

AMERICAN PUBLIC HEALTH ASSOCIATION

and

THE NATIONAL ACADEMY OF MEDICINE

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RESPONDING TO COVID-19:
A SCIENCE-BASED APPROACH

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WEBINAR #6: EXPLORING DISPARITIES AND
LONG-TERM HEALTH IMPACTS

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WEDNESDAY
APRIL 29, 2020

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The webinar convened at 5:00 p.m.
Eastern Daylight Time, Debra Perez, PhD,
Moderator, presiding.

PRESENT

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C O N T E N T S

Welcome by Dr. Del Rio.....	3
Introductory Remarks by Dr. Debra Perez.....	6
Dr. Sandra Quinn.....	16
Dr. Jeanette Kowalik.....	34
Dr. Umair Shah.....	48
Audience Question and Answer.....	67
Concluding Remarks.....	87
Adjourn.....	91

P-R-O-C-E-E-D-I-N-G-S

5:01 p.m.

DR. DEL RIO: Good evening, or good afternoon to those out West, this is Carlos Del Rio. I am Professor of Medicine at Emory University School of Medicine and Professor of Global Health and Epidemiology at Emory University, and I'm one of the Co-Chairs of the COVID-19 Conversations Expert Advisory Group.

Welcome to the sixth webinar in this COVID-19 Conversations series brought to you by the National Academy of Medicine and the American Public Health Association.

I would like to thank our cosponsors, Dr. Georges Benjamin, Executive Director of the American Public Health Association, and Dr. Victor Dzau, President of the National Academy of Medicine, for their support on this important effort. We're also grateful for the input of the Expert Advisory Group and my Co-Chair, Dr. Nicole Lurie. You can find out more about the advisory listed on the COVID-19 Conversations page.

The purpose of this series is to explore the state of the science on COVID-19 to inform policymakers, public health and healthcare professionals, scientists, business leaders, and the public. More information on the series and recordings of past webinars are available on the COVID-19 Conversations page.

Today's webinar has been approved for 1.5 continuing education credits by CHES, CME, CNE, and CPH. None of the speakers has any relevant financial relations to disclose.

Please note that if you want continuing educational credits, you should have registered with your first and last name. Everyone who wants credit must have their own registration. All the participants today will receive an email within a few days from cpd@confex.com with information on claiming credits.

If you have any questions or topics that you would like us to address today or in future webinars, please enter them in the Q&A box, or email us at apha@apha.org.

If you experience technical difficulties during the webinar, please enter your questions in the Q&A box as well. Please pay attention to the chat for announcements in how to troubleshoot.

The webinar will be recorded. And the recording transcript and slides will be available on covid19conversations.org.

Now I would like to introduce our moderator for today's webinar. Dr. Debra Perez will be our moderator. Dr. Perez is the Senior Vice President of Organizational Culture, Inclusion, and Equity at Simmons College in Boston.

Dr. Perez's primary objectives and commitment is to make Simmons University the most inclusive campus in New England. Dr. Perez is responsible for expanding Simmons' significant programs and practices underlying the university's commitment to diversity, equity, and inclusion.

Prior to joining Simmons, Dr. Perez spent 20 years leading research and evaluation in philanthropy, including substantial investment in

equitable research and evaluation.

Debra, over to you to frame today's conversation.

DR. PEREZ: Thank you, Carlos. I am so delighted to be a part of this important conversation. I want to thank the advisory committee, as well as my personal thanks to Georges Benjamin for his courageous leadership over these many years in raising important issues like equity and inclusion.

As Carlos said, my name is Debra Joy Perez, and I'm the Senior Vice President for Organizational Culture, Inclusion, and Equity at Simmons University. And my preferred pronoun -- (technical interruption) -- first of all that wherever you are, and whatever you do, you are doing so on the sacred land of people who came before you and the land that you are occupying. And at Simmons we recognize that all teaching and learning takes place on indigenous lands. And, for us, that land is located in the Wampanoag, the Nipmuc, and the Massachusetts.

So, I came across this quote that I wanted to share for our conversation today. And it's by Paulo Freire from the "Pedagogy of the Oppressed: "Looking at the past must only be a means of understanding more clearly what and who they are, so that they can more wisely build the future."

And that's what this conversation is about today, is understanding what we can learn about what's going on now that can help us in the future, as well as what we can learn about pandemics and crises of the past that will help us resolve disparities today.

On today's webinar, "COVID-19 and Health Equity: Exploring Disparities and Long-Term Health Impacts," we will look at the disproportionate impact that COVID-19 has on underrepresented minority and marginalized communities, what we can do to combat these disturbing health inequities, what we can learn from those past pandemics on how to provide equitable care for all.

Each panelist will have 15 minutes to

present. And then we will turn it over to you, our audience, for a Q&A.

Before I introduce the panelists -- and I will introduce them one at a time -- I want to set the stage for today's conversation by sharing some opening remarks and setting the broader context of what we all are facing right now with regard to inequity nationally, and regarding issues like xenophobia, racism, and discrimination.

So, in the public health community, many of my colleagues on this call have been involved in research that really has highlighted the impact of social determinants in our health and on our healthcare. And they've been doing this for decades. And what we're seeing play out right now in this pandemic is textbook inequities, racism, institutional and structural racism, and socioeconomic disparities. These are the key factors that have been exacerbating the effects on people of color of this pandemic.

Just today, I'm sure many of you read

the article in The New York Times titled "A Terrible Price: The Deadly Racial Disparities of COVID-19," where a researcher and an incredible scholar, activist, a woman who I deeply admire, a scientist, Dr. Camara Phyllis Jones, talked about research that she had just published describing the effects of an accelerated aging.

And she said in that article that we have evidence that the wear and tear of racism, the stress of it, is responsible for the differences in health outcomes in the black population compared to the white population. Dr. Jones, in a 2019 study comparing 71 individuals, 48 of them black, with a team of UCLA scientists found evidence that racist experiences may lead to increased inflammation in black Americans, heightening the risk of serious illness, including heart disease.

When we think about the disparities and inequities that we see today, we cannot ignore the historical impact of racism on our health. Globally, what we are seeing in terms of these

inequities are not unlike more localized crisis like Katrina. Do you all remember that conversation in 2005? Who was left behind? Who shouldered the consequences of social determinant impact on their health?

These pandemic inequities, that we're seeing right now in terms of infection rates, death rates, hospitalization and testing, are just mirroring the disparities of prior crisis. Many of these disparities are rooted in inequity such as the high rates of comorbidities among communities of color, who are more susceptible to COVID. Black and Latinx adults are more likely to suffer obesity and diabetes than non-Hispanic whites. Asthma is also more prevalent among African Americans and Latinx communities, adults and children.

Certainly, being low income are more likely to have more chronic health conditions. But it's also the economic fragility of many of our communities. Not all workers have the ability to work from home.

I recently heard, someone posted, like, enough of the praising of the essential workers, the cleaning folks, the grocery workers, the food service workers; you know, do more than just praise them, but really support them in understanding the disproportionate impact that this pandemic is having on those without the benefit or the privilege of having sick time, decent pay, and the ability to stay home.

I think what's interesting about this pandemic is that it's only been recently that folks have turned their attention to collecting the data that would demonstrate the evidence of this inequity.

The CDC publishes a weekly morbidity and mortality report. And in their last report, or the early reports, they indicated the inconclusiveness of some of the data. As early as April 6 -- or as late as April 6, Louisiana became one of the first states to release COVID-19 data by race. Other cities and states followed. Here in Massachusetts, it wasn't until after some

pressure that folks were mandated the collection of racial and ethnic data. And just as an aside, when they first released the report, 53 percent of the deaths were unknown race and ethnicity, which just indicates how little information was collected.

In Michigan, black people make up 14 percent of the population, but 40 percent of the deaths.

In Wisconsin, we hear later about Wisconsin, black people are 7 percent of the population, but 33 percent of the deaths.

In Mississippi, black people are 38 percent of the population, but 61 percent of the deaths.

In Chicago, blacks make up 30 percent of the population, but 56 percent of the deaths.

And in New York, where the country's highest numbers have impacted, African Americans are twice as likely to die than whites.

You know, we could go on and on. And this is not just true about deaths; it's true about

hospitalizations. Cities like Chicago, L.A., and New York City are seeing higher rates of hospitalization. For example, in Illinois, 43 percent of those people who were -- who died were African American, but only 28 percent of those who were tested were African American.

And other information, at least about testing, is that the initial indication shows that doctors are far less likely to refer African Americans for testing when they've been to the clinic with symptoms for COVID than they are to recommend others testing.

I mean, if you think about the genesis of this pandemic in the United States, the first population that was called in for testing were people who traveled abroad, leaving exposed and potentially infecting many communities because there was no testing available. So they were focusing on the more affluent folks who were traveling abroad in terms of testing. And in that time, the disease obviously progressed and went quickly and led to these incredible disparities.

I'll close by just saying that, among these things, it's not just the condition itself, it's not just the illness itself, it's what surrounds the illness that makes it possible for someone to survive and thrive.

Food and financial insecurity: low income families being more dependent on food pantries. Moreover, issues like unemployment, unstable or substandard housing can perpetuate these disparities. And certainly poverty is concentrated in communities of color, particularly among the disabled and the elderly.

So, today we want to focus much of this conversation not on recounting these differences as I have just done, but turning to our experts to really get attention to what are the equitable solutions. What do we do now? How can we learn from the past? What worked in the past? What can we implement now that will help address, if not mitigate, some of these disparities?

So, let me introduce our speakers. First up we have Dr. Sandra Quinn. Dr. Quinn is

professor and chair of the Department of Family Science and senior associate director of the Maryland Center for Health Equity at the School of Public Health at the University of Maryland. She is currently the principal investigator on a project examining vaccine misinformation on social media platforms.

Her research team pioneered new measures to identify the impact of perceived racial fairness, racial consciousness, and discrimination on vaccine uptake. And she led two national surveys during the H1N1 influenza pandemic examining public attitudes toward emergency use authorizations for drugs and vaccine.

She was the first to conduct an empirical test of disparities and risk susceptibility and access to care that can exacerbate existing health disparities among racial and ethnic minorities in a pandemic. She's a member of the National Academies of Science, Engineering, and Medicine Committee on

Evidence-Based Practices for Public Health
Emergency Preparedness and Response.

I am so delighted to turn this over,
the presentation, to Dr. Quinn. And Dr. Quinn is
going to lay out why vulnerable populations are
differentially impacted by the pandemic, including
broad discussions of social determinants, and what
can we learn from these past pandemics.

Dr. Quinn?

DR. QUINN: Thank you, Dr. Perez. And
thank you to APHA and the National Academy of
Medicine for inviting me here today.

Dr. Perez has detailed much of the
tragedy that we see reflected in these headlines
today. Why are blacks dying? Immigrant
communities facing catastrophic pandemic. Indian
country at higher risk. Minority community --
hospitals in minority communities struggle. And
all of these things were predicated on social
determinants of health that led to a
disproportionate impact of all the chronic disease
that we just heard about: diabetes, heart disease,

asthma.

Next slide. The social determinants of those health disparities are not new. They're not new to COVID. We know that. But they have left us with an underlying burden of chronic disease that puts people at risk for severe disease. So, let's talk about what we have seen from the past, and where we're going, a call to action.

Next slide. Very simply, we know that we have an existing burden of chronic disease. What we have not grappled with as effectively is that the risks of being exposed to this new virus are not evenly distributed across our population.

And so at the heart of, you know, that fundamental underlying racism and associated poverty, we also have, you know, the creation of environments, healthy environments, from poor housing to ongoing exposure to toxic substances to living in food deserts that place people in unhealthy environments.

We know that racism is also at the heart

of poor investment in public education, which is directly tied to limited employment opportunities.

So, when we think about risk of exposure to COVID-19, we are thinking about the people who are going to the grocery store for us, to help protect us. The garbage collector, the janitorial staff, but also home health aides. There are a variety of people whose limited employment options put them sort of at the bullseye for exposure to this virus on a daily basis.

Next slide. But that we know some of the other factors. None of this is news to us, but there are a couple of things that are important.

Since 2017, we know that the percentage of our population that are uninsured is rising again. The inadequate investment in public health infrastructure that Dr. Benjamin knows all too well, is that evidence in my own country, Prince George's County, where the per capita expenditure on health and human services is 38 dollars and some cents. In Montgomery County, next door, that per capita expenditure is 224 dollars and some cents.

So that infrastructure that we need today more than ever is struggling. We've been watching hospitals close in rural areas around the country. And we also know that the racial bias and discrimination in healthcare is not news. But it is also still here and it is a factor affecting whether people get adequate care.

Next slide. So, in 2009, my research team was funded by CDC. And, at the start of the H1N1 flu pandemic, we decided to operationalize Blumenshine and colleagues' model on health disparities during a flu pandemic.

We've talked already about the differences in social position based on income, education, occupation, race, ethnicity, immigrant status. So, all of these things that make a difference in disparities to exposure, but also they underlie the disparities to susceptibility, particularly to severe COVID-19 disease. And they underlie those disparities in access to adequate treatment once the disease has developed, but even

prior to that. You know, access to adequate care for those chronic diseases that put people at risk.

All this comes together in ways that are devastating and that lead us to the kinds of horrific statistics that Dr. Perez just shared of death and hospitalization and illness.

Next slide. So, in 2009 and 2010, we conducted a longitudinal survey. And I'm just going to highlight a couple of things here. And what we found was that there were a number of issues related to disparities in exposure, susceptibility, and access to care.

The first one that I want to highlight is that work-related inability to social distance.

So, remember what we've been seeing playing out: the restaurant workers, the people going to the grocery store and shopping. The people who do not have sick leave. The people who cannot do their jobs at home like many of us are doing. The people who will lose their jobs if they are not on their job site.

And what we've found was, while that

affected all the groups in our survey -- whites, African Americans, English-speaking and Spanish-speaking Latinx people -- for Spanish-speaking people, that was really a significant factor. They could not social distance from work.

The difficulty of accessing healthcare, which was true in 2009 and 2010, particularly for Spanish-speaking Latinos, has been exacerbated in these last several years of anti-immigrant actions and policies.

And the bottom line is, what did that give us at the end? When we looked at our longitudinal sample midway or toward the end of the H1N1 pandemic, these disparities, and particularly that absence of sick leave, contributed to a population attributable risk of five million additional flu cases in the general population, and 1.2 million among Latinos. That is a toll that is simply too high to pay again.

Next slide. So, I was asked to think about what are the lessons we should have learned.

And, obviously, one of them was passing a national sick leave policy. We have not really done that in a way that covers all employees, no matter how big the company or the workplace they're in.

And we've really not grappled with and recognized that, in our workforce, we are dependent upon entire groups of people who are largely racial and ethnic minorities, and certainly often rural, but entire groups of people in our workforce that stay at risk because they can only do their jobs there. So, think for a moment about the meat-packing plants and who is working in those meat-packing plants that are now forced to continue to work.

We began a move with the Affordable Care Act that increased access to healthcare. But, obviously, as we all know, we have a long ways to go. But not just the access, but is that healthcare acceptable? Is it sensitive? And have we addressed racial bias and discrimination? We're starting to. We're doing some work in that area. I think we're going to hear some of our

colleagues talk about it in a moment. But we've got a long ways to go.

We always say, you don't start building partnerships at the time of the public health emergency. So, do we have, and have we seized, the opportunities to create the partnerships between communities that are most devastated here and their health departments in the healthcare system?

But I would argue there's one other really important thing, is we could have had a pandemic plan that was informed by a health equity lens and by a health in all policies approach.

Next slide. So, how do we bring that health equity lens and the health in all policies lens to this COVID-19 response and recovery? And I add in recovery here because we will get there at some point.

So, one of the things goes back to what Dr. Perez mentioned, is that we really need to institutionalize reporting. We've seen better reporting. This happened, by the way, also in

H1N1, where initially we were not getting this kind of data. But it's not just reporting of the cases and the deaths, and that's what we've been getting more sporadically. We need who's being tested.

Then, what are the cases? What are the hospitalizations? What are the deaths for each of the populations that are severely impacted here?

I believe we also need to think about the policies and practices that are being put into place in hospital settings. We all know the story of too few ventilators and too few ICU beds. The question is, how do providers make that dreadful decision of who gets those and who doesn't? And my fear is that, if you come in with many comorbidities, as many African Americans and Latinos and others may do, that you may actually be disadvantaged from the time you come into the ER in terms of your access to these scarce medical resources. That's a tough ethical and practical problem.

We've seen local localities and states begin to address, you know, how do we make sure

our safety net and other programs help to sustain families and communities that are particularly vulnerable? They may have been poor to start with, they may have lost jobs, they may have more than one person in the household that's lost jobs. And they have been dealing with the wear and tear, as Dr. Jones talks about, of racism and that daily stress. How do we make sure they stay protected during this pandemic?

So, prohibiting evictions, prohibiting rent increases, for example. Making sure that local funds and state funds support schools so they can still hand out meals to students that would be on free and reduced lunch.

So, there's a whole array of complex programs that are needed to help protect people from falling further into a vulnerable position -- becoming homeless, going hungry -- in this pandemic.

What I haven't seen, to some extent, and I think we'll hear from some localities that are better at this than others, is, are people from

our affected communities really being integrated into the task force discussions of how do we reopen and how do we recover? And I'm not seeing that in a way that I think we need to have it there.

And moreover, then, how do we integrate and what kind of data related to health equity do we need to both plan for that reentry and plan for the recovery and monitor? So that again, we don't compound these disparities further.

Next slide. We know communication. Anyone who's been working in health equity and health disparities, we know communication is vital. You know, it brings the assets of communities and increases trust. There are a whole array of reasons we all know. But I think there's some specific things here. Let's engage communities on where these test sites are. Are they places where people have access to when public transportation is cut? Do they trust those places? Let's educate communities about what this testing means. Who can get testing and under what circumstances?

And, thirdly, we are hearing about hiring contact tracers all over the country. The question is, how will we prepare them to work with community members from whom they may differ by race or ethnicity or linguistically or in other ways that are important.

But we also know, and Dr. Perez mentioned this, that people are encountering barriers right now to getting tested and to getting care. Going into the ER and being told to go home. And then when they come back, it's too late. So we need to really hear from communities today on what are the things they're encountering. And what is feasible to change? What can we change today?

In Maryland, we will be having our first "Color of COVID-19" Facebook Live event tomorrow night with Maryland legislators. But I believe all across the nation we need to be able to hear concerns, worries, and needs from affected communities.

And, finally, I think we're all

heartened, it's the one hope I think we see, is when we know that all the assets that exist in every community are stepping forward. It was Links yesterday in Prince George's County, an African American sorority, out giving out meals to people so they're not hungry.

So, there are a whole array of things that we need to be doing to engage communities to help them, and to help us, do a better job at preventing further disparities.

Next slide. I wouldn't have spent all these years focusing on vaccine disparities, and I couldn't in good conscience walk away from this talk, without addressing this. So, here's what I know. I know year after year African Americans get the flu vaccine at lower rates. There's a history to that. There are issues of trust. There's the burdens of race and history. There's the burdens of the Tuskegee study. There's missed opportunities when healthcare providers don't offer the vaccine at a visit.

So, I think we need to start today.

We know that there is going to be a second wave at the time of the flu season. So, how do we get community health workers and leaders engaged now on planning for, you know, increasing that flu vaccine uptake? It's critical for fall.

But, moreover, that's talking about reaching out to the community, but how do we make sure that our providers, the pharmacies and other providers, have adequate supplies -- we know that is often an issue in an emergency -- in trusted community settings that are convenient and people will go to?

But we also know that participation in clinical trials, for many reasons we're all familiar with, is a challenge, and that many African Americans, Latinos, Native Americans, don't participate. But I also know from our own research that they're often not asked to participate, and they may be willing. So, again, to be ready and to have a vaccine that we know may be safe and effective for everyone, that's critical.

And, finally, we are starting to see the first emergency use authorization of a therapeutic drug coming probably this week. And we know that there's a possibility of emergency use authorized COVID-19 vaccines. We have to work with communities to get them ready. And, I would also argue, we have to work with healthcare providers so they can do a better job at making the case for vaccines.

Next slide.

DR. PEREZ: Sandra, I just want to note that we're at time. So --

DR. QUINN: This is the last slide.

DR. PEREZ: Great.

DR. QUINN: We're now faced with the fact, as Dr. King said, that tomorrow is today. We're confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there is such a thing as being too late. There's no time for apathy or complacency. This is the time for vigorous and positive actions to prevent the further tide, the tsunami of death, but also

to lay the foundation of changing those social determinants so that we are not in this position again. Thank you.

DR. PEREZ: That's fantastic. Thank you so much, Dr. Quinn. You know, I really appreciate the context you set around the challenges of African Americans and Latinx receiving treatment.

And you mentioned the respirators. And not just because those decisions are made based on the comorbidities that they may or may not have, but also let's acknowledge that there's bias, right? And that how -- what we know from the literature, is that they are less likely to receive adequate treatment regardless of comorbidities. And so that bias has to be taken out of the system.

And so I really appreciate your insights, too, about the devastating impact of these anti-immigrant policies and how that is all connected to these disparities.

I'm super excited now to turn the mic over to Dr. Jeanette Kowalik. Let me tell you a

little bit about Dr. Kowalik. She has had over a decade of progressive public health experience representing the life course. She began her career as an intern in the City of Milwaukee Health Department. And, after graduate school, she returned to Wisconsin to serve as the UW-Madison's Director of Prevention and Campus Health Initiatives, prior to her transition to the Association of Maternal and Child Health Programs in D.C. Dr. Kowalik served as the Associate Director of Women and Infant Health. And she has also, since September 2018, returned to her hometown of Milwaukee to serve as the Commissioner of Health.

She's inspired and motivated to move the MHD forward to maximize community impact. Dr. Kowalik's diverse set of experiences continues to motivate her to advocate and represent those who are unable to have a seat at the table.

She's going to talk to us about looking at nationwide data and sharing how communities of color are more severely impacted

and highlight details about some other jurisdictions' data. And she's also going to talk about a very interesting topic, which is what has been the impact on the commuter communities and how that relates to urban communities.

So, let me turn over the mic to Dr. Kowalik.

DR. KOWALIK: Thank you, Dr. Perez. Good afternoon, everyone. It's a pleasure to be here today. So, I first want to acknowledge Dr. Benjamin for the opportunity to just learn and grow in public health, and just the joy and benefit of being a member of APHA. Little did we know we'd be locking arms virtually to fight a pandemic. So, definitely, all of these opportunities for engagement are very, very useful and necessary now more than ever.

I use to be the chair of the Health Administration Section. Now I'm the past chair.

I'm also a member of the Maternal and Child Health Section. So I just want to shout-out my sections.

And I also want to thank a few folks before I dive in. Mayor Tom Barrett for the opportunity to serve my hometown. The Milwaukee Common Council. The Health Department staff, past and present, including our lab, who was one of the first in the state to start testing COVID-19. And then the other health departments in our county.

There are ten others. So, when people say Milwaukee Health Department, it's just the City of Milwaukee. And there are ten other health departments. There is Cudahy, Hales Corners, Greendale, Greenfield, Franklin, North Shore, Okay Creek, St. Francis/South Milwaukee, Wauwatosa, and West Allis.

So, since we declared an emergency, you know, now had our first case on Friday the 13th in March. Then that activated us into this emergency mode. So the Health Department of Milwaukee ends up serving as the lead for the county's public health emergency response.

So, just to give you a little sense of what Milwaukee is about, Milwaukee is about 87

miles north of the city of Chicago. So, most people know where Chicago is, so if you can just think north, that's where Milwaukee is. The city has about 600,000 people. And the county as a whole is about a million.

So, the way I have this broken out here is using the census data. The first numbers are for the county and the second numbers are for the city. Just to show you a comparison of how the demographics break down for our population.

And as you can see, the race and ethnicity of our area is pretty diverse. We are a majority minority city, which is very important because that also impacts how we drive public health in our community.

You can also see disability; uninsured, or not having health insurance, status; poverty; and median income. So, again, some of these measures here will continue to play out as we talk about our COVID response.

The next slide is just a general snapshot of what the City of Milwaukee Health

Department is all about. So, we went through this rebuilding phase. And we're still in it now. But our vision is "Living your best life, Milwaukee."

And our mission is to advance the health and equity of Milwaukeeans through science, innovation, and leadership. And we're seeing that play out very heavily in our team pandemic response. And then these are our values.

The next slide is just to give you a little sense of what is going on in Milwaukee. So, some people know about this through our equity work, and other people may not. But I want to just acknowledge some of the drivers behind why we are even talking about race and ethnicity in COVID-19, why we were one of the first jurisdictions to report on this level of data. Noting that all epidemiologists know that we always collect race and ethnicity data, but you don't necessarily share it publically until you feel confident that the data is valued -- or valid, should I say.

So, at the state level, in 2018, my chief of staff led this initiative to address

public health and declare racism as a public health issue. Lilliann Paine. Then, at the county level, in May, there was a declaration as well through the Office of African American Affairs.

So, through Chris Abele and Nicole Brookshire.

And then, in July of last year, the City of Milwaukee declared racism as a public health issue.

So, there are a number of people at the table. We have our GARE initiatives. There's a city one and a Health Department one. But just to show that there was some background to how we were addressing race and ethnicity and equity in the City of Milwaukee, and that we were in early stages of really bringing about true change throughout our city. Because, as you can imagine, there's a lot of work that still needs to happen.

The next slide is just showing you a comparison of an old redlining map from 1938. And this is from the University of Richmond, but this is Milwaukee Country. And the green is best. The blue is still desirable. Yellow is definitely

declining. And red is hazardous.

So, you can see, this north side of town, and then south side where there are these pockets. And then you can see listed here, Milwaukee County, and then the blue is the City of Milwaukee. So, just highlighting where the majority of the cases are. Looking at cases by zip code per 100,000.

So the zip code 53223 has a rate of 591.

53205, which is on the south side, has a rate of 539. 53210, which is where I grew up, has a rate of 499. And 53216, which is the north side, which is where our first hot spot was identified, has a rate of 471.

So, just to give you a comparison when you're looking at other jurisdictions, what's happening and how our inequities are playing out.

The next slide is just a snapshot of showing what has occurred from week one. Again, noting Friday the 13th all the way up through last week.

So, initially we saw the majority of

our cases among African American men that are middle-aged. Also, the majority of the deaths early on were African American. But, as time went on, we started seeing that decline. We also started to see more problems with the race and ethnicity quality as far as the data. So, like, the one note about 50 percent of variables not being available. Now we are at the 28 or 29 percent for the City of Milwaukee.

So, we're working on filling in the gap of some of those unknowns. We also know that that also could be attributed to people not feeling comfortable about releasing or sharing their race and ethnicity data with their providers because of fear of discrimination or being treated differently or having different access to services.

We also know that there are some issues along the continuum, from electronic health and medical records to the lab to the electronic disease surveillance system. So this is just to give you a sense of where things are at since we

received or detected our first case.

The next slide is a little bit about our election. Everybody knows that Wisconsin had an in-person election during the pandemic. And we really fought hard. A number of health officers from around the state, as well as our Wisconsin Public Health Association and Wisconsin Association of Local Health Departments and Boards of Health, worked together to really petition legislators to not have an in-person election during a pandemic. But that was overturned, so we were required to really consolidate polling sites in the City of Milwaukee and still hold an in-person election.

And it was extremely challenging. So, again, the Health Department staff and the Election Commission staff, and other volunteers that work on this effort, I just want to acknowledge and salute all the hard work that went into setting up social or physical distancing, enhanced cleaning, educating, and providing masks and face coverings to people to prevent the spread of

COVID-19.

So, this is just the kind of outline.

When we say election activity, what does it mean? If they were a poll worker, a volunteer. If they actually dropped the ballot off at a site. Curbside voting was also something that came up. And then, of course, traditional voting, voting at a polling site.

So, our initial data show that seven people in the City of Milwaukee had an infection, COVID-19 infection, associated with election activities. But, according to our last analysis, now 40 people in the county. And so we're refining that data now, and we plan to have an update later this week, because, of course, the media is waiting for more information about that.

But I just want to stress that we can look at correlation, but, of course, we can't establish causation. Because, again, of all of the factors that go into analyzing multiple variables across people that voted. But, as you can imagine, who is most likely impacted by this?

People of color in the inner city. So, just stay tuned for more information on that.

I also want to highlight just a sense of what's happening here and the need to be able to address race and ethnicity in COVID-19.

So, we were providing daily media briefs. And that was like local media, you know, your NBC, CBS, all of your stations. So, we reported that, earlier, by like week two, the data that I just shared with you, about how the majority of our cases were African Americans, as well fatalities. At one point we had 100 percent of fatalities were African American.

So, that got picked up nationally. The first news outlet or periodical that covered that was Essence Magazine. And that was in March of -- March 26. The next, April 1st, was Atlanta Black Star. Again, these are two, you know, not Milwaukee-centered or local periodicals or media outlets, but covering other spaces.

Then, on April 3rd, ProPublica covered or shared more detailed information about what was

happening in the City of Milwaukee. And then from that point on we started to see more interest, more push, started seeing more jurisdictions sharing their data, more states sharing their data. There's this push for the CDC to share their data.

And then there's the Kaiser Family Foundation issue brief that was released on April 7th. And then there's some other research that's still coming out that hasn't been peer-reviewed yet but should be coming out this summer.

So, again, just highlighting the process of what's happened here in Milwaukee. And I know I haven't really gone into detail about the commuting piece. But it's important, because, as I noted the difference between Milwaukee and the City of Chicago, there's a lot of people that move between our jurisdictions, as well as some of the other countries that are in between Milwaukee and Cook County.

But then there's also a number of people that either work in the city of Milwaukee and live in the suburbs or vice versa. So we have a lot

of movement that's happening. So, the first case in Southeastern Wisconsin was in a suburb called Waukesha, which is a western suburb. Predominately white, more affluent. And, eventually, our first case in Milwaukee was someone that had contracted the virus from that Waukesha case. And then our second case was an African American male that had contracted the virus from visiting in Atlanta.

So, just from those two activities, traveling, commuting if you will, and then going, like domestic travel, that's how we got our first cases.

So, it's important to note that there was so much emphasis on international travel, and very little on just movement period that that was a missed opportunity for us.

So, again, there's a lot of work that still needs to happen. But, we're glad that we're all talking, and we're learning from one another.

And, you know, looking at the past for what we need to do now. So, and then my last slide

is just acknowledging this Milwaukee Health Department team.

Oh, before I get into that.

DR. PEREZ: Yeah, we're at time. So, if you could wrap it up, that would be great.

DR. KOWALIK: Yeah, sure. So, just wrapping up here, what are some things that we can do to address the acute situation in the future?

Acutely, we need to provide support for people that still have to go to work. So, providing hazard pay, making sure people have their personal protective equipment.

Providing some subsidies or free, as far as basic human needs. Suspending rent and mortgage. Making sure people have healthcare. All of that is extremely important right now.

But long term, we need to be revisiting the conversation about reparations. And making sure that people are being paid fairly for the work that they're doing.

You shouldn't have to work three jobs to equal what a white man can make. So, you know,

again just how all this is related.

We're not going to fix it unless we're willing to really dismantle the system and rebuild it.

DR. PEREZ: That's wonderful. Thank you so much, Dr. Kowalik. I really appreciated your insight on the whole commuter experience and how important it is to focus on that community.

And I love this notion of really looking at systemic change versus, you know, at the individual level. So, thank you so much.

Now we're going to turn it over to Dr. Umair Shah. Dr. Shah served as the Executive Director of the local health authority for Harris County Public Health, the nationally accredited county public health agency for the nation's third largest county, with 4.7 million people since 2013.

He, upon completing his medical training, Dr. Shah began his career as an emergency department physician at Houston's Michael DeBakey VA Medical Center.

He started his formal public health

journey as a Chief Medical Officer at Galveston County's Health District to oversee its clinical health system and infectious disease portfolio.

Dr. Shah holds multiple leadership positions in entities like the National Academies of Sciences, Engineering, and Medicine; the U.S. Centers for Disease Control; Trust for America's Health; Network for Public Health Law; and the Texas Medical Association.

So, he previously served as the President of NACCHO, which is the National Association for City and County Health Officers.

And represents the nation's nearly three thousand local health departments.

So, please welcome and I'll turn the mic over to Dr. Shah who is going to talk to us about how to combat these disparities and cases of death in communities of color, and what we know about rural communities.

Dr. Shah, please.

DR. SHAH: Dr. Perez, thank you for having me. And thank you, everybody for your

fantastic, my colleagues for their presentations.

Dr. Quinn, absolutely spot on. And Dr. Kowalik, always great to see you again. It's been a while since we last connected, obviously on better terms before this pandemic unfortunately hit.

So, I really want to thank the National Academies as well as APHA and all the other organizers of this webinar. It's an extremely important opportunity for us to share what's happening on the front lines.

And I know that you all know this, but just so we underscore that, I am an unapologetic firm believer in the community, as well as the role of the local public health department.

And I do not apologize for that, because I sing that from the hymn book every single day.

And lately, I've been shouting it. So, I just wanted to make sure to say that right up front.

The real issue that I think we continue to have in our communities as we fight this pandemic, is the real challenge that is at the

bottom of my slide here, which is this hashtag invisibility crisis.

Unfortunately, we no longer have that invisibility. Everybody is looking at public health now.

But, over the years as I had forwarded this concept of invisibility crisis, it was really about the lack of capacity building that was really with the lack of investment in public health.

And that has really come to bear now as we all know. As we're looking across the globe, and especially across the country at public health agencies as well as public health systems not really having those resources.

In fact, not having the resources to be able to respond effectively. And I think that is a significant challenge that I am hopeful that we can continue to work towards.

But, as you all know, it is going to be a process. So, as I move to the next slide here, I want to just remind everybody that Harris County is big and diverse and complex.

We are the third largest county in the U.S. with 4.7 million people. We would be -- that makes us larger than 25 states.

We are larger than the state of Rhode Island when it comes to geographic spread. And to add to the complexities, the geopolitical and socio-demographic complexities, we have no majority population in Harris County.

We have over 40 percent Hispanic, 30 some percent Caucasian, 18 percent African American, and 8 percent Asian.

And so it's a very diverse community with multiple languages, over 90 consulates and all sorts of other socio-demographic diversity types of ways to look at our community.

That certainly comes into play when we're in the midst of COVID-19. Next slide.

And as I said earlier, I do believe very strongly that public health is very much that invisible workforce.

Everything that we do in usual time, obviously there's no social distancing in these

slides. But you know, restaurant inspections and certainly water quality, responding to emergencies, picking up dangerous animals, or trying to adopt out not so dangerous animals, and all sorts of other activities behind the scenes, whether it's for individual vaccinations or if you see just right to the Harris County Public Health insignia, is the H1N1 mass vaccination efforts during 2009/2010.

At the end of the day when public health does its job, it's largely invisible. Next slide.

The premise that we have in our community is that health really happens where you live, learn, work, worship, and play. And these are really, there's so many different ways of looking at us.

It's again, slicing a community or how a public health department or a system really responds to a community's health. But these social determinants of health really drive, and these structural determinants as well, drive what we are accomplishing in our communities.

But it really, in our minds, we very much try to parlay it into this place matters concept. Which really allows us then to respond as well as plan in advance of a response that's needed. Next slide.

In November 2019, it seems ages ago now, we launched a 2020 vision of health in Harris County. It was a landmark study for a ten year roadmap for the third largest county in the United States.

And we called it Harris Cares, a vision of health in Harris County. Next slide.

If you go to that, and obviously the website was there, you can go to Harris County Public Health website as well to download it. There were five key findings.

And I want to just highlight these. The first one is probably the one that I want to really highlight, is this 24 year difference in life expectancy based on where you live.

And I know we've seen this across the country. But I think underscores the existing

inequities that really come into play as you layer on top of that, COVID-19.

And certainly the next four bullets here about social vulnerability, the SVI, looking at the distance to healthcare access. The lack of health insurance and also obviously the concern about under insurance.

And certainly healthcare access in general. As well as specifically certain conditions like obesity as well as chronic health conditions like hypertension and diabetes and heart disease that come into play in COVID-19, where existing well in advance of COVID-19. Next slide.

As this comes through, you might have to keep clicking, because it will come through.

There you go.

Unfortunately we never have a dull moment, it appears, in Harris County. From Tropical Storm Allison on forward, we have unfortunately been a part of a significant number of large scale emergencies.

And this does not even take into account the smaller ones. And so, when we sometimes have tropical storms, we don't even think about them as emergencies, because we're faced with hurricanes like Katrina, and Rita, and Harvey, and Ike, and all the other kinds of natural disasters.

As well as what I would point out in the top right, is H1N1. Which our department was responding for 18 months in the midst of that mild pandemic.

And so, while it feels like we are -- that this has been going on for several months, and it has been. Unfortunately, we are still in this.

And it's going to continue to affect us and our communities for time to come. Next slide.

So, I think you all know this. It's obviously COVID-19, a global threat. You know, just really looking at unfortunately that the United States now has a third of the cases across the globe.

Which I think is also a point of note that we do need to be thinking about. As well as the number of deaths that we've had in this country.

Next slide.

And I do want to point out the public health challenges and solutions at the end of the day do not recognize borders. And if there is ever an underscoring of global and domestic health being intertwined.

And why we must invest in global health.

And thinking about global health inequity, this is absolutely the time for us to be thinking about this.

But this obviously predates COVID-19 and the pandemic that is at hand. Next slide.

Our response here locally started way back in January. It actually started about January 8 or 9, around the time that we learned about what was happening with COVID-19 officially.

But we were watching it even over the New Year holidays. I would say that January 23 when we all came together as our first in person

meeting again, not socially distanced at that time.

And it does seem odd when you look at pictures that are pre-social distancing and post-social distancing. And you can really have a moniker in terms of where in the response we were.

As well as our first cases in Harris County in March. And then in April as we focused our county elected official.

County Executive Judge Lina Hidalgo laid out just yesterday the three T's of testing, tracing, and treating. That at the end of the day that we were very much mindful of the fact that we needed to respond on behalf of our community.

And I do want to underscore what Dr. Quinn and Dr. Kowalik also said, which is that initially there was this incredible amount of vilification of the Asian American community in Harris County.

To the point where our Chinatown, our Asian American businesses saw about a 60 percent drop in businesses and restaurants and grocery

stores, because there was this real concern about what was happening in China.

Even though at that time there was no evidence that we had any cases here in Harris County. And there was a lot of beautiful, diversity aspects of what makes us strong as a community.

But also, there's some ugliness, which obviously we saw on social media and throughout. So, I do want to make sure to mention that as well.

Next slide.

This dashboard really illustrates that what Dr. Kowalik described. Which is at the end of the day what we're really trying to do is to share data, share information.

To give the public the best opportunity to understand what's happening. And it is very complicated, because a lot of times we are, we're being asked to share data points which have not been cleaned up, or have not -- that is not honestly accurate.

And that has been a significant concern

of ours. And I will say, one of those includes that when we were wanting to release race and ethnicity data, we found that 35 to 40 percent of the information was in the box of unknown or indeterminate or incomplete.

And it was because we were receiving laboratory results that simply had Umair Shah, a date of birth, and a phone number, and a positive.

And that was it.

And we had to go find that individual.

Which is not just contact tracing, it's actually pre-contract tracing of case tracing. Which has been an incredible challenge as well.

And then other people who just simply did want to provide information as well. Next slide.

DR. PEREZ: You have about five minutes, Dr. Shah.

DR. SHAH: You got it. So, we've been now, been very assertive about testing sites and including pop up testing sites and rotating testing sites.

And I think this has been brought up before. And I'll just underscore that we have two FEMA sites that are in large stadiums that are set up for testing.

But, we recognized that we also needed to set up testing where people were. Especially with socioeconomic issues and obviously transportation issues and vulnerabilities.

So, we have now been moving quite aggressively. In fact we're doubling our pop up sites that are in now communities, especially communities of color.

But, not just that, but what we're calling testing deserts. Because it really is like a food desert that you just don't have testing there. Next slide.

And here is some example of those testing site placements. And I do want to remind you that there are both Harris County, and there is the City of Houston Health Department.

We work in partnership with our city partners as well. We're using SVI, the social

vulnerability index and socioeconomic factors.

And this real concept of testing, so we can actually understand a desert. So we can understand where exactly we need to be.

And that really has helped us move into directions throughout our communities. Next slide.

And as you can see, this is where we're seeing individuals coming from. This is a heat map, so it's obviously not --it's protecting the privacy.

But, you can see where people are coming from to test. But you also see areas where people are not coming from.

And that is an equal pieced of the visualization. Which is very much about how do we really understand how to get to it.

Is it because people there are testing elsewhere? Or they don't need to be tested? Or is it really that they don't have access to testing?

Which is really a significant concern. Next slide.

And our outreach has also been very equity focused. From languages too again, partnering with key partners to really understand best how we can get into various, again, LLWWP.

Live, learn, work, worship, and play, to continue to respond in communities so we can be of the community. Next slide.

The three T's as I mentioned. A multi-disciplinary team that now we're sending out to congregate settings. Especially looking at vulnerable -- vulnerabilities in communities.

To really understand where nursing homes might have less resources than a nursing home in another part of the community. And that's also now in play. And we launched this just yesterday. Next slide.

So, addressing inequities of COVID-19 communities of color in our minds is really the long term solutions must take into consideration where communities live, learn, work, worship and play.

And really, want to make sure that the

data is driving decision making to form those strategies and solutions. And that we mitigate as best we can, long-standing health inequities.

But, we're in the midst of an overwhelming pandemic. It is almost as if we're layering on top the existing inequities, and wanting to do everything we can so obviously we do not worsen those.

And then certainly the data piece from race, ethnicity, location, age, et cetera, that helps keep health inequities a central focus of our response and procurement in analyzing as well as visualization of that data.

And finally this, the last couple of points here of, this is no time for politics. Though the reality is that public health is inherently political.

And that is a very big challenge that we have. And we have to remember it is ultimately about community trust.

And we have to work together. And yet, we know that not everybody is always working in

that direction. Next slide.

And I'm almost done here. The race-ethnicity, this is an example of some of the information.

As you can see, we've had especially with our African American or black community that we have had an over the number or the percentage of the representation in our community. We've had more cases, more deaths.

That is a concern. We're continuing to try to unpack whether it's because of the underlying health conditions?

Of if it's really related to the -- some other factor that we're also looking at. And certainly a very similar concern with our Hispanic/Latino community. Next slide.

I always bring this in. This is the football metaphor. Everybody has heard this perhaps.

I always say public health is the offensive line of the football team. Everybody knows number four in our community is our

quarterback, the healthcare system.

But we really are the offensive line that nobody really gives credit to number 68 or number 71. And we need to raise that visibility.

When you raise visibility there's value. When you have value, then you have validation like pro-health.

Resources are pro-health policies. Right now I would dare say that we have a visibility crisis, not an invisibility crisis.

But, I think people still don't fully understand what public health does. And so they're really trying to fill the blanks in, of what is contact tracing?

Great concept. New concept. Public health has been with this concept for decades. Next slide.

And so I may close by saying that this, a few images here. The image on the -- in the middle was when I responded after the earthquake in Port-au-Prince.

And it just reminded me of the kids

there. And I always would take this back with my own children.

And thinking that everybody, every child has the opportunity and should have the opportunity for the optimal health that all of us should be enjoying in a community, regardless of where we are across the globe or here locally.

The team on the left here, this is our Harris County Public Health team. Before again, COVID-19.

And I would just say that, you know, it takes a village. And our team is fantastic.

And what they have done and accomplished, I'm so humbled by working with them, working for them actually in so many ways.

And finally, on the right here, this is when I had hair. It wasn't gray. Back in 2005 had Hurricane Katrina response at the Astrodome.

And I asked for an official Form 214, which was not about new items or widgets. But it was for common sense.

And that has stayed with me for this

15 years here. That public health just makes common sense.

And we need to continue to invest in it. But we also need to invest in it because it makes sense for the benefit of our communities.

Dr. Perez, I'll turn it back to you.

Thank you.

DR. PEREZ: Thank you so much, Dr. Shah. Our first question is for Dr. Kowalik.

Dr. Kowalik, could you provide more information about how contact tracing is being used in Milwaukee? And how you're ensuring the workforce for contact tracing?

I know Dr. Quinn had mentioned before how important community engagement is when you're doing this kind of work.

So, can you talk about some of the strategies that you're implementing in Milwaukee with regard to navigating trust and cultural issues?

DR. KOWALIK: Yes. It's been very challenging. I mean, the reason why I moved back

home for this opportunity is because of some of the issues with management of the Health Department.

So, rebuilding, which included like a reorganizational process. And filling a number of vacancies, was something that we're still in the process of doing.

So, we had to initially bring back some retired nurses to our communicable disease unit, to help with some of the capacity issues.

Eventually, we started reassigning other Health Department staff to our CD unit to assist with the case investigations and contact tracing.

So, as of earlier this week, and noting it's Wednesday, that we had 19 people that were working as far as our Health Department. And we also are able to bring on, or leverage the support of other health departments in our county.

And then the state health department, which is based in Madison, had worked on bringing some additional supports for contact tracing.

They had acquired and trained about 100 people to assist.

So, those individuals are overflow when we hit our capacity. But, we have also added a whole other wave of health department staff to our case investigation and contact tracing activities.

Because as we're ramping testing up, we need to make sure that we have enough people to do the follow up.

So, there is a number of quality improvement measures that are being implemented, or in the process of being implemented.

So we can look at, how long does it take to complete an investigation, including the contact tracing?

Right now it's about seven days. So, we're looking at bringing that number down. We also have about a 92 percent completion for reaching out to anybody that is a case or contact.

That other 8 percent we're working on.

Some of those issues there are related to just logistical challenges for getting a hold of folks.

One for instance is that our health department normally has a private feature when we call people. So, how often are you, or how likely are you to answer the phone if you get a private call?

Also, trying to use some technologies. We're talking to our city attorneys about using social medial or other ways to reach out to people to say hey, call back the health department.

So, we're just trying to be a little bit more nimble. Kind of like what we do for STI and HIV work for the DIS. To be more successful in our outreach and investigation efforts.

DR. PEREZ: Thank you so much, Dr. Kowalik. Dr. Quinn, can you unmute yourself, please?

This question is for you. You know, perhaps given your H1N1 background, can you talk about how unique this American trend is? It's the question around these disparities.

Is what's happening here in the U.S. with regard to marginalized populations in other

countries happening?

DR. QUINN: I think that's a great question. And I think we can look at, in different places around the world, and it's playing out differently.

So, there's been a lot of focus in the last couple of weeks on Sweden. And how Sweden is managing this pandemic, and largely going about it, it's, you know, sort of daily life in hopes of creating herd immunity.

But, I also think about Sweden as many Scandinavian countries and European countries, these are countries that have built in access to healthcare.

They have built in some of the family supports that are really vital to help families.

Some of them have some guaranteed foundation in terms of income.

But in countries where that is not the case, and you know, you can look as we all know, across, you know, many vulnerable parts of the world.

So, from South America where in Guayaquil and Ecuador, you know, people are dying on, literally being left on the streets. And they are people who are the most vulnerable among us.

I think what makes to me what is so disturbing is that this is the United States. And we should be able to provide some fundamental supports to enable people to live a healthy life, no matter whether it's pandemic or not.

And we're not. So that marginalized populations across the world are always going to be more vulnerable. But it doesn't have to be that way.

DR. PEREZ: That's great a point. Thank you. Dr. Shah, this next question is for you, if you can please unmute your mic.

DR. SHAH: Sure.

DR. PEREZ: So, Dr. Shah, not much has been shared, you did share on your slides, some data on Asian Americans. You also commented on the issues of xenophobia and racism with regard to this, you know, pandemic.

And interestingly in the data you showed, you showed that Asian Americans only represent about 3.7 percent of the deaths, and 7 percent of the population. So, in some ways they're under-represented.

Can you speak to data for Asian Americans that are experiencing racism, and comment on those trends?

Is there data collection on the lived experience of the Asian American community? Is how are you and others working on that issue?

DR. SHAH: Thank you for that question.

And let me start also by saying that I'm a member of the Asian American community.

So, I also, you know, recognize the real challenge not just in the data side of the house, but actually in the awareness and raising awareness side of the house.

Because you know that it's also Ramadan right now for Muslims. And we're continually getting a lot of questions from our Muslim community about how to bring together people in

a spiritual way, very similar to during Easter and Good Friday and Passover, about again, being emotionally together and physically apart.

And that's been a challenge obviously in different faith communities as well. So, I wanted to point that out.

But, to your point, you know, this is still in process. I mean, there's really a lot of data metrics and measures that we don't really have.

We have not been able to unpack a lot of this. We're trying to do our best to just get rudimentary information out. But, I'll be honest, it's nowhere near what we would like to get out.

And if you look at our Harris Cares study that I described earlier, it is markedly more complete and markedly more robust in looking at all sorts of different data measures.

And we, simply when you're in the midst of an overwhelming pandemic, not an excuse by the way, but you simply are really trying to get as much information out. But you're really trying

to respond as quickly and methodically as you can to protect to community.

And so I think there has been this challenge of response that also has dovetailed into, then how do you then share information to protect communities?

So what we've really relied on again, is one, policy makers and elected officials in certain communities like Asian American communities to really say, hey, can you help us get the word out in these communities?

As well as we've focused our attention on these communities if we see that there is a lack of either testing or messaging, or other kinds of activities happening.

And then finally, it's really bringing this all together. And saying that it's really about the raising of awareness of how do people protect themselves?

That magically regardless of your race or ethnicity or your national origin or your immigration status, you are not any less or more

protected from a virus that is impacting all of us in a way that if we -- if it goes unfettered, we are all going to have untoward consequences.

And I will just close with saying that I really don't like the term vulnerable populations, vulnerable communities. Because I think, we all are vulnerable.

It's what is it in those communities that is, how more likely is it that something can actually move us into the vulnerability piece? And we know that that is a real term that a lot of us really have trouble with.

And so, I just want to bring that up as well, Dr. Perez.

DR. PEREZ: Thank you so much, Dr. Shah. Back to you, Dr. Quinn. Reflecting on your pandemic conceptual model.

Are there some immediate actionable steps that healthcare providers and community health workers might take to implement that model? And that might address these disparities?

DR. QUINN: That's a great question.

And so you know, and so if we think about the model first.

The risk of exposure and the differential risk of exposure. And healthcare workers and EMTs and our first responders are at huge risk of course.

So, I think some of the things that we really could think about is, I mean, in the best of all possible worlds we would have employers, be they hospital systems, be they grocery stores, be they meat packing plants, making sure people are adequately protected when they go to work.

And you know, we've seen disproportionate sort of, you know, we've seen that has not played out consistently for everyone.

So, I think that's one. But I also think for healthcare providers who are in local health departments, much as you've heard from Harris County and Milwaukee, are really doing their best to reach out to communities that maybe at higher risk to address that.

And help them be aware that and be

cognizant of testing. Make sure testing is accessible to them.

But, I think there are a couple of other things. And one is, you know, the long term issue, I think we all know in terms of susceptibility because of the burden of chronic disease.

I mean, yes, long term all of those social determinants that drive those, are things that have been challenges and remain challenges.

But there are other things that I think are, you know, if this is not a reminder for healthcare systems to really work hard at integrating much more prevention and chronic disease management. And being aware of that. And our policy makers, turning to, as we've done in Maryland, to budget models. Where hospital systems really actually having financial incentive to keep people healthy and out of the hospital.

But, I want to do one last thing. And that is also related to access to care. And Dr. Perez, you captured what was in my mind and didn't come out of my mouth.

And that was that, you know, I'm struck often when I see the news at night and the diversity of the healthcare workforce you see as, you know, patients are leaving the hospital.

I mean, I am amazed and thrilled to see that. And I know that you know, the -- exactly the point you raised, to what extent do we still have a lot of work to do to address racial bias?

And to have our systems begin to say, you know, are we looking at this with a health equity lens? Are we making some of these decisions about scarce resources?

You know, are we checking ourselves in terms of what bias we're bringing into that room?

And this is hard work and a very stressful situation.

DR. PEREZ: That's a great insight, Dr. Quinn. Dr. Kowalik, there's a question here, and probably each of you could probably address this, but this, you know, the challenge with data as you know, is often for certain populations it is nonexistent. Right?

So, Native American populations, Native Hawaiian, Pacific Islanders, those communities are often left out. And the question has to do with the mental health impact on communities that are -- that we can't measure. Right?

So, maybe I could start with Dr. Kowalik about kind of how do you address issues of data that don't fully reflect the entire population or the experience of the most marginalized?

And this question was referring to an earlier point around, with the impact of the wear and tear principal to these communities in terms of mental health and stressors.

So, Dr. Kowalik, why don't you start us off with that?

DR. KOWALIK: Yeah. Definitely. I'm glad that this question was posed. Because I know that there is a lot of concern about what -- who do we focus on?

You know, we tend to look at, who has the greatest disparity? And put a lot of energy

and resources into that. Versus, kind of zooming out and looking at it from across the board.

Some of the challenges with that are related to some of the points made earlier about lack of funding, under-resourced. You know, limited opportunities for local health departments to really address all of these various groups.

And even within say black or African American, there's groups and cultures within. So, just even with our outreach of looking at how are we really zooming out and then zooming in and meeting the needs of everyone?

So, you know, we're entering week eight of our response. Meaning, once we got our first case.

So, we're tailoring and adjusting things as much as possible. But, we're basically telling people in the community, you don't need permission to help.

The messaging, the foundation of the messaging needs to be the same. But, the way you go about doing it, have at it.

So, providing groups of resources to be able to address the various refugee populations and other groups that are in our communities across the country.

There needs to be an understanding that yes, because you don't see them taking up 60 percent, or representing 60 percent of your cases, that doesn't mean that you only focus on the 60 who have to also be able to address everyone.

So, just deploying other groups to help. That's my recommendation.

DR. PEREZ: Wonderful. Thank you, Dr. Kowalik. I guess maybe turn to you, Dr. Shah. Because you earlier mentioned in your comments kind of, you know, the invisibility of public health, right? Like no news is good news. No one ever appreciates public health until something goes wrong. And before the pandemic, it was, you know, a food borne illness. Or anything that would draw attention to public health.

And now we know because of the decades of under investment, under funding of public

health, and the undoing of public health, we're in the situation we're in.

Can you talk about how local public health and state health departments can support strengthening the public health infrastructure?

DR. SHAH: Yeah. Thank you for that.

And that is the deepest question. Is, how do we sustain this value proposition?

And you know, to me it's the three V's as I mentioned. And one of my staff members actually reminded me of the fourth V. And I never thought of it.

So, invisibility crisis and raise the visibility, first V. The raising the value. When people value something, they want to do something about it. That's validation with pro-health resources, pro-health funding.

But the fourth V was, virus. And you know, I will be honest that this attention to public health comes every time there's an emergency. And it goes away.

There is not the sustained ability to

continue for people to follow. And even now you've seen this in the concept of heroes, right? The heroes in the healthcare. So, I'm a physician.

I see patients. You know, I've been at the Texas Medical Center for 20, 25 years. I get all that.

I absolutely believe that our brothers and sisters in the healthcare system are absolutely heroes and sheroes and all those things.

However, public health, our epidemiologists that are working their tails off at two in the morning. That are doing everything they can without the recognition.

And then also get people looking at their field and saying, why were you not able to do this? Why can you not step up like that when we didn't invest in you?

And we didn't believe in you. They're actually asking questions about, should we even stay in this field?

So, I think it really gets to a deeper conversation that is well past this pandemic. That we need to have a very deep discussion and

a look in the mirror as a society, what do we value?

And how are we going to invest in that value? And that's not happening now unfortunately.

DR. PEREZ: Yeah. And sad to say, you know, I spent many years before coming to higher ed. Twenty years in philanthropy working with some incredible foundations, including the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, the Gordon and Betty Moore Foundation.

And I remember our investments did public health preparedness back in 2005. And how it was hard for anyone to envision back then that that investment was worth it, right?

And here we're facing what we're facing. You know, it --

DR. SHAH: Well, I didn't want to say that our county leadership got that. So that right before March 1 was when this pandemic hit obviously, in full force.

But, over the last two budget cycles, our local budget went up 15 million.

DR. PEREZ: Wow.

DR. SHAH: And that's amazing. And our epi budget has now increased, our epi size has quadrupled from 25 to 100 plus.

And we just received approval for 300 contract tracers yesterday with 43 new full time positions at local resources. Not federal. Not state. Local.

DR. PEREZ: That's great. Yes. That's where it's coming from Dr. Shah.

So, let me just close by saying, you know, we heard a lot on this conversation about the structural barriers that exacerbate disparities. Issues of food deserts, uninsurance, of, you know, Dr. Quinn spoke about the importance of focusing on community engagement.

Dr. Kowalik spoke about the importance of understanding movement that is localized. And of course Dr. Shah just highlighting again, the importance of local, of strong local public health.

You know, I would be remiss if I did

not mention the impact of COVID-19 in higher education where I sit as Senior Vice President at Simmons University.

All of these issues that we talked about today are magnified in colleges and universities across the country. Especially for our poor and low income students.

You know, the issue of xenophobia and anti-Asian, especially anti-Chinese harassment that has been happening. If you go to our website, Simmons.edu, you'll find a resource list of all of the information gathered around this anti-Asian racism and issues, and a statement that we drafted to show support for, you know, eliminating this kind of ridiculous xenophobia.

I know that foundations like the Barr Foundation have signed on to stand against anti-Asian xenophobia during the pandemic.

You know, everything from xenophobia and its impact on Asian Americans, the vulnerability of our LGBTQ+ students who maybe in less supportive environments that are hostile and

unsafe. Not having the social support that they used to have.

Mental health issues with regard to being isolated. And the potential for exacerbating that isolation if this contact tracing leads to, you know, apps that identify, you know, you're within five feet of someone who tested positive.

We have to really think of the implications of technology on worsening some of things that we're seeing manifest. First generation students who, you know, personally experience job loss in their families. Housing and security.

You know, the strategy at the end of the day, the solution is put together an equity team. Demand access to data. Analyze that data for equitable treatment and the protocols. We need programs like, you know, the master's in public health and health equity program at Simmons University. I have the explicit focus on undoing racism.

You know, foundations are doing great work. The Ford Foundation and their emergency funding for the pandemic. Robert Wood Johnson, Annie E. Casey, Kellogg Foundation, all with explicit strategies in funding this emergency relief focused on equity issues.

That concludes our webinar. A reminder that today's webinar has been approved for continual education credits. You will receive an email in a few days from cpd@confex with information on claiming credits.

Our next webinar will take place in two weeks, on May 13 at 5:00 p.m. Eastern. Everyone who is registered for today's webinar will receive an invitation to that webinar.

This webinar has been recorded. And the recording transcript and slide presentation will be available.

I want to thank again all our panelists. You've been amazing. And my thanks to the American Public Health Association, the National Academy of Medicine for sponsoring this webinar

series.

And thanks to you, our listeners, for joining us today. Thank you so much. Be well.

(Whereupon, the above-entitled matter went off the record at 6:31 p.m.)