

Prioritizing Equity video series: COVID-19 & Latinx Voices in the Field

On the May 14, 2020, Prioritizing Equity webinar, Aletha Maybank, MD, MPH, AMA chief health equity officer, and guests discuss the impact the COVID-19 pandemic has had on Latinx physicians and the Latinx community, highlighting how the public health crisis has deepened preexisting inequities.

Featured speakers

Moderator

Aletha Maybank, MD, MPH, AMA chief health equity officer

Panelists

- Ricardo Correa, MD, EsD, FACP, FAPCR, CMQ , assistant professor of medicine, University of Arizona College of Medicine and the Warren Alpert School of Medicine of Brown
- Joaquín Estrada, MD, FASCRS, surgical director, Digestive Health Institute at Advocate Illinois Masonic Medical, and the vice president of the Medical Organization for Latino Advancement
- Luis Seija, MD, resident physician, Mt. Sinai Hospital in New York
- Erika Flores Uribe, MD, MPH, director of language access and inclusion, Department of Health Services, Los Angeles County, assistant professor of clinical emergency medicine

Transcript

May 14, 2020

Dr. Maybank: Good evening, everyone. Thank you for joining this week's Prioritizing Equity webinar and series. Today we're going to be talking about COVID-19 and hearing from Latinx voices in the field, so very excited and looking forward to the conversation of this evening.

Just a few reminders of what we have available as a Center for Health Equity. As many of you may or may not know, we've now been around a little over a year as a center. We are the inaugural center, and it's the first time AMA has had this, but we've been working very hard, myself and the team, to make sure that we're trying to stay up-to-date with what's happening across the country, as well as sharing information that we hear.

We do have a resource center, a health equity resource center for COVID-19 on our AMA website, so please feel free to check it out. We will also put the link in the chat box. And last week, if you missed it, we had an awesome conversation with the med students. So inspiring. I recommend folks to just highly check it out. They have done a great job, and I think they're going to be wonderful leaders who know how to center social justice and racial equity, so please check that out.

And then next week we're going to be speaking with native voices from the field as well to hear what the experiences from our native community. So moving on to tonight's panel, we have four wonderful and esteemed guests that I'm very excited to have this conversation with. Dr. Ricardo Correa, who is at the University of Arizona College of Medicine. Dr. Joaquin Estrada who is surgical director of the Digestive Health Institute. Can you raise your hand a little bit because I realize folks may not realize who you are when I say your names. Surgical director of the Digestive Health Institute at Advocate Illinois Masonic Medical and is vice president of the Medical Organization for Latino Advancement, MOLA.

Dr. Luis Seija who is a resident physician here in New York City at Sinai Hospital, Mount Sinai. And Erika Flores Uribe, Dr. Erica Flores Uribe who is director of language access and inclusion at the Department of Health and Services in LA County and is assistant professor of clinical emergency medicine. So welcome to all of you.

I just want to before we go around, because what we're going to do is I'm going to have you go around and do your introduction and you can say—I kind of already said your organization, a little bit of your specialty, but still feel free to say what you want, but also I want you to talk about what Latinx physicians are going through during this crisis, what you've been seeing and what you've been experiencing. I do want to preface with we acknowledge that Latinx is a gender neutral and non-binary term, and I come from New York City, a lot of the millennials really held me accountable to this, of about promoting inclusivity. Luis is smiling and laughing. It was your generation, but I appreciate it.

Latinx are multi-ethnic, multi-racial population leading the nation's population as one of the fastest growing racial and ethnic minority groups in this country, but we also recognize that folks may use Hispanic and Latino interchangeably during the conversation, perfectly fine with that. So I just wanted

to make sure to express that and acknowledge that.

And then, I think, overall since COVID has been here, there has definitely been the elevation of inequities across the country. Lots of focus on black communities, but there's this constant tension and reality about the invisibility of people. And I think Latinx communities as well as native communities have not received as much attention from the media even though there are communities are all experiencing great inequities, and I think it's just really important that we talk about and highlight it. And actually looking at the latest data nationally, the Latinx population is about 27.6% of the proportion of cases, and blacks are 27.5%. So you know, they are kind of in the same space nationally.

Now, understanding if you go to certain communities, certain states, certain cities, there's going to be a variation potentially, but it is affecting communities and the Latinx community as well. So I'm going to have you go around and just again, you can say your name, and especially organization, where you are and what's going on as a Latinx physician during this crisis. So, Dr. Flores Uribe, can we start with you?

Dr. Flores Uribe: Thank you, Dr. Maybank. And thank you to AMA and the Center for Equity for this invitation, this really important conversation. So as Dr. Maybank mentioned, my name is Dr. Flores Uribe, and I am the director of language access and inclusion for the Department of Health Services. I think that it was a really good transition to kind of put into the introduction the limited health information that a lot of our communities are receiving. So my work is really focused on supporting the language access and cultural linguistic appropriateness of the communication that is public-facing. And I also work in the emergency department.

So our Department of Health Services is the second largest health system in the country, second to New York. We see a huge number of patients, that's 2.5 million encounters a year. And our racial/ethnic demographics are some of the most diverse demographics that we see across the country. We have 65% Latino population, 11% black or African American population, 5 to 6% Asian, Native, and Native Hawaiian. I understand that we would like to have this aggregate data, and that's our current limitation in representing those groups.

In that, 49% of our population actually prefers Spanish as their primary language. So we're really talking about the majority of our patients having a language other than English that they would either require an interpreter for in order to make an informed decision. In the emergency department I see this anecdotally based on the demographic data and most of my patients are Spanish speaking. I have maybe eight out of 10, nine out of 10 patients are monolingual Spanish speakers and can really understand the impact for this for some of our metropolitan cities.

So in the area of COVID we're really utilizing this platform as a way to expand opportunities to provide culturally linguistic-appropriate services and public health messages. I can get into the details in terms of what we're working on as a system in a later question, but I really wanted to elevate that segue in

terms of the limited health information and how do we bridge that gap for some of our most vulnerable populations.

Dr. Maybank, I believe—

Dr. Maybank: I'm on mute. Sorry about that. Before we move on to the next folks I just want to hear from you how has it been for you as a Latinx physician or Latina physician?

Dr. Flores Uribe: Yeah, thank you for that question. I think about this in different buckets, right. So there's the personal bucket. I am first generation in my family, both of my parents are monolingual Spanish speakers, and they're immigrants to the U.S. We've been in LA for a very long time. My family lives in this community, and when we think about essential workforce, my parents are custodians and all of those questions that come up in terms of, "Can people stay home? Can they actually practice the public health information or guidance?" is a very personal message to me. If I'm having conversations with my mother and thinking about is there paid sick leave, what is the implication for health coverage? Where can I get you information that's going to be reachable in terms of a cultural and linguistic, and also health literacy level?

My family is confronted with a lot of those challenges and confronted with the messaging around social distancing and living in multi-generational homes. From a cultural perspective, we're also very family-centric, so most of our support comes from being able to gather in, what I would say is a small gathering, but it would be greater than 10 people, which is the public health messaging.

Dr. Maybank: Right.

Dr. Flores Uribe: So those have been challenges in areas that we as a family have talked through in terms of how to create support, either through video chats or even by driving and saying hello while I'm in my car versus seeing my parents in close contact. And then as a physician, I think that it becomes a space where you know, it is a responsibility to elevate that need for communication and the need for our communities.

I've been fortunate that through my position I've really been able to have the support of my organization and the department of health services and the county in being able to raise awareness and seek support and resources for communications for our patient populations, as well as our groups who are working through patient-family advisory councils in order to co-design some of our interventions.

You feel the impact. It's very close. The patients who I take care of in the emergency department feel like my family. I think in terms of the very personal and professional level, I think now more than ever we are understanding what the need is in ensuring that our communities are represented in the medical areas and are part of the co-design of the system.

Dr. Maybank: Thank you. Thanks for that. Dr. Estrada, can we go with you?

Dr. Estrada: Thank you.

Dr. Maybank: How is it for you? And where are you at again? You're in Illinois, right?

Dr. Estrada: Yeah, so my name is Joaquin Estrada, and I'm a colorectal surgeon, a practicing colorectal surgeon in Chicago, in downtown Chicago. I did my training in LA County and following that went to Cook County, and then settled in Chicago. During that time a small group of us noticed that there was a significant need for Latino physicians to kind of rally around, particularly during the 2015-2016 election cycle. The sentiment and the depiction of Latinos had changed. And that was a galvanizing opportunity for us to create MOLA, which is the Medical Organization of Latino Advancement, so it's a completely volunteer, nonprofit organization now for the last four years.

Our work centers around creating a sense of community for Latino, Hispanic, Latinx physicians for career advancement, for linguistic and cultural competencies, standardizing that approach. We have program around personal wellness, and a lot of our work goes around health equities and trying to normalize the experience across all of our patients regardless of their ability to speak English or Spanish or whatever.

And then lastly, a lot of the work that we do is also centered around mentorship and creating a pipeline of future Latinx students that will pursue careers in medicine to help kind of complete that circle so that we can empower our youth to pursue careers in medicine and then go back into the community and serve those that need it most.

The COVID-19 situation in Chicago has been probably much similar as many of the other people that have spoken and that are going to speak. It's been a challenge obviously in trying to get the resources to the people that need it most. Luckily for me, we have this outlet within the organization that we've started to create PPE and face shields and gather masks and things and help distribute those supplies to the Latin community whether they're nursing homes that are primarily in Spanish-speaking communities or help hospitals that primarily help Latinos that are situated in our community as well. So that's been a very positive experience for many of our volunteer physicians where they don't know what to do. They want to do something. As physician we wanted to help our community, but we don't know how to do it because the traditional routes have been kind of closed off because of social distancing. Because we're not able to go into the office, we're not able to do certain things that we're accustomed to do, and this has been a nice outlet for many of our members to help give back.

So for me personally, I think I'm absolutely blessed in the sense that I have that as an outlet. I've tried to maintain a level equanimity and positivity through this, but I do see the toll it's taking on my patients as they lose their job, and then they're between insurance. Many of our Latino patients don't have the luxury of having COBRA, so they're going without insurance. So when I talk to hospital administration

they say, "Well, just have them go to COBRA." And I'm like, "That's not an option." Unfortunately, they don't have that as a capability, and so we're trying to navigate those waters where in this donut hole where they're between jobs, how do they still access the care that they need. So that's been some of the work that I've worked with both personally and also professionally with the organization.

Dr. Maybank: Great. I'd love to hear a little later how are you connecting those dots, specifically would be really useful to hear, I think, for folks in the audience as well as myself. All right, Dr. Seija?

Dr. Seija: Howdy. Can you hear me?

Dr. Maybank: Yes.

Dr. Seija: All right. So my name is Luis Seija. I am the resident physician in internal medicine and pediatrics at the Icahn School of Medicine at Mount Sinai in New York City. It's been a lot. It's been an experience. It's been a journey. It's been all of the above these past couple weeks and months during the pandemic.

I will start off by saying that when I first got to New York I always thought of my identity as a Texan more than anything else. I stuck out for saying, "howdy," and, "y'all," and all that stuff. Never because of the color of my skin or my culture or anything like that. But I think, especially in the context of the pandemic, that my identity as a brown person, an underrepresented minority in medicine, as a minority in general has really come into play, especially as the pandemic has highlighted a whole bunch of different social determinants of health and how it affects who is admitted to the hospital.

So as I was saying a little bit earlier before we started this, I was just reviewing my Instagram story and just kind of going back through things, and it just brought up a whole bunch of different memories and experiences about this pandemic in general. There's been a lot of good ones, a lot of bad ones, but I think the ones that stick out are the people that look like me, the ones that look like my mom, the ones that look like my sister and also the families that we take care of and how we try to make their experience, this isolating admission that is a COVID admission, the most human possible one, and something with dignity and something they can come out of.

There's also this idea that—I've never thought of this before, but these have been the most difficult discharges that you ever have to plan, a safe discharge plan, mostly because you have a lot of patients that are coming in contact with the health care system for the first time. They have newly diagnosed diabetes with an A1C of 13. All right, so but wait, they're uninsured, they're undocumented, so there's all these challenges that keep on coming. And then how do you ensure proper follow-up?

So I've learned that once you admit someone, the first thing you should probably think of is their discharge and start the discharge plan right from the get-go is one of the big takeaways for me.

Dr. Maybank: Thank you. And just to check in, are you going to need to leave by a certain time or

you're okay for the hour just in case—

Dr. Seija: We're good. We're good. I'm covered.

Dr. Maybank: Okay, okay, great. Glad you could join us. Dr. Correa?

Dr. Correa: Yes, hi. Thank you so much to the AMA for having us and talking about Latinx population. It's a real pleasure to be here. So a little bit of me. Originally from Panama, and then I did my training in internal medicine in Miami with a lot of Cuban population, and then I moved to Maryland for my fellowship with a lot of Central American population and started working in Rhode Island with a lot of Caribbean population. And now I'm in Phoenix with a lot of Mexican population. So at least I get a sense of different cultures in the Latinx population.

My daily work has been an endocrinologist and then I do some different things for the university I work for at the Office of Diversity and Inclusion. I'm the director for the diversity and the graduate medical education in trying to increase 100% of minorities for residence and fellows, and trying to decrease that gap that exists in Phoenix where 40% of the population is Latinx and just 3-5% of the population are physicians. So the community feel that difference and that's something that we have been pretty focused on during the last year.

Besides that, I always like to help my community, so I decided to join a charity clinic that, since six months ago, I have been the medical director at is called AZ PACH. It's an underserved clinic where we 99% of undocumented immigrants. It has been a very good experience because we have need to transition from the normal pattern of seeing patients to now trying to see these patients via telemedicine, but continuing with the access, we're trying to decrease them coming to the clinic.

So this population has no insurance. These are population that we are the safe place for them. Arizona, as you know per stories, is not a friendly place for immigrant population, oh no, sorry, undocumented population. So our clinic is a safe place for them. So we have been trying to provide, as much as we can, service to this population. One of the big things that we have been doing, is doing testing that just start this week. We didn't have resources to test our population, and then there were some events where we're sending the patients that require testing to the centers that are approved for testing, and ICE was outside. Then there was another issue. The community was very afraid.

So through the clinic, we have been able to produce a lot of educational material for the population, plus trying to bring, with partner with another non-for-profit, trying to bring that testing for PCR and antibodies now. The other part of my life is a member of the National Hispanic Medical Association. I'm board of director of NHMA. And with NHMA, we have been working very hard to spread the word across the country and trying to educate Latinx population that we are trying to produce things for our own community physicians, trying to get wellness and data, and we have been having a lot of phone calls and Zoom meetings by different chapter leaders to see things that we can do together and just

partner with everybody.

So up to now, a lot of the translation that has been happening, we have been working with NHMA central office for doing this, and that also help my country, Panama, and some of the rest of Latin America where I have been able to contribute what I'm seeing here, what I'm seeing on my patient and trying to spread that word to them.

Dr. Maybank: Thank you. That sparks a question for me. I think all of you kind of a little bit more explicit about it, but can you speak to the messaging that has been put out there, and how it potentially lacks alignment with the realities of folks? Clearly on the basis and the context of language itself, but even in the ways of messaging. I've been saying a lot that I just don't think the stay-at-home messaging has been nuanced enough in a way that aligns with especially communities of color, but I wanted to just better understand that for Latinx communities. What does the messaging create, and how does it create confusion potentially, or does it create confusion? And what needs to be done better in terms of the communication aspects of it? And you're all free to jump into this question as well.

Dr. Correa: That's an excellent question, and I can come with two parts. One is the messaging of staying at home, depending on where you are, it's not great communicated. Many of the times it comes from an English standpoint of view and do not adapt to the cultural standpoint of view that Dr. Flores already mentioned. So as a Hispanic community, we are very close together, so we like hug, to give kisses and to get out. We don't have to ask like in American culture, that you have to ask one week or two weeks before something to go to the home of another person. You knock the door the same day and you enter. That's how our culture is.

So, but that is changing. That is not what is happening in the last two months. And then that communication has not being straightly direct to the community unless you have partnered with, for example, in my case with a charity clinic that we really communicate in their own words what they have to do and what is happening. Because at the beginning what we felt was that this communities were just saying, "Okay, just stay at home," but staying at home meaning that you have 10 people at home. I was receiving a lot of phone calls, one of them from a grandmother that their daughter just came from giving birth, and she was asking me, "Oh, can everyone come and visit the baby?" Then you are like, okay, this is what is happening, and then you have to explain everything. Because our culture was like you have a new baby, everybody wants to go to visit. But then you have to try to explain.

I don't think that the message coming from the central offices are being direct to the communities, so it's more community-based and then if you are lucky and have somebody that is proactive in that community, then you get better, whereas since now, we don't have that. Now that we have had for at least one and a half months of trying to communicate through flyers, through using social media, through messaging of the electronic medical records that we have, now the patients a little bit

understand, or the population understand.

Dr. Maybank: Got it.

Dr. Estrada: I'd like to add to that if I can.

Dr. Maybank: Please do.

Dr. Estrada: So I think the point, there are some disconnects that you guys are touching upon. One of which the messaging is not culturally sensitive, obviously. That's the point that Ricardo made is that it's just not sensitive to our community. It's not how we tend to operate. Number two is that it's not being delivered by people that are traditionally trusted to give that information either. So it needs to be given by Latino doctors or Latino specialists, and unfortunately there's so few of us to give that message.

Number three, many of the Latinos don't consume the same media in the same way as other cultures do. Sometimes it's through the church or through print media and things like that, and unfortunately those things have been closed down. So the trusted guides that normally would be helping to articulate this message aren't immediately available. And then number four, stay at home. There is a disconnect because many of our Latinos are in a situation where they can't stay at home, the type of work that they do, so there is a disconnect like, "You're telling me to stay at home, but you're also telling me to go to work, and I have to support my family." So it's not nuanced enough.

Many of my patients don't have the luxury of working remotely. They have to go into the office or not to the office, go to the work site, and that inherently provides a level of confusion, where, "I feel fine, and you're telling me to go in. What's the deal?" It's not even being articulated that patients can be asymptomatic carriers and just stay at home.

So I think that's where the message stops, and it definitely needs to be relayed more thoroughly by trusted people that look like they belong to the community. I think that would go a long ways. Not to mention, being in the language that they consume.

Dr. Maybank: Right. Majorly important. Yes, please, go ahead. You just have to unmute.

Dr. Flores Uribe: I think those are very spot-on comments. I'll share this in terms of a patient's story because I think it really kind of drives some of these points home. I was in the emergency department the other night, and I had a 73-year-old woman who was coming in with a little bit of cough. So a lot of the organizations around us are suggesting and making recommendations that if the COVID well can go home, they should go home, and how can we prepare for a discharge or a follow-up for something like that.

So in engaging some of the initial questions with the patient, like, "What are the presenting

symptoms?" and waiting for the COVID test, she looked well, she didn't have significant shortness of breath or other symptoms that would be really concerning, in terms of admitting her from the beginning. But I engaged in the public health questions that we have for our general audience and said, "Okay, so if the test comes back negative or positive, are you able to practice social distancing and isolation at home?" And her answer was, "Yes, there's no problem. I can do that."

So knowing my community and my population and being a native Spanish speaker, I asked follow-up questions. "Okay, so tell me who do you live with and what does that look like?" So then she continued and mentioned maybe about 10 people, three of them who were also in their 70s or 60s she's living in a two-bedroom apartment, and I asked her, "Well, where would you stay? Could you stay in one of the bedrooms?" She's like, "Yeah, I can stay in one of the bedrooms. That should not be a problem." I'm like, "Okay, can you maintain six feet of distance from other people?" And in that I think her response was very sobering because she's like, "Yeah, no, that's fine." I'm like, "Okay, so you don't share your room with anyone?" And she mentioned, "Well, I share my room with my husband, but that's not another person." So even in that nuance of language we don't see the partner who we've been with for 50 years or a family as other people.

Dr. Estrada: Well I think that's probably a marriage thing though. Men get kind of written off a long time ago.

Dr. Flores Uribe: Yeah, maybe that's true Dr. Estrada.

Dr. Estrada: I think that transcends all cultures.

Dr. Flores Uribe: Yeah. I think that was a very sobering point though. I'm like, "Oh, interesting." So even in these recommendations, although we may be using the terms that seem to be general or common language, it may not translate to the behavior that we're hoping to engage in for safe communities. So I kept that patient because I mean, she didn't have the capacity to do medical isolation, and then she started to get a little tachypneic, so I think that made that decision a little bit easier for me.

But I really went home thinking what am I going to do for this large majority of patients that receive communications in this way, or that we print out the information in terms that may not be relatable. And I mean, our organization has done a really good job of getting the material translated, but that's also an assumption that our Spanish speakers can read. I mean, we have a very large immigrant population, and a lot of them are coming from an education level of third or sixth grade, and it's not the most effective communication platform.

And then, even within our own system, the way that we communicate certain things, it's an internal bias by the system, right? You have internet to check email, that you have wifi or you have access to a cell phone, which a lot of us do, but data plans might be limited, so even if we're sending text messages, can they access them? Are we having them incur a charge for a text message that we're

sending? Can there be someone who can facilitate opening emails and reading of that information?

So I mean to the earlier point by Dr. Estrada, the platforms in which some of our communities consume information is just not what's being released. And even if it is released, most of the time the information is delayed by two to three days if it's printed and translated at all. We target majority languages, but that does not include all threshold languages. And the information is not as detailed as it is in English. And venues to seek further information are also limited, right?

The CDC did a great job of translating all the information in the top five languages, but that was also very delayed. And when the message is "stay at home," what does that mean when we already have a population that has several comorbidities and already has some challenges with institutional mistrust when emergencies do arise. I've had other patients come in two days after they've had an NSTEMI. They're like, "Well, the orders were to stay home, so I didn't come until I started feeling even worse."

So I do think that there are opportunities for us to think about co-design. We've used our patient family advisory councils embedding some of our messages, and even when I speak to my patients, I take a very practical approach. "What does social distancing look like to you? How could we actually improve the current or create the current situation of where you live to meet some of these recommendations? And how can we connect you to resources?" Because in the end, if we don't have access to work or food, these other messages, they're not heard in the same way.

Dr. Maybank: Right. Luis, yeah please.

Dr. Seija: There's a lot of assumptions that go in with the messaging. I think number one is health literacy, which has been touched on by a lot of our other panelists here. But it's not just enough to hand someone their discharge paperwork and have the instructions on quarantining in Spanish and hope that they understand it. I mean, one of the things that we've learned, especially here, is that despite how hectic it is and chaotic it is, you have to take the time to explain a lot of different things.

You understand how to take your new insulin, all right. Or you're trying to set up a follow-up, but outpatient visits are limited now because we're trying to reduce exposure and person, blah, blah, blah. But we'll just set up a telehealth visit, we'll send a Zoom link. All right, you're making the assumption that they have Zoom. You're making the assumption that they have access to a reliable phone. And so there's a lot of ways that we have to rethink our discharge planning. We have to be up front and have a lot of honest conversations not only with the patient, but also with our consultants, the primary teams and social workers, like what is realistic for someone.

Last week I was in the nursery, and so having a baby is beautiful, it's wonderful, we love all that, but when you have a COVID mom who's trying to breastfeed, who wants to breastfeed, and they're asking, "Is it safe for my baby to do this and do that?" Or they have symptoms. You're on the adult side, and someone has symptoms and they're asking about their treatment plan, it's hard for us to

even start—for them to understand when we don't understand the disease itself, you know? There's still a lot of things in motion.

Then, more at a broader scale, in New York City at least one of the things we see from the messaging standpoint is we see Midtown desolate, Time Square no one's in it, blah, blah, blah. By zip code, Midtown's fine when it comes to cases. We need to talk about the Bronx. We need to talk about Queens. Staten Island. The only thing in Manhattan that we need to be worried about is 10029, which is Spanish Harlem. And not enough of that messages really gets out, I would say.

Also, the other thing too is, all right, the city sends out text messages, like broadcast text messages. Number one, during the surge period in particular, they're just like, "Make sure that you only call 9-1-1 if you are sick enough." So now we're asking our patients to self-triage, "Am I actually sick enough?" So you have a lot of people that are presenting late because of that. Then that's actually an issue because in the COVID treatment, your onset of symptoms and when you present is crucial. Are you a candidate for plasma? Are you a candidate for this clinical trial? There's all these different things that can go into play.

Then the other thing too that's actually a big deal here in the city when it comes to the messaging behind wearing a mask outside. So, I think something that we forget a lot is the way that we police our communities is a social determinant of health. Brooklyn, and then the NYPD just released a whole bunch of demographic data as it relates to arrest for not adhering to this. It's disturbing that black and brown people of course are the most affected. And of course we're also making the assumption that people have access to masks.

Dr. Maybank: Absolutely. Thank you for that.

Dr. Estrada: On that line too, wearing a mask as a man of color in public, it already can be a dicey situation. And then putting a mask on top of that, there's certain assumptions that are there that many, myself included sometimes, feels unsafe wearing a mask because if I'm going to a certain situation, people are assuming, if I'm not dressed like I am now, that I might be maybe not up to no good, and I have a mask on top of that that kind of casts a different tone in how people interact with you. So many people, particularly black and brown men, are very, very fearful of wearing masks in public for fear of how they're going to be reacted with police or with the public in general, so I think there's a disconnect there too.

Dr. Maybank: Absolutely. We have some questions already in from some of the audience, and it was one of my questions as well. Just speaking to how really public health patients' wellbeing is affected during COVID as it relates to public charge, and if we can—yeah.

Dr. Correa: Yeah, this is a great question because since before the COVID, a lot of the undocumented population, and population that were getting the process to permanent residency and all of that, they were a little bit afraid because of the public charge rule that was published exactly one

month before.

Dr. Maybank: Right. Oh no.

Dr. Correa: So that start a little bit of not good feeling in the community because the problem was that everything that you try to use, then can be used at the end against you, so they were not—and then COVID came, and things get worse. Even there was a statement that public charge rule was going to be hold, and nobody should be accountable of you if you come to hospital because of COVID. The population didn't believe that. And it's just because this administration has been certain things that has been happening that they mistrust. So that's a big problem that we have.

When a patient comes to see here, we cannot handle that in the clinic because definitely it's a hospital thing that we need to send. Whenever we tell them to go to the hospital we have to convince them, we have to take them. We have volunteers that do that work and try to see that at the end we don't get anything back. In the past, for example, outside of our clinic we have never had police, and then police start surrounding. Probably they are doing their job trying to see that nothing is bad, but also the community's, "Okay, what is happening? So the safe place that is for me in the past, it's not anymore safe place."

So all of this things has been happening. We are trying to make awareness to the community that in cases as Erika mentioned that you have severe event, MI, strokes, we have seen that they go two to three days later because they're afraid of COVID. And not only because they're afraid of COVID, because they are afraid that something else can happen to them regarding their process in getting a permanent status. So we are trying to communicate a little bit more and trying to use our resources that are limited. We're trying to use our resources more for that.

And I think that we need to do a better work communicating about the public charge rule and trying to advocate for this people during this time, for this community during this time because definitely it's not only affect the immigrant population, but it affect also the entire public health system. So that's something very important.

You're on mute, Dr. Maybank.

Dr. Maybank: Usually I keep myself off mute, but there was music in the background, so I said let me mute it. Anybody else want to reflect on that? There is another question. The question is, "Why isn't there more focus on farm worker, close-quartered workforce populations?" Anybody want to touch base on that?

Dr. Flores Uribe: Let me unmute. I mean, I can share a little bit about how our organization is thinking through more of what are the areas that we can work on. I think that this is a really challenging conversation because a lot of these opportunities were present before COVID. These were challenges that we were faced with before COVID. And the urgency of the state and the volume

of people impacted, I think, is just really creating more momentum for that.

So in terms of close-quarter workers, or even our immigrant population, the Department of Health Services actually has a program for those who are undocumented to access services. We actually have about 100,000 people who receive care through community partners and through integration of services through other Department of Health Services. Any of that communication is very clear. Any resources, any care that you get, it's not dependent on citizenship status.

In terms of testing specifically for COVID or care for COVID, the Department of Health Services is going to transition in leading some of the testing at the county level, and the communications around that has really been that these tests are free. You will not be asked about documentation status, and any information is solely for the purposes of connecting you to care. With that effort, there are focused priority groups, and that includes our patients who are experiencing homelessness, those who live in group settings, including our incarcerated population, our SNF population, our skilled nursing facility. And then a real focus on those who have the need for cultural linguistic-appropriate communication and our racial ethnic minorities and those who experience poverty.

So we've been working through the communication campaign, and communication campaigns and really working in collaboration with our joint information center, so that's our operations communication coming in that goes up whenever a county goes into emergency status to really utilize their platforms to engage multi-lingual media, to engage in public service announcements that we can then funnel through our text messaging campaign that can reach, for example, that program of 100,000 undocumented patients who we care for. So it's more targeted in that way and more specific in terms of the messaging that we're providing with a specific connection on linking them to services.

So those are some of the way we've been able to kind of leverage. Again, really trying to get out to radio, talk shows, the news, the El Mundo televisión whenever possible to engage in these conversations and just making it very clear. It's free, nothing depends on your citizenship status, and we're really trying to get you connected to care.

Dr. Maybank: To build just a little bit on that, is anybody connected to or seeing more models of use of community health workers specifically? And in your areas of work, there's a lot of—you know, the evolution of the workforce as it relates to health, but I think the importance and the need of community health workers, it really demonstrates itself now, so I just wanted to hear if anybody's connected to utilizing them or had any barriers to that?

Dr. Correa: Yeah, so we moved to that model since everything's starts, so we have some champions in the different communities around that we cover. And then all of them we train them in probably—we were training them before, but really we have to do the crash course in becoming a community health care worker, and now they are the ones spreading the word. They are the ones come to us and tell us what is happening and how we can target that community.

So I think that the volunteers that we train as community health care workers has been a blessing for the system, because we can understand what is happening frontline very fast, and we can try and accommodate our resources to that. And I think something that was mentioned is other things that not just come with being stay-at-home and all of that, but it's the other social determinants of health. A lot of our patients are not having food. We have to use a lot of our resources to buy food, and then with the community health care workers, we bring their food to them.

Our sick patients are visit almost every week by a community health care worker. They don't have to come to the clinic, because also the telemedicine for them doesn't work. They are very chronic, sick patients. So we are using a lot of that resources.

Dr. Maybank: Got it. Go head, Luis, go ahead.

Dr. Seija: Something that I find really interesting is how you don't necessarily have to have a title to be a community health care worker.

Dr. Maybank: Of course.

Dr. Seija: It's funny. I took care of someone that delivered me Uber Eats once, and it's just interesting to see how these people from Uber Eats or Grubhub or DoorDash or whatever it is, how they came together to help have their own little network and devise simple solutions to reduce exposure and deliver food safely. So while they don't have a title, it's funny, even though the weather's kind of warming up now, they'll still come in bulked up with three pairs of gloves or this or that, or a ski mask. So they just learn from each other and they take each other's advice. It's really, really nice to see how they come together to come up with their own solutions.

Dr. Maybank: Absolutely. And I think from an equity context, and from the context of communities of color, I think coming up with our own solutions is absolutely critical during this time period. It's what we've relied on for years and years and years of understanding that we know our communities best, and if it's not happening otherwise, we're going to have to find some other ways for just pure survival through these times and as we go further.

I have a—go ahead, Dr. Estrada.

Dr. Estrada: Yeah. I think we could probably do a better job, the collective we could probably do a better job however of articulating how important each of these members of society are to everything. Many people live in their bubble, and they don't realize that the food processing plants, these essential workers do impact them. And this is perhaps the opportunity to articulate that we are one community. While you may not see the Latino butcher or whoever, that's the person preparing your food, and that person is helping you feed your family. Without those people in place, we're not going to be able to live our life the way that we're accustomed to living.

So, while that might be intuitively obvious to everyone on this call or listening to this webinar, it's not so obvious to the rest of the society that these people are essential and they have these pressures, and these are jobs that many people won't do. If we lose them because we don't protect them and we don't provide them with PPE and we don't provide them with the social supports that they need, then it's going to directly impact your quality of life as well.

I think that's a couple steps removed, but that's also how we can articulate that problem and create funding so that we can care for us. But I agree with what you said that the solutions need to come from within, because those are the ones that are going to stick. We have the best understanding to the community, but where those that are in the positions to share that message, we have to do a better job articulating how interwoven we are as a society and as a community.

Dr. Maybank: Yes, I mean that question of value, who values who is kind of a rooted question, I think, and a critical question when it comes to equity as well. The reality is systems, people, structures, powers historically have assigned value to people, and it has advantaged some and disadvantaged others. I think it's a constant ongoing question: How do we get folks to affirm humanity and how do we get folks to value others and have the political will to do differently than they've done before?

We're almost to the end of this, which this went by really quickly tonight. I wanted to ask about another aspect of the workforce and just talk about any concerns and the concerns about the possible expiration of DACA and how this will impact the dreamers in terms of their work in the health care work field, especially as it relates to licensure and other critical issues. Anybody?

Dr. Correa: Yeah, I can start. I know Luis has a lot of things to say, but I think we have been fighting very strong for DACA since long time ago. We have trying to convince, trying to move communities, trying to tell what this means. I think that sometimes the big problem is set, and I still facing this even though in the physician community, even though I have been trying to talk for many years about this. I still facing people that doesn't understand what is DACA.

Dr. Maybank: Yeah.

Dr. Correa: They just think bad things when you mention that word. So still, I don't know if they need

more education, I don't know because more than what we have been doing, it's I don't know what else. But definitely it's a big problem inside of the community that there are people that doesn't understand yet, and definitely this impact the outside part that is what is going to happen after the Supreme Court make a decision, and then we are going to get some of the problems. I'm praying that everything goes in a good direction and that the Supreme Court—the bright minds make a good decision. But definitely this is something that we should continue educating every day our colleagues in medicine so they can spread that and they can influence others. So every time you mention DACA recipient they don't think that this is bad word and, "Go to your country," and things like that that you hear, you see in the social media.

This, it's just because I think it's not because they're aggressive. I think it's because they're not understanding. Whenever you sit down with that person and you tell them what this mean, they immediately understand.

Dr. Maybank: They get it.

Dr. Estrada: And I think along those same lines, when we're with a crisis like COVID and we have such a shortage of doctors and doctors that can speak Spanish or doctors that are from the community and everything else, it's even more important that we protect this group of young doctors. And along those same lines, our international medical graduates, there are many states that still have very restricted guidelines for international medical graduates to practice, but yet we have a doctor shortage. We're sitting on a group of doctors that are acculturated to America, that are here, and they want to help but they can't.

What we've done at MOLA is created a petition so that we can take that to our membership and then also then to our governor to see if we can impact some change in that way. But I think both of those things right now, this is the opportunity to again, articulate why it's so important. More so than ever does society need more doctors regardless, the America society, regardless of where they trained or where they were born. We need health care providers at this point during this crisis. And that's our job is to try to help our politicians understand that.

Dr. Correa: May I speak to what Joaquin said? The second part, the international medical graduate, that's part of my passion. I think that do the correct thing is also important because when you start seeing what happen at the beginning that, yes, we need more workforce then New York make a statement that they are opening for international medical graduates, but it was not so clear how it looked like. It was not direct through the people. It was also you didn't know if—okay, you're an international medical graduate, but I have friends that are working as secretaries. They are a physician, but they don't have a license in the US, so they were a secretary.

They are on the frontline, and they didn't get insurance. So it was not so specific and say, "Yes, we open to international medical graduate because we have a lot decreasing in the amount of physicians." But there were all the states that started doing this except for New Jersey that was a little

bit more clear. The others were not so clear on how they are going to protect, what is going to happen after the COVID pandemic ends with this people that help, physicians that help.

So I don't know how Illinois is doing, but probably it's better. What my feeling was that sometimes, yes, we say we need more, then governors you convince them, and then they start just putting a statement, and then all the unintended consequence that you don't think about it.

Dr. Maybank: Got it. Dr. Flores Uribe—okay, go ahead, Doctor.

Dr. Seija: I'll be short.

Dr. Maybank: You don't have to be short, well, we only have four minutes. You have to be—that time. Go ahead.

Dr. Seija: All right, so basically, I just want to say is a reminder that DACA recipients are not just physicians. They're pharmacists, they're nurses, they're all the above, everything that we need during a pandemic and beyond. And they are a great contribution no matter what, and same goes for IMGs. They're some of the hardest working and smartest people I know.

Dr. Maybank: Yes, thank you for that.

Dr. Flores Uribe: I mean, I was going to add a more provocative statement on that to Dr. Estrada's point and earlier comments that it's not regardless of where you're from, but it's because of the perspective that you bring and the impact that you can make in our communities. This is where elements of our workforce really need to be valued, and we have to do the steps that Dr. Correa outlined. How do we actually create the infrastructure to care for our communities that are all interwoven?

Dr. Maybank: Absolutely. And just the team who's on with me, they're going to post a link. The AMA also has been urging for the ability for IMGs to also work, so it's advocacy we've been really pushing for in policies and ways of being. So we have three minutes. So in the three minutes, one, I just first want to thank you all for making the time for this evening to have this conversation. Also, just wanted to hear from you very quickly. You know, we're in the space of potentially—it shouldn't be potentially, but this is going to be a challenge to reimagine clearly, to redesign, and potentially, reconstruct the health and health care system.

So what is that one thing as brief as you can possibly think of that you think is a critical priority as we move forward to really help address health and equities as it relates to kind of redesigning, reconstructing—a quick go. So, go ahead.

Dr. Seija: So, it shouldn't take a pandemic for people to care about equity. I'll leave it at that.

Dr. Correa: For me it's increasing diversity and inclusion at every level. It's the most important. So your communities should look like your physicians or your health care workers. And that should be our next goal.

Dr. Maybank: Thank you. Dr. Estrada, Dr. Flores Uribe? Your last comment.

Dr. Estrada: Erika, go ahead.

Dr. Flores Uribe: Thank you. Thank you, Dr. Estrada. I mean, to put it simply, we've got to be able to speak with one another in a way that we understand whatever that looks like for communities. And then to put it more on a macro level, I think that equity needs to be part of the framework and integrate into our systems similarly as patient safety and quality. That has to be integrated in the way that we make decisions and roll out programs.

Dr. Maybank: Thank you. Center and equity. Dr. Estrada?

Dr. Estrada: I would agree with everything that has been said. I think it has to be, for the people that currently hold the power, they have to understand that this is something that is worth their while. And as society changes, the dynamics and everything else has to change as well. It's in society's best interest to invest in everybody so that when it does mature to the point where we're in more positions of power and we can make that influence, we'll do the right thing as well. But the time is now. The time is now. The society's already changed, and we need to be reflective of that and inclusive of that.

Dr. Maybank: Absolutely. Well, I want to thank you. If you all heard in the back, I don't know if you could hear in the background, but it's 7:00 here in New York City, so folks are thanking the health care workers, and you all for all the work that you are doing through this time. Thank you again for the conversation. Thank you to all of you who joined to listen in. This will be available within a few hours actually posted on the AMA YouTube website. And feel free to please share it around. We'll have some other follow-up pieces and we'll be on social media as well. But thanks a lot for everyone on the call today.

Dr. Seija: Thank you.

Dr. Correa: Thank you.

Dr. Flores Uribe: Thank you so much.

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