



**Ready or Not 2022: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism  
Virtual Congressional Briefing & National Webinar**

**Trust for America's Health**

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**3:30-5:00 PM Eastern Time**

**Live Captioning by Ai-Media**

TIM HUGHES:

Good afternoon, and welcome to our congressional briefing and national webinar on the report 'Ready or Not 2022: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism' 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.

Real-time captioning is provided today by Jenna-Lee and Marielle from AI media. For captions, click on 'More' on the bottom of your screen on the three dots. Then click on 'Closed captioning'.

We encourage you all to share your thoughts and questions of today's presentation by typing them in the queue and a box. We will try and answer as many as we can as time permits.

To open the Q and A box, click the queue and day icon at the bottom of your screen. From there, select 'Enter' when you are ready to submit your question.

Now, it's my pleasure to introduce the moderator of this event Doctor J Nadine Garcia. Doctor Garcia is the president and CEO of Trust for America's Health. She is a national Health Equity leader with extensive leadership and management experience in federal government, nonprofit sector, academia, and professional associations.

As president and CEO, she leads TFAH's work to advance Health Equity, and make health promotion and disease prevention a national priority. Welcome, Doctor Garcia.

J NADINE GRACIA:

Thank you, Tim, and greetings everyone. As Tim said, I am Medina Garcia, and we are so pleased you are joining us today for this Congressional briefing and a national webinar.

I would like to thank our esteemed panelist for taking time out of their busy schedules. We are honored to have them here with us.

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On this slide he will see the agenda for today's briefing. After each of the panelists presentations you have time for questions and answers from the audience was the

Next slide, please.

Before we turn to our panel, I would like to review some of the findings and recommendations on TFAHs recent 2022 'Ready or not report'.

Since 2003, over two decades, TFAH has published the annual 'Ready or not' report which examines 10 key indicators will stop these are actionable steps that states can take to improve their overall readiness. It's not intended to be a report card or grading of states, but rather to give states tools to improve preparedness over a range of issues was stopped these indicators include actions by numerous stakeholders including policymakers, public health departments, healthcare systems, employers, and the general public.

In this year's report we highlighted the tragic lessons of the COVID-19 pandemic. Including steps that policymakers and other decision-makers can take to improve our nation's health security. As in all of our reports, we include evidence-based recommendations in several -- seven key areas.

With the pandemic is clearly illustrated is that there is more work to be done everywhere to protect the public's health during major events.

Our report measures states performance on 10 key emergency preparedness indicators across a range of emergencies. Not solely infectious disease outbreaks, but also weather-related emergencies, and other types of emergencies. Across a range of sectors from hospitals to public health, to state governments. We found progress, as well as areas of improvement, in every jurisdiction.

In this year's report, we found that 17 states and the District of Columbia were in the high performance tier which is demarcated by the green shading. 20 states were in the middle tier, which is orange. 13 states were in the low tier which is in red.

Overall, 12 estate improved their performance while 16 states slipped in their ranking. All-states performance is relative to other states.

We look at some of the key findings as it relates to areas of performance of strength, we know that all states had a plan in 2021 , for a 6 to 8 weeks surge in their laboratory testing to respond to a pandemic or an outbreak event was up only Columbia did not have a plan, but the plan in that district was in progress, and in the development phase.

We also noted that accreditation and public health and emergency management are important tools of measurement, of quality improvement, of accountability, and we found that most states are credited in one area or both.

More states have also joined the nurse licensure compact over the past few years which make it easier for healthcare facilities to bring nurses across state lines during a medical surge. 37 states are now in the nurse licensure compact, which is a net increase of 11 and 2017.

We have seen a promising increase in seasonal flu vaccination increase, holding over 50% in the -- for the second season in a row. This is an important measure of how well we are vaccinating all age groups. The vaccination rate for Americans age 6 month and older rose from 42% from the 2017 - 2018 flu season, to -- 52%. We are still well below the 70% target that is been recommended.

There are certainly also areas where there are opportunities for improvement. The federal government and state governments needs to increase public health funding for stopped decades of chronic underfunding of public health is but the sub public safety at risk. We need to invest in rebuilding the public health workforce, systems, technology. The staffing up project suggests it fate relies on (Audio Issues)... only about half of the US population is served by a comprehensive public health system. Without new and sustained funding the nation is at risk to confront the same -- the next public health emergency with the same challenging desperate challenges that we did with COVID-19 pandemic.

We also found that the -- most hospitals, to protect patients and staff, during nonemergency times, but also during an emergency. And only about half of workers is paid time off in any given month. In 2021. This is been particularly problematic when people who were sick or exposed of the virus should stay home which was critical to keep the virus from spreading.

Our report also examines the lessons learned so far from the COVID-19 pandemic, and we know that we are continuing to learn lessons in this pandemic. While all communities have experienced the pandemic, we know it did not impact communities equally. Communities of color, peoples with disabilities, households with low income, older adults, and others, have a disproportionate burden and do not receive adequate services.

We are seeing an example of this where funding for free COVID-19 testing is a minister, and people who are uninsured are being asked to pay out of pocket for equity must be central in a public health -- preparedness and response will stop

The pandemic is also put a spotlight on the public health system that is been hollowed out from years of insufficient funding, and will state and local health care -- needs assisting funding in order to continue to operate properly. Modernized health data and disease tracking systems are needed. In a coordinated and consistent leadership is needed, based in science. We also need clear roles and responsibilities, it's vitally important for future emergencies.

The one reason why this past year has been so difficult has been the lack of investment in our public health system. As noted before the COVID-19 response funding has been critical, but when we are pouring money into systems that have been eroded over the past decades, these systems really cannot be built overnight.

What this chart shows are the two primary funding sources for public health emergency preparedness systems in our country will stop the public health emergency preparedness, known as PHEP, and the hospital preparedness program. The public health preparedness program is shown in blue. These are dollars from CDC to help the permits for building the foundations for emergency response. And the hospital prepared this program which appears in red, are granted to states to develop healthcare preparedness including healthcare coalitions.

That, unfortunately, has been cut by 26% from 2003, or 40% if you account for inflation. The hospital preparedness program has been cut by 46%, or over 62% if you account for inflation.

What these long terms erosions of funds mean is that -- we lose workers, and expertise for the we found that some healthcare departments were tracking COVID-19 cases with phones and fax, instead of modern-day technology.

We see this boom and bust cycle of public health funding which is a repeated cycle that we have seen in most levels of government, and in many past public health emergencies. When public health is doing its job, community's are thriving, healthy, and most Americans are unaware of the role of public health.

The same is true for lawmakers, the decision-makers who control budgets for health departments, or other health agencies as a result, we see federal and state public health funding erode over time. Then, when a public -- when a crisis happens such as COVID-19, ZICA, or Ebola, --ZICA, we see the funding drained and in need again. When that funding expires, most of the people hired will be let go. Funds start to stagnate, and we are right back where we started. So, we must learn the lessons from the past public health emergencies, and certainly this pandemic, and make sure we are sustaining and modernizing public health, not just during disaster.

In the 2020 'Ready or not report', we outline it several policy recordations will stop I highlight a few of the key federal once tearful to we certainly need to get out of the boom and bust cycle of public health funding, and that includes increased annual funding for programs like the public health emergency prepared this program, and also, importantly, direct, and sustain flexible (indiscernible), such as infrastructure and data modernization. In both of these have been proposed for funding increases in the president budget.

As we knew earlier, equity must be central to preparedness and emergency efforts, and specific regulations have been laid out. Federal agencies should make sure that there are meaningful (indiscernible) reaching community-based organizations. In the social determinates have to be prioritized to help build resilient communities, including incorporating equity in leadership, and

to preparedness and response, and to ensure that funding is reaching the communities that are experiencing disproportionate impact.

Congress should also pass protections for paid sick, family, and medical leave, guidance to stay home when sick is not possible for many Americans who cannot afford to miss a paycheck, possibly even lose their job if they miss work.

We need to invest in ended to end research and develop, as well as the infra-structure to distribute medical power measures such as vaccines, therapeutics, and educate the public and providers about their use.

Policymakers and healthcare workers also need to prioritize the readiness of the healthcare system. For all types of emergencies, including through increased funding for the hospital preparedness program.

We certainly have seen the importance of having an effective public health communication at all levels will stop we need to ensure that there is an effectiveness of those community issues, including research into best practices, and effective messages to diverse audiences, and addressing misinformation.

Finally, we recommend that Congress create and fund communications to learn the lessons of the pandemics, and such a commission could really provide a blueprint for policymakers and practitioners moving forward.

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You can access our full ready or not report, and its findings and recommendations on our Trust for America's Health website, with the link provided directly here for we also encourage you to follow us on social media.

I will now turn this to our panel to start our presentations, and that will lead into our discussion.

We are going to save questions until after all of our presenters have delivered their presentations. Just a reminder to please submit your questions in the Q and a box. Not the chat. We will respond to his many questions as possible during our Q&A period.

I am now pleased to welcome artist in which panel.

Our first, Doctor Leandris Liburd was the associate director for Minority Health and Health Equity, for the Centers for Disease Control and prevention, and the agency for toxic substances and disease Registry. In this role she provides agency leadership, direction, and accountability, for CDC's policies and programs to make sure that they are effective including Minority Health, Health Equity, and women's health.

She has a critical leadership role in determining CDC's vision for Health Equity, and she also served as CDC's first-ever Chief Health Equity Officer during the COVID-19 response.

Second panelist is Doctor Thomas Bob--Dobbs, the state health officer for Mississippi State permanent health a stop he is an infectious diseases physician using at the intersection of public health and patient care, both domestically and internationally. With specific expertise in HIV, tuberculosis, and Health Equity.

Doctor Dobbs has served in other health roles including district health officer, in-state genealogists in Mississippi, and Doctor Dobbs also serves as an associate professor at the University of Mississippi teaching epidemiology at the school of population.

Our third panelist in Celine Gounder.

She is best known for the coverage of the bola, Zika COVID-19 opioid overdose and gun violence epidemics. As you can see, we have truly a wonderful and distinguished panelist of speakers this afternoon, to have this important conversation.

Now it is my honor to turn to our first presenter, Doctor Leandris Liburd from the CDC. Welcome Doctor Liburd, I will turn over to you.

LEANDRIS LIBURD:

thank you Doctor Garcia, good afternoon everyone. Can we go to the please? I also want to thank TFAH for inviting me to join you today. I'm going to speak on the important role of advancing health equity systems.

So, I'd like to set the stage for why I am here today to talk about the pursuit of health equity as an agencywide priority for CDC. At CDC, we are committed to address health disparities in the United States and our overall mission is to protect Americans from health, safety and security threats. Both foreign and in the United States.

We could not possibly meet that mission without addressing health disparities that permeate our entire country. While we at CDC have been working to address the equities at various levels and in various parts of the agency, I believe that we are in a historic moment where we have the opportunity to make holistic, transformative progress.

Over the last two years the world, our nation and our agency have been waking up to systemic inequities. One year ago, for the first time, CDC declared racism a serious public health threat.

Many of our partners are wrapping up their efforts and health equity as well.

This is language from a presidential executive order regarding equity.

In addition to this executive order, there are other mandates and action items stemming from this and other policies.

At non-emergency times, CDC works to address health inequities rooted in racism, including scientific research, community programs, policy efforts and workforce development.

Through this work, we aim to better understand social determinants of health and to combat the racial inequities illuminated through the COVID-19 pandemic and in future public health emergencies.

CDC works with public health partners to reduce and ultimately eliminate racial and ethnic inequities in health by addressing the structural and social conditions that give rise to them.

As an agency, CDC is transforming its public health research, surveillance and implementation science efforts to shift from simply listing the markers of health inequities to identifying and addressing the drivers of these disparities.

In 2021, CDC launched a core health equity science and intervention strategy. It is designed to work in collaboration with partners to transform our work at its very core. And to strengthen our ability to keep our nation safe and healthy, today and in the future.

This new strategy has a vision of health equity and challenges our CDC centers to incorporate health equity and efforts to address health disparities as a foundational element across all of our work.

From science and research to programs. From partnerships to workforce.

Throughout the COVID-19 response, CDC has worked with national, state, tribal, local, territorial and community partners to promote vaccine equity.

To support these partnerships, CDC has provided funding for organizations that reach racial and ethnic minority groups. Some examples of this funding include: \$3 billion awarded to 64 jurisdictions to support local health departments and community-based organizations in launching new programs and initiatives to improve vaccine equity.

\$2.25 billion also awarded to help departments across the United States and its territories to work in collaboration with community partners to address COVID-19 health disparities.

\$348 million to organizations for community health worker services to support COVID-19 prevention and control.

\$32 million to organizations will for community health worker services to support training, technical assistance and evaluation.

Ensuring health equity is not only essential to ending a public health emergency such as COVID-19, but critical to saving lives.

To meet these needs, the first chief health equity officer unit was established early in the COVID-19 response structure.

With the sole focus of ensuring and all the response approach to identify actions aimed to disparities and inequities. Performed efforts that align with HHS strategies for racial and ethnic minority populations and the long-term plan for recovery and resilience of social behavioral and community health.

This also redouble CDCs commitment to diversity, equity and inclusion to achieve our public health mission.

Having CHEO in key leadership role provides health equity champions more direct access to funding, relationships and influence spheres required to successfully implement strategic health equity initiatives.

The CDC COVID-19 response health equity strategy was developed under the leadership of the chief health equity officer. To afford a robust platform from which CDC and its partners pursued deeper engagements with diverse communities where they created stronger infrastructures to better support data-driven action and increase the culturally responsible reproaches optimized -- approaches optimized to serving diverse and differential populations in different areas.

COVID-19 may exacerbate already existing health and social inequities.

Data highlights groups that increase risk of COVID-19 that include, racial and ethnic populations, persons with disabilities, those who are incarcerated or detained, and people born in other countries.

As well as people living in rural and frontier communities.

Racial and ethnic and other minority populations at high risk for COVID-19 face unique circumstances. Effective public health intervention planning accounts for the particularities of the populations to increase the chances for success.

Cultural and linguistic needs may determine the success or failure of a public health intervention strategy. So, as we continue to learn more about the impact of COVID-19 on the health of different populations, continued action is critical to reduce COVID-19 disparities among the populations already known to be a disproportionate risk.

At CDC, we are committed to addressing racism as the root cause of racial and ethnic disparities in the United States.



Across the agency, there is an ongoing environment -- vibrant body of work, including health equity strategies and funding for health departments.

One example that you have hopefully seen is CDC's racism and health website. Which will be a hub for CDC's activities on Health Equity related to race and ethnicity.

We all have a part in helping to promote fair access to health to advance equity. Both now and in future public health emergencies.

To do this, we have to work together to ensure that people have resources to maintain and manage their physical and mental health.

Including having access to information and affordable high-quality medical care.

In adjusting these differences through new approaches we consider the impact on different groups.

Some examples include: understanding how differences in access affect communities, developing and implementing approaches to address those differences, considering the impact on different groups, mobilizing community engagement and support, identifying inequitable conditions in the social environment, changing community dynamics to support health. As well as implementing public health policies that address underlying causes of health inequities.

I want to take the time to go through all of the resources that are available on our health equity and action webpage. But I do encourage you to visit that website. This is an important communication tool that can serve as a resource for partners, media, policymakers and anyone else interested in CDC's health equity efforts during the COVID-19 response.

Before I close, I want to invite you all to connect with CDC's office of minority health and health equity. Our office uses various platforms to share information and to promote meaningful engagement with public health practitioners, academics and others interested in advancing minority health and health equity.

We encourage you to connect with us through these newsletters, blogs as well as the social media platforms.

Thank you for your attention and I look forward to the discussion later on in this gathering.  
Thank you

J NADINE GRACIA:

Thank you, Doctor Liburd. I look forward to that discussion.

We turn now to Doctor Thomas Dobbs, and turning it over to you Doctor Dobbs.

THOMAS DOBBS:

Thank you. My title slide is something we may not have paid attention to recently, but we have been expecting a pandemic. People always ask me and say, "Can you believe we had a pandemic?" And yes, we have been talking about it for years.

We had planning documents, and security indexes with predicted mortality. If you look at the pandemic severity index that we reviewed going into this pandemic. We knew that the mortality rate, based on initial data, probably put us around a category 2. He had predicted we maybe would've lost 200,000? 250,000 people across the country based on the severity of the illness but but what we -- when we consider what has happened, we have lost 1 million+ people. We have lost hundreds of thousands of people that did not have to die. If we do not have our hands up in fury about this unnecessary loss of life, I don't know what would get our attention. It's really been a tragedy.

The slide below is the mortality rate in the city -- in Mississippi. We look at what has happened in Mississippi, we have lost over 12,000 lives from COVID. That is clearly an undercount. Over 1000 people under 50 years of age, so it's not just older folks, a thousand people, think of that, 13 children, all of whom were unvaccinated, all who died after vaccinations were available to their age group. Tragedy that could be prevented.

If we look at this in context, we can see how many Mississippians were lost in the Vietnam War. 637 stop for World War II, obviously the deadliest war in our last century, 3500. The pandemic is three times more deadly than our most deadly war. He can see the effect it's had on our state, but also our country.

We face many challenges. One of the things we went into a lot, and I have spoken on panels multiple times, is we need better infrastructure.

Analogy, imagine that when you have a challenge and he wants to grow a crop, and you have seeds, you need to have fertile soil so that when you plant the seeds you can reap the benefits of that investment.

But what we have, is we have depleted and exhausted oil in our public health infrastructure. Then we throw a lot of seeds on top, but we don't get the results we need. That's because we haven't had that steady stream of supported funding and we have a resilient operation ready to react. We have underfunded operations. We have siloed and restricted funding, which I will talk about in a little bit. It's not just our response funding, it's everything. You can't use (indiscernible) money for HIV, and vice versa. We have everything so precisely siloed, that we are limiting ourselves and the resources available to solve universal problems.

We have short-term siloed and reactive planning. When we look at what happens with COVID and other events, a previous but lesser magnitude, the health department or the public health response unit, are active for months before funding is available, right?

Then, we have to spend a lot of money to get new systems on top of what we have cobbled together with no funding, in order to have a reasonable response for stop funding is often overly prescriptive, and does not meet community needs. That's one of the things we realized in the pandemic, is when we are working with communities, we sit down first and ask what they need and what will work for them.

What we have had a lot with the pandemic, also... As an example, we were told we needed to have a massive drive-through center that was funded through FEMA. Well, we already had them built! And they told us we needed them anyways, but we already had them, we didn't need to build them again, and we wasted a lot of time trying to get a resource integrated that we did not need.

We also have an underdeveloped workforce. Remarkably, Mississippi has a smaller public health workforce now than we did in 2019. In spite of all the funding, and all of the new positions that been made available to us, we are lower. Keep in mind, this scale does micrograph is not to scale. It's not that much lower, but it is declining will stop shooting with this investment we should have a more robust healthcare system, but it is worse.

We have severely uncompetitive salaries, a lot of that has to do with state issues, but it needs to be addressed if we want a resilient public health system.

When it comes to nursing, which are Accor operation for most states, if you look at what's happening for the past few decades... since 2000, we are down almost half of the nurses workforce that we had before. Nurses are shortage, I get it. It's hard to come by. But in public health, when we depend on this specialized training, you are lower in 2022 than we were in 2020. A measure of our current plans are gonna get us where we need to be with the current structures we have.

Again, this is more national data, but you can see across the country the number of public health workers has declined at a time when we need the most. We have to have a quibble strategy that gives us a firm and resilient public health workforce.

These are some of the public health threats that I have dealt with in my time, in public health. This is not all of them, there have been others, but you can see West Nile, Zika, Chikungunya, H1N1, Ebola and COVID, and they all have one thing or several things in common... they are threats to the general population, right? So it's the same public health infrastructure you need to do a lot of the same stuff. But what has happened universally is we have had a depleted public health workforce that had a new charge that we had to ramp up. We had to borrow resources from other important operations like family planning, HIV prevention and treatment, so that we could respond. Then, we would get a lot of money... a little bit too late, that would then fund, for a long time, beyond the period of need.

Then, we can use that money for anything else because it was siloed for Ebola. We spent years with Ebola money try to figure out how to put it into public health infrastructure, but was very difficult because the money was so siloed to Ebola, we could make it work for the public health.

What you picture on Army, Army in the United States, that is allowed to only fight certain countries because they are siloed in funding.

It's the same with public health, the threats are universal, you never know when the next one's going to come, and we have got to have a more robust, broadly funded, prospective, forward-looking public health infrastructure so that we can respond to the threats of tomorrow, not the threats of yesterday.

That's all I have. Thank you very much.

Oh, one more thing, I forgot! Go back the top one think that Doctor Ryerson I, an epidemiologist, always laugh at, this is my only paraphrase from the 'Men in black' where they are always witnessing external threats will stop (Reads) "There is always a new public health threat..." But we know about these threats, just because they're not getting attention doesn't mean they're not important.

J NADINE GRACIA:

Thank you, Doctor Dobbs will stop that wonderful presentation for topic looking forward to our discussion shortly. Rita taken out to our third speaker and panelist, Doctor Gounder.

CELINE GOUNDER:

Thank you so much; it's really an honor to be here with all of you today.

I thought it would start with an update from the headlines, and then

Speak on a couple key issues I think are worth highlighting.

First of all, many of us have been wondering and have been asked what is the BA2 going to mean for all of us. We still don't have the answer to that for the US population. I think we'll have a better sense within another week or two.

But we do have other places we can look to help us predict, foreshadow what is to come here in the United States will stop two of the places I look to our the experience in the UK, and also how things are playing out here in New York City.

What we saw from the UK, is a country that is really well vaccinated, relative to most of the United States, also more vaccinated and boosted among their elderly. One key difference between the UK and the United States, is that the UK made much more use of what are called adenovirus vector vaccines, in regards to the AstraZeneca vaccine, they are not as effective as the vaccines we been using here in the United States will stop so, that is that significant

difference, even though they are better vaccinated, at least some of their population, they are vaccinated with a less effective vaccine.

And yet they saw an increase in -- hospitalizations and deaths from the recent sub variant. What we're seeing in New York City, which is also very highly vaccinated, relative to the rest of the United States. We have a vaccination rate up into the mid-70s. And our elderly are also well vaccinated, although less well boosted and well vaccinated than in the UK.

We've seen an increase in cases, we have also seen an increase in hospitalizations and deaths, specifically among those who are not vaccinated.

We saw those numbers and cases of trend up, and very recently start to go down again. That is across the board for vaccinated and unvaccinated. That may be a reflection of the fact that people's behavior changed. I have heard of more cases of COVID recently than I have, really, at any other point in the pandemic full stop

So what we may have seen is a combination of people seeing transmission in their own committee -- community, tightening up the behaviors.

The other possibility is that we saw this a new Asaba variant really running through those --sub-variant, then as usual. So those who had immunity from their vaccination dose or prior infection, that it raged through those people, and hit a wall of immunity after that. We do not have an answer as to which scenario that is full stop

The good news is, we are seeing cases trending down now in New York City.

How this will play out in the rest of the country remains to be seen for stopper particularly given that most of the country is not as well vaccinated, not as well the -- not as well boosted, and in populations that are older, in particular, perhaps have higher rates of (unknown term), this could still play out poorly for many people, and I do hope that were vaccination rates and boosting rates are low among the elderly, we really do need to be concerned. There still may be a surge in hospitalizations and deaths to come in the subsequent weeks.

There are concerns about the vaccines that we have. I am hearing some say that part of the issue is that it's really about the vaccine technologies we've used. I don't think that's really the issue here, in terms of breakthrough infections. I think we have a combination of a virus that is mutated very rapidly, and some of the predictions modeling as to how quickly this virus will continue to mutate, some of those models are shifting now. That remains to be seen. Are we going to see a slower, step by step mutation? Or we going to see big jumps in mutation as we did with omicron? And we don't have a good answer for that yet, either.

What we do know is you need new vaccines, new technology in particular that complement the existing vaccines, like our MRNA vaccines; so those might be nasal vaccines that will increase

(unknown term). You may also see developments in the form of skin MicroArray patch vaccines, where again, you are eliciting a better mucosal immune response.

Finally, trying to anticipate how the virus may mutate in the future, and trying to ahead of the virus developing universal coronavirus vaccine. I do think there is a lot of work still to be done with respect to vaccine development. It is not a criticism, necessarily, the current vaccines, but we need -- do need to stay ahead of this.

Also in the news this week is backslid, the antiviral -- (unknown term), the antiviral pill. (unknown name) is a pill that can be taken for the treatment of COVID, is highly effective in treating hospitalization, and death if taken early in the course of disease. So, soon after infection, or soon after a symptom onset. The challenge has been that the supply of (unknown name) has been limited until recently, and even now as the supply is opening up, access remains an issue.

This is for a number of different issues. We have a broken issue of care in this country. One in four people in this country don't have a primary care provider, and even if they do, they may not have a consistent relationship with that provider for if they try to get an appointment, soon after, say, developing symptoms, they may not be able to get an appointment within that three? Five day 3-5 day window when it would have an impact.

Retail pharmacies have stepped up to try and provide this pill, but that still requires a test. A licensed provider being able to see that patient, and say if it's appropriate for them to take that medication, and also dispensing that medication will stop and not all pharmacy sites have those providers.

One possibility would be to try and have more of these possibilities shifted to pharmacists themselves, through standing orders. But that would still require building a system to do this safely -- safely.

Federally qualified health care centers have played a big role in vaccinating people, and they should also be playing an important role in providing treatment. Again, that will require building up capacity training providers.

One of the issues are facing right now is that many providers are still confused about who is eligible for treatment with (unknown name), who's not. How quickly need to provide the medication. What are some of the drug interactions? And very often, when people are confused, the easiest thing is simply not to prescribe.

This is another obstacle that we do need to address.

Finally, as a buddy who worked in public health themselves, I think that over a decade ago, after the last recession, when I was running the TV program in New York City, and was really having to face some very difficult decisions about whether to keep our TB clinics open. Or

perhaps close some of those, because of the funding cuts you are facing. And this is the moment, seeing the difficulties were seen, that we are facing with Pax Livid (?), understanding all of the obstacles there, that you can't treat the money if you can't test somebody. 10% of Americans do not have health insurance, as I said earlier, and one in four do not have a primary care. It's going to be very difficult to get people treated. There's a very important role for public health clinics whether that's for treatment of tuberculosis, sexually transmitted infections, or for COVID. This may be part of what we need to be thinking about in the future, which is providing treatment through public health clinics for COVID.

Those are some of the issues, top of mind in the headlines. I also want to shift gears a little bit, to highlight a couple of other issues. One around metrics. How we measure the pandemic.

Many of us were concerned when in January the CDC moved its measures of community risk to simile looking at community transmission to then focusing on a composite measure, really, of cases, hospitalizations, and hospital capacity.

The concern that many of us had is that the way that has been communicated by the Centers for Disease Control and Prevention and others, and the ministration, is that we saw these maps of the country dramatically shift from much of the country on fire with transmission, to most of the country supposedly being low risk. What those maps really indicate is how stressed is the healthcare system in this part of the country? In different states? Different counties? And if you were to get COVID, how likely are you to receive routine standard of care or crisis standards of care?

The challenge here is that as public health providers, we want clear, simple, easy to understand messaging. One metric is not the right mattress -- metric for every one. You need to match the metric with everyone. When you are asking what the COVID risk in your committee is, you're really asking if if you go out the mass, without taking any special precautions, how likely am I to get COVID? That's really what the average person is asking. That's not what that current metric of COVID community risk really indicates.

That said, there's a place for looking at hospitalization and deaths as a measure. What some of us have advocated is that the appropriate metric for assessing, for exam, your vaccination program. How well your vaccine is working. Were your vaccines in combination with other mitigation measures. How well is that package working to reduce hospitalizations and death?

We need to be careful and matching the question to the measure. Another approach that some of us have advocated is that ? instead of us focusing just on COVID, we want to look at composite metrics of all viral infections. Such as influenza, RSV, in combination with COVID.

If you think about matching your intervention in with your measure, if you have an intervention that prevents multiple infections, such as a masking or improving indoor air interrelation -- ventilation.

? Very often patients are not treated with drugs like (unknown term) also known as Tamiflu, when they could be. We have these missed opportunities and thinking about our interventions is not just against COVID but against a number of different viral respiratory infections, measuring that accordingly and communicating that would also go a long way towards making better use, efficient use of these different interventions in tandem, parallel.

Another example of this would be ? looking at indoor air quality and the impact on health of children in schools. We have seen a decrease in asthma flares, asthma attacks as a result of decreased viral transmission of all sorts.

Really looking at those kinds of measures, again, as a composite would be very powerful here.

The other key issue that I want to highlight is this shift from public health to clinical or collective versus individual. The challenge with that is when you do not have equal access, equal availability ? for example, cost, do you have to pay out-of-pocket? Is it something that is free, cheap, convenient for you to use, and is it easy for you to use?

Do you have health insurance to cover that? Do you have health insurance to cover your provider? In the absence of that, you're putting the onus on the most vulnerable to be carrying -- caring for themselves. At the grocery store comedy of candy by the checkout aisle or not? That makes a big difference when you make something, a healthy behavior easy, people are more likely to adopt it.

In addition to having these tools now innovated and created, whether it is vaccines, treatment, testing ? we need to make it more readily available so it would include everything from health insurance, during the pandemic we have seen more people enrolled on Medicaid. But, when the public health emergency expires, there will be a charting off the roles and there will be fewer people remaining on medicated during the public health emergency, where we had more generous subsidies for people to buy into the Obama care marketplace plans.

Those also expire and we will go back to the original level of subsidy. One in 10 Americans still do not have health insurance. Many Americans are do not have paid sick and medical leave, which means it costs money to stay home when you are sick, cost money to stay home and take care of a child at home rather than sending the child to school.

There are costs to caregiving whether it is caregiving for a child or an elderly adult. These do not fall on everybody equitably.

If we are to make this move from public health to clinical, it really does mean, one, having more equitable healthcare systems and to have safety nets, whether it is paid sick, medical leave. More generous health insurance, disability, caregiving supports and the like ? to catch those who fall through the cracks of our healthcare system.

I think in the interest of time, I will posit there and turn it back over to our moderators.



J NADINE GRACIA:

Thank you Doctor Gounder for that presentation. Thank you to help highlight these critical issues. We are going to conclude our panel presentation and open up for our dialogue, Q&A, enter reminder to our audience to submit your questions and to open up the Q&A panel and type your questions to all panelists and we will be able to see those questions. I'm happy to be joined by my colleague, who is going to assist with the audience Q&A that is coming forward to direct those to our panelists.

To kick things off, I'm going to start first with you Doctor Liburd. You importantly highlighted the way in which CDC has been focusing on in caring for the importance of equity in preparedness and response. One of the dimensions that you spoke about, specifically was the chief health equity officer and pre-pandemic there were some entities, states, counties who had this but it is getting more traction and even into policy and to agencies at the federal state, local lateral. -- Level. We would appreciate you sharing the lessons learned of critical elements with the states, localities with thinking about this chief health equity role.

And how we can ensure and prioritize equity in response.

LEANDRIS LIBURD:

Thank you for that question, first of all, I think it is important that I mentioned that coming out of CDC's office of minority health and health equity was where we for decades now have given considerable time to understand both the science and the practice of Health Equity.

In the event of the pandemic, we were able to leverage the office and his expertise to move right into this role of chief health equity officer and be able to make meaningful contributions. What was critical in that success as well, is that the chief health equity officer was part of the leadership of the COVID-19 response and that there was a clear expectation that all task forces within the response structure would have a focus on achieving health equity.

The elevation of health equity, elevation of the experience and the expertise, office of the minority and health equity, brought into the response I think were critical things. I think we also had an opportunity to leverage issues such as language access, which is also long-standing public health issues. We saw in the pandemic that we were put in the position of really having to create prevention messages in more than 60 different languages.

The pandemic exposed if you will, sometimes we say late bear, both are the areas that we really need to focus on more in public health. And how diverse our nation is and the things that we need to do in order to be responsive.

J NADINE GRACIA:

Thank you Doctor Liburd. In particular, as you noted, the importance of leadership and centering it across all task forces and that you also articulated, the existing infrastructure of the

opposite minority of health and health equity and how that it was critical to provide that expertise into the response. Doctor Dobbs, let's go to you. You spoke about, the silo funding but also the underfunding and the ability to be able to address a whole host of health emergencies.

I was hoping that you can help us paint a picture for us, in regards to how states utilizes funding, for example when we talked about the two of the leading emergency preparedness programs such as the hospital preparedness program, declines over many years. How does that impact you within the state of Mississippi to engage in the type of public health emergency response over the years?

THOMAS DOBBS:

It's an amazing challenge, and let me start off by saying that if we did it well it would cost less full stop we built systems that were prepared, we would spend the last full top it's not that we - it's not how much, it's how. More than anything.

We seen this over and over again, something becomes a priority, we find it, it claims over time, and people say we don't need this anymore full stop but this is happened over and over again. This is not the last pandemic, this is not the last new infectious disease threat. There may be a new flu variant, or there may be a mosquito borne disease, especially with climate change underway. There are always threats,

And then with our hospitals, that's really kind of sad because that was our most vulnerable spot. That was hospitals. They were really at the point of folding, in a way that we have never seen, especially in our state full top luckily we made it.

It's shortsighted not to look ahead, it may cost us a lot of money. Hospitals are a vulnerability that, if we don't have built-in mechanisms to make sure that they are ready, what they are geared toward is making money on an outpatient basis. If we don't have their attention and capacity to be responding to these threats, then they don't see themselves as players in the operation.

J NADINE GRACIA:

Thank you for that, and elevating the challenge regarding hospitals and hospital closures as you noted. Even pre-pandemic to now.x

Doctor Gounder, let's turn to you, you have been writing prolifically about the pandemic for top for exam, the national strategy for the new normal, in March you talk about some areas around social determinants in our schools. Looking at issues like economic opportunity with paid sick leave. We talked about communities, and the importance of rebuilding community bonds.

Write recommendations would you have for policymakers? In this phase of the pandemic, and as we continue to navigate through the pandemic, what should policymakers be prioritizing at this time? As we think about strengthening public health and equity.

CELINE GOUNDER:

It's very difficult to talk about equity without data. Regardless of what else you think we needed to be strengthening in public health, I think our data infrastructure is probably number one. Number two and number three. Everything flows from there.

In terms of COVID, specifically, should we be counting every case? That's not really how we do surveillance for most conditions. What we typically do is random representative sampling from the population, and that is one form of surveillance the do what is called 'Syndrome make surveillance', where you see how many people show up with a fever and cough. You see what the trends are, again, in a composited respiratory (indiscernible), and that is another metric full stop ways to understand surveillance is another important tool. It is not one that has been fully optimized yet. We don't have enough surveillance sites across the country. Sewage is processed differently, at different wastewater sites. Then, how it's measured, the amount of virus in that wastewater is measured somewhat differently.

So, those that need to be standardized and optimized, but I do think that wastewater surveillance will be a very important tool. So, that is one kind of data.

There is also the data information technology systems, and how do you get that data reported from local and state health departments up to the CDC in a complete, timely, accurate way? Some of that will mean investment at the local level.

I can tell you some of the systems I was using over a decade ago in New York City. One of the best resource public health to pardons in the city full stop where MS DOS based systems from the 1980s. So, when that is the level of technology you have in the field, where people are having to do data entry into Excel sent -- spreadsheets, of course it's gonna be hard for them to report up to the CDC.

But then, does the CDC have the ability to standardize how the data should be reported? To require reporting up to the CDC? To have a centralized database? What are the powers that the CDC has? Does it have levers to enforce that?

I think these are issues that are being actively debated now, and to what degree the CDC perhaps should be better empowered to manage our national data infrastructure.

J NADINE GRACIA:

Thank you for elevating those critical issues will as you know data and data modernization is an important investment that has begun to be made through the COVID emergency legislation, but the recognition that we need more to really strengthen and shore up those data systems is at all levels. In the operability of our data systems as well.

Let me turn it over to Dara to take an audience question.

DARA LIEBERMAN:

Were getting a surprising amount of questions about politics and how that influences the work that you're doing at the national and state levels. I would be interested in Doctor Liburd or Doctor Dobbs take on this.

Quite a few of our participants were talking about how working on things like Health Equity can be triggering for politicians, or for government in some states and some communities.

How can a CDC and public health, or other health officials, work on promoting Health Equity? Or addressing social determinants in a climate where it may be difficult to talk about those issues with policymakers?

Let's start with Doctor Liburd.

LEANDRIS LIBURD:

Thanks, Dara.

The first thing I would say is, health disparities and inequities are draining our entire society. It's not just impacting those populations that are suffering from the disparities.

One of the things that COVID-19 has actually shown us is the disproportion impact on these populations, not just related to underlying medical conditions, but also significant social determinants of health as well.

We heard earlier about the impact of not having paid sick leave, to be able to stay home. We went through an experience of designating people as essential workers, and those essential workers were essentially people who did not have control over their public exposures in many instances. So, I don't need to recount all of what we went through in the early days of the pandemic, but I think what is clear is that the lack of equity, and the lack of justice has really helped to contribute to this historical pattern of health disparities and inequities.

What we're doing from a CDC is working very closely with our partners. I will name the association of states territorial health officials is one partner were working with in order to assist state health departments with how to message, and how to engage around these issues. Because we do recognize that not everyone views this in the same way.

I think the data is clear, that equity is really important in terms of us being able to turn around these historic trends and disparities.

THOMAS DOBBS:

Boy, that such a great series of questions.

If we look at the political context, one of the things that's a really good zone for public health is to be honest all the time. If you catch flack for it, that's part of your mission, right? Sometimes

the politicians are the ones who have to make our decisions because they're the ones who were elected. There are zones of responsibility is that we need to protect for isolation -- for public health, isolation, etc. And we have to be really careful about that. But you have got to be honest.

And speaking of honesty, when it comes to health equity and systemic racism, and structural racism, one of the things that is helpful is to help people visualize it, and what I've said before is, "We have a segregated school system, same as Mississippi (?)" it's obvious, everybody knows it, it's not by law or policy, but de facto, most schools are segregated for top especially low performing schools in the state of Mississippi.

Visualizing that reality brings it to force the obviousness of it. That's obviously not where it stops, but it carries on to neighborhoods, wealth creation in neighborhoods that don't have the same sort of capacity for generational wealth and acute relation.

Anyway, there's a lot of stuff out there, but I think mostly you have to be honest and take the darts when they come.

DARA LIEBERMAN:

Thank you. It's very help full.

Doctor Gounder, as someone who is worked in both media and policy, can you talk about how policymakers and public health officials can better work with media outlets to disseminate reliable and trustworthy information? Not just BoCo VOAD or the COVID vaccine, but about the public health overall? -- Not just about COVID or the COVID vaccine, but about the public health overall?

CELINE GOUNDER:

Is a public health official, I think it's important to state "Here's what we know. Here's what we don't know." Also, to be clear about what are the different issues or factors that are being weighed in making a decision, and providing advice. Science is early part of that calculation, but very often you have other issues that are being weighed as well. Whether that is supply, availability of resources, values, social values of different kinds... I think a great example of this was the discussion of masks early in the pandemic. Were many people already suspected that there was aerosol transmission.

Speaking with aerosol experts -- I remember speaking with aerosol experts back in 2020 full and there was a conversation that we needed to take precautions to reduce aerosol spreads. But we had a limited supply, and we needed to limit that supply for healthcare workers. They were the front lines. I was on the front lines at Bellevue, and so on, and we needed those resources available to care for patients.

So I think be very clear about what's the state of the science, and what are the other factors involved in making policy, again, is part of it.

Also, in terms of public health departments doing communication, it's not just through mass media, right? You also have a lot of community outreach that is being done, and I think that is most effective when it is done through community organizations, community-based organizations, that already have relationships in the community, and a history in the community.

But that also means that they need to be resourced, and capacity needed to do that kind of outreach, to do that kind of communication. It has not been something that is universally, appropriately resourced in public health department budgets. But they have a robust communications budget. People who are trained in doing communication. Whose job it is to do this. Who have relationships with those community-based organizations. You can provide grants to those organizations to this kind of work.

I think one of the lessons of the pandemic is that communication is a branch of public health, and it should be treated as a core function of public health.

DARA LIEBERMAN:

Yeah, that's certainly a point we made in the report as well. Especially small, local health apartments that just don't have that communications capacity. Especially for addressing misinformation.

Question for Doctor Liburd. We have seen through some of the recent funding announcements that came out of CDC as a result of COVID response funds, several of them have included health equity requirements, and direction for (indiscernible) to partner with community based organizations. Is there a way that CDC can make sure that funding is getting to communities that been disproportionately affected?

LEANDRIS LIBURD:

Yes, absolutely. As I mentioned earlier, our core Health Equity science and intervention strategy, integral to that process is we are taking a deep dive, if you will, into our notice of funding opportunity, structure, and a template. We are very intentionally integrating expectations around Health Equity.

So, we have been in this process for a few months, and going through the necessary betting, but our goal is that there will be integrated within the funding structures, expectations for pursuing health equity. DARA LIEBERMAN:

This is a public health workforce question so let's talk with Doctor Dobbs, and then Doctor Garcia you can add after.

Can you say, and talk a little bit about how the stresses over the past two years including political pressures may have influenced the public health workforce and what can we do to better support the workforce?

THOMAS DOBBS:

On the support side, I will tell you one thing that is really easy and very helpful for me. It is positive feedback. I got a lot of it. I have cards, mail, emails, phone calls from political leaders across the state.

That goes a long way because if all you are seeing is a negative, you think that is all that is out there. If you can, support those who are with you. One of the challenges, I think this gets to some of the stuff that Doctor Gonder said before, but other factors need to be mentioned. Although there is a strong public health role, finding that balance between economics and safety is not public health job.

It is our job to outline the risks and to make sure that we are doing accurately and fairly and not overplaying it, and certainly not underplaying it. We get into trouble is where people change the facts to suit their narrative instead of making a hard decision.

Here, in Mississippi because we were not forced to make those decisions early on, it was made by political leaders and the masked mandates and those things and the business limitations. We didn't -- we got plenty of fury, mind you but things that were ridiculous. Recommending vaccinations, we would get death threats for that, which was bizarre.

Public health people cannot make political decisions and if we do, we get extra vulnerable.

J NADINE GRACIA:

Thank you for that Doctor Dobbs, and thank you for being on the front lines on that everyday.

And every member in our audience who is in the public health workforce it has been such a challenging time and we have seen that as it has been (indiscernible) in regards for those who have left the workforce and who had no choice but to leave the workforce.

I think, critically areas that we address such as TFAH, in particular, with regards to (indiscernible) to Doctor Dobbs have noted, the importance that public health ? there needs to be an understanding around the science, evidence that drives the process with public health and to do greater outreach to ensure that policymakers, decision-makers, leaders and other sectors see us as a partner and not being against the efforts that they have and assuring that there is coordination as well from the federal to state, local level and support exists. These are challenging times and to be able to manage the expectations when we are seeing the changing of guidance, helping to understand that again, this is not a manufacturing of what the data should be, but as we learn more about the virus, to the pandemic. That guidance is going to change.

The importance of the communication and also that leadership support is critical. I want to touch upon, something that Doctor Gounder was raising around with public health communications and recognizing that as the core foundation capability, and it really is when we talk about infra structure. How critical health public health communication is and yet we don't

provide the resources, yet someone -- so many do not have that capacity. That is what makes these investments, as we talk about the need to increase the flexible and sustained funding for these crosscutting (unknown term) ? messengers will be the public health leaders, but other members of the community who may be in other sectors and building and forging those partnerships before the crisis happens, such as when the crisis happens, there ways to engage with community, ways to engage with other leaders of other sectors to ensure that those passages are well received. It is challenging and we have much that lies ahead of us and the thing that we should not do is to assume that as if the pandemic is over, the need to engage is over. We need to understand the true mission of public health, which is to promote and support and protect the health of all residents.

DARA LIEBERMAN:

Thank you so much, I wanted to ask Doctor Gounder this question, we talked about some of the challenges, but what have you noticed that have been effective communication strategies used to turn the tide of attitudes towards the vaccine or the public health measures over the past couple of years especially in hesitant communities. How do you think information has been compacted effectively?

CELINE GOUNDER:

What I have found most effective both as a frontline healthcare provider as well as doing some communication on a broader scale. It really does take patience and time and curiosity. That would be a really important ingredient here. What I found to work, particularly with more vulnerable communities of color, is to take some time to hear about their experience.

I will give example of a woman who is a Baltimore security guard. Her experience living and working in Baltimore before the pandemic, interactions with healthcare system, what -- it was like as a security guard in Baltimore, and protections offered to her during that time. I think asking those questions entering curiosity entering that you care about the whole person and their family and their extended network goes a long way.

I think people are not going to be open to recommendation if they do not feel like you care about them and that they have good reason to trust you.

I will say, it has been more challenging to reach out to people who are partisan or ideological reasons are opposed to simple measures such as vaccination. I think it has been difficult.

I do reflect on experiences in other settings and I will give you an example. I served as an Ebola aide working in West Africa and those countries were in the middle of the presidential elections and it was highly predictable when you have a scary new pathogen, outbreak occurred during a presidential campaign that the incumbent will find that very threatening because US incumbent want to say "hey, I got everything under control and things are going well." So very quickly, whether it is here in the US or in West Africa, on Mars.



That is what you can expect to happen, that this will become politicized and I think that's what had me, at least really terrified back in early 2020, seeing how things were unfolding because once an infectious disease becomes politicized, it is very difficult to backtrack on that and to get back to where it is no longer seen to that lens.

DARA LIEBERMAN:

Thank you so much I think we have time for one more. Doctor Liburd, I think you may be able to answer this, but what is your perspective on the role of mental health in public health management, and how can we better implement mental health into public health responses?

LEANDRIS LIBURD:

We have seen the tremendous toll that the COVID-19 pandemic has taken on. The mental health of all communities as well as youth.

We have to think holistically about how we approach our public health practice to not be focused on the physical dimensions but also on mental health as well as on the social environment. I'm very pleased to say that CDC is launching a focus on mental health and mental health strategy that we can implement at a population level.

Mental health is critical and I think also speaking to issues of social cohesion and connectedness. Which is among the social determinants of (indiscernible) has also shown itself to be critical as people are starting to reconnect with family, friends, having seen the devastation when we were so isolated. Understanding that we were doing those things in the interest of protecting our families, communities.

Mental health pressure moving forward is going to be key in our health work.

DARA LIEBERMAN:

Thank you so much. I think we may need to leave it at that, unless Doctor Garcia, you have anything to add?

J NADINE GRACIA:

Thank you, we have certainly been experiencing a mental health crisis before the pandemic along with many other issues. We have seen how that has been deepened over the course of this pandemic. We have seen the impact of different communities. (unknown term) ? we have been around one of the highest drug overdoses that we have seen in the nation. The Trans now with suicide, drug overdose, communities of color who have not experienced higher rates of (indiscernible) in the past.

It is not also the health inequity, but all of these (indiscernible), roots of structural racism that really have under pertinent much of these inequities that we are seeing. So it is vitally, critical that we as a nation truly address this crisis that we are facing and that it has to be across the spectrum of prevention, treatment, and (indiscernible) to ensure that there is little access to

ensure that it is in our school, youth, and the advisory with protecting medical health and the president with the national strategy.

These are going to be important methods for us going forward around mental health and well-being. It includes prevention in our schools, communities, investing in programs that actually support social emotional learning, safe and supportive learning environments and also ensuring that there is equitable access to treatment and recovery, supports that are along with social and economic needs in our communities.

I think that was our last question that we are taking for today's briefing and webinar. In closing, we certainly want to thank all of our panelists for their excellent remarks, input, recommendations and their experience and expertise that they provided in course of today's discussion. We have truly appreciated all of your input, experience. I would also like to thank our staff, team at Trust For America's Health working hard to put all of this together, and thank you to our captioning service, AI media, for providing captioning services for the course of the briefing. And thank you to our audience for participating. Thank you for everything that you do, each and every day with the support that we are able to strengthen our nation's public health system and to ensure that we are better prepared across the nations across all (indiscernible) whether it is disease outbreaks to disasters, weather related emergencies or others has emergencies. For us, to truly have a strong, healthy, resilient nation, we have to take this call from this pandemic as the clearing call to action, to not return back to the way that we have such as the past public health emergencies. It is time to take action, invest in our public health system and to ensure that everyone has a fair and -- just areas. Let's prepare for and be ready to prepare for and respond to future emergencies. I'd like to thank all of you, our recording of our webinar today along with the slides and additional resources are going to be available on TFAH's website@tfah.org in the coming days. Thank you for joining us for today's webinar. Take everyone, be safe and be well.