fourth panelist is Dr. Barbara Ferrer, a nationally known public health leader with experience as a philanthropic strategist, educational leader, researcher, community advocate and public health director.
Dr. Ferrer is truly on the front lines of responding to the COVID-19 pandemic as she currently is the Director of the Los Angeles County Department of public health which protects health, prevents disease and promotes equity and wellbeing among L.A. County's residents. A budget of $1.3 billion and will addresses a workforce of staff and integrates at Department of Health, services and mental health.
Her previous positions include chief strategy officer for the Kellogg foundation and Executive Director of the Boston public health commission.
Many thanks again to all of our panelists.
Our speakers are presenting, as we noted at the top of the webinar, you may begin to share your thoughts and submit your questions using the Q&A box. We will respond to as many questions as possible during the Q&A session that will follow the presentations.
I would like to now turn it over to Dr. Williams. Dr. Williams?
>> David R. Williams: Thank you so very much. It is truly an honor and privilege to be here as part of this distinguished panel today.
What I would like to do in my talk today is to give an overview of the larger social context and factors that drive the patterns that we are observing in communities of color. The next slide looks at the Washington, D.C. and multiple states. You can see the top line shows the percentage of deaths in that locality from COVID-19. And the bottom line shows the percentage of the population that is African-American. So you can see in Washington, D.C. we are 44 percent of the population is black, 79 percent of the deaths are. You see a similar pattern in Michigan, in Louisiana, in Wisconsin and Illinois.
The next slide continues the litany of Georgia, Maryland, Mississippi, New York, New Jersey. I would continue with multiple other slides. That pattern is true virtually everywhere.
To put the disparities of COVID-19 into context we are looking at blacks in the United States from 1950 to 2015. There is good news on this page. In 19 African-Americans had a life expectancy at birth that was eight years shorter than that of whites. And we have cut that in half: By 2015.
At the same time the disparities and the persistence is considerable. If we were to freeze the current life expectancy of whites and have the life expectancy of African-Americans increase at an average life at which life expectancy has increased in the last decade it will take about 30 years to eliminate the gap. You can see that in the data. Look at the life expectancy of whites in 1950, 69.1 years and ask how long did it take for African-Americans to have the health equal to that which whites had in 1950? You can see it wasn't until 1990, 40 years later that African-Americans experienced the health that whites had in 1950.
The next slide now begins to drill down. How do we make sense of these differences? They are large racial ethnic differences in economic status.
Here is the most recent income data for the United States, from the Census Bureau report in 2019, looking at median household income and race in 2018. You can see for African-Americans and Native Hawaiians, the median income, household income is $41,000.
The next slide. I like to translate that into a way which you can't possibly miss the point. Standardizing on the household income of whites is one dollar and for every one of those dollar, Asian households receive 123 cents. This is made up mostly of immigrants. Asian households have more people.

Let's look at the historically disadvantaged populations, for every dollar of income White House holds, Latin received 73 cents and Native Hawaiian and blacks, 59 cents. What is stunning, for African-Americans, the 59 cents is equal to the black white income in 1958. 1978, the peak year of narrowing the black white gap in income as a result of the federal anti-poverty policies of the '60s and '70s and Civil Rights initiatives, we reduced it to 59 cents. Today it is still 59 cents. Has it been stable at 59 cents over time? No, it hasn't. Throughout the '80s it fell from 59 cents. Reaganomics was not good for the black population. It got back from the 59-cent figure, it has been up and down since then by a penny. Most Americans think we have much more progress in economic lines than p these graphs show.

Income data dramatically under states the racial gap in economic circumstances. The next slide highlights the importance of wealth.

Wealth gives the economic reserves that households have to cushion shortfalls of income, home equity, savings and other property that individuals hold.

And the latest data in the next slide from the Federal Reserve board shows that for every dollar of wealth that White House holds have, black households have ten cents. Continue animating the points on the slide.

For every dollar that White House holds have, black households have ten pennies, continue, and Latino households have ten pennies.

Next slide.

What these data indicate is that -- one more time. Yes.

What this date indicates, that low economic status means that even though we are in the same storm, we are nonetheless in different boats. The next slide spells out some of the ways in which low income puts individuals at higher risk during the COVID-19 pandemic because not everyone can work from home. And low wage, non-salaried workers with unpredictable and unstable hours it is just not practical for them. A study in New York City indicated 60 percent of the essential workers in New York City were persons of color. It directly impacts risk factors.

The next slide points out not only does the directly impact on risk factors, but that the lower economic status, living in disadvantaged segregated neighborhoods and exposure to racism leads to economic stress, psychosocial, stresses, chemical and other stressors. I want to highlight the chemical stressors, sometimes ignored. This slide talks about the stressor of air pollution. One study showed that if you live in areas of higher air pollution, in fact you have more severe cases of COVID-19, higher death rates from COVID-19.

As one source of stress that we often neglect.

Next slide. I want to begin talking about the stress of racial discrimination and the impact of racial discrimination on health.

The next slide illustrates what the everyday discrimination scale, one measure of racial discrimination I developed. It doesn't capture all aspects but it captures the little indignities on a day-by-day basis. Being treated with less courtesy, being treated with less respect, receiving poorer service in restaurants and stores, people actually think you are not smart.

What has been found with this scale in terms of its impact on a broad range of health outcomes is spelled out in the next slide. The multiple columns in the next slide, go through them filling out the entire slide, it shows the range of outcomes that have been linked just to the everyday discrimination scale.

Incident, cardiovascular outcomes, multiple indicators of pre-clinical disease states, coronary artery calcification, heart rate variation, multiple indicators of biomarkers, inflammation,

telomere length, allostatic load, poor sleep duration, higher risk behaviors, less use of screening services, higher rates of mental disorders, higher rates of obesity.
This illustrates how pervasive the negative impact of the stress of discrimination is and then we are put in the stress of COVID-19 on top of this high level of stress that persons of color are experiencing in the United States.
The next slide. Points out what researchers have been assessing. The impact of all of these stressors. Different terms are being used. Some are using the term that disadvantaged minorities in this country experience accelerated aging or premature aging or biological weathering. What they are referring to is the evidence that at the same chronological age, disadvantaged persons of color in this country are literally physiologically older than white persons who are at the same chronological age they have.
You see, if you live in a bad environment, your age not only captures how long you've lived, it also captures how long you have been exposed to adverse conditions and how physiologically compromised you have become as a result of that. Early onset disease as a result. The next slide shows us data from the CDC. Early onset of hype, African-Americans experiencing high blood pressure at younger ages. Looking at the 50 to 64-year-olds, 61 percent have problems compared to whites. Next slide for diabetes, you see the same pattern as the early onset of disease.
The next slide will show the significance of that. The next slide, yes, co-morbidities from one of the largest studies so far from COVID-19 patients, 6,000 patients from New York City and among patients hospitalized for, 57 percent, hypertension, 42 percent obesity, and so on.
Next slide shows the clustering of risk factors, the co-morbidities. Only 6 percent of these hospitalized had none of those co-morbidities and only 6 percent had one.
So 88 percent had two or more of these co-morbidities.
But the point is it is not the fault of those communities and individuals. I'm giving you the larger context that has driven these higher risks of co-morbidity in these populations.
Next, quickly I want to mention as the next slide talks about individual discrimination in healthcare. The next slide shows the picture of the national academy of medicines report on unequal treatment that discussed and documented the pervasive racial bias in medical care. That is still a problem today. We need to be alert to it in the context of COVID. What can we do about this? The next slide talks about what are the challenges? What can we do?
And I want to talk about the need for what I call communities of opportunity. Disparities cannot be solved simply by interventions in healthcare, although we need those. But we need to think of what else we can do to put communities of color on pathways to opportunity in terms of employment and quality neighborhood environments, reducing childhood poverty and building the political will so that we can address all of these challenges.
My final slide is, I leave you with the words of Martin Luther King. He said: It may well be that we will have to repent in this generation not merely for the vitriol I can words and violent actions of the bad people, but for the appalling silence and indifference of the good people.
We cannot let this COVID crisis go to waste. We cannot be silent. We need to raise our voices and work together to build those long-term policies that will ultimately eliminate these inequities in health. Thank you very much.
>> Nadine Gracia: Thank you, Dr. Williams, for an excellent overview and historical perspective to the current day. Very insight full and certainly will contribute to our discussion that we'll have following the presentations.
Let's now turn it over to Kathy Ko Chin. Over to you.

>> Kathy Ko Chin: Thank you, Dr. Gracia and thank you for inviting me to this esteemed passion. I'm happy to present the Asian and Pacific Islander American Health Forum. For over 30 years we have been the clear strong voice for the nation's capital of the health of Asian Americans, Native Hawaiian, and Pacific Islanders. We have connected with partners in 35 states and across the positively, the Pacific with the highest level of Congress, the legislatures, Congress and if necessary the Supreme Court.

We bring community needs we see across the country, we understand what those needs are. In the COVID-19 situation an we work with our partners to get critical information out to our clients an patients so that our whole country can address different public health challenges as we are facing now with COVID-19.

Next slide, please.

So what I want to talk about today are four different key issues that our communities are facing in the face of the pandemic. The first one is disaggregated data. Thank you, Dr. Gracia for talking about how important this is in, primary language data are to understand where the greatest impact of the pandemic is being experienced.

So disaggregated data is so important for us to understand how ID races and different ethnicities are experiencing the pandemic.

Really, this is a foundation towards health equity to understand this data and have it collected in an accurate and granular fashion. And good public health requires that the data really can show us the way to evidence-based decisions.

Next slide.

Let me give you an example from the ACA of how disaggregated data can be used to drive towards solutions.

Before the ACA health insurance expansion when you lump together data by race an ethnicity you can see here that it looks like Asian Americans, and there wasn't enough data about Native Hawaiians and Pacific Islanders about insurance. When we went and disaggregated the data by ethnicities, you can see especially above the 13 percent bar, all the communities for whom uninsurance was a significant issue. And in particular, those communities for whom language access was a real challenge.

So what we did is we helped along with 70 other national and local partners developed a response to ACA enrollment and used limited resources to target those communities that were most in need of getting enrolled.

And through that, by 2016, we were able to get the uninsurance rates down to, on average, 7 percent in our communities, which at that time eliminated the disparity in uninsurance.

You can see that disaggregated data is a powerful tool to target one of the resources of time and money to reach the most people we have in order to have the greatest impact.

As we now turn to COVID-19, the lack of disaggregated data, the lack of data by race and ethnicity prevented us from really addressing the places of greatest need. Fortunately we are starting to see that information, so that the resources can be distributed by greatest need.

And unfortunately, the most tragic impacts have been in communes of color. Not only those that Dr. Williams cited in the African-American and LatinX communities and as we all have read about in the Navajo Nation and the Native American communities but in particular in our communities of Pacific Islanders, whether it is in southern California in Dr. Ferrer's region or in Salt Lake City, Utah.

We are seeing major metropolitan areas and states are collecting that data, but not fast enough to address the pandemic in a more targeted fashion.

Next slide. So this is just to give you a sense of how the health forum is doing our response work. We are working in three interlocked areas. One is to provide support and resources to our network of 100 community organizations in 35 states and across the Pacific. We are also working because people have already spoken to the wide onslaught and impact that COVID is having in public health and physical health but other kinds of impacts to build along with our other groups a coordinated response and also building with our communities of color a national response on how communes of color are responding to COVID-19.
Next slide, please.
You can see how these three different efforts are really interlocking, from the health forum, the national coalition, to our table of nine racial equity anchors funded by the Kellogg foundation.
The next slide. Let me turn to the next issue that we have been dealing with, language access. Overall, over 61 million people speak a language other than English at home. And 25 million are limited, in the communities, where two-thirds are immigrant, a full third are limited English proficient.
Next slide, please. What has been having with COVID, very little language access was available in March and April. And only starting to be available through community efforts in Spanish and other languages starting in later in March and April. So there has been a lot of news coverage about how language access really has been a barrier, not only to the understanding between patients and their physicians with tragic results. People not being able to convey accurately to their clinician what symptoms they are having. But also about just basic information. So, for example, in Arkansas, the Arkansas coalition had to pull together an emergency fundraiser in order to raise the funds to just do basic translation of what to do if you are symptomatic or what is sheltering in place? Just minimal work at translation to understand the prevention steps that everyone needed to take.
Hospitals have been described as war zones, in a time that -- where time needs to be consumed for front line care as opposed to trying to find translators and interpreters to be able to communicate.
And fortunately we have strong community health centers that serve low income an marginalized groups to fill the gaps but they are not in every community.
So very early on in March, I think it was March 9, the health forum, hearing from our communities across the country that there wasn't enough language access, reached out and created a community library. You can see the link there at our website, Barb slash COVID-19. This library has a crowd sourced over 400 resources in 40 different Asian American, Native Hawaiian, Pacific Islander languages plus Spanish.
In the early days, it wasn't that long ago, two months ago but that felt like the early days of the pandemic, in early March, this was the only resource for language access materials and resources in the country that we know of.
Also in addition to that, we have been working with our Congressional champions to try to get language access included in the number of Congressional bills that have passed. Unfortunately it wasn't in the HEROES Act, but Senator Hirano introduced the Corona bill, which includes fund for this. And there is a Language Access Act which requires that federal agencies provide written resources in 19 languages which is the FEMA standard.
Next slide, please. Another thing that Dr. Gracia's slide referred to is how in the Asian American communities not only are we trying to cope, prevent, and recover from the infection as everyone is, we are also experiencing another tragedy that many communities of color have experienced for hundreds of years, but that tragic experience of racism. So fueled by COVID-19 anti-Asian

rhetoric from our government officials as well as campaign ads, there has been a backlash of hate crimes and incidents against Asian Americans and other communities of color across the country.
We have formal reports of 1500 hate-motivated incidents against Asian Americans and two-thirds of them are women.
This is not a new phenomenon where Asian Americans have been targeted by racism. Whether it be in 1882, the Chinese exclusion act or during World War II, Japanese American incarceration, or just 40 years ago the murder of Vincent Chen in Detroit, being mistaken as a Japanese national. As well as after 9/11 where anti-Muslim and anti-brown hate reared its head.
The dichotomy that we experience in the Asian American community in particular are the large numbers of Asian Americans who are serving in the fight against COVID, whether it be as researchers or clinicians where Asian Americans make up 17 percent of all physicians in the country, 9 percent of physician assistants and nearly 10 percent of all nurses, where we represent 6 percent of the total population.
As well as Asian Americans are leading some of the most promising vaccine solutions in the country.
Next slide.
Fortunately with some of our colleagues, in particular the Asian American advancing justice, Asian American Justice Center, they have developed this website. This is up actually for the last ten years with a lot more activity since this calendar year. Standagainsthatred.org. This is a great resource for tracking Asian American hate instances but they have a bystander toolkit as well as they are holding bystander training.
And what Asian American Justice Center has been doing for the last ten years is to train everyone who is interested. At this point, since March, they have been training 2,000 people a week who are interested in being allies on the small things you can do to really show support for somebody who has been victimized while also taking care of yourself. Even asking how the victim is doing in the case of ethnic harassment situations or standing closer to them if it is in public.
As we move out of sheltering in place, we do have a serious concern about the rise of these kinds of incidents.
The last area that I want to talk about is how COVID-19 doesn't discriminate by English proficiency, race, or socioeconomic status. But it also doesn't discriminate based on immigration status. As I said earlier, two-thirds of our communities are immigrant and how one is covered for health services, whether it be testing or care, is a determined by your immigration an residency status.
So fortunately, in the heres act there was inclusion in Medicaid for expanding Medicaid for a particular COFA and Pacific Islander populations where we are seeing the highest rates of COVID-19. And looking to how to not make immigration status the greatest social determinant of whether or not you are covered in our country.
So thank you very much again to TFAH and to Dr. Gracia for inviting me to speak today. I look forward to the other panelists as well as for the discussion.
>> Nadine Gracia: Thank you very much, Kathy, for a great presentation an discussion.
We will now turn it over to Danyelle Solomon. Danyelle?
>> Danyelle Solomon: Thank you, everyone. Thank you for having me today. It is an honor to join this panel to talk about this important issue.

I am the vice-president of the race and ethnicity positively, for those who are not familiar with Center for American Progress we are the largest think tank in the country, we put out public policy to improve every day people's lives. My team is focused on improving the lives of people of color in America and look to change our current economic and social systems to have better outcomes for people of color.

Today I am going to talk about the economic impact of COVID-19 on communities of color and pandemics, like any other national emergency, really shed a light on inequity and COVID-19 is no different. COVID-19 is not only spotlighting inequality, it is spotlighting disparities we have seen for decades.

Dr. Williams noted earlier, these disparities we are seeing are not the result of individual behaviors. These are the result of years of public policy, at the federal, state, an local level that have put people of color at greater risk of exposure of COVID-19 but also at greater risk for higher racial and ethnic disparities. For example, red lining, occupational segregation, environmental policy, all of those public policies, intentional, explicit, have put a negative impact on the lives of people of color.

What we are seeing with COVID-19 is systematic racism and realtime. Racism is pervasive across all American structures.

Next slide, please. So before COVID-19 even started, people of color were already in an economically precarious situation. Dr. Williams touched on this a little bit. I want to start by talking about wealth. Wealth is the best overall indicator we have to determine how an individual or a family's economic situation is doing. Wealth allows people to move through their life easily. It is the thing that allows you to buy your first home, put your kids through school. In this case it would allow you to weather that unexpected emergency like a crisis like COVID-19. Unfortunately in America, wealth is unequally divided along racial lines. In Washington, D.C., white households have 81 times more wealth than black households.

It is important to note there is a discrepancy or differences between African-American families and LatinX families. I highlighted that here so you could see the racial wealth gap in between different groups. For example, today for every dollar of wealth a typical LatinX has, a typical white family has seven dollars. Similarly for every dollar black family has, a white family has ten dollars.

It is important to note when we talk about wealth as it relates to communities of color to center women of color in particular. Women of color are more likely to be head of household or breadwinner. If we aren't looking at policies to close take gap, we are missing a huge part of the discussion. I want to talk about the importance of centering women of color when we talk about this.

I also wanted to highlight the impact of the jobs that people of color hold and how that plays into not only wealth building but the impact we are seeing on COVID-19. People of color are over represented in service sector jobs. Service sector jobs are what we would deem, especially now, essential jobs. But they have always been the backbone of the American economic system. We are talking about grocery store workers, child caregivers, domestic care and home health aides, restaurant workers, servers, barbers, haircutters, these are people who hold jobs that are low wage and typically lack quality benefits, and by that I mean, healthcare, childcare, 401(k)s retirement benefits, savings accountings. They lack those benefits.

When you lack access to healthcare and other quality benefits, it is harder for you not only to save for wealth but it is harder for you to respond to that unexpected emergency.

You can see in the third column for most Americans but particularly for Americans of color they can't afford that unexpected $400 expense. That transcends non-college to college educated. Here I wanted to highlight that 30 percent of black college educated households can't afford an unexpected $400 expense and 20 percent of LatinX college educated households can't expect an unexpected $400 expense.

Again the lack of wealth that we see in communities of color is having a real impact on their ability to weather this storm. COVID-19 is definitely costing individuals and families more than $400.

I would add here again, just highlights the impact this is having on women of color, two-thirds of black and LatinX women don't have enough savings to live at the poverty line for three months. Huge impact on women of color this particular.

Next slide, please. Here I wanted to highlight a few other key points when looking at the economic impact. The unemployment rate, you have probably seen I, is at the highest level we have seen since the greatest depression. This is sitting at 14 percent right now and it is likely an under count. For communities of color those numbers are much higher typically. Right now you can see black it's 18.7 and LatinX, 14-point, 18.9.

Communities. Color are not able to access claims. States cannot handle all the claims that are coming in and people are going without aid from the state government.

It is important to note here that people of color have less liquidity, less liquid assets and access to cash are, money on hand. More than one in ten Asian American households and one in four American Indian and Latin households live in poverty. Communities of color have less liquidity than white counterparts.

35 percent of Latino workers reported losing a job. Again huge impact on communities of color. The poll found that 43 percent of Latino workers had trouble making their rent and 29 percent of Latino workers who owned a small business lost substantial revenue or had to go out of business. Again a huge economic impact on communities of color.

The third column highlights a little more information around minority businesses. You all are sure, I'm sheltering sure, familiar with the PPP loan program from the government. That was geared to keep workers on the payroll and help businesses keep their doors open after COVID-19.

Unfortunately, what we have found is that the likelihood of being accesses a PPP loan for minority businesses of color is very high, 95 percent of black businesses are likely to be denied a loan. 91 percent of LatinX businesses about are likely to be denied a loan. So on and so forth. As you can see on this slide.

I would like to highlight again here that half of all women-owned businesses are owned by women of color. Women of color business owners are one of the fastest growing business owners in the country. Again they are being hit extremely hard by COVID-19.

Congress has provided additional funding, more funding is needed specifically to small businesses of color. Congress has provided some additional money targeted to CDFIs and minority serving financial institutions to help money get out. But I have to tell you from what we have heard from folks on the ground across the country, is that the money is not getting to those businesses soon enough. It is not only having an impact on the small businesses themselves but also the larger community as a whole. It is really important to note that small businesses of color are not only providing jobs to those folks in the communities but also providing services to those communities.

So it's a double hit, the impact that they are feeling in the community.

Next slide please.
Here I wanted to highlight new analysis we did a few weeks ago around connecting the economic to the health. So at least 28 percent of people of color between the ages of 18 and 64, so working age folks. That's more than 21 million people in total, have a condition that would put them at higher risk of severe illness from COVID-19. Like Dr. Williams was talking about asthma, obesity, all of the hypertension. 28 percent of people of color are more likely to have one of these underlying conditions.
But it is also important to note as I said before, people of color are more likely to be in service sector jobs, jobs that require you to interact with the public. You are not able to socially distance. One of the key public health interventions in fighting COVID-19. Less than one in six black workers can actually work from home. One in five LatinX workers can work from home. The idea that they can socially distance is much harder if they need to earn a paycheck. We also see high impact on women of color, again in this slide, having much more likelihood of having some of these conditions.
I'll break it down a little bit more for you. One in four LatinX workers, one in three black an multiracial workers an half of native American workers have an serious underlying health condition.
What I want to flag here is the unfair position take people of color are being placed in really having to choose between a paycheck to feed themselves and their families and their health and the health of their families as well as we begin to see states open up.
Next slide, please.
It is important to note that we have seen this before. And we don't have to look all the way back to the Great Depression to see when a pandemic or epidemic or nationality emergency happens that the economic hit on communities of color is harder. If you look back at the Great Recession in 2007, 2009, the unemployment rate peaked at 10 percent. For black unemployment it was 16.8. American Indian, Alaska native, it was 13.1 and LatinX, higher.
If you look at the wealth, black households lost 48 percent of their wealth during the great re-decks, LatinX lost 13 percent and blacks 48 percent. They didn't gain their wealth back, just lost it, compared to whites who gained their wealth back.
I want to highlight the importance of saying we have seen this before. For me what I hope COVID-19 does is require us to do something different than what we have done before. We should be moved beyond just the immediate fixes while those are important and we should be providing folks policy inventions to help them weather this storm in this moment.
We must demand our policymakers do the hard work of structure change and ensure that we actually help people of color have better equitable outcomes than what we have seen for decades. That requires intentional public policy action.
Next slide, please. And so here I've listed some, not all -- these are all very much focused on the economic solutions, not on that health side. Some possible solutions that should be considered obviously short-term items that we called for, ensuring folks can actually access unemployment insurance. We should be extending moratoriums on foreclosures an evictions. Nobody should be kicked out of apartments or homes during this. Prohibit negative credit reporting. We know the impact credit reporting can have on communities of color.
Provide access to capital for minority businesses which will require targeted access delivery to capital for those businesses. Provide paid sick and family leave, ensure there is hazard pay. Again we are seeing grocery store workers begging for hazard pay. They should not have to pay for hazard pay. Nurses, doctors, on the front end, they should make sure they have that pay.

Policymakers need to look at long-term solutions to ensure that people of color are better able to handle the next epidemic, nationality emergency or pandemic our country will face because we know that will happen.
So we need to ensure that we have policymakers who are willing to close the racial wealth gap. That cannot be closed by doing one thing. There are multiple policy interventions that must take place to ensure that we close the racial wealth gap.
We also need to ensure that we are increasing wages for our workers. Workers need to have more than a minimum wage. They need to have a livable wage. They need to have robust comprehensive benefits where they have access to quality, affordable healthcare. It is not just about coverage of care. It is also about the quality of care they can receive in their community. They also need to have robust other benefits like access to 401(k), childcare. These are all quality of life benefits that are needed for our American citizens.
I would also say we need to have robust Civil Rights enforcement. What we see is that even when African-Americans and LatinX Americans purchase homes, their homes are devalued and they don't get the same return on investment, despite purchasing a similarly situated home as white counterparts. That will require more robust Civil Rights enforcement. We need to broadly rediscuss (indiscernible).
Communities of color. What I'm talking about there is student loan debt, credit card debt. These debt burdens need to be tackled in a way that is long material and not just short-term.
I could go on and on about a number of other policy recommendations on the healthcare side as well as the economic side, but I am cognizant of time.
You can, next slide, please. You can learn a lot more about the work we've done in COVID-19 at amprogress.org. We have posted, I want to say over 150 different products, specifically on COVID-19. There is a wealth of information there. And you can also find myself and a lot of the other work my colleagues have done at any of these Twitter handles as well. Thank you so much.
>> Nadine Gracia: Thank you, Danyelle, for that terrific presentation and overview. Let's turn it now to Dr. Barbara Ferrer. Dr. Ferrer?
>> Barbara Ferrer: Are you able to hear me?
>> Nadine Gracia: Yes, we can hear you.
>> Barbara Ferrer: Perfect. Great. Good afternoon, everyone. Thanks so much for inviting me. I'm going to dive into sort of what does COVID-19 look like in one particular jurisdiction. I work for L.A. County. We are a county of 10 million people plus. One of the largest counties in the country.
And the largest county health department. Obviously, we have been working for a long time with a lot of our partners, our community partners and other county departments. On issues related to inequities in health and striving for a better allocation for the resources and opportunities that everyone needs to enjoy optimal health and wellbeing.
I think being in the middle of the pandemic, it has been extraordinarily devastating to see the pattern of disproportionality affecting our communities of color consistently.
Since about really -- since the beginning in some ways. I'll talk about that for a second, but in terms of outcomes, we've really been noticing an acceleration an widening of the gap since the beginning of April.
So I'm going to share a little bit of the current data. If we could go to the next slide?
We are tracking on testing hospitalizations and deaths. Unfortunately, this again, one of the big policy issues, the testing data is not, does not collect any information on race and ethnicity. We

added a field to the sites that are in control of the county. There is still a lot of testing data that doesn't give us good information.
In terms of looking at the distribution around who is getting tested, since the very beginning here in L.A. County people in communities where there is more wealth have been tested at a higher rate than all of the other communities. There has been an accelerated effort this last month to make sure that we are narrowing the gap on the opportunity to test. So you'll see in some of our communities with the most poverty we've done a much better job. But we need to continue to pay attention to the lack of access to testing.
As more and more people go back to work and we are in our recovery stages, not having access to testing is going to be an Achilles heel for all of us. There are a lot of asymptomatic people who end up being positive and are spreading. For our workers in many cases putting their lives on the line as they go back to work, not being able to access testing in a situation where there may be an outbreak at a job site is going to continue to haunt us.
Next slide, please.
When we look at cases we will start to see a pattern of disproportionality. Even though testing is done more often amongst our wealthier communities, which in L.A. County and I think in many places tend to be communities that are predominantly made up of people who may be white, we have some Asian people are also who may live in some of the wealthier communities.
Of course, there are people of all races in those communities. But the highest rate of poverty exists among people who are black and Latino or LatinX in L.A. County.
If you look at our rates, you will see immediately that this pattern of inequity in cases, who ends up being positive, very much shows up by race and ethnicity.
Our Native Hawaiian and Pacific Islanders, although a relatively small community in L.A. County is off the charts in terms of disproportionality that starts here with the diagnosis of cases.
I go to the next slide.
Differences noted in terms of who is positive, people who live in communities with lots of poverty are over two times more likely to end up being positive once they are tested.
Next slide. When we look at information around who is dying in L.A. County, again this is sobering and should be alarming for all of us. And I think David covered some of this early on. So did Kathy. The rates are devastating. You know, two times as many people who are black are dying in L.A. County of COVID-19. Ten times as many people who are Native Hawaiian are dying. And even for the Pacific Islanders and LatinX are showing disproportionality. We are showing disparity for native American and Alaska native are showing very, very small. We our data might look difference as it does across the Navajo Nation. This is just a very small number of deaths in that community.
Next slide.
And the same disproportionality follows us when we look at our information by income here. If you live in a community with higher rates of poverty you are three times more likely to die from COVID-19 than if you live in communes with much lower rates of poverty, or wealthier communities.
The next slide.
We are clear about the factors contributing to the disproportionality. We know that lower wage earners have higher risk of exposure and more likely to be essential service workers and also likely to work in the lower wage jobs here. And they are working in some sectors where there has not been adequate protections in place, including the use of PPE.
Again as noted, by earlier speakers, inability to have access to basic rights like paid leave.

We also here in L.A. County have a serious housing shortage issue and many, many people with less income are living in much smaller spaces and sometimes with very high occupancy rates. And as noted again, by earlier speakers, people of color in L.A. County, as everywhere in the United States, have disproportionate burden of health conditions, the very health conditions that are now putting them at risk for serious illness and even death with COVID-19.
Next slide.
And there is not a question here of people not understanding their susceptibility. As a matter of fact in all of our surveys there is a lot of good information. People have done really well in terms of understanding what the virus can do and how they can take steps to protect themselves. But I do think that depending on who you are and what else you are responding to may determine the kind of actions you are able to take. And one thing that is clear here is if you do get tested and your test results are positive, you will need to be in isolation for a minimum of ten days. If you are in close contact with someone who is spoke, you need to quarantine for 14 days. That has a devastating impact on the ability for some of the wage earners to continue to have access to some semblance of economic security.
There are also many people who have let us know they don't have the supports that they need either to get diagnosed and treated the way our systems are operating right now. We have, still, L.A. County has very few uninsured people at this point in time because we have a state program that does not insist that you have to be a citizen here in the state in order to get insurance. And the same thing at the county level. We are able to cover a lot of people. We still have both uninsured people and people who don't have their documentation and are unclear at this point or afraid about accessing any benefits.
And there are also people who are unable to often times follow our, what we call simple public health directives but they are not so simple if you live in a very over crowded situation where you are sharing a bathroom and everybody sleeps in the same room. Hard to isolate. Almost impossible to quarantine.
There also has been as noted by Kathy a barrier in being able to access information in everybody's primary language. We do a good job here in the public health department on the information side of sharing our information and posting it in multiple languages. That doesn't translate to the kind of information people need on a day-by-day basis in their own communities. I just want to say we are not seeing disproportionality with COVID-19 as some new experience for people of color who have economic problems in L.A. County. This is something that affects everybody here. There are degraded conditions in many of our communities. Over time there has been a disinvestment in infrastructure in some of our communities. We have really not necessarily thought about how to do enforcement of regulations that offer some relief, relief around things like pollution and zoning. That also has a checkered pattern, so much so that we've got communities of people who are extraordinarily limited in their economic resources that face some of the biggest contaminations by lead smeltering plants that we've seen anywhere in the United States.
We call this a significant problem where those people of color and those people of limited resources have for many, many years faced this disproportionality, including in high rates of morbidity and mortality. Next slide.
We think when there is discrimination, social exclusion, racism, you end up with communities that are completely stressed out as well as individual people.
Next slide.
I'm trying to go fast because I know there are questions.

And again, as other people have so eloquently described, the impact of racism is undeniable. There's example after example of the impact of discrimination and what it does to people's ability to access the kinds of resources and opportunities they need to thrive.
There is the toxic stress issue that David talked about, which is the biologic impacts that racism has on people's health and wellbeing. There's victim blaming, what I call the false narrative that the problem here is really on the backs of those people who have the very worst outcomes and the least resources accessible to help them obtain absolute good health.
For us, we are clear and we hope it is clear in our county that none of the inequities we are seeing in L.A. County are due to individual behavior.
Next slide. Because of that, our plan here to address the inequities before us, both as a short-term plan and a long-term plan, I want to just focus for a minute on some of the immediate urgent issues that we need to attend to today. We have to improve access to testing. Testing is free but it is only good if it is somewhere you can get to it. We need to tie it back to providers who can help with care coordination and making sure that people have easy access to free testing.
If you know -- 92 percent of the people dying in L.A. County in COVID-19 are people with underlying health conditions. If you know that, it is paramount that folks are connected immediately with a healthcare provider and provided with easy access to any treatment as soon as they show the slightest signs or symptoms of COVID-19.
There also needs to be a whole host of supportive resources to make up for the economic devastation that has occurred across L.A. County, disproportionately again affecting those with the least resources. And so that network of support around making sure people are still able to get paychecks and unemployment benefits and have protection against evictions have access to legal services when they need to, can get in in fact and make sure that they have access to day care when they are essential workers. All of that, what I call safety net that really has not existed over decades needs to be shorn up more than ever. When school is out, working parents are facing added burden of trying to provide a educational opportunities for their children while they are working an creating a safe environment for their families.
>> Barbara Ferrer: I would say as restaurants open, restaurant workers are at high risk. We know our grocery clerks are at high risk. We know people in our factories are at high risk. Without attention paid to modifications that allow for more distancing and allow for better infection control, including appropriate use of PPE and or face coverings, we are now creating even a greater risk for our low wage workers.
I talk to a lot of businesses who want to do right. These may be small businesses, and they need resources so that they can make the modifications that will protect their workers and of course their customers, but the workers are there for eight-hour shifts. If you think about a restaurant worker who is doing serving and they are going to be at tables for seven or eight hour shift with people now not going to have face coverings on because they are eating, we need to think about what kind of masking does that restaurant worker need to have in order again not to continue to have the lower wage workers bear the burden, disproportionately of this horrible pandemic.
In the interests of time I want to note where we take our leave from our community partners and we are working diligently to make sure that our information is out there. We have a lot of dashboards so that the community can watch how we are doing as we again go through our recovery roadmap. We never lost our ability to do contact tracing and we are partnering with community partners who have trusted relationships as we try to make sure people have what they

need to be able to either isolate or quarantine if they are positive or have had an exposure to someone who is positive.
>> Nadine Gracia: Dr. Ferrer, if we could -- perfect. I was going to ask if you can do a few more seconds an then go to Q&A.
>> Barbara Ferrer: I am going to stop. Thank you very much.
>> Nadine Gracia: Thank you, Dr. Ferrer. It is helpful to hear what is happening in local communities and the important work there responding to the crisis.
We are now going to move into question and answer with our wonderful panelists. They've presented excellent information. We have been seeing questions streaming through. So we are going to get to as many questions as we can.
We will start off first with one to the panelists. You have all really articulated well some of the long standing challenges and inequities, systemic and structural, that are disproportionately impacting communities of color.
Audience interest, what are some potential advocacy strategies? What are some specific tangible solutions, whether that be policy solutions, that our audience and others can really work to address to try to actually address the structural inequities? Dr. Williams, you I want to hear about specific examples for which we can move forward with regard to this pandemic and beyond.
>> David R. Williams: This is David Williams. Quickly I would say that my colleague, Danyelle Solomon's presentation, Center for American Progress, was all about strategies that could be done. She pointed to a website that could be used. I think there is a lot that could be done and a lot.
>> Kathy Ko Chin: Thank you so much for the question. The HEROES Act that passed the house last week made a lot of progress and so it is really pushing the Senate to have anything that is comparable. But let's not delude ourselves that that is going to take care of everything. Those are immediate responses.
We are thinking about the policies that changes, structural changes that are needed through actually four stages of COVID response. Immediate relief, construction, addressing structural changes as well as repairing from the trauma because all of us have been traumatized by it. Remember there is a census going on and how critical that is especially for communities of color where we have an under count usually every decade. It is a time to remind ourselves and our family members and friends to complete the census. And there still is an election coming up in November. So to really support those policymakers who really understand the importance of health equity and how the impacts of COVID are disproportionately affecting communities of color.
>> Danyelle Solomon: I would support everything that has been said. I mean, the other thing I would say is, you know, call your Congress members. They actually do keep a record of everybody who calls and what they are calling about.
I encourage you to engage governors and mayors. We are seeing that governors and mayors have a higher rates of people -- people are happier with mayors and governors than with Congress. Engaging elects is important in how they are responding to COVID-19. I could not agree more around the election. CAP has been working hard to ensure that all states get federal money to ensure that voters can vote by mail. That we extend early voting. That we are in line with public health guidance for individuals who have to go into the polls and vote. Those are some immediate advocacy strategies that can be helpful here, but also really in the long-term structural change work.

>> Nadine Gracia: Wonderful. Dr. Williams referred to one of Danyelle's slides too in which she articulated both long and short-term solutions. Certainly in particular as it relates to some of the structural economic reforms that there are opportunities there as well.
Let me turn it over to Cecilia Thomas. Do we have a question from an audience member to ask our speakers?
>> Cecilia Thomas: Yes, we do. And let's start with Dr. Ferrer. What strategies are being implemented to build trust for contact tracing among communities of color that often have deep distrust for government officials?
>> Barbara Ferrer: That's a great question. One of our strategies -- well, one of our initial strategies from the very beginning has been to really build a lot of partnerships with all of our community organizations. We at the very beginning when there was an enormous amount of discrimination and racism and violence against Asians in L.A., we realized that we needed to make sure that trusted community partners had good information about COVID-19 and were able to use that information in their communities as we talked about how we could respond effectively to the pandemic threat.
We have never lost that ability. Now, of course, everything is remotely, but we do tele-briefings every week with all of the different sectors, all of the different partners so they have the kind of information that they can then share with their community members and also be a voice.
Like this is first off a huge county. Second of all, as you noted. Government folks are not always the most trusted deliverers of messages or places where people like to get services.
So we worked really hard to make sure that our partners have the kind of information that they can use to help explain.
Collectively we make little progress and we face the possibility, very real possibility of overwhelming the healthcare system.
So that is what we've used. We have had pretty good luck. I mean, you can, if you want to get a sense of the volume here, we get over a thousand new cases every day. And each case right now because we've still been safer at home for a while had somewhere between three to four contacts. That means the contact tracers already are following up on somewhere between four and 5,000 people every single day. Obviously we have hundreds and hundreds of people who are contact tracers. They go through a training.
You know, it is pretty complete. Hardest task is sometimes not having the correct numbers or emails to contact people. But when we do have good information, most people do in fact talk with us.
I think where we are looking for a lot of help is trying to figure out how to support people who need to stay home and often out of work for extended periods of time, if they are either isolating or quarantining. We are working with community partners to figure out how to headache sure that people are -- make sure that people are well connected.
We do that through interviews but we need more help with that. We are looking forward to working with community partners on that.
>> Kathy Ko Chin: I would like to follow up with Dr. Ferrer to talk about the policy environment that really has caused a chilling effect on all of these aspects of seeking care or contact tracing.
So the urban institute just released data and findings regarding the negative impact of the public charge regulations that wept into effect in October, coming out of the White House.
And so half of all the respondents to the survey have not sought Medicaid or used their SNAP benefits, their food benefits, for fear of recrimination. There are significant policy impacts that

are adding to the impacts of the pandemic. So as one is calling your member of Congress to also raise that to really provide that kind of relief during the pandemic period to lift the public charge requirements.
(Switching captioners at 3:25 p.m. EDT.)
(CART captioner signing off.)