Ready or Not 2023: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism
Virtual Congressional Briefing & National Webinar
Trust for America's Health
May 3, 2023
2:00-3:00 PM Eastern Time

TIM HUGHES:

Good afternoon and welcome to our Congressional briefing and national webinar on the report, *Ready or Not 2023: 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.

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We encourage you to share your thoughts and comments on today's presentation with the Q&A box. We'll try to answer as many as we can, as time permits To open the Q&A box, click the icon at the bottom of your screen. From there, select enter when you are ready to submit your question.

And now, it is my pleasure to now introduce the moderator of this event, Dr. J. Nadine Gracia. Dr. Gracia is the President and CEO of Trust for America's Health (TFAH). She is a national health equity leader with extensive leadership and management experience in federal government, the nonprofit sector, academia, and professional associations.

As President and CEO, she leads TFAH's work to advance sound public health policy, address the social determinants of health, advance health equity, and make health promotion and disease prevention a national priority. Before joining TFAH, Dr. Gracia was the Deputy Assistant Secretary for Minority Health and Director of the HHS Office of Minority Health during the Obama Administration.

Welcome Dr. Gracia.

DR. J. NADINE GRACIA:

Thank you to everyone for joining us today for this briefing and important discussion. My name is Nadine Gracia and I am president and CEO of Trust for America's Health. I would like to walk you all and thank our esteemed panelist for participating in this event.

Next slide, please. I would like to start with a brief overview of the Ready or Not Report. A full copy of the report is available at TFAH.org and we will include a link to the report in the chat.

This is the 20th edition of the Ready or Not Report. Which includes 10 key indicators of preparedness across the range of topics. In this year's report, drawing on lessons learned from the COVID-19 pandemic and pass public health emergencies, we also included a special feature on the intersection between health equity and emergency preparedness and the challenges in measuring equitable preparedness and response appeared weekly rec mentation for policymakers to improve the nation's health security.

The Ready or Not Report tiers states and the District of Columbia into three performance levels for help from -- preparedness, high, medium, and low. This report placed 19 states and Washington DC in the high-performing tier, 16 dates in the middle performance tier and 15 in the low performance tier.

We look at 10 indicators which are selected largely from the national head of security preparedness index in consultation with experts. It is important to note that this is not intended to be a comprehensive assessment of preparedness but to give states actual data and steps but they can take to help improve their readiness and even states in the high-performance tier of opportunities for continued improvement.

This is not an evaluation of any single department or entity and as you will hear, preparedness requires action by multiple government agencies, lawmakers and other decision and policy makers, the healthcare system and providers and the public.

In this year's report, we found some areas of progress over the past few years. Some include an increase in the number of states participating in the nurse licensure compact which allows nurses to practice across state lines. In nearly every state the public health laboratory had a plan to be able to search their testing capacity during times of emergency. Most states are accredited in either public health or emergency management or both. Most residents have access to safe drinking water.

We have also seen some major investments in the past few years in developing the public health infrastructure and workforce which could certainly have significant benefits to a system that has been chronically underfunded. Next slide please. We certainly also saw important challenges, only half of the US population is served by a comprehensive public health system that provides essential services to everyone, we saw a decrease in seasonal flu vaccination rates, too few workers have paid time off to be able to stay home when ill and recover from illness or be able to take care of a sick family member. Not enough hospitals are achieving top quality patient safety grades. These factors make it more challenging to be able to protect every community during an emergency. For a full description of the state-by-state data, with the recommendations that accompany that report I encourage you to explore the full report on our website. Next slide.

We also included a special feature on the intersection between community resilience, emergency preparedness, and health equity. It has been widely discussed how the COVID-19 pandemic has exposed and exacerbated health disparities and this is true as well in past public health emergencies. Here we discussed the interdependence between health equity and risk during an emergency. We also discussed the complexity of measuring health equity and its impact on emergency preparedness would also underscore how vital it is to address health disparities and planning and response. We believe strongly that would help emergency planners, policymakers and others in the future and in meaningful partnership with community to better understand the disparities and structural inequities that exist in their communities, to be able to promote community preparedness, resilience and recovery.

Finally, our report includes recommendations for policymakers at all levels as well as health officials, the healthcare system and other stakeholders. 2023 is an important year in terms of public health preparedness. This year, we are urging Congress to reauthorize the pandemic and all hair hazards -- hazards preparedness act, Topamax, which -- PAHPA which will enable some of the mechanisms you will hear about from our speakers. It currently expires this year and we are calling on Congress to enable better responses through better public health data capabilities which are critical to quickly detect and contain health threats.

We want to make it easier for health agencies, including at the federal level, to hire people during an emergency and we support apposite -- a budget designation that would allow federal funding of health programs without the same budget restrictions as many other programs.

We also want to extend advisory committees that exist on children, individuals with disabilities and older adults, that are going to be sunsetting this year so we advocate that those advisory committees should be extended.

In addition to PAHPA we urge lawmakers at all levels to invest in public health infrastructure. They are so integral to our nation's preparedness. Researchers estimate that an additional 80,000 time state and local public health workers are needed to provide a minimum set of basic public health services. We are calling for increased funding in public health emergency prepared miscreants and hospital preparedness funding that goes out to every state to be able to prepare for a range of health threats.

We also want to make sure everyone has access to, and vaccines -- recommended vaccines. We want states to pass a job protected pay leave and states should have the responsibility to ensure that their residents have those types of production spirit we support the develop it and distributions of medical countermeasures, the drugs and vaccines and devices used to prevent and treat outbreaks.

And we cause for addressing nonmedical but health-related factors such as nutrition and housing that impact resilience and recovery in the face of disasters.

Here is the link we are encouraging you to review, to the full report, we encourage you to

review the report and the other information available on our website and do not hesitate to reach out to our organization if you are also engaged in this work.

We will save questions for the end of reminder to please submit your questions in the Q and a box, not the chat, and we will get to as many of those as possible after our presentations. So with the background on the 2023 Ready or Not Report I am pleased to welcome our esteemed panel and I will introduce each of them and then turn it to the first speaker. Our first panelist is Doctor Mysheika Roberts who is the Columbus Ohio health Commissioner. She leads a team of more than 500 public health professionals. Doctor Roberts has a prolific 20 year public health background at the local, state and national levels. Prior to her appointment as health Commissioner in 2017, she was medical director and assistant health Commissioner at Clovis public health.

Doctor Roberts is also the immediate past chair of the big cities public health coalition. Our next speaker is Doctor Joelle Simpson, chief of emergency medicine and medical director for emergency preparedness at children's National Hospital in Washington, DC. And an associate professor of pediatrics and emergency medicine at George Washington University School of Medicine and health sciences. She is a member of the national bio Defense science Board providing guidance to the HHS Assistant Secretary for preparedness response on scientific, technical and other matters related to public health emergency preparedness and response. In 2022, Doctor Simpson was awarded a grant from the health resources and services administration to build a pediatric pandemic network. She also serves on the American Academy of pediatrics Board of Directors. Our third speaker is Mr Andrew picket, director of the Bureau of emergency preparedness and response with the Pennsylvania Department of Health. Having been appointed to the position in 2015. In his role, he manages public health and medical preparedness and response efforts across the Commonwealth of Pennsylvania. He currently serves as the chair of the Association of state and territorial health officials, director of public health preparedness, or group and has previously served on several public health preparedness committees and workgroups.

We have a tremendous panel of experts joining us today, to be able to tackle some of these critical issues as it relates to public health preparedness. It is my honor to welcome Doctor Mysheika Roberts from Columbus public health is our first speaker. Welcome, Doctor Roberts. I will turn it over to you.

DR. MYSHEIKA W. ROBERTS:

Thank you so much for having me on this panel, this afternoon. It is my pleasure to be here and share my perspective as well as many of the perspectives of other big-city health departments across the country. As we'll know, the last few years have taught us many things. What really rises to the top is what is most important or challenging, this has been a very challenging time to be in public health. But it has been an enjoyable time at the same time. COVID-19 put the spotlight on public health, many individuals had no idea what public health did, and what public health entailed until the pandemic hit.

The critical work that we do every day, even when there is not a pandemic, with diverse communities all across this country, and yet in spite of this, in spite of the spotlight, in spite of everything we have learned, we are still faced with public health funding challenges. Which impede the great work that we want to do and must do to protect our communities.

If we all go back to September 2020… September 11, 2001, we know that after those attacks the federal government gave public health a large amount of preparedness funding. That funding was sustained for some years but as the trip -- terrorism fears Wayne, Congress attendant -- attention shifts and the funds have been reduced gradually every year since then.

Today, public health funding is not sustained nor is it predictable. It is leading to a boom or bust funding cycle. This leads some health departments unable to maintain a basic level of preparedness and response and we saw some of that firsthand when the pandemic happened, some health departments did not have the infrastructure in place to respond appropriately. Only a handful of large city health departments received resources directly from the federal government.

Most, like mine in Columbus, Ohio, must wait on dollars as well as supplies like vaccines to filter down to state governments. When they are faced with public health emergencies, this extra time impedes our ability to help those we need our help the most. It slows us down and thus can really negatively impact our residence. Time is critical when we have an emergency so having those resources on hand already and not having to wait for them to be passed through creates a lot of extra time and extra frustration.

Many cities have plans in place for emergencies like COVID-19. The dollars needed to make those plans work lag far behind as well so it is not only money but it is resources. Our fellow -- federal government in the past and from the long-term past has had this attitude they are going to give very time-limited and disease specific resources. Usually when an outbreak occurs. The federal government's tributes most of its dollars on individual diseases rather than core capabilities. This has meant that health department still have available dollars from COVID-19 that we have not used and if we are not able to use in a timely fashion, might have to be sent back. This will affect our ability to respond to the next outbreak because then we will have to wait on additional funding for that.

This can threaten lives, threaten public health safety and the health of our community. I will take the next slide. The best example of funding limitations in practice is the mpox outbreak that happened in my community in the summer of 2022. Local health department's received federal dollars for mpox but it was after we responded. We were in the process of responding to COVID-19, still providing vaccines for that, still tracking cases and then mpox appeared.

That meant that we had to track individuals with mpox as well as close contacts. Shortly thereafter we had a vaccine we could give to individuals who are at risk for mpox. What we heard loud And clear from our state in Ohio is that we could not use COVID dollars to respond

to mpox. We can only use COVID dollars to respond to COVID.

We were fortunate in Columbus that we had some local room and our general fund dollars that we could adequately respond to this mpox outbreak using general fund dollars but it was very unfortunate that it took several weeks for our state and federal government to say OK, you can use some of your COVID dollars. That slowed us down initially because we were limited on what path we could use -- staff we could use for vaccine clinics, case investigations, but eventually it caught up but took a good three or four weeks before we were able to go full force ahead with the work that we needed to do.

I having vaccine events, pop up clinics, community outreach, to do a public campaign, communications campaign that you can see here. It was challenging and we did the best that we could with the resources that we had. That is a real example of how the same type of work is being done for two different diseases but you can't cross the resources, financial resources to make them work together. I will take the next slide.

Another real-life example of what worked here in Columbus is our measles outbreak. We had a measles outbreak that started in the late fall of 2022. We obviously do not have a budget for measles. We give lots of measles vaccines but this was a large outbreak, it was the largest outbreak in the United States in 2022, we had a total of 85 confirmed cases, 36 hospitalizations, fortunately no deaths and of those 85 cases in central Ohio the majority were in my jurisdiction. This took a lot of work and a lot of effort to respond to this outbreak, to get vaccines in arms of individuals who are not vaccinated, and to get the message across.

There was no budget for this, we were using general fund dollars, and any resources that we had. Just give some background, I will take the next slide, the breakdown of some of these cases so you understand, the vast majority of cases were male, but you can see that many were young. The vast majority were between the ages of one and two years old were eligible for the vaccine but not vaccinated. I will take the next slide.

You can see the number who were not vaccinated of the 85 cases that we had, 80 had never received the vaccine, for had received at least one dose, and one we were not able to verify the vaccine status so the assumption is that they were not vaccinated. As you saw from the previous slide, most of these kids were age eligible for the vaccine, you should get your first dose of the MMR vaccine at the age of one, it is a two dose vaccine series so you get the first dose between the age of 12 and 14 months or one years of age and the second between four and six years of age.

What was our public health response on the limited budget that we had? Lots of agitation and outreach to the at-risk communities, we collaborated with a lot of our partners, we brought the CCC in for an MPA, we work closely with the State Department and the Children's Hospital in town, we were trying to make the MMR vaccine available wherever we could. Not only at the health department, but also trusted community locations where our community members felt comfortable, attending and going to and we had our nurses there providing not only the

vaccine but education.

We did a lot of contact tracing and KC investigation -- case investigation which probably sounds familiar, just like with COVID-19, we created a public dashboard like with COVID-19 and we did a lot of media blitz and raising awareness. Initially we were told that we could not use COVID-19 dollars to respond to this very large outbreak.

I'm trying to give you some real world examples of what we are seeing on the front lines of local health departments. We have a few recommendations that we would like everyone to consider. We want to look past COVID-19, past mpox and think about how are we prepared for the next outbreak. We are one missed vaccine away from the next outbreak or one plane flight away from the next outbreak.

We want to serve all of our residents to protect the health of our communities. We know there are things we need to do now to prepare for the next outbreak or the next pandemic. This boom or bust cycle of funding has undermined health departments preparedness and communities of all sizes in the United States. Stable funding is needed to strengthen public health and healthcare systems across the board, with different needs in communities of different sizes.

Funding should be focused on developing core public health capabilities. Not specific to diseases or time limits. Congress must invest broadly in health, not just restricting the funding to specific diseases so that we can shift and respond as necessary. More federal funds should be did -- provided directly to cities like my own, recognizing different needs of communities of different sizes so we are prepared and can hit the ground running to respond without waiting.

Finally, we need to support and invest in a strong public health workforces. This was mentioned earlier but it is true, our teams are tired, battered, many people are leaving public health or at retirement age and we need to bring in a new generation, that does things differently and wants different ways to be compensated then previous generations.

With that, I will take the next slide. I know we believe questions till the end but I appreciate this time to speak to all of you and share our experiences in Columbus with you. Thank you.

DR. J NADINE GRACIA:

Thank you Doctor Robertson and thank you for those real-world examples you have given in the perspective of the big city and the multitude of responses that you have occurring at the same time. We will now turn to Doctor Joelle Simpson from children's national. Doctor Simpson, we turn it to you.

DR. JOELLE SIMPSON:
Thank you for having me and what an awesome landscape that was set and I will damage my next slide that talks about the directions I would like to take this particular presentation. I want

to talk about the landscape of pediatric emergency care in the US as it pertains to the recent pandemic and also talk about the pediatrics surge in disaster management and lessons learned and preparation for the future.

We know that children comprise about 25% of the US population. Children often exist within the context of families. They are our children and grandchildren. 30 million children seek emergency care every year, the majority not in a pediatric health system like mine but rather in general emergency departments that may individually see less children per day than I would at a Children's Hospital. I will ask Lane why that is particularly important when we manage the surge. -- Expand why that is particularly important when we manage a search.

There have been persistence disparities in access to and quality of pediatric emergency care and historically a focus on adults in emergency and disaster planning which was revealed during our response to the COVID pandemic and other crises.

The national pediatric readiness project was the survey issued by the merger co-medical services for children program in 2013 that found that 50%, less than 50% of hospitals and there was a greater than 80% of hospitals surveyed across the US, less than 50% included pediatric specific needs and disaster plans. COVID-19 exposed and exacerbated those gaps and when you see the graph there that shows what we will talk about that has been phrased the triple pandemic which is the surge of respiratory viruses affecting children during the COVID pandemic we see how that exacerbates the strain on our infrastructure when we were not pediatric ready as we say.

RSV, influenza, COVID and others contributed to the so-called triple pandemic. I really want to be sure to highlight in that narrative that it was not the constellation of viruses that was concerning us as pediatricians, but rather the lack of capacity and capability to care for children at that time. What we saw was that there was decreased Children's Hospital capacity post COVID, many pediatric beds across the nation had been shifted to meet needs during COVID for non-pediatric patients, we had significant staffing limitations, significant sick call outs and we have talked about the mental health crisis that has been unveiled to a greater extent during the pandemic than before.

In addition, as I spoke about the fact that the majority of children seeking emergency care seek them outside of children's hospitals and that is purely for access issues. For the majority, they are quite frankly insufficient children's hospitals to meet the needs for the ZIP Codes that all of our children's exist in.

It makes sense if there is an emergency room banner that any parent or family member can take their child and feel reassured they came -- and care for the children. But what we have found is that a lot of pediatric services were sacrificed during COVID. There had been decreased availability of beds, and certainly pediatric specialists for children that has been on a downward trend for many years.

Limitations in pediatric equipment and that pertains to the various sizes, for instance in our institution there was a concern about a shortage of small pediatric facemasks which is critical to administering a lot of the respiratory medications needed during a respiratory crisis, many pediatric nursing, no inpatient pediatric beds and critical care beds, they created tremendous anxiety among our families and those of us trying to meet the demands of caring for our children.

We tried a few responses and certainly I am proud of the American Academy of pediatrics efforts to provide guidance of how we reduce the crowding in emergency departments and think about some solutions in a more systemic way. I urge you to search for this policy report, technical report issued by the American Academy of pediatrics, that not just highlights the issues but offer some solutions.

To talk about some of the narrative that emerged during the pandemic, we realized there was a critical need for evidence-based guidance of the care of children in non-pediatric settings. I am proud of the evidence we have issued for those of us that are able to provide service in a Children's Hospital but when the majority of the kids are being seen outside of our institutions, it is important that the evidence guides us and how we care for them in those settings. The image on the right is a screenshot of the American College of emergency physicians that didn't awesome God -- did an awesome job in doing a webinar around how to work general emergency medicine population take care of children in those settings when they are not resource the way a Children's Hospital might be.

We needed this response is to be rapid, we needed the dissemination of guidance to be broad and we needed to think about proactively the mitigation strategies needed to mitigate the shortages of medications and supplies that emerged during the pandemic. Everything as simple as liquid Tylenol was a critical shortage during the pandemic and certainly needed to treat our children.

Other responses that came about that we should learn from is a national, nationally there was a coordinated pediatric focused town halls, for us to talk about what is going on in real time with our federal partners as it pertained to each HHS region. Doctor Roberts is correct that the uniqueness of each region is not to be understated. What happens in Washington, DC is different than Ohio, different than California, and it is important for that regional approach to the voice between our federal department and local committees to better reach solutions. Regionally, we started to work and I know particularly in our DC, Maryland, Virginia area we talked about a pediatric badge -- bed triage system to be coordinated in order to better triage the patients that would need to be seen in a pediatric system and how many could be managed in outlying facilities. We had to come up with protocols for contingency care, the realities of managing children in environments that are not typical such as hallways, creative use of outpatient facilities, in order to care for children that may not have been sick enough to get to our children's hospitals but still needed care.

There was just in time communications, dashboards as Doctor Roberts discussed, tracking tools

and certainly this plight of being left without being seen which has been growing in number on average across emergency departments across the country and is itself concerning.

Some of the federal response that I think is important and prickle for us to continue to support include the following. The HRSA funded emergency medical services for children innovation and improvement center has tackled this issue. They are the issuers of the pediatric project I talked about that surveyed hospitals across the country in terms of readiness. The icon at the top talks about their prehospital pediatric readiness project that is being issued to better question not just what happens in our emergency department sent hospitals but also what happens before arrival to those systems.

How can we better serve kids from the minute they leave their homes all the way through the healthcare system? The domains covered by the emergency medical services for children talk about the priorities that we need to find solutions as we respond to pandemics and other threats.

I am particularly proud of the Assistant Secretary for preparedness and response and their leadership in funding three pediatric disaster centers of excellence and I will show you a map of how the regional distribution of these centers helps us talk about the different approaches we take across the country to serve our unique communities. The Gulf 7 Western regional alliance for pediatric emergency management, region five for kids, collaborate with the third resource that has been funded federally, the HRSA pandemic network which is described on the next slide.

This funded network is one I have -- and proud of as principal investigators but it outlines the 10 children's hospitals coming together in this network to learn from the lessons that we have frankly learned from during the pandemic. And also think about the other layers as addressed in the report around health equity and disparities, the urgent need to have community engaged directives and how we respond to the pandemic and other disaster threats.

Also how to build evidence in real-time as well as shared data resources across our systems that serve kids to better support our facilities that don't serve as children's facilities on a day-to-day basis. The resources can be found at that website, next slide?

This is a landscape of those multiple resources, the emergency medical services for children's program, the three ASPR funded centers of excellence as well as the pediatric pandemic network. This is an impressive landscape that covers many states but there are certainly areas that could do with additional resources as well for us to be able to tell better the narrative of what we need to do to step up and caring for children in disasters and threats.

Most urgently in addition to funding for those resources I mentioned, also where we go to for real-time advice in crisis also afterwards in terms of lessons learned and how we respond to future threats.

The national advisory committee on children and disasters was initially conditioned -- commissions in 2019 and I cannot say urgently enough on behalf of children's hospitals, the American Academy of pediatrics and for me as an individual pediatrician trying to do better for our children, it is urgent that we authorize this committee.

The recent guidance that is shown on the screenshot, the January 18, 2023 report from NACCD talks about some other underlying issues that are critical and I don't have the time to sufficiently touch on here but the children's disaster mental health challenges that have been unveiled particularly during this pandemic, key lessons we have learned from the COVID-19 pandemic and how we use those as action items moving forwards and how we continue to respond to the healthcare surge during respiratory Infectious Diseases that happen every year but when our infrastructure is that weakened and threatened after the pandemic that we recently faced, it becomes a greater threat each time these respiratory surge viruses emerge so I'm concerned about this next winter and how we best respond to the needs of our children moving forward.

Here are our recommendations. We need to coordinate our national data sources and include children in that narrative. We need financial and legal productions for hospitals to create flex ability where it did not previously exist and this is outlined in the Trust for America's Health report. We need to reestablish and expand our pediatric capacity in our communities, by the tools we have used to centralize patient coordination across facilities and also supporting our telemedicine tools to better serve our communities.

Last but not least, we do need to reauthorize our national advisory committee on children and disasters. With that I thank you and await your questions.

DR. J. NADINE GRACIA:

Thank you very much, Doctor Simpson, really excellent information and hearing in particular something that was also articulated by Doctor Roberts is the important emphasis on infrastructure. Both in the public health system as well as the healthcare system and the importance of infrastructure, capacity and the workforce. That is not at the time of an emergency what we begin to think about that and restructure so we were certainly dive into those in our question and answer period.

It is now my pleasure to turn it over to Mr Andrew picket from the Pennsylvania Department of Health and to our audience, a reminder, please submit your questions to our panel using the Q and a future. Let me turn it over to you. Welcome.

ANDREW PICKETT:

Thank you, it is great to be here, and is the third presenter I have an opportunity to build upon the work that Doctor Roberts and Doctor Stinson have shared -- Simpson have shared so I will try to move through this and leave time for questions and answers.

Within public health we have a diverse mission set and we have to put our Pennsylvania Department of Health mission here but I think it's important to emphasize what preparedness is all about and it is making sure that we can do all of those things that are part of our core public health mission no matter the circumstances. I think that is where we try to build as much capacity, even given the challenges that have been brought up and will continue to be brought up in the conversation. Next slide.

A bit of background around the role of Pennsylvania and what state public health is, we have a very diverse population and many state health departments have challenges that come with a diverse population from major urban centers in Philadelphia's metro area of 4.2 million and communities and counties with less than 10,000 residents, diverse socioeconomic levels across the Commonwealth and with that, the politics of public health also play a factor.

Next slide. Specifically within Pennsylvania and many states have similar challenges, we are both the health department in our own right but also have a role in supporting our local partners with in emergency preparedness activities. Within the Commonwealth of Pennsylvania we have our state health department and 11 local health jurisdictions that we call collectively our county municipal health departments but we have seven counties and four municipalities and that leads -- leaves the remaining 60 counties across the Commonwealth where our agency is the local health jurisdiction. We have to play multiple roles within the public health space.

State emergency preparedness also has a responsibility in the healthcare preparedness side through the federal healthcare preparedness funding and our six healthcare coalitions. It is a diverse role that we have to manage at the state level that touches on multiple facets of preparedness. We can go to the next slide.

In addition to working up and down between federal partners and local partners, federal partners provide the guidance and funding and the funding has been a big topic of conversation today. We also have the responsibility of working across within our own organization and across other state agencies that have roles within emergency preparedness and response missions. They are not traditional public health partners but touch upon aspects of public health, for example, our Department of human services in the Commonwealth is the state lead for mental health support. So we are locked sink with them in regards to those aspects of preparedness. Emergency management is another partner that is key when we have public health emergencies.

The role of state public health means reaching out and touching a diverse set of partners and being able to build those relationships. We can go to the next slide.

This is where I'm going to spend most of the time in the conversation talking about many of the responses. This is within the last 12 months. All of the different things we have had to deal with in the Commonwealth and our local partners, at the state level, COVID-19, mpox, Doctor Roberts did a great presentation on the impacts of mpox within Columbus and certainly they

were no different here. Immediately to her east, in Pennsylvania.

But the train derailment, we often think about the public health threats, biological, bioterrorism, communicable disease outbreaks, but there are certainly a much wider set of threats that public health much be prepared for. The train derailment in East Palestine Ohio was not within Pennsylvania's jurisdiction. It occurred only 842 feet from the Pennsylvania border and as such, the impacts were tremendous on our side of the fence as well.

Our preparedness program in the Commonwealth allowed us to have a good relationships that we needed with our environmental health partners, emergency management partners and local communities to come in and support them in our preparedness program was able to stand up a health resource Center in the community that served over 500 residents in about three weeks, providing for general information needs, behavioral health needs, physical health needs, and allowing them to share their stories and information and concerns with state and local government partners.

As the State Department of health we also have to support our healthcare facilities. Every year we have a number of infrastructure issues, often utilities but we have also had staffing shortages that were pronounced, quite pronounced during the COVID pandemic. Our local partners also require us to come in and step in whether that is providing guidance or support, information as well as funding. They have had many of the same challenges that we have at the state level.

We have already gotten a great overview of the TFAH report, you can go on to the next slide, please. Certainly, there are other ways that public health at the state and local level assesses our capability and capacity. What is important is what those Telus. Let's go to the next slide. -- Tell us. Let's go to the next slide.\

What does the Ready or Not Report tell us? Fortunately, this gives us a good cross-section at a high level of what is the state, not just look health preparedness but healthcare, preparedness and at a policy level. There is certainly more work that needs to be done to bring different groups together, public health, behavioral health, healthcare, community services agencies.

Often we exist in silos of excellence where we are doing great work within our own right but how are we breaking down the barriers between us? There are also a number of issues that the Ready or Not Report brings up that do require high level legislative consideration to help us to work through those. We can go to the next slide.

The reports also tell us at an operational level that there is still work to be done and still more that needs to be invested in preparedness. And being able to operationalize our preparedness capabilities to become a response capability can sometimes be difficult.

We will get to recommendations for my perspectives -- from my perspective and funding has been brought up at the public health and healthcare level but I will reiterate from a state level,

and emphasize that it must be built on a strong basis of operational capability. Many of our partners within the public health space, healthcare space, significantly even in our EMS space rarely have the funding and resources to keep the lights on and doors open.

When that is the level of the baseline we are working from, additional preparedness becomes very difficult. Building broad-based funding to support the day-to-day infrastructure of healthcare and public health is the only way to build that framework that preparedness can add on to.

Certainly, we will still need targeted and sustainable preparedness funding, the (unknown term) program and HPP program are essential to build that capability and capacity but that flexible and timely response funding is also key. We have recognized that by the time federal government gets funding to state and local public health, the aspects that that funding has been earmarked for are no longer the concerns that we are addressing. I know that Doctor Roberts talked about the discord between COVID and mpox and even within the COVID response, as that three-year response elongated, the funding we had for the beginning was not the funding we needed at the end. If we can go to the next slide?

State preparedness programs can and should continue to be the convenience and collaborators with all of these partners and I would encourage federal partners who are on this call or listening to this, recognize that we are an opportunity to be a sounding board and provide input into the federal plans and procedures, especially around medical countermeasures, around preparedness strategies.

We are doing a lot of work coming out of this COVID but we need to make sure that no single entity on this chart is making those decisions or plans in a silo and we are all collaborating to develop the best plans possible. I will stop here and hand it back to Doctor (unknown name). -- Doctor J. Nadine Gracia.

DR. J. NADINE GRACIA:

Thank you, an excellent presentation emphasizing operational capabilities, so our audience you have heard this from the state level, local level, with the big city health department, to our healthcare system, how critical this is to have this, ASCII in nonemergency times as well as the ability to search during emergency times.

This concludes our panelist presentations and we are now going to open it up for Q and a and a reminder to keep submitting your questions in the Q and a box and we will answer as many questions as possible. I am pleased to be joined by my colleague, director of government relations at trust for America's health who will help us to moderate the Q and A.

DARA LIEBERMAN:

Thank you and thank you to our speakers for the excellent presentation and I wanted to

verbally answer a question from the chat, the recording as well as the resources shared today will be posted on TFAH website in the coming days so we will be sure to send that out to everyone who registered.

This is a question that I think nearly any of our panelist could answer although it was directed to Doctor Roberts. Among the barriers that you mentioned, administrative, regulatory, political, spending money, in a smart, timely fashion, what changes do we need to make as a public health system to overcome those barriers?

DR. MYSHEIKA W. ROBERTS:

Thank you for the question, as a public health system we need to be nimble and flexible and I think not every else department has the capacity to do it. I am a large department, I have over 500 employees so I have some local room and I move someone from one program to another to respond but smaller health departments do not have some of that same electability. -- Flexibility.

We tell our staff when they are hired that in the event of emergency you might be asked to do other things. We prepare them for that, we do drills, we make sure that people are aware of that and understand what that entails so that is something that we can do on our end but that still does not help us with the response if we need financial resources. We might have the people power but we still need some financial resources and for those health departments that do not have the people power to do it, they need flexibility whether that is hiring nurses through an agency, which are stated and that helped all of us across the state throughout the pandemic, -- state and that helped all of us across the state through the pandemic, they had agency nurses that could do vaccines and help with case investigation so that is something that the state health department cannot provide local health department says well.

Preparing -- as well. Preparing staff to be flexible and being a physician leader, I think I come with the perspective of the clinical perspective like Doctor Simpson in an ER, you have to be able to respond to all hazards and be flexible because you never know what will come in the door.

DARA LIEBERMAN:

Similar question, in terms of those challenges that Doctor Roberts was discussing and you both discussed the boom and bust cycle of public health, can you talk about the challenges that a department may face with underfunding over multiple years followed by short-term funding? How does that challenge your workforce or the overall response for an emergency?

ANDREW PICKETT:

Certainly the additional response funding is always helpful, but when the additional response funding is placed upon an organization that has already been suffering or a system that has

been suffering from chronic underfunding, the management of that response funding needs personnel, administrative personnel, grant management folks, contracting and procurement folks to help move that money through in an effective way to help address the response.

When you are placing that burden of significant quantities of additional funding on an already overtaxed administrative workforce, we have certainly at our agency run into challenges with that. You can use that money to hire more, to bring in contract staff, but there is always that drop in productivity after onboarding someone as you bring folks up to speed and indoctrinate them into the policies and procedures of an organization. Without that baseline capacity that has to exist from day one, there are challenges no matter how much response funding we get.

DARA LIEBERMAN:

Thank you. For Doctor Simpson, in particular this question was about hospitals that serve under resourced communities, what can they learn from your experiences in Washington?

DR. JOELLE SIMPSON:

One of the big takeaways I had from responding to the pandemic and ongoing threats has been partnership. I think the healthcare coalition in my region has been pretty powerful in order for conversations to happen not just across health systems but I see a question about the other areas that children and families exist. Not just the children but there is a whole school nurse movement that took place in order to better deliver vaccines and be able to assess kids in the school system as they reenter and certainly the ministers of school systems that reached out in my region to those of us in the healthcare system to better navigate all of the nuances of bringing the children back in and communicating with them and educating.

I think about the support, financially and otherwise, breaking down barriers in order to facilitate those partnerships in an efficient, non-free time, after work type of structure which would be tremendously welcome moving forward in a more coordinated fashion.

DARA LIEBERMAN:

Thank you so much. This is a question for any of our panelists, can you talk about how to underline -- the underlying health of the community such as rates of chronic disease impact response and recovery from a public health emergency?

DR. MYSHEIKA W. ROBERTS:

Others might be able to have a better response but I wanted to piggyback on something that Doctor Simpson mentioned about partnerships, we could not have responded to the pandemic in Columbus the way that we did without our partnerships. Particularly with hospitals. A perfect example when you think about underserved communities, you all remember when testing was very limited across our country and if you had a healthcare provider and a phone number that

you could call for your healthcare provider, you could probably get those tests done but if you did not, it was very challenging. Those were some of the same residence who were working on the front lines, who could be exposing other people and so, early on in the pandemic, we partnered with our hospital systems to provide testing to our community free of charge, no matter if you had a healthcare provider or not. Our community greatly appreciated that and I know as a local health department we would have never been able to do that on our own. We don't have a lab.

That would have been impossible for us to do but with the assistance of our healthcare and hospital partners, we were able to make that service available to all of our residents, so when you think about some of the underlying health conditions of our community, one of those are uninsured, underinsured, those individuals who are not connected to healthcare and now in the word of electronic -- world of electronic health records where everything is electronic, that was a challenge for some of our residents as they would get tested but did not have email access.

How did they get their test results? We had to assist with that as well.

DARA LIEBERMAN:

I thought that Doctor Simpson was going to speak up.

DR. JOELLE SIMPSON:

I was, Doctor Roberts hit the nail on the head, I was the healthcare system that got a call and said we have to vaccinate kids because first of all, many people were not comfortable with vaccinating ages three and under so when the vaccine became eligible for those populations we had to step up and move into the communities to provide that, not just in our healthcare system.

The other thing we observed is there is also the threat and challenge of misinformation and mistrust of our public health officials and healthcare system in general and that contributed to the fact that when we put forth our drive-through walk-up system for testing, it took about six weeks before some of our populations, where we saw the greatest disparities showed up to access those resources.

What we had been told was a narrative that testing sites were showing up and people were not using them, they were not sure what information was being collected and so forth. Certainly we need to tried and true and longevity in the funding and support of those systems as they exist with our healthcare partners in order to serve our communities.

DARA LIEBERMAN:

Final question, we got a couple of questions about environment health and you touched on this with the trainer ailment but can you talk about the role of environmental health workforce in

emergencies and responses? -- Trainer ailment that can you talk about the role of environmental health in emergencies and responses?

ANDREW PICKETT:

Environment to health is one of the more challenging aspects of emergency preparedness from my perspective, because it is such a broad topic, what does it mean to you, at the state level we have three different agencies that have a role in environmental health, the state Department of health which has a small but robust, mighty team within our Bureau of epidemiology, the human aspects of environment health, we have an entire agency, Department of environmental protection, so it increases the need for that collaboration and coordination between different partners when you talk about something as broad as environment health.

Certainly the future threats that public health face will be environmentally based, issues of climate change and health impacts of climate change, they are not lost on anyone here. Building those relationships, not just within the program but across the broader spheres of influence who can work together to address these challenges is going to be important.

DR. J NADINE GRACIA:

Thank you for sharing those audience questions with all of our panelists and to our audience, I hope that you have truly gleaned some of the expert's recommendations and experience that each of our speakers have shared. Far too many to recite. Certainly issues around funding limitations and the importance of yes, we have specific issues but also the importance of having flexible, sustained, increased, flexible funding to meet these core capabilities, both in healthcare and public health and the importance of partnerships, the importance of working across all levels of the system, federal, state, local, tribal, territorial and how critically important that is.

You have heard real world examples of what some of these challenges are but also the opportunities as well as the power of public health. In the healthcare system to promote and protect well-being so trying to move away from the boom and bust cycle of funding to ensure we are investing in protection of public health and the broader health ecosystem to meet the rise in rates and severity of health threats across the country.

I would like to thank our panelists for your excellent presentations, recommendations and responses to audience questions. Many thanks to the staff at Trust for America's Health, Ai-Media who has provided live captioning services, and to each of you in our audience joining us this afternoon, this is clearly an important issue that we will continue to keep at the forefront as we talk about the importance of modernizing public health, strengthening the public health system and ensuring that we improve our nation's health security.

A recording of this congressional briefing and webinar will be available along with the slides and additional resources on our website@tfah.org in the coming days so we encourage you to stay

tuned and we will also share the resources in the near future. Thank you for joining us. Take care and stay well.