Trust for America's Health

Congressional Briefing: *Ready or Not 2021: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism*

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>> Good afternoon and welcome today's Congressional briefing. Ready or not, protecting the public from disease, disasters and bioterrorism hosted by Trust for America's Health or TFAH for short. My name is Tim Hughes at TFAH. Would like to thank our speakers and audience for being with us today. For today's webinar, audio will be access to their computer for headphones. Real-time captioning is provided today by Jamie Cruz of ACS captions. The captions click the multimedia viewer icon with three dots at the bottom of your screen. Next on the right side of the screen, locate the link in the panel that says, show header. The caption window will appear click the multimedia video icon at any point to bring it back. 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 panel click the circle with three dots at the bottom of your screen. From there select all panelists in the drop-down menu and your question will be sent to the correct location then press enter. Now I am pleased to introduce the moderator for this event, John Auerback, MBA. John is president and CEO trust for America's health. He oversees work to promote sound public health policy and disease prevention and national priority. Over the course of a 30 year career, he's held senior public health physician at the federal, state and local level. Welcome, John.

>> JOHN AUERBACK, MBA: Thank you, Tim and thank you everyone for joining us today for this important discussion. First I'd like to take a second to not only welcome you but to think our esteemed panelists for taking time out of their busy schedules to attend this event. The purpose of today's briefing is to help our audience get a better understanding of the policies and programs that impact our nations preparedness and response for disasters of all kinds throughout the pandemic and extreme weather and man-made things. We'll hear from distiller to panel speakers of unique perspectives on our nations health security. And after their presentations, as you heard from Tim, will have questions and discussion from you. Next slide, please. First of all I'd like to go over some findings and recommendations from our recent report. And also to share TFAH 's vision for a more resilient nation moving forward. Since 2003, TFAH has been publishing an annual ready or not report. In that report we have 10 priority indicators. And those indicators are intended to be a checklist of actionable steps that states can take to improve their overall readiness. We are not attempting to do a report card or grading system per se. And not surprisingly, in our report we highlight the tragic lessons of COVID-19, as well as acknowledging some of the heroic work that's been done by the public health sector. We include discussion of the steps of policymakers and what can be done to improve the health security, learning from the lessons of COVID. And as in all of our reports we include policy recommendations for different

sectors. Next slide, please, Tim. Again, ready or not is our annual assessment of the state level of preparedness to protect the public in an emergency and as indicated, we measure 10 key preparedness indicators across a range of emergencies. Not just infectious disease outbreaks like COVID-19. Also natural disasters like those caused by with the weather, bioterrorism or other types of emergencies. Our report considers the work needed, not just in public health but in other sectors too like the healthcare system, hospitals and state governments and other policymakers at the federal level. This year, not surprisingly, we found both progress but we found significant room for improvement in every jurisdiction. We differentiate the states into three tiers with regards to their preparedness on indicators. 20 states were in the top tier. 15 states fill in the middle tier and 15 states in the lower tier. Again, it is not a report card. Though states in the top tiers still have room for improvement and those in the lower tiers had many strengths in their emergency preparedness work in spite of this ranking. Next slide. Please let me give you an overview of what we found. Some areas were found strengths first. Most states and a growing number of states over the last few years have plans in place to expand emergency response and healthcare capacity in an emergency. This means be able to quickly increase the availability of medical and response personnel cross jurisdictions including doctors nurses and first responders and epidemiologists. Secondly, all plans had had key components of emergency response in many instances. Next, most states are accredited in the areas of public health or emergency management. And many are accredited in both. Finally, the large majority really about 95 percent of Americans, get the household water from a community water system. That has safe water. That is important again in terms of preventing an emergency. Next slide? Now, I'm going to focus on some of the areas where we found that there was need for additional attention. One area significance relates to the seasonal flu vaccination rates. We did see improvement in those who were being vaccinated during the past flu season but the overall rates are still very low. The vaccination rate for Americans aged six months and older rose from 42 percent during 2017 and 2018, to 52 percent during the 2019 and 2020. It's a 10 percent increase and I think it's a lot to do with growing concerns around COVID. 52 percent is not very high. This is well below the 70 percent target vaccination rate established in the US healthy people 2030 report. We can see the consequences of an undeveloped vaccination system in the COVID response. A second area of concern is a disturbingly limited number of Americans have paid sick leave. In 2019, average of only 55 percent of employed people in the United States have paid time off when they or family member was sick. The lack of access to paid sick leave is unhealthy at all times. But during COVID-19, we saw very dramatically, what the consequences were. When people were sometimes having to choose between going to work and getting paid for it, it will cover rent and food on the table with their risk of spreading the disease or exposing to the virus that should never happen. The third point is perhaps most significantly we found the court public health funding at both the state level and at the federal level, were woefully inadequate. Decades of chronic underfunding of public health systems has put the public safety at risk. And over the last 20 years, we produced public health funding and only extended in a short time during one major emergency after the other. Often, the emergency funding comes too late to prevent many deaths and illnesses and/or injuries. We desperately need to invest in the sustainable rebuilding of the public health workforce systems and technologies. We estimate that $4.5 billion per year is needed to meet the nations state, tribal, local and territorial public health infrastructure needs. Without an infusion of new and sustainable money and magnitude like 4.5 billion, the nation is at risk of having to fight the next public health emergency in the same manner that we have struggled against with COVID-19. Next slide, please. Everyone may be affected an emergency that we seen in many emergencies, such as COVID, people of color and low income people, they are a

heavier burden of preventable serious illness and death. We've seen this and other emergencies as well. For example, in the Katrina hurricane. As just mentioned, COVID-19 emergency funding while critical, is one time funding and not a solution to chronic underinvestment. The chronic, the investment needed, is needed to pay attention to equity in a significant way. And make it a priority. We saw what happened this year when underfunded health departments were really taxed to the limit and then they received large amounts of money but during COVID, and as a result of that, they worked really hard to rapidly fire and trained new short-term employees and or distribute time-limited funding and contracts sometimes through time-consuming complicated procurement processes. Just to the point that their energies, the public health experts were really needed on the front lines. And then a final thing I would say that we learned during COVID is that the healthcare system is also underprepared for an emergency. And one reason for that is that the federal funding for the hospital preparedness program, a key program set up after 9/11, helped the healthcare system prepare for emergencies. It's actually been cut over the last 20 years. In real dollars by more than 60 percent and that has left some hospitals without the trained personnel and equipment that they need when lives are at stake. Next slide?

>> This chart illustrates the erosion of funding and it is contributed to lack of adequate preparedness. In the past years. The countries gone into a pandemic having lost one quarter of the local workforce since 2008 with positions. We really started from a deficit. This chart specifically shows the two primary funding sources for public health emergency preparedness in their country. Those of the public health emergency preparedness or theft programs that is shown in blue and these are the dollars from the CDC state local tribal and territorial health departments for court emergency response. And also shows and orange the emergency preparedness program that I was mentioning in the last slide that goes to help the healthcare system and its preparedness. The public health emergency preparedness program has been cut by about 26 percent since 2003. Or 40 percent if you actually account for inflation. And as I said earlier, a hospital prepared his program is cut by more than 60 percent for inflation. These long-term erosion funds means that we lose workers, with his expertise and the systems just cannot modernize. And that is why we saw and will continue to see health apartment across the country that are tracking the disease with telephones or fax machines instead of modern and time sensitive, real-time information systems. Next slide. All reports provide significant detailed steps needed to learn the lessons of the past and what preventable injuries, illness and death. The chart shows a few of those. We need to get out of the boom and bust cycle of been describing includes increasing annual funding for programs like the ones I just mentioned. But also direct funding for crosscutting public health infrastructure that 4.5 billion I mentioned and by the way, that is being proposed by Senator Patty Murray in the public health infrastructure saves lives act. Also need to guarantee basically to enable workers to stay home for the reasons I've indicated. We need to make equity, central to our preparedness, including expanding public health capacity to work on equity and work on social economic and environmental determinants and partner with other sectors as well as with community-based organizations and residents from the communities that have been marginalized so that we can work more effectively in those communities. We need to be, we need to be sure that the investments we are making in vaccines and other health research and development continue beyond the next year to so we are ready when we need another vaccine or antibiotics or other treatments. And the same is true for the networks we are building for vaccine distribution, we need to maintain the ones are being developed for COVID and utilize those and tap into them if we have future emergencies. Two more. We need to seriously strengthen the readiness of the healthcare system for major surges and patients are in

need of hospitalization or care and finally, we need to recognize that national disasters and particular, those related to climate change and weather related emergencies are increasing in intensity and frequency. We've had a record number in the last 12 months but we hardly noticed because our attention was on COVID-19. And we need to be providing resources to help public health and healthcare systems adapt to these weather related threats as well. Next slide? Finally, this is just a list of some of the available resources that we have at Trust for America's Health. Please go to our website and take advantage of these resources. Now, now it is totally my pleasure to introduce our extraordinary panelists of speakers. They represent the experience of working at the local, state and federal levels. They each have been tested in emergency response for COVID as well as in response to other emergencies and to the day-to-day urgent matters that affect the health and well-being of people in America. This panel I think of is a dream team of experts who you would want in an emergency. The first up is Cameron Webb, MD, JD. Dr. Webb is what has policy advisor for COVID equity. Physician, attorney, former White House fellow where it included criminal justice reform, through the my brothers keeper initiative as well as healthcare policy. A former assistant professor of medicine and public health science at University of Virginia where he served as codirector of the health policy program. And Dr. Webb generously joins us today because at the last minute Marcella Nunez-Smith, MD, MHS was unable to speak because of an urgent matter last minute. Thank you, Dr. Webb. Next, will hear from Dr. Nesbitt. Directive District of Columbia Department of Health in Washington D.C.. That is the position that she has held since 2005. And in this role, Dr. Nesbitt has led the city in addressing the full range of health matters. Those include controlling obesity, preventing violence to combating maternal and infant mortality prior to her role she served as director of Louisville Kentucky national department of public health and their she led initiatives that were critically important for health. Focuses on part on the affordable care act implementation and on violence prevention. And finally will hear from Dr. Mayfield. The director of the US COVID-19 response initiative at resolved to save lives. She was the first African-American and first woman Commissioner of public health for the Commonwealth of Kentucky. And after her tenure as State health commission she led the transformation of the largest of care system in Kentucky as a senior vice president and chief medical officer for population health. I'm proud to say she is a board member of Trust for America's Health. You can tell from these introductions what next urinary panel we have. And with that, I will turn things over to you, Dr. Webb.

>> Thank you for that kind introduction. And so that everyone knows I am pulling in for -- filling in for Doctor Nunez. I like to acknowledge the report that you just went through, this powerful and important timely, I cannot help but remember the first time that you and I met when I was at the White House a couple of years ago, it's a nonpartisan program so continuing with the Trump and missed ration at the time you're coming in really, advocating to invest in public health and I get chills when I think about where we would be today had we heeded that advice. Because I think that there is a call for preparedness and is there it has been there and you've all been there for that so thank you for your leadership and advocacy. I'm honored to serve as a senior policy advisor for the equity White House COVID-19 response team. Being a front my work on the current bar is seen at the University of Virginia and being in the pandemic. The first week I noticed, all the patients were black and brown. Those being admitted to the hospital. Those going to the ICU and dying. In so many ways pandemic really shined the light on a lot of us have been doing work in public health and doing work around health equity for years. But we know that they were enormous inequities in the healthcare system. We knew that they were disproportionate and unfair. We knew that they strip people of years of life, years of time with loved

ones, and instead a dynamic that has no place in society like ours in the 21st century but it was not until COVID that seem like the rest of the country woke up and realized these inequities are problems. And also exposed the fault lines across a society. It exposed really across society with rich food access health, transportation, healthcare, front-line employees and essential workers, who they are. We realize how much we are putting syrup operations at risk every single day because of the lack of access and lack of resources and so-called social determinants. So as we come to this moment, we recognize that the pandemic has created a unique moment in the public health. His created a moment when there is more public awareness of the interplay between society and these social structures and we realize that it is fully unfair you see often people assign blame when it comes to certain health conditions but with this pandemic people are not assigning blame in the same way and I think it's created a place for us to talk about equity in a new and different way. Coming to this administration we had a really clear mandate from the people to focus on equitable access to the COVID response. And the way that it plays out, this vaccine effort rolled out in December, it was getting vaccine to states but we know that the idea of speed, really getting vaccine everywhere it needs to go sometimes can work against equitable distribution and so we wanted to think through something that which we could achieve equitable response. We will lead into the great leaders like Dr. Nesbitt in Washington D.C. and those across the country who are creating and driving the change because it is necessary, it is such an important dynamic for our public health infrastructure such an important part of how we get to better health and how we get, we wanted to complement that strong federal program and what I want to do is briefly talked through some of the federal approach to equity, how we are measuring it and how we are doing and just give you a sense of where things are as of today. We first started out with and how are we going to define COVID equity? And I was in the White House team asking Howard we defining this? And you will get about 10 different answers from 10 different people and we have to sit down and think what does it mean? With regard to vaccinations, shots going into arms, people being vaccinated, we need to look like people across this country everyone needs to have a fair shot of opportunities to get the vaccine. And so it's really what the foundation of this conversation has been. And what's been interesting is the president and the vice president have been adamant that equity be at the center of this response. And so in the programs we designed first I will describe the VAX -- mass vaccination sites. It is designed to place the sites in areas with high social vulnerability and those areas with the greatest economic disadvantage. The thought being that if we are able to have these 3000 6000 shots per day, some of the areas that have the most economic disadvantage they are able to reach some of the folks that have been the hardest hit and are at the highest risk. So far the program has done pretty well in reaching some of those hardest hit communities even if you look at race and ethnicity about 70 percent of shots to the CDC mass vaccination sites and FEMA sites are going to communities of color. And so that is helping to advance the equity goal in those states, it's important for us to get to as many people as we can but we know it's only one part of the response and 2 million shots at this point we have over 100 million who received at least one shot. A lot more room to go. Next program is the critical partnership. When I was in my internal medicine residency in Long Island City, it was so important for me to see the role that the centers played in our community. It's more than just a place to receive care at the hub of information, a habit of trust in a place where families and communities have care centered around them so we have over 1400 centers across the country as being vaccinated it is so important. So we roll this out and $0.25 and quickly 250 then shortly thereafter, additional 700 to 950 of 1400 sites receiving vaccines and we are continuing to scale that up, the president scaling up even further, what's exciting about these community health centers is who they serve because we are ready know that two

thirds of the patient population at the centers of people experiencing poverty. We know that 60 percent of folks from communities of color as directly marginalized populations and a 50 percent are living in public housing and a large percentage experiencing limited English proficiency so it helps us reach some of the other marginalized populations and certainly helps us to reach for markers and people expensing homelessness, these are a key mechanism to press toward equity especially with their reach all over the country. We been able to target select sites preferentially in terms of priority of the roll out, sites are serving those hard to reach populations and then we focused and on rural communities and focused and on sites that serve a large proportion of racial and ethnic minority groups. If we are focusing in on those the hardest hit and the highest risk, we can really mobilize these three trusted line in this work as you move forward. Really connecting the idea of having vaccine available but tying it together with the trusted messenger and a trusted message. And the retail pharmacy program, one of the largest programs as of last week -- was great as that of the 17,050 percent were located and this goes as high social vulnerability index. Without partners we really impressed upon the importance of locating the pharmacies selecting sites in the areas of highest socioeconomic disadvantage. Still, the president made a call last week that was really important. He said we need to make sure 90+ percent of Americans have access to vaccine within five miles of where they live and to do so we activated the entire pharmacy network that's over 40,000 pharmacies to include. We recognize that when you do that we have to be very mindful and every community doesn't have the same relationship with the big chain pharmacies so independent pharmacies are just as important and not every community is going to feel like getting vaccinated is the key so really encouraging those partnerships between pharmacies and community based organizations and faith-based organizations is going to be key and will continue to hold proxy partners accountable. Will continue to press toward equity using that mechanism understanding 40,000 sites all over the country, really important. And finally, the last big mechanism is the mobile unit. And it is so important to make sure that we are getting to those hard-to-reach areas, one of the most nimble mechanisms that we have an yes we can be mobile to pharmacies but also FEMA is doing local sites and also DoD and VA have mobile sites leveraging as well. Federally funded over about 100 mobile site so far and will continue to put that up because we know is key to reaching some of the hardest hit communities. When you put all of these together you get the opportunity to show federal leadership how to design around equity but we know it's really competent to the great work happening estates and localities across the country. The lift of great examples of what we are seeing in Connecticut and North Carolina and New Mexico and Alaska. Places all of the country have taken a lead on how they are approaching. I can't tell you how may times we talked about the approach to scheduling for vaccination because it is important to share those messages with people around the country so they can think to finally how to connect some of the hardest hit communities with vaccination. At the end of the day if we don't roll the program out we know what's going to happen. We know cases continue to increase, the risk is that folks will continue to get sick and die will be from communities of color. Want to complete the vaccine work with other key elements with testing and therapeutics we want to make sure we don't do is lose sight of the mission and the role, equitably distribute vaccines and equitably respond to this pandemic. I'm really grateful to work in administration where the President Biden and Vice President Harris, they'll just talk about that. And with that I am really excited to be with you this afternoon. I'm excited to learn from you and alongside you. And the work that TFAH has been doing is incredible and work you will be doing in the country is really inspiring and we are, I know that I speak for all of us when I say we are listening and we hear you and we are excited to equitably get to the end of this. Thank you so much!

>> JOHN AUERBACK: Thank you so much, Dr. Webb. It is incredibly informative and also, a reason for optimism, to ensure that everyone has access to the vaccine and it is distributed in a way that we can overcome some of those obstacles to equity that we have seen. And so, really very much appreciate you joining us today and sharing the great work that you are doing with your colleagues in the White House. Thank you. It is now my pleasure to turn things over to Dr. Nesbitt. Dr. Nesbitt?

>> LAQUANDRA S. NESBITT: Thank you, thank you to you and for Trust for America's Health for hosting this critically important session today. At such an important time for us to be focused on our infrastructure. For responding and the needs of public health both at a systems level workforce etc. Again, kudos to you and Trust for America's Health for always keeping this on the agenda. Want to start on the next slide by talking about how the DC Department of Health and DC health really prepared for public health emergencies. And what some of our core baseline infrastructure is and some of this was highlighted regarding tiering estates. In the District of Columbia health department is a physically designated as a lead agency for what we call emergency support functions. This falls under the construct, it gives us great framework to be able to get every person that works in the agency to understand that you have a job you applied for and part of your other duties includes ability to respond effectively to public health emergencies. We are successful in our efforts given that we have a close working relationship with ODC Homeland security and emergency management agency on a daily basis and in the event of an event or incident the district agencies and ESF leads responsible for responding. Internally, we have a very diverse skill set within our agency and if there is an emergency responding to that does not necessitate a tremendous amount of additional support from colleagues and other agencies or other ESF functions was to have capacity within the agency, using subject matter experts to convene her own incident management team. It can expand or contract based on the incident. The type of individuals who may be involved in an emerging response may be very different than those who are helping us to respond to man-made or natural disaster. On the next slide, you will see that we really have ability to again, be flexible across our enterprise in terms of the preparedness that we do related to exercising and training and planning for these disasters and emerging infectious diseases. I want to recognize, there's lots of conversations in terms of how public health is communicated about the COVID-19 pandemic. While those things are just inherent to emerging infectious diseases that prevent unique challenges responding to natural and man-made disasters, you receive rapidly changing information regarding the incident, science related to the packages or infectious agent involving and in order to be prudent and responsible you must evolve your policies and programs consistent with that evolving science prudent availability of resources. I will talk about this a little bit more about public health budgets are not significant in terms of being able to acquire or procure all of the resources and other sets of equipment needed for a large-scale event. So how quickly financial resources are made available from the federal government for the localities and from a defense space is important to resubscribe to and I've been a huge champion of this professionally. All hazards approach. To prepare for disasters and emerging infectious diseases. The basic foundational infrastructures to be built and created for people to know what their roles and responsibilities are and then we can provide training to any staff or community members who may be involved in the response. Next, I will talk briefly about some of the ways that we prepare for disasters being in the nations capital. In the nations capital, we tend to be a place that is both prone to natural disasters in terms of hurricanes, we have went toward civil disorder because of the residents to would like to bring grievances to their government, bring them in our city. That we are responsible for protecting and keeping safe. And we also do some of the same things other

jurisdictions do in terms of planning for bioterrorist agents like anthrax and other things such as active shooter events which we unfortunately have had in the District of Columbia with substantial loss of life. Response is released to COVID-19, was really on the next slide. Was really able to take off and a rather quick pace. And that's because we have a need to collaborate across agencies and with the federal government partners on an ongoing basis. The federal government has a designation called national security events, it was created and over 50 percent of national events have occurred in Washington D.C.. Those events can range in scale and scope from being as big as the papal visit to the United States, or something that people consider to be routine such as the state of the union address. In January 2020, we built off of the relationships that we had with our federal ESF agencies and partners in the capitol region to and how it within the opposition will create the management team. We quickly began in January coordinated messages for the public that would range from the science of what we knew at the time, as well as how to access resources that they consider who is most at risk at the time and ensuring all the information. We work with healthcare partners to device protocol to keep workers and patient safe and a tremendous amount of guidance to effective leadership. In the next slide you'll see by February, the incident management team that we have in the agency was rolled into the district emergency operations center that was directed to activate under the direction of emergency management agency via the mayor's order. And it was put out very clearly that we would have a whole of government response. Every agency was responsible for being engaged in the EOC, and all the risks that might happen to mitigate the impact. Over time, you'll see on the next slide, I want to talk about all the things that public health is done. During this COVID-19 response. People tend to be very familiar with testing and vaccination. So much more happens in a state and local health department we are responsible for surveillance, when you're looking to compare what's happening when you're in the jurisdiction looking to understand whatever populations are being impacted from a geographic perspective from a race and ethnicity perspective as well as gender and age, that is critically important. The investigation and -- disease and contact tracing. We do it all the time! We were very involved. But the scale and scope by which we have to do this investigation and contact tracing for COVID-19, required us to almost increase the workforce within the agency by about 60 percent. And we needed to do in a relatively short time to be able to have everyone on boarded, trained and not only COVID-19, information but in customer service. Because it is not a small thing to have to communicate to people have been given a diagnosis that for which you have tremendous concerns. Republished over 100 health guidance documents to the community. They are directed to our sectors, they are for how restaurants should operate, how pools should operate how care services should operate they are very detailed to ensure that all of the leaders in our community, business owners and residents understand what is to help mitigate risk. Risk communications is a big thing and think public health does. In many agencies the communications department is very small. So, he had to be begin to be very nimble and understand everyone in a leadership position in the organization has communication skills and the information is timely and accurate. Letting people know what you know now, what you do not know and what you expect to know soon in the future. We provide public health consultations and technical assistance. Directly to any entity that is concerned about a new diagnosis, or outbreak over 3000 of those have occurred which is separate from the work of disease investigation and contact tracing. These complications have been again with we have a large hospitality sector here. Our schools want to thrive and be will have children and work closely with them to do the work. And the last is the vaccine program. As well with testing. We have a scarcity of tests over the last year and testing opportunities for COVID-19 very early on in the pandemic response. Essentially, only the CDC and shortly after, state

public health labs, had the ability to test for COVID-19 and we needed to continue to be able to ramp up opportunities for people to get tested in the community and a number of locations. We publicly operated testing sites that operate 6 to 7 days a week. In all parts of our city. Reaching into the communities that have the highest burden of disease even on a pop-up basis. Reviews that same modeling for the vaccine program for using surveillance data to drive interventions and the intensity of interventions in particular neighborhoods. Some of the challenges that we have on the last slide, I will just talk a little about opportunities for improving the public health system. The performance of the public health system. Particularly, as it relates to events and incidents. We've always done after action reports. We do after action report after inaugurations, we do them after we had a natural disaster. There are many opportunities to do after action reports and to improve the existing plans we have at the local level. This happens at state and national levels related to response. We have learned that we had to do after action reports in the middle of this pandemic. Before the action is over unfortunately. And that is to make sure that all of our partners are engaged and that the playbook we are using is still appropriate for the situation. I think the ways we really need to be focused in terms of the short and long-term investment to improve the public health system, is based on lessons learned with COVID-19 and H1N1 and other civil disorder activities in the past year is critical need to be able to share information and data in real-time. Although information and data systems are interoperable. In a timely sharing of data internally, externally with key stakeholders and residents. We have to do much better job in terms of early detection of emergent or reemerging infectious diseases and pathogens as well as being able to focus on how to identify chemical, biological, radiological and other agents that may be threats to the communities as well. Using our program as an example but needed to expand efforts even further so reaches more communities within a state as well as many communities at the city level. Our workforce development needs are critical at this time. We highlighted how it had a substantial loss in the public workforce and when we surveyed the public health workforce it is in fact aging and while lack of attention is getting to it healthcare providers on the frontline taking care patients needed during the COVID-19 pandemic, much of those occurred in the public health workforce in terms of skilled development and in terms of the risk of burnout and moral injury. As a result of the pandemic. And so is critically important that we recognize the public health workforce and in terms of the needs of to cultivate more people and to the workforce as well as provide professional development skills and activities. They absolutely augment each other. One of our five strategic priorities here is to close the chasm between public health and clinical medicine. We recommend strengthening one without the other as it relates to responding to the emerging effects of disease and disasters will still leave the community extremely vulnerable. And lastly we need to have more flexible funding streams that allow for us to expeditiously prepare resources at the time of need. And at the time of identification of the need. It was mentioned that public health emergency preparedness and epidemiology, and the preparedness funds, they've not been consistent over the past three years. You may see anywhere from seven or eight percent increase in then it goes away the next year. And then you see a 20 percent increase. And then that goes away the next year. It makes it very difficult to be able to engage some of your key stakeholder partners may be relying on resources to train safety officers etc., within the organizations, having stability in the existing funding stream as well as flexibility overall access of public health resources is critical to our success. All of these things again, really do help to show if you build the right infrastructure if your programs are strong and you have a diverse and culturally competent contact tracing and disease investigation staff they can help position you much better to be able to identify inequities in your community and develop interventions for them. While we do recognize that

there is a need to create and talk about a lot of the special initiatives that focus on achieving equity, if your foundation is weak, a program you put on top of it will crumble. I just want to be will to highlight those today and I look forward to this discussion with my colleagues as well as taking questions from you all. Thank you for the opportunity.

>> JOHN AUERBACK: Thank you so much, for that. That fascinating insight into how you lead the effort in DC and I think that the residents of the city of which I am one, I have personal gratitude for your work. I really have benefited from your wise, steady and effective leadership so thank you very much.

>> LAQUANDRA S. NESBITT: Thank you.

>> JOHN AUERBACK: Now we're going to hear from Dr. Mayfield. Looking forward to your comments.

>> STEPHANIE MAYFIELD GIBSON: Thank you John, I really appreciate the work that you have done on producing this very relevant and timely report. And permitting me to be here with my esteemed colleagues, Dr. Nesbitt and Dr. Webb. I would like to talk to about some critical COVID-19 challenges that approaches a strengthening public health. Next slide, please a little about where we are right now. Vital strategies as a global help organization, working in over 17 countries to strengthen public health systems. Results in saving lives and it aims to prevent 100 million deaths from cardiovascular disease and prevent epidemics. A provision of that, you program results to save lives supporting countries throughout Africa and beyond to respond to COVID-19. Next slide, please? Showing what we offer. We are an integrated team of experts in epidemiology, technology, communications, community engagement, all working to help health departments across the United States. To protect public health and safely reopen communities and economies during the pandemic. Our efforts have focused on promoting an equitable and efficient COVID-19 vaccine roll out and advancing prevention, testing, contact tracing, isolation, quarantine strategies and more recently vaccination. Next slide, please? We created alert level systems that you will find in the New York Times. We developed this framework to guide local, regional and national governments on best practices for level systems and how to clearly communicate the actions people should take in response to changing COVID-19 conditions within their community. And this depicts what you can find in the New York Times. It includes county level risk assessment and tracking cases for nearly every county in the United States. That is more than 3000 to heighten public awareness of the severity of COVID-19 that spreads in each area. Next slide, please. We also have learning opportunities for all counties and getting ready for regionally. We discussed topics on how to communicate about vaccines. Mapping, how we can use geographic data to best inform local COVID-19 response. Using data to inform school openings and closures. And prioritizing contact tracing during the surge. Next slide, please. We've worked with multiple partners to achieve these goals. These are just some in the national correlation we work with. Next slide, please. Our states and partnerships that we work with, we will call the double voucher jurisdictions where we implemented digital tools to increase efficiency in the response to COVID-19 and we have a light touch site, we help with dashboards that we also utilize various tools on the website. Next slide please. The current areas of focus, we know that there is a need for greater and more sustainable public health funding and transparency like you just heard from my colleague, Dr. Nesbitt. We were disconnected public health infrastructure. We are focusing on gaps and publicly reported COVID-19 vaccination data. And COVID-19 vaccine in equity. Next slide, please. With respect to funding, the US is, at the public health system, it's suffered from chronic underfunding because there are many competing priorities. We have heard this from Dr. Nesbitt and you will see this in the report.

Recently, public health funding has been a subject of strict committee budget cuts and the threat of -- as we work to recover from COVID-19 is very clear we cannot afford another multitrillion dollar pandemic. But we can afford health security. Greater and more sustainable resources are needed to help ensure that we can prevent and have a better response to the future health threats and responses need, save lives as advocated for Congress to establish a budget exemption. For critical public health functions by creation of a operations designation that we refer to as this HDO. it would be with programs integral into the health system this is what would help ensure that we able to fight and work against the next pandemic or the next threat that faces our nation. Next slide please. We have a disconnect. This is what we have seen in some of our jurisdictions and others from the lack of transparency of federal, state and local funding streams. We want to make federal response funds publicly traceable down to the local government level. And we want to include local health department expertise in the development of federal grants and funding. Next slide please. We do not have a disconnect in jurisdictional operations. States have contracted private entities for contact tracing. Some counties have discontinued contact tracing to focus on delivery. And in some instances, schools are opening up and doing their own contact tracing and managing in the absence of public health. Next slide please? We want to encourage a public health workforce integration to build resilient communities. The public health workforce needs to be robust with its own public health department to start with disease and prevention specialists and epidemiologist, informatics staff, educators and communicators and more. And clinical settings, and working with community-based organizations to address some of the things we heard Dr. Webb speak of earlier. Next slide please. Another one of our focuses as we look at equity, as we look at distribution of vaccines, we recommend five key COVID-19 vaccine indicators. And they raced to curb the spread of COVID-19. We need data to maximize speed, and equity to help address the gaps and help save lives. We have five recommended vaccine did indicators to inform COVID-19 response efforts. And provide transparency on vaccine roll out. In the recommendations we reviewed all -- available on January 25. And we focused on the three primary components of the US COVID-19 vaccination. We are seeing progress on some states starting to adopt recommendations and continuing to disseminate the funding, their findings and with these reports, the underscore the importance of standardization where we seen irregularities in data. With so much inconsistency in what is reported and how it is reported, it is really difficult to compare across states and identify which strategies are really working well. And with days trying a different approaches, we need to be able to quickly identify and amplify these strategies that are yielding equitable and effective distribution. Next slide, please. You can see this is a graph on the type of family foundation. One of the more striking features on the graph is at 40 states as of March 29, have a need for greater capturing of data reporting on race and ethnicity. Particularly, we see the impact on specific races in the United States. Notably, COVID-19 vaccine uptake is increasing in all populations. But they are disparities that we need to continue to address and effectively address that, we need to be able to capture the data. Next slide please? This is a slide on one of our states and jurisdictions, North Carolina. Dr. Webb mentions earlier on vulnerability mapping. And in an effort to make COVID-19 vaccine distribution more equitable. Our team is helping with specific counties within North Carolina, implement the equitable programs through the vulnerability mapping. We identify those most vulnerable based on social vulnerabilities impacts. For the sake of time I will continue to move forward. What is notable is that there is a equitable dosing that is done in North Carolina to ensure communities receive their fair share of doses. In other states are doing that as well. Another community-based organization on equity that we are working with is advancing the choose healthy life initiative. Is led by reverends Calvin O. Butts and Al Sharpton.

Focusing on testing has pivoted to vaccines and their supporting national vaccine rollouts and recently expanding to vaccine pop ups in the three major cities. The focus has been in New York, Atlanta, DC, Newark and Detroit. Next slide, please. One of the things that we have noticed is that to strengthen our public health system, we really need a health defense operation fund to help ensure America's long-term health security. Better coordination, transparency of fund flow and use, optimizing federal/state/city and local roles, correctly positioning in locating COVID-19 support in vaccine services. To build resilient communities, we have a gap in data we need to improve real-time, stratified and transparent data that leads to change in policy and practice. And again, promote equity, throughout the public health system and large focuses on vaccines. Thank you for this opportunity to present our work at resolve to save lives. Back to you.

>> JOHN AUERBACK: Dr. Mayfield, thank you! Resolve to save lives and your leadership are really redoing remarkable work and thinking about how do we, implement of these complicated challenges throughout the responses to the complicated challenges throughout the country. Thank you for that. Please do submit your questions following the guidelines that are on your screen now. I'm going to start by asking questions, Dr. Webb I don't know if you're still here. I don't know if Dr. Webb was getting called back to the White House. You're still there, terrific! Thank you so much. Maybe I'll start with a question for you. Undoubtedly come with efforts that you were relaying, is going to be progress made in terms of equity with COVID response to address some of the disproportionate burden that we have seen. And the challenges and access. Many folks are concerned that there is a lot of attention now on the issue with COVID and the resources but it will be difficult to sustain that in the post-COVID period. Do you have talked about how to carry forward, some of the progress that will be made with the kind of initiatives we were talking about in a post-COVID period.

So that we do not lose progress, we continue to combat inequity.

>> CAMERON WEBB: That's a fantastic question. And I think is the right want to be asking.

I do apologize.

I have to leave early but have to answer this because it's so important. I will give you an example.

We do current initiatives, we are vaccinating all patients working through the organizations because 50 percent of the patient to get COVID end up getting really sick or dying from COVID.

It is disproportionately minority groups. Lindy ability to mobilize this resource, 375,000 doses of vaccine up to this community really quickly I think was an important show that we want to address the disparities.

Today I had a conversation with some colleagues saying what do we do next? We don't stop with we vaccinated a population. And the reason I bring this up is that Ambassador Rice and I, and Doctor Nunez, we had several conversations about how COVID equity is spread and health equity -- everything we are learning about COVID equity and how we can rally resources from the federal government with COVID equity there is no correlator. It's either long-term efforts to address health equity more broadly in the community. We started to draw the connections between the current and how it will play in the broader health equity effort.

We want to acknowledge Doctor Nunez leading this task force. That task force is made up of people around the country. Community leaders, organizational leaders and members of the federal government. They are meant to give a final report, recommendation to the COVID team and also meant to give recommendations of future work in health equity. I'm excited how we can move from this to the marathon not miss the opportunity to center on health equity.

>> JOHN AUERBACK: Thank you for that answer. That is great that the focus is there and the discussions are taking place. It is just wonderful to hear that. And also, thank you again for joining us and we do know that you have to leave early. We appreciate you making time with little advance notice. It was really helpful for our listeners.

Dr. Mayfield, on the issue of equity, and the fact that you relate, you relate you are working with people in different parts of the country. You know, one issue that sometimes comes up as we grapple with emergency response in general, is understanding the different kinds of responses needed and different geographic areas based upon a variety of issues. But included in that on the issue of rural versus urban, what are your thoughts about the challenges and potential responses to that, that might be different in a rural area?

>> STEPHANIE MAYFIELD GIBSON: Thank you for the question. We know that COVID has highlighted words always been there. Some of the challenges that have been there for quite some time in rural areas, communication challenges. Lack of broadband throughout. I was glad to see the president put that in the budget to expand broadband because that impacts how you can respond during an emergency. Whether it be natural or nefarious, it impacts the ability to offer health delivery services without broadband. In rural areas when urban areas have an opportunity for options, quarantine, it can be very limited in rural areas. Another point of note in rural areas, and I'm putting on my former Commissioner hat now. Often times, EMS response, relies on volunteers. And so that gets back to the budget and being able to move forward. Rural hospitals, many of them have closed or reduced bed size, capacity and that impacts when you have COVID. What happens when you do not have many beds in rural areas and patients have to be sent into the city which could be over 100 miles away in some cases. There is surveillance, we're lacking in funding for surveillance. Yes, there are some common features between -- but their uncommon features and the lack of capacity and lack of access, quarantine facilities and EMS challenges given many of the workers and volunteers. It is just some of the challenges that we see in the rural areas.

>> JOHN AUERBACK: Thank you and another you grappling with those when you're Commissioner in Kentucky. Dr. Nesbitt, in some ways were geographically in this unique position in terms of policymakers. You know and there probably, in the District of Columbia there probably more policymakers and elected officials per square foot than any other place in the country! And so I wonder you know, I'm thinking of whether you have thoughts about what would be the single most important message to some policymakers without the local, federal or state level that you think is really the one item that you think they need to hear most importantly?

>> LAQUANDRA S. NESBITT: Thank you. I tried to address this every chance I get for preparedness and emergency response. It's critically important that we shift from focusing on the disease or event du jour and creating funding mechanisms and capacities to be able to respond to all hazards. If you reflect on the past 10 years in this country, just from pathogens and infectious disease perspective we've had

Ebola, we've had zika virus and now we have COVID-19. The approaches that were taken to financing and funding the response to the initiatives were highly varied. They were not as quick as I should have been. To be able to preserve life and mitigate impact. And if you think about the one that had impact on fewer US residents, Ebola, it received the most funding at the beginning and still has designated programs. We are responsible for Summerow federal grants to identify Ebola treatment centers. They are actually called Ebola treatment centers. And so, when you're thinking through the flexibility and funding and with the foundational infrastructure is that you need in your healthcare system, public health system, being bound by the name of a specific pathogen or disease as it relates to preparedness is very limiting. And so we need to be able to go beyond funding, sometimes I think maybe it would be to a degree of People's credit with emotion and a sense of urgency. If you think about the amount of funding and resources being invested right now for the COVID response over the past year and where it's being invested, we would is a substantial opportunity to be thinking about better tools for disease investigation or intervention using all of these tools and databases and applications created for COVID-19, wouldn't it be remarkable if we could just move those over to TV? If it can move those over and structure them that they have the book to help us reply. Getting it's Doctor Mayfield draw feeling a little bit. If you start talking about specific instruments and laboratories that contest for multiple pathogens, if all your changing is the assay. Those are the things we had to think about, how to leverage greater impact in the long term, as opposed to only looking at what's right in front of us?

>> JOHN AUERBACK: I think that is such an important issue. As working at the CDC when both Ebola and zika virus were happening in the country. And when the Ebola monies on the states and locals, Zika hit in many local and state official said, can we just use some Ebola money we've already received to work on Sica? And we were told no, not to use it for that purpose and therefore, they needed to wait until there was specialized zika fund and it didn't really make sense to those on the front lines and it's an example of where there are limits for disease specific and discuss a new way of public health evolving. Dara Lieberman at Trust for America's Health a long time emergency preparedness expert, you been looking at questions coming in from the listeners. Would you like to share an initial question from one of them?

>> Sure and or money can get questions put in the Q&A. How is DC responded to mental health needs of residents related to COVID-19?

>> Sure, this is been a intentional focus of hours and something that we wanted to elevate early on. Especially stay-at-home orders came into play, we were seeing rapid loss of life in the community. In the first few months. As well as having people be very overwhelmed by everyday tasks that they were continually doing that needed to be modified. We did something that can be rather small. Anyone who presented a public health testing site received information on when you received information on how to get -- on the other side of the page it was how to take care of the mental and emotional health. And well-being. Including giving them the phone number to our access helpline that's available for those that may be in crisis. Our helpline was typically utilized by people experiencing a psychiatric emergency. It was really expanded in terms of the scope, to be able to offer services without them having a confirmed diagnosis. Without them being in acute psychosis. It really opened up those reinforces and many of them were able to access a number of -- before able to do long-term referrals. We were very intentional creating something for family, school-aged children and I think it goes without saying that teaching a child at home while doing your job is a struggle for many people. And taking on those

responsibilities and trying to communicate with children in terms of why they are not engaging as much with classmates, friends and sports teams. It took a completely different skill set and coaching for parents so we have wellness Wednesday for parents to be able to ask questions, to get support. And lastly, I will say that in long-term care, as for seniors and elderly, those in any type of care, when they were unable to have visitors because of the risk and the facilities where the death rates were much higher, it was higher than the general population. We provided the facilities with technology, with iPads and things to be able to keep families connected. Over the past year. We have been very sensitive to the needs of individuals, training staff, a couple of weeks ago we went back to some of the rich programs we had in Kentucky there also here like some psychological things in how people understand that the resources are available for them to access. Inc. you.

>> DARA LIEBERMAN: This pandemic has demonstrated there was a problem before -- this is really important to hear about. Maybe Dr. Mayfield can address his question. Regarding collection of data. Decent push to desegregate further so we can better reach populations? For example, the audience member provided API population. Often London to one or two categories. There are over 30 countries and over 100 languages and categories.

>> JOHN AUERBACK: And to clarify is AAPI.

>> DARA LIEBERMAN: That can be dozens of nationalities within that. How can we better target responses and better collect data?

>> STEPHANIE MAYFIELD GIBSON: It's a good question. I hate to call populations were not currently collecting data on. We certainly hope that looking at particular states, they will advance the collection on the data. Some people we have to be, they don't want to give that particular data. That reflects a smaller minority of the lack of the data collection. But other systems have been retooled to collect the data based on the population that exists. We really are struggling with that. When you look at the Keiser family foundation, I presented some of the more common data collections, we still have at least 10 or 15 states not reporting out all on that. It continues to be a challenge but the bright light will be that COVID has highlighted these disparities. And data collection and it is an opportunity for systems to be retooled, the federal funding coming down so that we can get more data and learn what are the additional populations in our community. There is an opportunity for us and yes, there's a push to disaggregate that data.

>> DARA LIEBERMAN: Dr. Nesbitt, who defined are the hardest to reach communities? And what are some best practices in reaching them?

>> LAQUANDRA S. NESBITT: I will anticipate that the hardest to reach population are not eligible yet but they will be in a couple of weeks. I'm very concerned about our ability to reach. And don't mean in terms of knowing where they are but the ability to reach and move them to action, our younger population. And especially the younger residents who are members of communities of color. Getting them to move to action in terms of vaccination, getting them to go to action in terms of testing and identification of symptoms for COVID-19 early on, has been a challenge. And so, it would not be wise of us to overlook them as a hard-to-reach population. In the very sort of programmatic, connected way. On the other side, we created very early on, both a technology solution and then for our seniors. People live in communities where they may not have Internet access or I'm sorry, a desktop or laptop in their home. But someone in the home has a smart phone enabled device etc. We've been very focused on

how to continue to go door-to-door and make sure they have information to know that vaccines are available and help them sign up for vaccine without them even having to engage with the technology solutions and tools. And they get effectively a business card, for who is not designated there vaccine body and help them be able to navigate the process. So those are some of the populations that we have had concern about because while we have less of a gap between non-Hispanic white population and non-Hispanic black population in the District of Columbia in terms of vaccination rates, then other most jurisdictions we still it is still not parity. And when I think about parity I think of it as a perspective from vaccination rates and the proportion of those individuals in our community and it should also, for real equity to be achieved it should take into consideration that we are making strategic investments and vaccinating individuals who are in the communities that were hardest hit by COVID-19. And most of the impact in the communities were due to the risk of exposure. Multifamily households, working in essential worker positions in the community that really did not afford them the ability to stay home. So, we really are focused on again, continuing to close the gap and then have rates similar to be on par with the demographics from a city perspective. It is reassuring not only in the Keiser survey but the polling was done locally. That user perspective on the vaccine or changing in a good way. We have demand in the community, we just need to be able to meet the demand about having adequate supply of vaccine for everyone who wants it.

>> DARA LIEBERMAN: Hesitance doesn't necessarily mean -- the numbers of changing and we need to focus on axis in addition. John, how can we ensure that the focus on public health preparedness and public health funding can be maintained even when the third of the pandemic eventually subsides?

>> JOHN AUERBACK: I would say one thing is, we cannot wait. We have to be talking about post COVID now. And we have to be talking to our policymakers at the federal, state and local levels. And really driving home some lessons we've been talking about. Today, that we know there is going to be another emergency, we have seen just how frequently they have been coming in the last couple of decades. So, we need to make the case that right now, we need to invest in public health and we are glad there are some concrete proposals to do that peers such as the $4.5 billion initiative that has been introduced in Congress for consideration by Senator Murray. I think we also to be super concrete about what it is we want. We have to have a vision of public health for the future that isn't simply the way that it's been in the past with a little more money. We really have to think about data systems that reflects state-of-the-art activity. State-of-the-art technology. We are to think about the health issues that are facing us that did not face us before. I mention one with weather related emergencies but we've also seen in recent years, behavioral health issues related to substance use, suicide, etc. As well as continuing was that we've had that we need to make more progress such as obesity and tobacco. We have to make the case, to be concrete and we have to be farsighted. Think about what other needs going to be and what does it look like and paint the picture for the policymakers.

>> DARA LIEBERMAN: Thank you. And one final question for Dr. Mayfield before we turn it back to you for closing remarks. Dr. Mayfield, what are some key lessons that you fill the public health community has learned from the US COVID-19 response effort?

>> STEPHANIE MAYFIELD GIBSON: The most unfortunate lesson we learned is that we were not prepared. And one of the major recommendations going forward, everything John said just now, plus advocating for the health systems operations funding. So that we can advance the future health and

economic security that is achieved by permanent budget caps exemptions for critical public health -- we will line up supplemental funding for the crisis of the day. Thank you.

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>> JOHN AUERBACK: Great questions, thank you to the audience raising those. We are just a few minutes left. And so, I ask each of our speakers, Dr. Nesbitt and Dr. Mayfield for closing comments. Your closing thoughts about you know, what have we learned? Where do we go from here? What would you leave our listeners with? Dr. Nesbitt, let's start with you.

>> LAQUANDRA S. NESBITT: Thank you. I think we are in a relatively, I want to call it a good place. In terms of public health policy. We have increased our intentional focus on achieving equity. I want to make sure that we emphasize that in order to achieve equity we have to have a good foundation. The infrastructure for our work and public health and healthcare has to be solid. In order for us to have a effective health equity intervention. If we can't do basic things, such as surveillance, then you can't know the populations were disproportionately impacted. We can't develop basic functions in terms of having a diverse workforce, it will be difficult to reach people when we have issues that happen in our community that require home visits, doorknocking, messages from credible messages. All listings will only be successful if we really are intentional. Number one attention about building a good foundation with core capabilities and agencies and be mindful of the need to have a very diverse workforce. Thank you.

>> JOHN AUERBACK: Such wise insight and advice. Thank you for that. Dr. Mayfield?

>> STEPHANIE MAYFIELD GIBSON: Yes in additions to the operation funding, coordination and transparency of the fund flow and also the use of those funds. How we optimize those monies. And then to build resilient communities, integrate public health more into primary care community-based organizations, and navigators to address the social determinants of health, having the ability to collect and put to use, real-time and transparent data to impact policies and practice and continue with equity and vaccination. For immediate problem with COVID-19. Thank you.

>> JOHN AUERBACK: Thank you. And again thank you both, for the work that you do and the significance of that to the nation. And for joining us today and sharing your perspective. We are very grateful to Dr. Webb for his presentation. I want to share with all the people that are listening, that as we have done in the past, this webinar will be available on our website in a matter of days. And so, if you want to share with others who were not able to attend, you can let them know that it will be available on the website and it can be easily played at that site. Also, please go to our website to look at the ready or not report, if you have not had a chance to see it. It is worth reading through and looking more carefully at the recommendations that are at the end of the report. With that, I would say to all involved, thank you again, thank you to our listeners and thank you for the questions that you raised. And with that, I hope everyone has a good day, take care!