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Trust for America's Health Holds Webinar on COVID-19 Vaccine

LIST OF SPEAKERS

HUGHES:
Good afternoon and welcome to "Ensuring COVID-19 Vaccine Access, Safety, and Utilization; Building Vaccination Confidence in Communities of Color," hosted by Trust for America's Health, or TFAH for short. My name is Tim Hughes, the external relations and outreach manager at TFAH. We would like to thank our speakers and audience for being with us today.

For today's webinar, audio is through your computer speakers or headphones. We encourage you to share your thoughts and questions about today's presentation by typing them in the Q&A box. We will try to answer as many questions as we can as time permits. To open the Q&A box, please click on the circle with the three dots that are on the bottom at the far right of your screen. From there, select all panelists in the dropdown menu so your questions will get sent to the correct location and press enter.

Now, I am pleased to introduce the moderator of this even, Dr. J. Na--Nadine Gracia. Dr. Gracia is the executive vice president and chief operating officer at TFAH. Prior to working at TFAH, she served as the deputy assistant secretary for minority health and director of the Office of Minority Health at U.S. Department of Health and Human Services. Dr. Gracia, the mic is yours.

GRACIA:
Thank you very much, Tim, and thank you to everyone in our audience for joining us today for our web forum. For your awareness, today's webinar is being recorded by C-SPAN for

airing later this week. In addition, the recording will be available on the Trust for America's Health website next week.

Today's event, as Tim noted, is entitled "Ensuring COVID-19 Vaccine Access, Safety, and Utilization; Building Vaccination Confidence in Communities of Color." And this webinar is focusing on important and serious issues related to vaccine hesitancy, building vaccine confidence, and vaccine access among communities of color. Next slide.

On behalf of Trust for America's Health, I am so pleased to moderate this important discussion. As background, Trust for America's Health is a nonprofit, nonpartisan, public-health policy, research, and advocacy organization that is based in Washington, D.C. We recommend policies to advance an evidence-based public health system that is ready to meet the challenges of the 21st century. And undoubtedly, the COVID-19 pandemic is one of these immense challenges. At Trust for America's Health, we envision a nation that values the health and well-being of all and where prevention and health equity are foundational to policymaking at all levels of society. Next slide.

Since the spring of this year, we have held a series of webinars focused on the impact of COVID-19, including the importance of paid sick leave to stop the pandemic, protecting older adults from the harms of social isolation, how the pandemic is complicating current gaps in mental healthcare, and the disproportionate impact of the COVID-19 pandemic on communities of color. We also cohosted a congressional briefing on advancing racial equity by promoting health, economic opportunity, and criminal justice reform. And if you were not able to tune in for any of these events, the recordings are available at Trust for America's Health COVID-19 resources' portal on our website at tfah.org. Next slide.

Now, it should really go without saying that the COV--that COVID-19 is certainly an unprecedented and devastating pandemic in our lifetimes for our nation and the world, the likes of which has not been experienced in this century. While we have certainly seen disparities in past public health emergencies, the COVID-19 pandemic has greatly exposed our nation's systemic inequities. Because prior to the pandemic, communities of col--color already faced inequitable opportunities for health and well-being.

In the COVID-19 response, Trust for America's Health has been engaged in advocacy to Congress and the administration for emergency funding to states and localities to address the immediate public-health crisis, calling for data disaggregation to identify the populations at greatest risk for severe illness and death from COVID-19, and urging that federal resources be directed to communities that are disproportionately impacted.

And while we are raising attention to these immediate and pressing issues, we are also focusing on long-term solutions, calling for increased and sustained investment in public health infrastructure and public health approaches to advance equity and address the social determinants of health. Importantly and certainly the focus of today's webinar is advocacy includes increased funding at the federal, state, tribal, territorial, and local levels to strengthen the immunization infrastructure and systems to ensure that everyone has access to, and receives recommended vaccinations, to improve vaccine confidence, and to fight misinformation.

As we prepare for a COVID-19 vaccine, it is important to recognize that vaccine hesitancy and access issues are not new. For example, adult vaccination rates remain far below targets in healthy people, including for Hepatitis B, seasonal flu, pneumococcal and shingles vaccines. And these numbers are even more concerning among people of color, as racial and ethnic disparities continue in vaccine coverage among adults. And the underlying reasons are many, from higher rates to being un--being uninsured or under-insured, to lack of access to healthcare, to mistrust that's significantly stemming from historical to present-day experiences of injustice and discrimination as you'll hear from our panelists today.

Trust for America's Health has been one of the leading voices advocating for policies that would increase equitable vaccine access and build vaccine confidence. TFAH advocates for increased funding for the Centers for Disease Control and Prevention to strengthen vaccine ac--infrastructure and outbreak prevention response. And in addition, our organization has supported legislation such as the Vaccine Act and the Community Im--Immunity during COVID-19 Act which seeks to provide funding for CDC to increase vaccine confidence and create more equitable immunization distribution when a COVID-19 vaccine is available, as well as other vaccines. Next slide.

Now the COVID-19 pandemic, we have--have heard many saying that this should really serve as a clarion call for action to end system inequities and realize fairness and justice for everyone to be as healthy as possible. Just two weeks ago, Trust for America's Health released a blueprint for the 2021 administration and Congress focused on the promise of good health for all, and truly to transform public health in America.

And this blueprint report makes policy recommendations within five key priority areas, strengthening the public health system which has been chronically underfunded, protecting against health security threats, addressing the social determinants of health, and dismantling racism to--to achieve health equity as well as improving health, safety, and well-being for all people across the lifespan. And this report is available as well on our website. Next slide.

So, with that background and introduction, I really am excited to turn us to today's discussion about ensuring access, utilization, and safety of a COVID-19 vaccine and building vac--vaccine confidence in communities of color. Our objectives for today's webinar to highlight the importance of addressing the issues impeding access to, and utilization of, a safe and effective COVID-19 vaccine, and with these distinguished experts to delve into both the immediate and ongoing efforts that are needed as well as the long-term recommendations to build vaccine confidence.

As we have this conversation, I remind us though to never forget that we're not simply speaking about statistics and policies and programs. These are people, people's lives, their family members, their friends, neighbors, workers who have been on the front lines, and loved ones. And so, with that background, let's get started.

It's my pleasure to introduce our esteemed panel of experts. First, Dr. Wayne Frederick. Dr. Frederick is the president of Howard University and previously served as provost and chief academic officer. Most recently, the Howard University Board of Trustees selected Dr. Frederick to serve as the distinguished Charles R. Drew Endowed Chair of Surgery. A distinguished scholar and administrator, Dr. Frederick has advanced Howard University's

commitment to student opportunity, academic innovation, public service, and fiscal stability.

Dr. Frederick is the author of numerous peer-reviewed articles, book chapters, abstracts, and editorials, and is a widely recognized expert on disparities in healthcare and medical education. He continues to operate and teach medical students and surgical residents at Howard University's College of Medicine. And Dr. Frederick has received various awards honoring his scholarship and service.

Next is Dr. Julie Morita. Dr. Morita is executive vice president of the Robert Wood Johnson Foundation where she oversees all programming, policy, research, and communications activities. As the nation's largest, private philanthropy dedicated solely to improving the nation's health, the Robert Wood Johnson Foundation is focused on building a comprehensive culture of health that provides everyone in America a fair and just opportunity to live the healthiest life possible.

Before joining the Foundation, Dr. Morita helped lead the Chicago Department of Public Health for nearly two decades, first, as a medical director and ultimately being appointed to the department's top position as commissioner. As commissioner, Dr. Morita led the development and implementation of Health of Chicago 2.0, a four-year health-improvement plan focused on health equity by addressing the conditions in which people live, learn, work, and play. She has served on many committees including the CDC's Advisory Committee on Immunization Practices.

And our third panelist is Michelle Cantu. Michelle is the director for Infectious Disease and Immunization at the National Association of County and City Health Officials, also known as NACCHO, a nonprofit representing the nearly 3000 local health departments nationwide. At NACCHO, Michelle leads the immunization program to increase local health departments' capacity in prevention and control of vaccine-preventable diseases.

She oversees the management of the immunization advisory work group, national partnerships among multidisciplinary groups addressing vaccine-preventable diseases, and evaluation to further enhance programmatic strategies, practices, and activities. Michelle

has over 13 years of experience in public health with a focus on infectious disease prevention.

Thank you, again, to all of our panelists for agreeing to join us today. And to our audience as our speakers are presenting, you may begin already to start sharing your thoughts and submitting your questions and using the Q&A box. And, as Tim noted, we will respond to as many questions as possible during the Q&A session that will follow in the presen--follow in the presentations. I now have the honor and pleasure of turning it over to Dr. Frederick. Dr. Frederick.

FREDERICK:
All right, thank you, Dr. Gracia, for that kind introduction. And I'm certainly very grateful to Trust for America's Health inviting me to speak to all of you today. If we can get the second slide please. Next slide.

I want to begin with a note of optimism. Even amidst the worst pandemic in a century that has claimed the lives of more than 200,000 Americans and a protest movement that has forced our country to reckon with centuries old racial injustices and present-day ina--inequalities, I have never been more excited about our--or confident in the future direction of our country. As a (INAUDIBLE), I know the biggest obstacle to a successful operation is not the magnitude of the challenge, but the clarity of the problem at hand. I never go into a surgery blind. I examine X-Rays, as you see here, and dissect lab results to try and accumulate as much information and insight as possible before I use my scalpel to fight any affliction.

In American society today, all of our problems are laying right there on the surface, staring us in the face. That is not to say that there aren't those who would try to bury the truth. Of course, there are plenty of challenges that we have to deal with, but I still believe our country is ripe for change and good. Scientific research and advancements have improved in leaps and bounds from where we were decades before.

We understand the health issues facing the American population, how they are caused, and what we can do to prevent them. Public thinking is shifting to more widely acknowledged at disparities communities of color have to face and struggle against. We have data to definit-- to definitively prove that our cries for injustice are not groundless or baseless, they are indeed indisputable fact.

And every day, we are getting closer to finalizing approval of a COVID-19 vaccine. Even as recently as January, hardly anyone in the scientific community, including myself, would have believed this accelerated timeline was possible. But it goes to show that, when the world focuses on our communal problems and dedicates our collective resources to finding a solution, that this is proof of what we can achieve.

The existence of a vaccine, however, is not in and of itself a--a panacea. The vaccine will not be 100 percent effective for all people. But even more importantly, this achievement of science will not exist in a vacuum devoid of politics and history and economics. The vaccine will not be equally accessible to all people nor will every person who can access the vaccine be willing to take it. And to maximize the positive impact of a COVID-19 vaccine there is much we need to understand and prioritize prior to its approval and distribution. Next slide.

Unfortunately the realities of the Coronavirus pandemic have enforced a deep seated mistrust of the medical establishment among the black community. African American men and women are twice as likely to die from COVID-19. The reasons for this discrep-- discrepancy are many-fold and cam--and complex and require independent as well as interconnected solutions.

But amidst all the complexity of this statistic there is also the simple explanation that black people do not receive equal healthcare compared to our neighbors. And unfortunate but undeniable truth is that black patients have better health outcomes when we are treated by black doctors. Historic prejudices and unconscious biases among the medical profession continue to do real harm and restrict the upward mobility of the black community.

Throughout the pandemic black individuals have been turned away from hospitals when we should have been admitted. We have been prematurely discharged even when our problems

required further medical attention. And because of the income inequalities that continue to affect people of color we are more likely to work in jobs on the front lines where there is a greater risk of exposure to the disease.

All of this adds up to the black community bearing the brunt of a pandemic and being overly represented in COVID-19 deaths. These present day problems echo with a disturbing history which are captured prominently in two films, Miss Evers' Boys and The Immortal Life of--of Henrietta Lacks. There's the infamous racism of the Tuskegee syph--syphilis experiment where black men infected with the disease were lied to and permitted to go untreated despite the researchers knowing it was not in the best interests of their health.

There is the exploitation of Henrietta Lacks whose cancerous cells were taken and used for research without her knowledge or consent. The family received no financial compensation even as her cells reap tremendous rewards for scientific advancement. And Miss Lacks' medical history information was for many years publicly available. Again, without sanction from her family.

There are too many examples of African American individuals being used in scientific research without being fully informed or without giving their approval. We also have a problem in the opposite direction. Too many scientific research opportunities are conducted without involving enough or any black participants. Advance the next slide.

Drug makers approve for phase three trials of COVID-19 vaccine have been slow to report the breakdown of participants. But Dr. Francis Collins, the director of the NIH--the National Institutes of Health--has stated that Moderna, one of the companies working on a vaccine, received a "C" for including minorities. As of early September Moderna reported 26 percent of study participants came from communities of color including black or African American, Latinx, American Indian, and Alaska Native. If there are not enough people of color who participate in the trial then we cannot be ensured that the vaccine is safe (INAUDIBLE) of those communities or effective.

A vaccine with limited tes--testing could have unanticipated effects on black (INAUDIBLE). As in all drug trials the impact of medication can differ significantly depending on the

genetic makeup of a population. This is even more so with vaccines that depend on altering the immune system. It is therefore vital that the trials which usually hold about 30,000 participants include as diverse a set of participants as possible. And especially those who are more at risk.

This problem of trust has the potential to undermine the efficacy of a COVID-19 vaccine. If people do not believe in the effectiveness or safety of the vaccine they will not accept it. And if too much of the population remains susceptible to the disease it will not be safe to reopen our country and resume life as normal. The first step to resolving this issue of mistrust is to acknowledge a historical wrong and present--and present day problems that contribute to it.

Trust can never be restored if we dismiss and ignore those who feel anxious and hesitant. We have to understand where their mistrust comes from and give them good reason to begin to trust again. The good thing is we are making progress. While many companies working on a vaccine have not included enough black individuals, the 26 percent of participants from communities of color they achieved is much higher than the average clinical trial.

Research participants should look like the population and that would be 32 percent for these four groups. And I think Fauci, director of the National Institute of Allergy and Infectious Diseases has called for twice that number because of how high COVID-19 has hit them. And I have to agree. Clearly leaders within the medical profession are making di--diversity and representation a priority. Next slide.

The next step is for the medical establishment to partner with institutions that already have a high level of trust within the African American community. Institutions like Howard and other historically black colleges and universities should serve as a conduit to bring in black individuals for clinical trials in order to cultivate and repair the relationship between medicine and people of color. We are making great strides in this area as well. Morehouse School of Medicine and Meharry Medical College have been identified as clinical trial sites.

And very recently Howard has been selected by the national COVID-19 prevention network to participate in an upcoming phase three vaccine trial. This represents a vital development

to increase participation from the black community in the medical establishments' efforts to treat and eradicate the Coronavirus. It is vital that we make it as easy as possible for black Americans to participate in these trials and other clinical research.

We cannot expect them to disrupt their lives and go out of their way without compensation. While we're told some assurance that some of the circumstances that they're in would be at least taken into consideration. And we must make perfectly clear the value and significance of these endeavors on their lives--on the lives of their loved ones.

If (INAUDIBLE) should be included in plans to distribute the vaccine once it is approved, if the vaccine comes from some place people know and trust more individuals are likely to accept that it is safe and effective. In all areas of life we need to achieve equality. And the participants of clinical trials must resemble the population they represent. This is a problem but thankfully it is being recognized as one.

Today even historical wrongs are being righted while the scientific community continues to use healer cells named after those samples unwittingly taken from Henrietta Lacks whose family is now being involved in that research. And approval to use her genes and release her genome deep data must go to (INAUDIBLE) phase.

If we can correct some of these mistakes of our past then we should be able to solve the problems of our present. Unlike any other time in the history of our country we understand the magnitude and nuances of these problems and we have an abundance of people constantly working on solutions. Progress will be determined based not on our technical expertise or scientific advancements but on what we choose as a nation to prioritize.

By continuing to pay as great a emphasis on diversity and representation I am confident that we can end the pandemic on a more equal note than it was begun. Thank you very much.

GRACIA:
Thank you very much, Dr. Frederick, just for that incredibly insightful presentation historically to present day and--and really understanding some of the reasons for mistrust

but also the optimist that you express as well and the hope that we have moving forward. And we will--we'll delve into that more in--you know--our Q&A.

I'd like to now turn it over to Dr. Morita.

MORITA:
Thanks, Nadine. Can I have my first slide please? Hello. I'd like to start by thanking John Auerbach, Nadine Garc--Gracia and the entire (INAUDIBLE) team for hosting this important discussion, for their ongoing partnership with the Robert Wood Johnson Foundation, and for their steadfast support of public health especially now during the pandemic.

I'm pleased to have the opportunity to join this discussion about vaccine access, safety, and utilization and to share my perspectives as the Executive Vice President of RWJF, which is focused on building a culture of health and advancing health equity. And as the former health commissioner of the Chicago Department of Public Health where I worked for two decades and lead the department's 2009 pandemic influenza response.

I have marveled at the speed at which COVID-19 vaccines are being developed and I believe a successful vaccination program is an essential component of our control of the pandemic. And yet I'm concerned that the lack of confidence in our nation's vaccination program imperils the success of the program. In the next few minutes I'd like to share some recommendations for how we can best address the mistrust of vaccination particularly in communities of color. Next slide.

Before I review the recommendations I want to provide some background information. This slide depicts the disproportionately high COVID hospitalization rates among Native, black, and Latino Americans in the United States. I know the disproportionate impact of COVID-19 on communities of color reflected in this chart is not a new concept to any of you. And yet I feel compelled to share them with you because they underscore a few things. They underscore the systemic and structural barriers to health--health equity that plague our nation of baseline and are exacerbated during public health emergencies.

They make clear that these disparities are not unique to COVID-19. We have seen similar graphs during measles outbreaks, natural disasters, and H1N1 pandemic in 2009. And these graphs have inspired the nation and RWJF to confront health and racial equity more boldly and more strongly than other public health emergencies have. Next slide.

This slide may not be as familiar to you. It summarizes the data from a recent PEW poll revealing that across races Americans are hesitant to get a COVID vaccine. With the lowest rates of trust lying within the black community. And we know that the higher levels of vaccine coverage will be required to achieve herd immunity that we're seeking and to prevent the disproportionately higher rates of hospitalization and death among communities of color.

I share this slide with you because it represents the opportunity and the responsibility for us to create a vaccine program that is equitable. Predict--next slide.

Predictably, the communities that have long faced structural and systemic barriers to health and wellbeing are again being more adversely impacted. It can be challenging to know how to put the concepts of health equity into action. So RDJW released a set of health equity principles as a useful road map to guide more equitable and lasting response and recovery.

The principles include co--collecting, analyzing, and reporting disaggregated data including those most affected in decision making, establishing and empowering racial equity teams, identifying and filling policy gaps, and investing in public health and social infrastructure. Next slide.

There have been several sets of recommendations for ensuring an equitable vaccination program. Today I'll focus on a set that are closely aligned with RWJF's health equity principles. In June the NIH and CDC asked the National Academics of Sciences, Engineering, and Medicine to convene a committee of experts including renowned public-health experts doctors William Fadi and Helene Gayle as co-chairs. They were asked to develop a framework for equitable allocation of the COVID-19 vaccine.

Although the groups prioritized for vaccination in this report caught the most attention from the media, from policy makers, and public the committee also released seven excellent recommendations for federal agencies. Today I'll not be talking about the priority groups. Rather I'll review some of the other recommendations and highlight their role in building the vaccine confidence. Next slide.

The second and third recommendations are critical components of ensuring an equitable vaccination program leveraging--the--the second one is to leverage and expand the use of existing systems, structures, and partnerships. The third recommendation is to provide and administer vaccine at no cost to those being vaccinated. In the next couple of slides I'll review why those recommendations are so important. Next slide.

I know firsthand that these things need to happen. During the H1N1 pandemic, CDC provided national leadership and coordination with international organizations, state, territorial, and local health agencies, vaccine manufacturers, insurance companies, and other federal agencies to ensure that vaccine and supplies were widely available at no cost to the vaccine recipients. Next slide.

CDC was able to do this because they tapped into the existing immunization infrastructure, which is in place because of TFAHs and many of your organizations' strong, consistent advocacy for ongoing stable public-health funding. The cornerstone of this infrastructure is the vaccines for children program, a federal entitlement program in which the CDC works with state, territorial, and local health agencies to distribute more than 80 million doses of vaccine annually throughout the United States for Medicaid eligible, uninsured, and Native American children, approximately 50 percent of children in the United States.

The section 317 program supports other critical elements of the system and can ramp up to support the investigation and control of outbreaks through the delivery administration of vaccines. Building on this system is efficient and effective and--a mechanism for getting a vaccine to communities most impacted by COVID-19. But making a vaccine available won't be enough if nobody shows up to get vaccinated. Next slide.

I know that some of you are having a flashback as you recall your own experiences during 2009. However, I wanted to share how Chicago expanded our VSE program to include more than 800 healthcare providers to distribute more than 1.1 million doses in less than four months. This map depicts the H1N1 sites where vaccine was provided.

The Health Department collaborated with a few community and faith-based organizations to disseminate vaccine information in their communities. Unfortunately, these efforts resulted in only small increases in vaccine acceptance and demand from communities of color. Next slide. Chicago learned great lessons from that experience. We have learned that we needed to earn trust and establish authentic communication with communities of color during times of calm, and we also learned that two-way communication involves not just talking, but really listening. Next slide.

Since 2009, the Chicago Department of Public Health and many other public health agencies have been focusing on health equity and rigorously developing and implementing plans that bring more voices to the table, including those who have historically faced the greatest barriers to well-being. Healthy Chicago 2.0, and more recently Healthy Chicago 2025, prioritized health equity in content and in process. Key pillars of both plans include leveraging disaggregated data for planning and for use by the community, and engaging communities of color in the development and implementation plans for both. These established relationships were key to addressing COVID-19 when it emerged. Next slide.

The city of Chicago was able to rely on the Healthy Chicago partnerships when it became clear that the majority of COVID-19 deaths were people of color. These partners helped the city launch its Racial Equity Rapid Response Effort, a data-driven, community-based and community-driven plan to mitigate COVID-19 illness and death in black and Latino communities. To meet these goals, they focused on listening and responding to community partners in order to benefit and not burden communities, and working in partnership with black and Latino community organizers and leadership to develop a city-wide community mitigation effort. These relationships will be essential to the effectiveness of Chicago's COVID-19 vaccination program. Next slide.

The National Academy's fourth, fifth, and sixth recommendations are aimed at building public confidence, especially among communities of color. The committee recommended that federal agencies lead the coordinated response. They recommended that HHS create and fund a vaccine risk communication and community engagement program. They recommended that CDC develop and launch a national vaccine promotion campaign, and they recommended that CDC and NIH build an evidence base for strategies for vaccine promotion and acceptance.

Each of these recommendations emphasize the need to engage with communities to understand the concerns, develop appropriate messages, and identify appropriate messengers. More federal coordination and funding are needed for these recommendations to be fully implemented, and for the full potential of the COVID-19 vaccination program to be realized.

In 2009, and in every large public health emergency since then, CDC hosted media briefings and healthcare provider webinars that provided clear and consistent updates, guidance, and messages. CDC, ASTHO, NATO, and AIM estimate between six to eight billion dollars are needed to support vaccine distribution efforts. Without this coordination and support, widespread vaccine hesitancy will likely continue, and communities of color will continue to be disproportionately impacted by COVID-19. Next slide.

Although federal coordination and funding have been limited to date, some of this work is already happening. I heard from state health officials last evening who have. already begun this work. Last Friday, they submitted their--to CDC their immunization plans, which included their communication plans as well as community engagement plans. Other organizations are responding, too. TIFA (SP), the National Medical Association, and Unidos, has scheduled a convening on October 29th with a goal of developing policy recommendations for ensuring access to and utilization of a safe and effective COVID-19 vaccine among communities of color.

Some academic institutions are rapidly putting together initiatives to fill knowledge gaps and help inform decision-making about vaccines. RWJF is supporting Johns Hopkins and

NACCHO, a project focused on understanding and addressing vaccine hesitancy in communities of color. And RWJF is also supporting a high-level panel to make recommendations for managing misinformation related to COVID-19 vaccines. Next slide.

The critical thing to remember, is that earning trust for the vaccine and the vaccination system within communities of color is essential to building vaccination confidence. That means while we speak, we need to communicate clearly, consistently, and transparently; and, we need to remember that communication is a two-way street. All of us can work on this now, whether you are federal, state, territorial, local, public health staff, health care providers, vaccine manufacturers, policymakers. We need to be focusing on earning that trust of communities of color, by understanding their concerns, determining what messages and information will address their concerns, and identifying the most appropriate messengers. Next slide.

I hope the--I hope the recommendations and examples I shared today were helpful to you. The bottom line is this, there's quite a few things we can do right now to earn trust and help ensure a more equitable vaccination program. Once again, here are the resources I mentioned that help guide and inspire our work. At RWJF, we have made health equity our central aim, and the pandemic has made it even more clear; this is the work we have to focus on. It's time for all of us to work together to dismantle the barriers of structural racism. Together, we can set our nation on a course toward a more fair and just society, where everyone has the opportunity to thrive. Thank you.

GRACIA:
Thank you very much, Dr. Morita, for that informative presentation, the resources, and for indeed sharing the lessons learned, and practical examples from the H1N1 pandemic. We'll now turn it over to Michelle Cantu. Michelle.

CANTU:
Thank you. Can we go to my first slide, please? Great. Good afternoon, and thank you to Trust for America's help for inviting me to join you all today. It's an honor to participate on

this panel, and thank you to our previous speakers, Dr. Frederick and Dr. Marita, for providing your feedback and your words on this timely and crucial topic related to COVID-19 access, safety, and utilization. While COVID-19 pandemic has exposed the many cracks in our nation's public health infrastructure, I'm excited to be here today to convey how local health departments are tirelessly working to build confidence within their diverse communities and also share policies associated with this work.

Now, I'll first begin just by providing a little more information about the National Association of County and City Health Officials, or NACCHO. Next slide, please. So, we are a non-profit that serves a leader, partner, catalyst and voice for the nearly 3,000 local health departments across the country. We engage in activities listed here, and also conduct research and evaluation on local health departments through our National Profile Study. By advocating for local health departments, we aim for optimal health equity and security for all people in all communities. Next slide.

NACCHO has a 25-year history of working hard to focus on health equity and social justice. We know that health inequity is rooted in injustices associated with racism, discrimination, and social class, and all of these have implications for our work in public health. From developing the roots of health inequity course, to supporting the recent advancing public narrative in health equity and social justice, NACCHO is devoted to exploring solutions, and some examples of our work on this slide.

Another important concept in creating a shared understanding of health equity is the social determinants of health. And at NACCHO, we work closely with health and human services to support the adoption of Healthy People 2030 Metrics, including the Healthy People 2030 Social Determinants of Health framework, which identifies five key determinants. Our work in all of our programs at NACCHO is rooted in health equity and social justice. Next slide, please.

Local health departments are on the frontlines, and we know that nearly 90 percent of local health departments provide direct immunization services to both adults and children. Further, they play a role in other essential immunization activities, such as conducting

surveillance, providing education, and developing communication campaigns to bolster immunization rates within their communities. Local public health professionals remain committed and dedicated to addressing vaccine coverage, prioritizing health equity, and preparing for the anticipated COVID-19 vaccine. Next slide, please.

Through the national profile, we're also able to see how local health departments are governed, as units of local governance or state, shared, or mix. This is important to know for program implementation, as well as from a federal policy perspective, as policies from the federal level come down through a different context to get to the local public health level, and--and impact that work locally. Next slide, please.

NACCHO identifies that local health departments serve as their chief community health strategist. And in this slide, the public health agency sits at the core, and that is because they are uniquely positioned to convene and coordinate a multidisciplinary network within their community on any public health issue.

This network of local health departments and their community partners is critical for reaching and supporting people of color and other priority populations. And this is particularly important when we talk about immunizations at the local level. Local health departments are working with their community partners to disseminate credible information, calm fears, and dispel myths. They are experts on their regions, and understand not only the science but also unique needs of their communities. Next slide.

NACCHO has also conducted a 2017 assessment of local health department immunization programs to identify and explore the many facets of their efforts to address immunization and vaccine-preventable diseases within their local jurisdictions. This 2017 assessment highlighted two out of the five identified barriers, being vaccine hesitancy and lack of confidence, which create a significant barrier to the uptake of vaccines in local communities, and is a significant concern to local health department immunization programs. As outbreaks of vaccine-preventable disease continue to occur, it is imperative to mobilize local health departments to combat vaccine hesitancy and misinformation. Next slide, please.

Vaccine hesitancy and the lack of confidence in vaccines has drawn the attention of public health providers at all levels. And the Centers for Disease Control and Prevention has designated opportunities and funding to address this public health threat, through the Vaccinate with Confidence strategic framework. This has afforded NACCHO to work with demonstration sites to identify pockets of low vaccination within communities, and support local health departments in communication campaigns to work within their community to improve vaccine confidence.

It is also through this investment that NACCHO was able to build local health department capacity to address vaccine confidence and misinformation in un and under-vaccinated populations, through the Equipping Local Health Departments to Address Vaccine Hesitancy Project, and to continue to identify exemplary practices of the inclusion of communities of color through community partnerships and communication. Next slide, please.

During this time, NACCHO explored the impact of COVID-19 on local immunization programs, and the results of a survey conducted at the end of May showed that nearly 88 percent of local health department immunization program staff were reassigned to respond to COVID-19 response efforts within their local health department. Nearly 90 percent indicated that essential immunization program services were impacted, and 62 percent reported a noticeable decline in vaccine coverage rates. Despite this, local health departments adopted new and innovative strategies to provide services for their communities. And these essential services were provided through extended hours, through telemedicine, through providing home visits, and even through drive-through clinics. Next slide.

When we address Vaccine Hesitancy Project and to continue to identify exemplary practices of the inclusion of communities of color through community partnerships and communication.

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During this time, NACCHO explored the impact of COVID-19 on local immunization programs. And the results of a survey conducted at the end of May showed that nearly 88 percent of local health department immunization program staff were reassigned to respond to COVID-19 response efforts within their local health department. Nearly 90 percent indicated that essential immunization programs services were impacted, and 62 percent reported a noticeable decline in vaccine coverage rates. Despite this, local health departments adopted new and innovative strategies to provide services for their communities. And these essential services were provided through extending hours, through telemedicine, through providing home visits, and even through drive-through clinics.

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Well, we've seen many examples of local health departments working within their communities to bring community members to the table through stakeholder meetings or hosting clinical events in the community. We've also seen local health departments engage with influential messengers, community navigators, and community health workers to develop culturally appropriate messages, lead community conversations, and conduct trainings and participate in and recruiting for vaccine access events.

As many of you know, state COVID-19 vaccination distribution plans were due to CDC this past Friday. And as those that were made available or publicly available, it is clear that these are still in their interim phase or interim stage, given the many complexities and unknowns that still exist regarding the upcoming COVID-19 vaccination. However, many of those plans incorporated community partners and their offices of health equity.

As one example here, the Memorandum for Partnership for Health has been working over the past few months to develop guidelines for expanding immunization delivery during COVID-19. They put together recommendations to help implement various vaccine delivery efforts and to lay the foundation for a trusted analytical approach to disseminating a COVID-19 vaccine when it becomes available. This document was based off of Colorado's off-site vaccination clinic operation playbook that can be adapted to different circumstances to increase vaccination rates. It also addresses populations, key partnerships, and guidelines

for expanding vaccination services, including communication tips and guidance on specific delivery scenarios.

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Now, prior to COVID-19, we had seen a decline in workforce and budgets that have not rebounded since the recession. And alarmingly, state and local public health officials have reported an increase in job losses, resignations and threats from the public as they recommend public health guidance to mitigate the threat of COVID-19 in their communities. Regardless, public health remains committed and dedicated to addressing vaccine coverage, prioritizing health equity, promoting vaccine competence, and preparing for the upcoming COVID-19 vaccination rollout.

During this unprecedented time and in preparation for a COVID-19 vaccine, we need to ensure that all policies have a component that intersects with health to reflect what people in their communities need. In these policy recommendations, we say that increased programmatic spending should be continued and support the continued work within the community. Increased workforce and investment in workforce capacity is not only there to support vaccine delivery but also to ensure that local health departments are working closely with their community partners. Investment and infrastructure systems can ensure sustainability. Ensuring people with lived experiences are part of the process at every step of the way, and strong policies where the authority of public health is preserved.

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Now, I just want to highlight a few congressional bills that incorporate key components to assess state-based communication, education and that have implications for communities of color. As mentioned a little earlier, the vaccine awareness campaign to champion immunization nationally and enhance safety for 2019, where the VACCINES Act really was a bill that requires the CDC to take a series of actions related to vaccine rates and awareness to identify pockets of underutilization of vaccine in areas of low confidence and refusal. It also is an opportunity to conduct a national campaign to increase awareness and identify and prioritize engagement with communities with high rates of unvaccinated individuals.

Additionally, it also looks at the National Vaccine Advisory Committee under the Office of Infectious Disease and HIV/AIDS Policy to assess national confidence in vaccines and update a specified 2015 report accordingly.

The second is protecting seniors through the Immunization Act of 2019. And this bill focuses on providing key information to seniors regarding vaccines in the Medicare and You handbook and increase the coverage of vaccines under Medicare Part D, addressing barriers to uptake by including language to remove cost-sharing.

And then finally, the coverage, the Community Immunity during COVID-19 Act of 2020. And this bill is introduced into the House and referred to the House Committee of Energy and Commerce. And it's emphasized the need to increase the rate of recommended immunizations during COVID-19 public health emergency. Health department grant funds can be used to develop and distribute culturally and linguistically appropriate messages and combat misinformation.

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Now, these four COVID relief packages have passed related to response activities addressing the workforce. However, no dedicated dollars were put into vaccine deployment within these bills. One area to highlight is that the CARES Act passed by Congress in March categorizes the COVID-19 vaccine as a preventive health service, which means health plans must cover the entire cost. And this applies to individual and employee-sponsored health plans regulated by the Affordable Care Act, as well as traditional Medicare and Medicare Advantage plans. There still remain some gaps that apply to short-term health plans. Nor does it apply to Medicaid, the Children's Health Insurance Program and Vaccines Children's Program.

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Now, the following have not been passed, the health and Economic Recovery Omnibus Emergency Solutions or HEROES Act has language to cover those three groups that were left out within the previous bill that I mentioned. And in September, some of that language

was adapted to have a HEROES 2.0 bill that really looks at Title VII vaccine development, distribution, administration and awareness. And it's within that awareness piece where we're really looking at combating misinformation about vaccines and disseminating scientific and evidence-based vaccine-related information.

It also looks at reducing barriers to accessing vaccines and partnering with community organizations to develop and deliver evidence-based interventions. In addition, I've also highlighted the HEALS Act, which was introduced by Senate Republicans in July, and Delivering Immediate Relief to America's Families, Schools and Small Businesses Act, which was introduced by Senate Republicans in August. And both of these bills highlight some funding is going to enhance seasonal influenza vaccination efforts.

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Now, an upcoming request, we have specifically asked for $8.4 billion for COVID-19 vaccine distribution, plus $500 million for seasonal influenza. And I just wanted to highlight the dollars going to outreach to priority populations, communications and educational efforts to increase vaccine competence and combating misinformation.

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In addition, we're also asking for broader needs related to local health department workforce, including the public health loan repayment program, as well as dollars going to core public health infrastructure.

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I've provided a list of resources from some of the things that I talked about today. And I'm happy to share additional slides from my presentation.

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The importance of strong, predictable federal investment in the public health system is even more vital now as the economic impacts of the pandemic are felt nationwide. And we've clearly seen the evidence of the disproportionate impact COVID-19 has had on different

racial and ethnic groups, along with different communities. COVID-19 vaccination distribution is the largest operational undertaking that as anything we've done under COVID-19 to date. And we need coordination and partnership at every level to support those most heavily impacted by this pandemic. Any investment that is put into this effort must consider public health and infrastructure in the long-term to get us through the pandemic and set us up for better outcomes and the next public health crisis.

Thank you.

GRACIA:
Thank you, Michelle, for really helping to provide that in-depth overview of--of the function of local public health and infrastructure and the importance of funding, which we're hearing as it--as a recurring message with regards to seeing the--the impacts of the chronic underfunding of the public health system at all levels, as well as the resources that you provided. And--and really helping to give a great legislative and policy overview for this conversation.

So with these presentations, we're going to move now into our panel discussion. And for our audience members, please share your thoughts. I'm hearing from our team that--that there are many questions in the queue already. And to submit your questions using the Q&A box, I'll just repeat the instructions that we'll respond to as many questions as possible during this session. To do so, just open the Q&A panel by clicking this circle with the three dots at the bottom of your screen. The panel on the right side of your screen. Select all panelists in the drop-down menu to get your question sent to the right place. And--and we'll go through as many questions as possible.

I'm actually going to start with--with our audience, given the--the interest and--and a number of questions that are being asked to--to share with our panelists. I'm being joined by my colleague, Cecelia Thomas, at Trust for America's Health. And we'll moderate together with regards to questions from (INAUDIBLE). Cecelia, do you have a question in the queue that you can ask our--our panelists?

THOMAS:
Yes, I do. I just want to make sure everyone can hear me.

GRACIA:
We can hear you. Please, go ahead.

THOMAS:
All right.

To all of the panelists, here's a question. Do you have any resources--do you have any resources for local health departments on developing strong relationships with trusted messengers outside of the health department that can reach other communities? This is--this includes young people, people who are undocumented and other populations.

FREDERICK:
Yeah, I'll be happy to start.

You know, here in D.C., (INAUDIBLE) participated with several committee members, especially in the faith-based community, to stand up something called the Black Coalition Against COVID. And that has proven to be a very vital resource. We--that coalition has engaged--the community engaged young people in--in producing ads on metro buses, et cetera, to talk about social distancing, etc. And as we think about vaccination, they are going to--they have also produced PSAs, etc. and as we move into this (INAUDIBLE) vaccination, we anticipate that they will also play a significant role. So that's an (INAUDIBLE) example outside of the--the local health system. As it were, that coalition has really, really helped to push the decision on the vaccination. They've held a few webinars, not very much just like this, where they've had federal and local health officials bring a few messages to (INAUDIBLE) people and talk about the vaccine and the process.

MORITA:

But--I guess I would reiterate what Dr. Frederick said in terms of thinking broadly and reaching widely because I think, as a local public health agency in Chicago, we partnered with other governmental entities to identify community groups that they had engaged with in the past to help us broaden our reach. We have our community and faith partners that we've worked within the past to extend the reach to others. And so really partnered with our Department of Aging, Department of Human Services, Transportation Housing to identify different organizations that they partnered with to help expand their reach. Because I think tapping into those communities who actually have their ear to the ground and can actually understand what the concerns are and help to identify trusted messengers through those routes is what's actually very helpful.

CANTU:
I guess and just to finally just add on a little bit, I--I know that a multitude of different local health departments works in close collaboration with Immunization Action Coalitions. I know the Immunization Action Coalition has a list of different coalitions as well. I know that there have been multiple different examples of ways in which local health departments have engaged their communities and community partners.

I think about Harris County, for example, who has also expanded partnerships well beyond just the traditional--of historical partners, whether that's health care. They're really looking at various influencers in their community.

I think there's also an opportunity to think about ways in which we can also look at linkages to support services. And I think that's something you highlighted a little bit, Dr. Morita, in your comments. But the ways in which local health departments have engaged with other groups within their health departments or their community groups beyond immunization where we can really link services, particularly during this time.

GRACIA:
Great, thank you all.

Cecelia, let's take another question from the audience.

THOMAS:
All right.

This is for each of the panelists as well. Are there any evidence-based approaches to developing health messages for communities of color, especially in the area of vaccinations? And then the second part is, do the panelists have suggestions for the optimal approaches?

MORITA:
So I think one of the key things to keep in mind is that we have years and years of experience within building and--and enhancing vaccine confidence through our childhood vaccine programs. Over the course of decades, there has been challenges to the safety and efficacy of vaccines. And so the CDC has a (INAUDIBLE) of information just in terms of how to talk to parents about vaccines, how to talk about vaccines in general, and those are tried and true messages that may resonate and may work with a lot of people.

Whether or not they connect with communities of color, it is not clear. And I think that's where this concept of really--we're identifying community groups to work with and to really engage with them in--in bidirectional communication, so there's a way to hear from them, what the concerns are, what are the types of information they need to be reassured about the vaccine safety and efficacy? And then who are the messengers to actually convey the information?

I don't think we can just rest on what has been done in the past to be successful moving forward. I think what we have to do is innovate and really reach where--you know, really engaged with the partners that we've identified in the past and really under hear from them and understand from them, what are the concerns, what are the answers and what are the solutions that we can--we can make and build together to address this issue.

CANTU:

Just to kind of build off that response as well. I--One of the things that we didn't go into great detail about is the--the spectrum of vaccine hesitancy and the ways in which we approach vaccine hesitancy for each individual person. And I think that what COVID-19 does is it really changes what that looks like related to vaccine hesitancy. This is a new emerging infectious disease. This is a new vaccine. And really having those one on one conversations at the community level to really understand what people are thinking, what people are really feeling towards the vaccine is really needed.

And I know that so many different groups have done such great surveys, whether that is the Harvard Group or PEW or Kaiser Family Foundation. But we also know that there is a need for that information in order to be able to inform how we talk specifically about COVID-19 vaccination.

When I think about other communication campaigns, I know that there's been some great success in other areas of public health, whether that is through your HIV/STI viral hepatitis arm or that's in your maternal child health arm or even smoking cessation. So looking at those communication delivery methods or looking at how they did that work would be incredibly crucial as we're running against a clock. But at the same time, ensuring we have that formative research to really inform some of those practices is going to be incredibly crucial moving forward.

FREDERICK:
Yeah, and, you know, the Black Coalition Against COVID here in D.C. also had a couple of competitions around, like the spoken voice and things like that. So that--that culturally appropriate and--and would drawl both participants in but also a broader community in, in terms of being able to receive those messages.

The--the adolescents are a key group, I think, that when you look at the impact of COVID itself, that isolation, as it were, from their normal socialization, has been a challenge. And they've also put up a--webinar that I believe is now available on YouTube where, you know, kids were able to talk about their challenges around that isolation and the things that they're doing to cope with it. So I do think that peer-to-peer engagement, so I'm not sure about the

data that might exist, but I think as mentioned by the two previous speakers, we're--we have to create these things now in this contemporary circumstances that we're in. That's very, very unusual as well. And it has such a big impact and influence from social media.

MORITA:
I want to just add a little bit more if that's okay, Nadine.

GRACIA:
Please, Please.

MORITA:
Yeah, the one thing I would say is I think that we really need to keep it--it is really important to have clear, consistent and transparent communication from the top down. So starting at the federal level, there should be consistent and clear communication and transparency about what is going on with the vaccine development and the process; what can we expect as a vaccine becomes available.

I think in terms of how much vaccine would be available, that it will be in small supplies, that not everybody will get the vaccine. There will be a need for prioritization. There are adverse events that might occur that weren't previously detected, and that's not uncommon, because we'll now be vaccinating millions, whereas we vaccinated about tens of thousands with the trials. So really clearly, consistently, and transparently communicating the facts and what we know and what we don't know, and setting expectations. So that has to happen across the board.

And then there needs to be customization of those messages to the communities in a way that really makes sense to them, and addresses their concerns. And the only way that we are going to do that is if we really work with the communities and earn their trust and get--so that they can actually--and engage them in a way that allows them to participate in the process of addressing the problems. Thank you.

GRACIA:
Dr. Morita, you just touched upon a key issue, and actually both you and Dr. Frederick talked about the importance of transparency. So it was taking that step back even from the beginning of thinking about the vaccine development in and of itself. And Dr. Frederick, you talked about the pace and how the scientific community is seeing the vaccine development process. You know, as many of us know and it was featured here in this webinar, the National Academies have the committee on equitable allocation of the vaccine, and in particular emphasize the importance of transparency.

Can you offer some suggestions and recommendations, you know, whether it's at the federal, to the state or local level, of thinking about how we can ensure that that transparency is being communicated, especially for communities of color, and where some may actually fear and think that the pace of this is faster and are there truly going to be safety precautions in place for a COVID-19 vaccine?

FREDERICK:
Yeah, you know, I think it's an excellent question. I think there are a few things that have come to mind. And just to be clear, sometimes when this conversation comes up, I think people feel that the people who may not be interested in doing this may not be highly educated, et cetera. I live in a house with a 16-year-old son, a 14-year-old daughter, and obviously my wife. And of the four of us, I'm the only person right now who is willing to participate in a trial and/or take the vaccine if it becomes available tomorrow. And so that just goes to show you the challenge that does exist.

So I think there are a few things that we must do. I want to emphasize that I think sometimes when we talk about the speed of it, and this was--these are lessons learned. I think calling it Warp Speed, the operation of coming to a vaccine quick, didn't help. And so some of what has been done has to be undone, so to say.

Our public health officials have to come out and speak about the collaboration. So when I speak publicly, I try to emphasize to people that in my lifetime in being a patient, first and

foremost, with sickle-cell and Type I diabetes, and a practicing surgical oncologist, I have never seen such scientific collaboration.

And that is the reason for the speed. I think sometimes when we say speed, we suggest--I think people hear that as if we skip steps. I think what we should be speaking about is the unprecedented collaboration of the scientific community, and that would help level-set the conversation.

A second thing that we should do around the issue of the transparency is that once FDA has gone through their process, there should really be a full-on--a full-on effort to explain in as much detail as possible the timeline to people, so that people can see that no steps were omitted, but what happened was unprecedented effort to make sure the steps were done as quickly as possible. And I think that that would help.

And the last thing which has been emphasized again by the prior speakers, you have to have people communicating who are trusted partners in the community. And that's why I suggested that we should mobilize our 102 HBCUs throughout the country to really participate in the communication effort to the communities of color, as well as our faith-based leaders. They are very much connected, and I think if you mobilize those two forces well, I think you will get at least a better platform in which to provide the communication.

MORITA:
Yeah, I think Dr. Frederick said it right. I also think that it's really important to talk about the existing infrastructure for immunizations. We have--children get prevent--protected from more than 17 diseases in their routine vaccine childhood immunization schedule. And that system has been in place for decades. And there's processes in place at the FDA level and there's advisory committees that advise FDA.

Then there's also processes in place at the CDC level, and an advisory committee that has external, independent experts in public health, pediatrics, adult medicine, immunology, across-the-board wide range of independent experts who advise these federal agencies regarding whether or not a vaccine should be licensed, in the case of FDA, or an emergency

use authorization is approved. And then for CDC to make recommendations regarding who should get the vaccine, what are the priorities, et cetera.

But few people know that these systems are in place to assure that vaccines are safe and effective. But these systems are working now and actively working now to make sure the vaccines that come out, the COVID vaccines that come out, are actually safe and effective. But we need to talk about that and share that information, and reassure people that the systems that are in place to ensure that all those vaccines that our kids get on an annual basis and regularly are still being used and are being tapped into.

And that if those systems are followed, we can be confident with a vaccine that becomes available. But people don't want to hear about the technicalities and those kinds of systems and processes, but they're important to share because it's part of transparency of the process and why we should have confidence in the system.

CANTU:
Great, and just to piggyback a bit more on that. I think that what the two previous speakers have really done is talk about the various groups across the federal government who are working in this area, and the ability to coordinate it all has been enormous. You know, even within NIH who recently launched a Community Engagement Alliance Against COVID-19 Disparities Group, you know, there are so many different facets of groups that are working on this, particularly now.

And I feel like during your presentation, Dr. Morita, you talked a little bit about lessons learned from H1N1. And I think that there are some components there that are also particular to this particular pandemic and COVID-19 rollout.

And I think that some of that was the ways in which there was more broad communication, just ensuring that there is that kind of consistent--consistent visible communication, where you could have several groups of HHS experts at the table providing weekly updates to the media on the status timeline and emerging information that is coming out related to the dissemination of COVID-19 vaccination, and trying to facilitate that in a way that really

provides that transparent overview. But what is being done to ensure safety and efficacy for these--for this vaccine that is coming out.

GRACIA:
Great, thank you all for those really insightful recommendations and points. Cecelia, let's take another audience question.

THOMAS:
Okay, this one is for Michelle. Will public-health departments receive all vaccines for their jurisdictions, or will some vaccines go directly to healthcare providers for direct distribution to their patients? Will these decisions be made at federal, state or local levels?

CANTU:
So that's a great question. And I think that those are kind of the nuances that we are still exploring. So it depends on the vaccine that does come out first. We do know that this will be a phased approach, and there will be some vaccine that will come out in a limited amount in the first phase. And that is still being determined at this point in time.

What I had mentioned a bit earlier in my presentation was that each state health departments or maybe 64 jurisdictions that are directly funded through CDC submitted interim plans to CDC related to vaccination distribution. And so all of those plans really are focused on the distribution. But again, they're all very much in draft form, given the various scenarios that will take place.

So when we're thinking about that first iteration of vaccine coming out, and if in fact we are focused on the priority populations that the National Academies have put out related to their equitable framework, we are thinking about that going directly to healthcare providers. And in some cases, the vaccine may come directly to the states and then go to hospitals or healthcare providers through closed PODs or points of distribution.

And when we look at the second phase and the second part of the rollout when we are really expanding that on to other priority populations, that vaccine distribution plan can shift and those vaccines could come down from the state, down to the local level. And so I think there's a lot of variation.

Again, 64 jurisdictions submitted plans. That's the states, territories, and several--the handful of directly funded cities who we know are working closely with the states, but all of those plans may look a little different in the ways in which they're rolled out. It's still yet to be seen, given the complexities of which vaccine will come out first.

GRACIA:
Cecelia, let's take another audience question.

THOMAS:
All right, this is for all the panelists. If the existing infrastructure did not help increase vaccine acceptance and vaccination release, what is going to change on that model for better outcomes among black and Latino--black and Latino populations? What changes need to happen for a successful vaccination campaign?

FREDERICK:
I would say disproportionately, the African-American population has to be vaccinated because of the risks. Two to three times more likely to contract the disease, twice as likely to die. And therefore, when (INAUDIBLE) who are far more likely to be a front-line worker where their transmission of the disease is going to be high.

So when we think of distribution and success, remember to get to the type of immunity levels we are thinking some--you know, depending on what study you look at--60 percent to 90 percent of the population would have to have some significant immunity. And outside of contracting the virus, which we aren't fully sure everybody who contracts the virus has developed long-standing immunity, vaccination is the other way to get immunity.

And so we really are going to have to have a significant number of those most at risk to be vaccinated. I would hate to speculate on a specific number, but what I would say is that we have to disproportionately vaccinate. The very same people who disproportionately were affected would have to be disproportionately given the vaccine as well.

MORITA:
The interesting thing that I think that Nadine mentioned earlier on was that we know that a baseline, we have disparities in adult immunization coverage levels. And so whether it's flu vaccine or a shingles vaccine or hepatitis vaccines, people of color have lower coverage levels overall.

What that is is a reflection of inconsistent funding to support adult immunization infrastructure over time. What we often see with health is that when there's a (INAUDIBLE) COVID, there's a surge of funding that comes in, and public health scrambles to use the funding that becomes available, but then there's not sustained levels of support. And so we're not able to build the systems, address the issues, establish the relationships with the community, so that we are able to address the inequities in vaccine coverage levels at baseline. So when the next public health emergency comes, we are not looking at the same problems, and we don't see the same disproportionate impact.

So when I look at it in terms of the long-term solutions, what I think this does is this is yet another example of a public health emergency where sustained public health funding over time would have allowed us to be better prepared, so that we wouldn't see this disproportionate impact.

If we are able to address these underlying inequities in vaccine coverage that we see at baseline, we won't have these same problems, or we will be better able to quickly respond when the next public health emergency arises. So to me, the solution is really sustained high level funding to support immunization infrastructure or public health infrastructure.

CANTU:

Great, and I would just add that as it relates to that infrastructure and the need for that infrastructure, again, there is still a lot of work that I think needs to be done. And this just kind of comes back to me echoing what we talked about a little bit earlier about community engagement and the ways in which we've seen that work in any type of communication campaign or immunization campaign. And the ways in which local health departments or even folks at the local level are just engaging their communities to participate in being at the table. And a lot of that takes funding and a lot of that takes time.

And so just to kind of echo the continued need for that infrastructure to be built, in order to ensure the sustainability of the efforts. But knowing that we have, if we have the opportunity to have people at the table, or the communities that are most impacted at the table, we are certainly going to be able to help and address some of the issues that folks are facing and further understand the best ways to communicate some of these messages.

GRACIA:
So to our audience members who are hearing also this recurring message of the importance of funding and the chronic underfunding of the public health system, and that this pandemic really has exposed, you know, that issue with regards to funding shortfalls for public health.

We've put into the Q&A, and just as a reminder for those of you that are looking for resources, whether it's data, specific policy recommendations, you can visit Trust for America's Health website. In addition to our Blueprint report, we also produce an annual public health funding report, which shows, you know, as a nation, for example, we are spending $3.5 trillion annually in health spending, but less than 3 percent of that is for prevention in public health. So really some important issues, especially as we talk about addressing health disparities.

Cecilia, let's turn to another question from the audience.

THOMAS:

Okay, so this is for the panel. Before a COVID-19 vaccine even becomes available, the upcoming flu season requires us to increase vaccination rates among biopic and underserved communities. What are some of the most compelling messages that can be delivered to build trust in the flu vaccine.

CANTU:
Well I know that CDC has definitely put out some key messages. I know that currently CDC is also working with the racial-ethnic approaches to community health or REACH-funded groups to look at flu vaccine messages, specifically focused on adult influenza, and those groups that were funded through that reach project. I think that when we look at those messages, ensuring that people at the local level can then further take what CDC has put out, and look to see what messages would resonate with their particular population, whether that is with the ability to have formerly done formative research, or with the ability of just knowing your community and your community population, and the way in which the messages may resonate.

I think that for many people, we are--particularly in public health, we are very nervous about this flu season particularly, about what could possibly be a twindemic of many flu cases and potential flu hospitalizations. And at the same time, COVID-19 cases increasing, and again experiencing hospitalization. So then, you know, again, tapping all of our resources in terms of the ability to prevent COVID-19 and those bad outcomes. But I think that, again, when we think about this particular flu season and we think about the messaging, it is incredibly important to ensure we are consistent and clear with those messages, and ensuring that folks know that there is a flu vaccine that is available, it is effective, and folks should take their flu vaccine starting now, and well into December and onwards, if possible.

MORITA:
I agree with Michelle, that clear and consistent messaging is important, and focusing on the safety and the efficacy of flu vaccines is critical. In Chicago, when we were promoting influenza vaccine--because it was an annual process of encouraging folks to get vaccinated,

we really focused on the fact that by getting vaccinated, you were not only protecting yourself, you were also protecting your loved ones. So there--there are some folks who might not choose to get vaccinated because--to protect themselves because they don't think they'd get that sick or it's not that big of a deal, but appealing to their sense of responsibility for their young babies that are at home, or for the senior citizens who they're caring for in their lives. Those--kind of appealing to that aspect of it, of the value of the vaccine.

The other thing I think this year that we have is, helping people to understand that having influenza--if you get sick with influenza, it might be difficult to differentiate that between COVID and--and influenza. And--and so seeking healthcare services might actually require--you might need to go in and seek healthcare services, which might increase your chances of getting exposed to COVID as well, if you have flu, and--and vertically burdening the health care system. So, in addition to the usual messages about the safety, the efficacy, the benefit to others, lifting up the reasons during COVID that it's beneficial to get the flu vaccine would be important.

FREDERICK:
Yeah, and I think a lot--I think what has been said is really--those are the primary answers to the question. My secondary answer is that I have got my flu vaccine. And I think that one of the things that we also have to do as leaders is to make sure that we do those things, and that we make it clear. So I wore my sticker that I got my flu vaccine on my mask for a couple of weeks, until it eventually fell off. But I think we also have to lead in terms of demonstrating the behavior in the communities that we want to see as well.

GRACIA:
Excellent message, Dr. Frederick. Yes, indeed, to practice what we--what we are preaching, indeed. Cecelia, another question from the audience.

THOMAS:

This is also a panelist question, and it goes like this, how can we be sure the safest vaccine is not the most expensive? If the cost of vaccinations. falls on low-income households rather than the state, how can the local health departments in good-faith push that on their communities of color?

GRACIA:
I'm going to ask just for one panelist, just given where we are with time, to answer that question. Anyone want to do that--volunteer for that question?

MORITA:
I--I can take that, I think. I'll try. So, the U.S. government has paid for the vaccine, and so the cost of the vaccine--individuals that get vaccinated should not bear the burden of any cost for the vaccine itself. What I believe is being negotiated at this time is whether or not there'd be a cost for the administration of the vaccine. Because in addition to the vaccine itself, does it--there's usually a fee associated with the administration. And in 2009, that fee was waived, and so individuals were not charged for the cost of the administration.

And I'm hopeful that as the program is rolled out, that those same kinds of protections will be in place. Because in the city of Chicago, we were able to provide vaccines free of cost to anybody who wanted the vaccine at our mass immunization clinics, that we had an expectation that providers that administered the vaccine also were not charging their patients for administration or the cost of the vaccine.

GRACIA:
So I'm going to--and have this as one final question before we move into our--our closing. All of you have spoken to the importance of partnerships, and you haven't just said partnerships, you've said authentic partnerships, especially in community. And Dr. Frederick, if I could pose this question to you, you spoke, for example, of partnerships, for example, with historically black colleges and universities.

Certainly, it won't do justice to only give you a minute or so to--to talk about--to HBCUs. But given that there is just such growing national attention to the importance of--of historic--of the historical black medical colleges and HBCUs, broadly as a community, can you talk about that--that meaningful connection and partnership from the perspective, for example, of being a historically black medical college and university?

FREDERICK:
Yeah, I think it's a very good question. I think what it allows us to do, and I think there's enough data to show that black physicians and black physicians develop a very different type of relationship. We don't have enough black doctors for every black American to have a black physician--so let me clear about that. Not every single student who is at our colleges is black, but they do get a significant amount of cultural competency when they do come to us, regardless of their--their background.

And what happens here is, I think it's--it's trust over time. And I know that we've used the word trust several times, and that trust is about building an authentic relationship that has a long history. So while some of our institutions may not be able to do that overnight, one of the things that I think this awakened and has done is to--is for all of us to recognize, regardless of what our institution is, that we should be developing those relationships and making that effort now.

The other thing that's important is that our graduates are more likely to go back into those communities and serve as well. And that's the other thing that cause--that raises the trust. When people come back home, as it were, the communities tend to be very proud, very trusting, and very different when you go to a physician and you know that person's mom, and aunt, and that person's grandmother. It's a very different dynamic that's set up. And it's--I should also emphasize, it's not just physicians. We talk a lot about physicians, but the reality is that the center and the nucleus of our healthcare system is the patient, so we always should be obsessed about the patient.

So nurses, dentists--I--I mean, even with the vaccinations, we're talking a lot about what the physician community should do, but let's think of how much time you spend in a dentist

chair. And if all of us are getting a check-up every year from our dentist, that's another opportunity for us to arm a healthcare professional that has a captured audience, when you're sitting in that dental chair, to talk to you about vaccinations and about the preventions that we should be employing as well.

GRACIA:
Excellent, thank you. Trust over time. And Dr. Morita, you also talked about that, building those relationships before the emergency. And Michelle, to ensuring that the systems and the infrastructure are actually in place to be able to respond to what are a growing number of public health emergencies. We could certainly continue this conversation for hours, but we are at the hour, at the--at the conclusion of our webinar today.

And--and I just want to thank, again, our excellent panelists, Dr. Frederick, Dr. Morita, Michelle Cantu. And to thank all of you in our audience for engaging in this important conversation, and to recognize that the work is just beginning, and that with all of us working together, we can truly strive to achieve these goals of building vaccine confidence, building access to a safe and effective COVID-19 vaccine for communities of color. And building trust in a way in which we can ensure the safety, health, and wellbeing of our communities. Tim, if you'll go to the next slide.

We hope that you will join us again next month. On November 19th, we are going to be hosting a congressional briefing on "The State of Obesity," and our "Better Policies for a Healthier America," which will be taking place at 12:30 PM Eastern. If you are not tapped into our weekly--biweekly newsletter, we encourage you to visit our website, where you can sign up for our newsletter and get access to information such as when this briefing announcement comes out to register for the webinar. And--and Tim Hughes will also be following up with additional information after this webinar, for those of you that have tuned in and registered. Again, I want to thank our panelists for a really informative and excellent discussion, and I'm going to turn it back to my colleague, Tim Hughes, to close us out.

HUGHES:

Thank you, Dr. Gracia, and thank you monitoring--monitoring today's webinar. Again, a special thank you to our esteemed speakers, Dr. Wayne Frederick, Dr. Julie Morita, and Michelle Cantu. Many thanks to our TFAH team and partners who helped orchestrate this webinar. And lastly, thank you to our audience for joining us today. Be sure to find a recording of today's session, along with slides on tfah.org that will be made available next week. As you exit, you will find a brief survey to complete. We would gladly appreciate you all to take a few minutes to fill it out. Thank you again for joining us today, and this concludes our webinar.

List of Speakers

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NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS INFECTIOUS DISEASE AND IMMUNIZATION DIRECTOR MICHELLE CANTU

ROBERT WOOD JOHNSON FOUNDATION EXECUTIVE VICE PRESIDENT JULIE MORITA

HOWARD UNIVERSITY PRESIDENT WAYNE FREDERICK