



English Transcript of  
*"An unequal crisis: Addressing the intersectional dimensions of COVID-19"*  
Webinar presented on Tuesday, April 14, 2020 by YW Boston

**Beth Chandler:** Alright, we'll get started. I want to thank everyone for joining us this afternoon for today's conversation "An unequal crisis: Addressing the intersectional dimensions of COVID-19." My name is Beth Chandler and I am the President & CEO of YW Boston. Before I tell you a little more about YW Boston and our program for today, I do want to share that the demand for this webinar was huge. So, we apologize in advance if we have any technical challenges. We are going to do our best to keep everything running smoothly this afternoon.

So, to give you a little background on YW Boston, for over 150 years we have been dedicated to eliminating racism, empowering women, and promoting peace, justice, freedom, and dignity for all. Today, we engage individuals and organizations across the state to create more inclusive and equitable environments for women, people of color, and women of color in particular. As part of that work, our LeadBoston program is cultivating inclusive leaders with the skills and understanding of systems necessary to address disparities in all sectors. Our panelists, Dr. Julie Levison and Dr. Jonathan Jackson are both alums of our LeadBoston program.

Julie is Co-Director at the MGH Chelsea HealthCare Center Community Research Program, Assistant Professor of Medicine at Harvard Medical School, and a member of the Infectious Disease Society of America. Julie's research focuses on understanding and addressing disparities in HIV outcomes in minority populations with specific attention to immigrant populations.

Jonathan is Founder and Executive Director of the CARE Research Center at Massachusetts General Hospital and Harvard Medical School. The CARE Research Center investigates the impact of diversity and inclusion on the quality of human subjects research and leverages deep community entrenchment to build trust and overcome barriers to clinical trial participation. His research focuses on midlife and late-life health disparities in clinical settings that affect Black populations.

Julie and Jonathan, thank you so much for joining us in today's conversation.

**Julie Levison:** Thank you.

**Jonathan Jackson:** Thanks, Beth.



BC: Before we get started, you are both human beings who are dealing with what's going on. So, before we get you to go into your clinical and scientific mode, I just wanted to ask, how are you both doing? Julie do you want to go first?

JL: Okay, sure. First, I want to say thank you to YW Boston, to Beth, her team, and Jonathan for inviting this conversation. As the numbers—I can also see the numbers bloom on the bottom of the Zoom screen—and I can't tell you how heartening that is. I think one of the challenges in an emerging infectious disease crisis, or any kind of crisis, particularly in this moment where we're physically separated, is the emotional consequences of that physical separation. So, we're finding new ways to connect and the fact that over 400 people so far logged in fills me with a sense of optimism and solidarity. It's that kind of feeling that gives me a restart, refresh button every day. So, I just want to communicate a tremendous sense of gratitude for being with all of you.

BC: Thank you. And Jonathan, how are you doing?

JJ: Wow, Julie, that was a really great introduction. I'm doing alright. I think like many of you, trying to balance a whole host of responsibilities that I had gladly left to other people. So, you might hear a few noises in the other room as my daughter does her homework and the neighbors who are upstairs. I think overall, I'm doing well. Four weeks ago, I started presenting with symptoms of COVID but since then I've bounced back. There were a few kind of scary days there. So, for anyone who is now dealing with those symptoms or caring for a loved one or worried about those symptoms, I'm right there with you. And, I hope that over the course of the next 54, 53 minutes that we can bring some order to your world and help you figure out where we go from here.

BC: Well, thank you. And thank you for sharing that you personally were affected. Thank you both for your opening comments. And Jonathan, can you talk a little about what your observing at MGH with regards to COVID-19?

JJ: Yes, goodness. MGH like many other hospitals or academic medical centers is very much on a war footing, which means that everybody who can be reached to help the effort is helping the effort. They are bringing lowly PhD's like me to help with the medical and the clinical side whenever possible. Not doing patient care, but I am handing out masks and trying to keep spirits up. But on the scientific side, which is really where I spend most of my time, I've never seen a more impressive redeployment of resources and focus of efforts. It's difficult to get any two scientists to agree on what time it is or what day it is, but nevertheless we see tens of thousands of researchers and thousands of research labs all singularly focused on the challenge of COVID. I've never seen anything like this in my lifetime, I've never heard of anything like this in my lifetime. And I doubt very much that we'll see this sort of singular focus again. It's truly impressive the minds and the diversity of the minds that are at work on this.



BC: Thank you. Julie, any additional observations?

JL: You know, I really concur with Jonathan. I think despite whatever disagreements we might see in sort of the larger political landscape, as a medical institution I would say, on the whole, we are so resolute in our purpose. As a clinician, one of the things that we train for, and it was interesting when I was in the selection for residency, they used to say we pick people who we want to be up in the middle of the night at 3 a.m. in a crisis with. You know, those are the people that you want to stand side-by-side [with]. And so, one could have debates over whether we could foresee such an event like now, I think in many ways, in particular infectious disease, we train for the worst-case scenario. So, we get a little bit of bristles in our hair, we stay resolute about the things we think are really important for saving lives and improving wellbeing. So that kind of message day-by-day I think has been very helpful. Jonathan and I receive multiple emails a day about hospital status and where things are going. So, I think communication has been very clear and people are marching forward with a very short timeframe so we can deal on a day-by-day basis and adjust as needed.

BC: And, Julie, one of the things you wanted to talk about too is thinking about the health inequities that this pandemic has shone a light on. Can you talk a little bit more about what you are seeing?

JL: Sure, well we can talk about Massachusetts and many of the stories in Massachusetts are being mirrored across the country. My clinic, I'm an infectious disease specialist at MGH Chelsea, for those of you who are in the area, Chelsea is a city not too far from the airport. We have about 40,000 residents whom 60% are Latinx and half of our residents are non-U.S. born. And one of the beautiful parts of our history in Chelsea has been our welcoming of our immigrant populations over time. So, we have a long history of an old Jewish population, Irish population, we really are a multi-cultural city. With that, we have many of the challenges that come with, not only non-US born population, but also those with low socioeconomic advantage. And those have laid the foreground for vulnerability to this condition. And I frame these comments and I'm talking about Chelsea because we are currently the highest case count in Massachusetts at 92 per 10,000, which is equivalent to the state average of New York in terms of COVID-19 cases. So, we have high population density, our household composition is dense and intergenerational. So, why is that important in terms of COVID-19? We are learning things that are new every day about the disease, so we know that maybe 40% of individuals will have no symptoms or mild symptoms. But there's also what's called the pre-symptomatic phase. So, individuals may have no symptoms 2 to 3 days before they have cough or fever, but they're still shedding virus and actively infectious. So, when we have households where there may be children who have mild symptoms or individuals who have no symptoms and they're congregated in close conditions, it's like wildfire. And then the other lighter is that about 80% of our



citizens in Chelsea are essential workers who lack the luxury to be able to adhere to physical distance. So, we're emblematic of [what] I would call multi-level inequities that go from the individual to the community to the structural environment. And these are mirrored across the state as well. We see Lawrence, Everett, Revere, Brockton, other communities that are really enriched with racial ethnic minorities; and around the country Chicago, Milwaukee, North Carolina. So, I mean, the only thing that I would add to that is just how important it is to be systematic about how we're thinking about possible inequities. I've mentioned some, and a key component is bringing in as many stakeholders as we can to expand what we think are the key drivers here so that we can really be as comprehensive as possible.

BC: Thank you. And, Jonathan, I wanted to ask you, why is it important to be reporting on the age, race, and location of those affected and why States took so long? I know Boston is doing that now, I know some states have taken a while, even the CDC were reluctant. So, I would love for you to talk about why it's important to share that information and tracking? And what was getting in the way of organizations and states doing that?

JJ: Yeah, it's a great question. And I think for the people that work in the field that I work in, this was something that we expected a bit of a hammer blow when it came to starting to hear about inequities because, I know that COVID-19 kind of broke time, but about a month ago we were all talking about COVID-19 as the "great equalizer." The fact that anyone anywhere could get it, and so we all needed to join together to combat this really frightening virus. But I think over the last ten days or so, the public has really started to understand that that is not the case. Never, ever the case. Where we are seeing these hotspots for COVID-19, we are starting to see some of the same old rhetoric popping up which is that this is something behavioral, this is the fault of the communities somehow. Even if we're sort of benignly chiding them, we're starting to see that. But really the way to understand a disease, the way to understand anything, is by measuring it, by having information, by gathering data. And most importantly, most crucially, being transparent about where that data comes from, how good of a quality you have, and what the shortcomings are. Transparency is always good in a crisis. It helps us do the big, fancy things that you hear about in the news like contact tracing that we're seeing that might be coming from Apple and Google, it helps us deploy resources which is why we talk about how the Census is so important. But, from a purely scientific standpoint it is absolutely crucial to have this kind of inequity information because it helps us understand what the disease looks like, how the disease works, and how to stop it. So, we know that the most advanced medicines that we deployed in the last 10 years aren't any kind of cures or treatments that are unnecessarily all-powerful, but they are precise. They are targeted. They are rooted in the idea that we have a very deep understanding of what's going on in the body and what's going on with the disease. So, a case in point is thinking about the advances we've made since 2010 in cancer are mostly down to something called immunotherapy.



And the only reason that something like that works in this case of cancer is because we spent decades, billions of dollars, understanding the ins and outs of every kind of presentation of cancer that we can. So, understanding where COVID-19 hits hardest, who's affected most, what kinds of comorbidities are really driving the risk, is the only way that we can have a complete understanding of COVID and this novel coronavirus which didn't really exist until the end of last December. So, the more information we have on who is vulnerable and where it's striking, the quicker we can defeat the disease. The problem is that it's really hard to get this data. There's missing data, there are problems with privacy and identification. So, if you are going to a hospital that mostly serves privileged people and there are only like three people that look like you, and one of you has COVID-19, it's not going to take a genius to figure out which of you has it. So, we have to protect people who are most vulnerable, we have to make sure we have high data quality, whether your gender, status, race or ethnicity, we know that we have a lot of missing information, so it's low quality data. And we know that data is not reported consistently across institutions. It's tough to put all this data together in a way that makes sense. It's tough to make sure that we get this data. And then there are obviously systemic concerns. We are living in an age when people think it's a good thing to say that we don't see race and backed on the idea that everybody should be treated exactly the same irrespective of their gender identity. There are lots of places that don't ask for it because they feel like that's doing a good thing. But the problem is that we are losing detail, we're losing specificity, and the more that we can do that, the more that we can share information and partner with vulnerable communities rather than patronize them, the better and more quickly and the more efficiently we can defeat the disease.

BC: Thank you. And do you or Julie feel that because of this lack of data, communities are being most left out because we are not getting the data in a timely way to know how to help address those communities?

JL: One point that I would add is, and we've seen this in HIV and in general with the acceptance of primary care and health promotion activities, our health system is really a cultural construct. It's based on what's convenient for healthcare workers to deliver care from usually 9 to 5, and I'm making an assumption there, we do have facilities that provide evening care and early care, Saturday care, but the reality is that for many of our most vulnerable populations that have one, two, three jobs, the ability to come in for an appointment is a luxury. I think the fact that we are, in most settings, waiting for patients to come to Health Centers, if they can even get a test, is an assumption that that is either something that they can do or would do. I think that we have to demand for testing to be more accessible and to be community-based, but to really revise our thinking through trusted care providers. Health Centers that have community health workers and trusted community agencies that have workers that know—on a block-by-block basis—families, communities, and begin checking in on one another on a systematic basis and have the capacity to give tests. We really need to reach out to



people. I think what we're seeing is an understatement and we have wildfire. And it's very difficult to envision a future of containment without actual numbers. And I think, exactly, I just confirm with [what] Jonathan [was] saying about knowing our populations. We can't understand transmission without having a better hold. I would invite us to really think about new models of not waiting for people to come to us, but with love and compassion seek out our populations and really better understand the needs that they have to be able to fulfill what we think are public health guidelines, which are physical distancing, that's again another luxury, and we really need to understand how to support that.

JJ: And Beth I'll just weigh in really quickly just to zero in on the question that you asked which is, who is left out. So, if you imagine that in any crisis you deploy resources to wherever you can think of or wherever you need it most, that's kind of where we are with COVID-19. I wrote this on Twitter the other day, but I think this is the best way to describe it. It's like knowing a hurricane has made landfall somewhere in the United States. You don't have any maps; you don't have any information. The only thing that you have to go on is a small flashlight in your pockets and what you can hear, if you can hear the cries of people who are needing help. So right now, we are operating in the dark from a scientific perspective and from a medical perspective. We can hear only the most privileged. We can see only those who are around us, but we know that far, far more people are affected. And unfortunately, because of the nature of our work, we are only primed to hear and see those who are most privileged. Those who are less privileged, whether that's because of their race, ethnicity, their gender identity, their immigrant status, where they live, if they live in a rural area, God forbid they live off of the coast of the United States. We don't hear or see them nearly as well. And so, we are left largely without a clue of the true impact of where COVID has landed.

BC: This raises a question for me in thinking about and something Julie talked about—the role of community centers. How are community centers being impacted currently and what is going on? Are there resources being directed their way since they often serve voices that we don't hear?

JL: One of the key features in an emerging infectious disease, like COVID-19, is being able to separate individuals who may be infected and contagious, and those who are not. So, one of the things that rapidly happened at MGH Chelsea was an evolution. We are like a little hospital. We have an emergency room, we have multidisciplinary specialists, we have primary care, OBGYN. And what we needed to be able to do is transition the health center to predominantly a respiratory infection clinic, which in the past week is what it's become. And I think what that shows is [that] the challenge for many Health Centers and health systems is to continue base level care for chronic disease management. Those things don't go away, the heart disease, dementia, substance use, mental health issues. So, we need to continue to serve those needs, separately respond to—both geographically and in an encounter—a highly contagious



disease. We have supplanted the usual routine care with Telehealth. That really reconfigures what we think of the community health encounter and the primary care encounter, which is really based on seeing one another. Communicating not only verbally but with non-verbal cues, often visiting, seeing patients as family. And not all patients are ready for Telehealth and not all health systems are ready for Telehealth. And so, it's changing the quality of those encounters. And so, I think the silver lining is that, yes, many patients need broader access to help and maybe we will shorten or in soon time escalate a method of really out-reaching patients in a community health center, not only the one-on-one but the Telehealth. But to be really able to do that in a way that keeps care individualized. Many patients don't have a smart phone or are unable to maintain the bandwidth for video conference over a sustained period of time. So, I think it's creating new challenges.

BC: And I would also think that certainly for some of the elderly, that Telehealth is also more challenging, because of being able to be technologically savvy as well. So that's another population that may be underserved during this time. I wanted to ask a little bit of a different question and think about the vaccine for COVID-19 and how do you think about the testing for that, the research that gets done, and the equity considerations that go into developing a vaccine?

JJ: Yeah, I'll start and maybe Julie can weigh in as well. This is actually where I've been spending the bulk of my work during the last weeks. So, we have a little bit of a problem when it comes to the COVID-19 vaccine. And let me set the stage for you, you probably heard through the CDC or Dr. Fauci mention that the timeline for getting a vaccine approved is probably about 18 months from when this all started. We are looking at probably August 2021 before we can have a vaccine for COVID-19 that we're highly confident about. And, honestly, that is much faster than we normally do clinical research. Much, much faster. So, we have to acknowledge that science is slow, even at its fastest. We've broken records in terms of sequencing the virus, in terms of developing a number of therapies, we've launched a whole bunch of clinical trials. But on the surface of it, number one, science is slow. So that means that people who are unusually vulnerable to COVID-19 will not be able to take advantage of a vaccine, and they won't be able to really participate in a research study that might give them early access to this vaccine. The second problem is where the vaccines are being developed. Now, Julie and I are privileged enough to be a part of Massachusetts General Hospital, one of the teaching hospitals of Harvard Medical School. It's one of the ten national centers that really gets to be mobilized for any kind of major disaster of an infectious nature like this. We get to be on the frontlines of helping advance those efforts. But guess what hospital has zero protocols for a COVID-19 vaccine or for a clinical trial. There's no one in the BMC system that has any access to a clinical research study that might give them early access to a vaccine for COVID-19. So if your insurance does not allow you into something like the Partners Health Care system, or you have to jump through hoops to get it, which is going to be hard to do in the best of times much less



during a global pandemic, then you have no opportunity to take advantage of early access. And then what's worse is that when a therapy does come along, we will not know how it works on safety-net populations, we will not know how it works on the most vulnerable communities, most of which do get their care outside of the Partners Health Care system. Now, Partners does serve some marginalized populations, especially those coming out of Chelsea, but the vast majority of folks, rural individuals, older individuals, black and brown individuals, individuals who are non-binary, they get their care elsewhere. And we are not offering those vaccines in an investigational stage to many of those other facilities. So, just like we see with many, many other research clinical trials, we don't know how this works on the most vulnerable, even though we're seeing devastating effects on the most vulnerable. So, they are being left out of any really strong acute care possibilities, they're being left out of clinical trials. And, honestly, I think what we will find is that the country as a whole, as we start to "reopen the economy," will tend to leave these groups behind. So, there's a triple whammy that we're in the midst of. I know that we've talked about multiple waves of these pandemic and unfortunately even when it comes to the development and rollout of a vaccine, vulnerable communities are being left behind again.

BC: Julie, do you have anything to add?

JL: Yeah, to follow up with Jonathan. Jonathan and I see things often similarly which is why I often love working with him because I learn so much from his perspective. Both of our work is heavily community engaged, my research uses a framework called "community-based participatory research." The framework on its head says that we are embedded within communities, we change the relationship of academic research to try to, I think, democratize the process to say, I may have a certain skillset, as well, individuals with their lived experiences have an equally valuable skill set. And what I would say the application here is, which we know now but we knew this before, is the vital role that community stakeholders play not only in development of protocol about data acquisition and privacy and confidentiality, but also in protocols about how vaccines will be tested, developed, and implemented. We know there is a long history, it's called this quality chasm, the 17-year gap between developing an evidence-based intervention and actually getting it into practice. We know that is highly unsatisfactory, we want to accelerate the integration of science into care. And part of that is to be able to integrate the populations that will experience the benefit of science so that they can tell us how to do it right. What is adherence going to look like? What are our concerns? What are potential conceptions around getting an injection? We did this kind of work, and do this kind of work, in Puerto Rico around ZIKA with colleagues that were highly concerned that communities were not involved in a vaccine process related to ZIKA. And we were worried about issues of community trust and adherence to any kind of uptick of the scientific promise of a vaccine. I would underscore the importance of Jonathan's work and the work that his team is doing in really having a presence in the community. As well as at MGH Chelsea with the research program trying to solicit





people's feedback about what a vaccine would look like. Now we have to be creative about how we get that input, maybe it's Facebook, maybe it's social media. Maybe it's Zoom, Whatsapp, but we still need those voices to inform how these protocols should be.

BC: I would imagine that there are potentially things that people could do to perhaps get leadership in hospitals and other places to be more, I guess, intentional around this. Is there something people can do? I could imagine folks on this call or listening to this Zoom would want to know, can I do something perhaps as an individual to help encourage people to test vaccines on greater populations? Is there anything, any recommendations, thoughts on how people might be able to influence this conversation?

JJ: I'll go first. Those of you who are on the call who know me personally, I'm an individual who always has ideas. I have no shortage, and this is no exception. There are two things that I want you to remember. Number one, remember that what's valuable about the people that are on this call, the more than 500 people that are on this call right now, is that this is probably one of the only venues that is robustly cross sector. I spend my time talking with a lot of...you know, for me, "diversity of job or position" means that sometimes I'm talking to a medical doctor, sometimes I'm talking to a research doctor, and then sometimes I'm talking to a research assistant. That is what diversity looks like in my average day. And there's a lot, there's still a lot of varied opinions. But the 500 people on this call are incredibly different in terms of the lives they lead, what they are seeing in terms of COVID, the power that they have, how helpless they feel, who is being affected, and a lot of things about their specific identities. All of that matters. What I will say, the people on this call, these 500 people, have power. If even 10% of you were able to set things aside and mobilize a response, we could flatten the curve much more quickly, much more steeply with the help of any 50 of you, than we could on our own. So, keep that in mind. The second thing that I want you to remember, when we recover from COVID-19, and I promise that we will recover, we are humans, we're inventive, we will bounce back, just I would love for you to hold on to how helpless you have felt at times in the last five to six weeks. And I need you to remember that some people never get to feel any differently. They never get to feel any less empowered any less effective, or any more effective than these dark moments that we have right now. No matter how remote you are, no matter how few people you know who are personally affected by COVID, we will only ever be as safe as the most vulnerable of us. So, we have to find ways, creative ways just as Julie said, to listen to those voices and make sure that we defend their value. So, there are big-scale things that we can do. Number one, vote. Vote at the top of the ballot, vote at the bottom of the ballot. Make sure that the voices that you value, make sure that the perspectives that are important to you are represented in our democracy and that they are able to make decisions that you largely agree with. You probably aren't going to find somebody that's perfect but find somebody that gets to you and talk to them. Don't just vote, but also communicate. The second

eliminating racism  
empowering women



thing, might seem a little weird, is to do the Census. That has gotten a little buried with this COVID stuff, but it really is important. It feels scary and invasive and you can do it online which makes me feel a little weird, but it's really the only way to appropriately allocate resources. And we know that the most vulnerable folks are living in communities that are the most robust, and that are changing most quickly. And if we don't update that information, we won't get resources to them. Not just during COVID but any time after. But maybe you're looking for something that's a little bit more specific, so I'll run through a quick list of options. Number one, the most selfish thing that I can ask you to do is consider getting involved in medical research. There are a ton of research studies that are available online, [clinicaltrials.gov](https://clinicaltrials.gov), so [clinicaltrials.gov](https://clinicaltrials.gov) has a comprehensive list, including COVID-19 trials. Most major academic medical centers, again there are some notable exceptions, have some kind of page where new trials are being added literally every day. They are looking for people with symptoms, people without symptoms, people who have recovered, people who have yet to be exposed. So please consider getting involved in that. The number one thing that you can look for is to really demand transparency on the information. We talked earlier about reporting of specific data around COVID. We know that Massachusetts is doing this, we know that Boston is starting to do this, we know that those data are not complete. So, look for transparency, demand more from your elected representatives in terms of what they're offering and what they're able to do. And the last two things that I'll ask you to do and then I'll stop, try to support three people in your life. Support somebody financially, emotionally, musically, physically, technologically, historically. Whatever you are doing right now in your life, you have something to offer somebody. Even if you are just bearing witness to some else's story or struggle. Whether you're able to give a couple of extra bucks to somebody who isn't able to take time off. Whether you're able to offer an extra FaceTime or Zoom call to somebody that you haven't touched base with in a while. Everybody needs support. And right now, the most important thing that we can do as society is to be vulnerable with each other and to support one another. Because the government won't be able to save us all, we shouldn't expect it to. We have to try to do some of this work ourselves. Especially, ironically, the folks who need it the most. I have a group of friends who are working on what I think is probably the single most important response to COVID for vulnerable communities, which is they're trying to make sure that there is a more robust backbone and framework around mental health support, especially around peer recovery networks. So, if you want to learn a little bit more about that, you can get in touch with me personally, I'm going to regret this, but I'll give you my email address, it is [jjackson31@partners.org](mailto:jjackson31@partners.org). So that's jjackson, that's my name, 31, at partners.org. If you want to get involved with these efforts, if you have no idea what you can do and you want me just to throw you a list, I'll do that. But again, the most important thing that you, personally, individually, can do is to be supportive in underpinning, getting trained, offering financial support for these peer recovery networks, especially around mental health. This is the infrastructure that will save us if everything else goes down. Feel free to in touch with me if you need a list, if you need



an idea to get you started. Jjackson31@partners.org. I promise that there is something that you can do.

BC: Jonathan, thank you so much. I think so many of us are feeling a sense of helplessness and wanting to know what we can do, so being able to share what you did is wonderful. I think we are going to, for folks that signed up, send out follow up information, so people have that. If there are other things that you have for actions that individuals can take, feel free to share those.

JL: I think on my first two comments I'll focus on some leadership aspects, and the third about the peer component. One thing that has impressed me so much about the Chelsea response has been the whole-of-society approach. So, every day at 4PM there's a Chelsea pandemic preparedness call. All of us related to Chelsea are welcome to join. There are eleven subcommittees, from mental health to something called diversion and activities, which is some ways to keep people occupied, housing, and there is room for anyone who wants to help. And I think to me that speaks volumes, because of this idea that there is so many aspects to health. There are so many aspects to countering COVID-19. And so, one, the whole-of-society approach. For all of you that are on the call and have the opportunity to organize in your workplace or groups, to really think as broadly as possible on the domains that are impacting health, from mental health to environmental exposure, to access to care and spirituality, I can't emphasize that enough. The second part that Jonathan was alluding to is the issue of transparency. Many organizational settings are now in an incident command structure, which means that in many ways it is a militaristic structure, but the purpose really is to unify the communication channel so there's one message or simplified message coming out. But what that really behooves institutions to think about is how the information is getting up to the individuals that communicate out. So that really relies on building structures that require channels back and forth from the large amount of people that make up an organization or community, to the individuals who will be communicating and taking that information in and out from the outside world. So, we have this call at 4PM, and again everyone is welcome to join, and we are all learning on a daily basis as to what's getting better, what are the challenges, and trouble shooting. So, from a town that is affected greatly, to have this kind of structure is a microcosm of what can be simulated on a larger level. And the third item, which Jonathan spoke about, is the peer support which I think is a really unknown correlant of resiliency and how we bounce back from adverse conditions is knowing that we are not alone. That we really do need to lean on one another and sometimes it's just the mere idea of asking someone how they are doing and sticking around long enough to really hear the answer. But it's the curiosity for one another. And I hope that one of the silver linings is that we'll have more time for that curiosity. I know in my own clinical encounters with patients, because I still see patients during COVID, we have Telehealth visits, and I am starting the visits just asking, how are you? What is important to you now? Really learning from my patients, not only am I learning new content but I'm finding it sustaining as well because we're



connecting with one another. I can't underscore enough the value of the peer support and the curiosity for one another. I think that's emotionally sustaining and so critical.

BC: Thank you. I wanted to leave some time for questions. So, if folks want to send questions and I will try to pick out some questions to ask in our last remaining minutes. And while I'm waiting for questions, Julie and Jonathan, I know one of the questions that came in beforehand was somebody wanted to know what the world and the new normal would look like once the curve has flattened, three months or six months removed, how might our lives be different?

JL: A lot of that, I think, part of the anxiety with this is the sense of uncertainty. And part of that is driven by, for those who are able to adhere to the public health [guidelines], and part of it is wanting the individuals who have authority over many of these procedures, how much they're tapping into the community needs. I think we'll learn a lot over the next couple of weeks. I mean, even with the science in terms of understanding how we'll learn about immunity will change. So, I think, I am also thinking about... I am an inherent optimist, not that it's tethered to some naiveté, but really because it's our only way out. And I'm hoping that we can have more forum than have 500 plus people where can begin to think how would we reimagine or reengineer the type of society that we've wanted. One that addresses historical injustices, provides resources to those who most need it, and makes sure we have equitable inclusion of stakeholders. So, I think there are enormous opportunities, it's going to really be the responsibility is really on also on all of us when we're not necessarily seeing the change as fast as we may want on a more official level, that we begin to think as local stakeholders how we can make that societal change happened and push for it.

BC: Jonathan, anything to add about what the future, the new normal, may look like?

JJ: Yeah, I will try to be brief. I think that the number one thing that is likely to happen, we'll start to see signs of this in three months, we'll be fully in the swing of it by six months, we will realize that so many parts of our day-to-day lives and so many parts of our work infrastructure, our bank infrastructure, our life infrastructure, needs to be more flexible and more dynamic. And I think that a lot of the shifts that we've put into place, specially around our health, will be made permanent. But I don't think they'll be made permanent for everyone without loud, vocal, sustained support from the people who are on this call. So, like Julie mentioned, Telehealth is now broadly available for a lot of folks in a way that certainly wasn't before. I think a lot of that will stick around. But again, it'll stick around for the people who were maybe kind of fine, only slightly inconvenienced before it. It will remain a little bit tougher and maybe a bit more out of reach for vulnerable communities, places that don't have reliable access to Internet. I grew up on a farm in Texas, my parents still have dial-up, they think it's fine. So, Telehealth is not an option for my parents in rural east Texas and it isn't for many, many rural communities. Many nursing homes that don't have reliable Internet access, things



of that nature. So, we need to make sure that as we enter this new era, that is likely to be more flexible and dynamic, that everybody has a chance for that. Because we know that inequities emerge when systems are inflexible or selectively flexible for some. And if we can make sure that across multiple stakeholder groups, multiple sectors, again talking to the people on this call, we can make sure we have that flexibility that is offered to everyone, I think we'll all be better off.

BC: Great. Thank you, both. And another question around access for LEP patients. Can you talk about that and if you wouldn't mind also defining LEP for those who don't know?

JL: So LEP is Low English Language Proficiency. I'll speak to our institution which has now made treatment protocols available online in Spanish and spent a lion share of the first part of the response making sure materials were as available as possible in multiple languages. But again, to echo Jonathan, it's not just the language, it's the way in which encounters occur. And it's the solicitation of patient's preferences and trying to understand what their experiences are. We know that historically populations of color have been disadvantaged by the quality of the encounter with more directive statements rather than solicitation of their preferences. So, I think we're going to need to, as Jonathan said, be creative about delivery of mechanisms in terms of Telehealth. Yes, think about language as key, that loan applications can be submitted in languages other than English. But think more broadly than language as a disparity, but what is also embedded in culture and the manner of the human interactions in this clinical, hospital, and health system encounters.

BC: And, Julie, somebody asked how do they access the 4 PM Chelsea call?

JL: They can contact me, but I would imagine that on the [chelseama.gov](https://chelseama.gov) page there is a Pandemic Preparedness flag, otherwise someone can email me.

BC: Another question around [a] small foundation [that] has limited resources, maybe \$10,000, wants to know where might they be able to direct that, in your thoughts, to be most impactful?

JJ: I'll take a stab at this question. You know, what I think is maybe implied by that question is, how can we make that money go the farthest possible? How can we reach as many families, how can we reach as many communities as possible? And I would really encourage whoever is trying to think that way, that it is not lesser to reach lesser families more profoundly or more deeply. So, if there's a way to maybe alter the way that you're thinking about this question in such a way where reaching 100 families for a week is perhaps somehow better than reaching maybe 10 families for a month. That we try to think a little bit more about what equity can and does look like. Unfortunately, the state of nonprofits in Boston, and frankly in America, is terribly fractured. There is a lot



of people trying to raise a lot of funds to do things that are only slightly different, in some cases, than each other. So, I would recommend that if you have to go it alone, that you maybe try to reach a community that is deeply affected, maybe a community that is not necessarily appearing in the news so much, and that you try to reach communities of color, communities that are disenfranchised. Obviously East Asian communities which still are dealing with rampant racism, and it's not only happening when you hear about it on the news, especially here in Boston. But then the other thing that I would encourage you to do is to be fast, to be flexible, and to be collaborative. The odds are pretty good that there's another nonprofit foundation that's in the same situation as you and there's a chance that maybe you can team up. And maybe work with some kind of larger organization or funder to increase the fund or increase the reach of those funds. Again, I know lots and lots of groups that are trying to get things off the ground, really bottom-up types of things. If you're interested in supporting them, I can put you in touch. Again, I'm happy to give out my email for that. I would say to think very carefully about what equity looks like. And try to reach a group whose voice maybe hasn't been amplified through all this messaging around COVID.

BC: Thank you. And then somebody asked, can you provide a few actionable steps for how to support their most vulnerable employees? I imagine there are steps that MGH is taking, I would hope, for employees who are essential on the front lines. It may not be doctors or nurses, but even people having to work in the kitchen. So, are there practical, actionable steps that organizations can take for folks that don't have a choice but to be out?

JL: Thinking about measures such as paid sick time. We have employees that don't have earned time that's available that can't come to work for whatever number of reasons. So, giving people the financial flexibility so [to] not [be] living on the edge, either a day-to-day or week-to-week basis. Public transportation is a major source of spread and also one of the ways that many of us have been traveling to work. So, thinking creatively about options for those who can work from home. And making sure that, if you can't work from home, which is many essential workers, that they have a mask when they're able to commute. So really thinking on an hour-by-hour basis on what the experience is going to be like for the employee over the course of the day, and also when they get home. Really begin to troubleshoot as to which moments in their life experience are points of vulnerability. I think that these are moments when we want to be accountable to our staff, not only when they're at work but think about the exposure, vulnerabilities, challenges, as well as the assets that can help them when they are at home, like family that are nearby that can help with childcare and things like that.

BC: Jonathan, any last thoughts?

JJ: Gosh, I think the only thing that I'd like to say, I know a few people have dropped this call, we still have over 400 people, but please don't look away. Don't be unaffected.



I promise that as helpless as you may feel, as disenfranchised and disempowered as you may feel, you have the ability to change the course of this pandemic across Boston, across Massachusetts, across America. You just have to know what to do. If you need help, reach out to one of us, we can help you. But please don't throw away your power or underestimate it, because it's going to take all of us to move this needle forward together. And I think the best thing we can do is start to needle together almost a shadow infrastructure of support and vulnerability across a number of sectors that is flexible for everyone who needs it. That's how we are going to be able to protect the most vulnerable, but again, we are only as strong as the weakest of us. And if we can't defend them, then we are all going to remain highly vulnerable. Whether COVID comes back in the Fall or the next pandemic, or the next disaster, we have to protect each other.

BC: I want to thank everyone who joined the call, and particularly Julie and Jonathan for generously taking time out of your days to share your knowledge and expertise. We are really, really appreciative of this conversation. I know I could have gone on for another hour with questions, just wanted to hear from you both. For folks listening, we will be following up with a recording of the webinar along with links to the resources mentioned, and ways to support those most affected by COVID-19, and more information on the systemic inequities discussed.

If you would like to continue the conversation about racial equity and COVID-19, and identify ways your organization can be supportive, please consider participating in YW Boston's Stand Against Racism campaign this April. Visit [ywboston.org/StandAgainstRacism](http://ywboston.org/StandAgainstRacism) for more information. And then, you can also find information about YW Boston's DE&I programs, such as InclusionBoston and LeadBoston, again both Jonathan and Julie are alums of that program, information [is] on our website. And if you are in a position to contribute to the organization, we would greatly appreciate that to continue to do the work that we're doing and offering opportunities like this. So, again, thank you, Jonathan and Julie. It was really enlightening, thought provoking, and again for those that listened in.