Ready or Not 2024: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism
Virtual Congressional Briefing & National Webinar

Trust for America's Health

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Live Captioning by Ai-Media

TIM HUGHES:
Hello everyone, seeing you all coming in, get started in just a second here. Alright. Good afternoon. Welcome to our Congressional briefing at the National webinar on the report 'Ready or Not 2024: Protecting the Public's Health from Diseases, Disasters and Bioterrorism' posted by TFAH. We would like to thank you and our speakers and audience for being with us today.

Real-time captioning is provided today by Lee from Ai-Media. The captions, click on "More" at the bottom side of your Zoom screen. Next, click on "Closed captions". Asol interpretation is also being provided by Keystone Interpreting by Judy and Hannah. If you would like to use ASL interpretation, click at the bottom of the Zoom screen.

We will try to answer as many questions as we can as time permits. To open the Q&A box, click the keep it AMAC icon at the bottom of your screen. From there, select "Enter" when you are ready to submit your question.

As always, today's webinar is being recorded. These recordings will be available on TFAH's website by the end of the week, as well as all the previous webinars we have held.

Now it is my pleasure to introduce the moderator of today's event, J. Nadine Gracia. She is a CEO of Trust for America's Health, and a health equity leader with extensive leadership and management experience in federal government, the nonprofit sector, academic and professional associations. As president and CEO, she leads TFAH's work to advance sound public health policy, assessed the social determinants of health, advance health equity admit health promotion and disease prevention in national priority.

Before joining TFAH she was a Deputy Assistant Secretary for minority health, and Director of the HHS office of minority health during the Obama administration. Welcome Doctor Gracia.

NADINE GRACIA:
Thank you, as was mentioned I am J. Nadine Gracia, and I would like to first thank you all for joining us and thank our esteemed panelists for participating in this briefing. We are so

honoured to have you here.

After the public presentation we are going to have time for questions and discussion from the audience. We hope you will leave a better understanding of the policies and programs that impact our nations preparedness and response to emergencies and disasters of all sort. From outbreaks and pandemics, to extreme weather, to man-made disasters.

Before we introduced our panel, I would like to begin with a brief overview of the 2024 'Ready or Not Report'. A full copy is available on our website, tfah.org, and will include a link in the chat. It examines the public's readiness for state emergencies for data, as well as put it in the broader national context of national preparedness. Notably this year's report includes a special feature on the health impacts of extreme heat and its disproportionate risk for some populations.

As always, we include recommendations for policy makers to improve Nation's health security. The issue of public health emergency preparedness is as important as applicable for health and economic facility of the US. 2023 was a historic year, in which the nation experienced a record number of the billion-dollar Wever disasters. Just last week we saw the national oceanic and atmospheric Administration or NOAA predicted 2024 could see a record number of hurricanes and cyclones.

Across the states, public health and agricultural officials are working to track and contain the avian outbreak that is affecting daily cows antedate, to cases in their view workers. And an increasing number of cases are appealing in the national demographic of the Congo, and all of these effects illustrates the need to redouble our efforts to prepare for and respond to public health hazards wherever they begin.

These effects also highlight how the public health and emergency response systems are regularly responding to multiple forms of emergencies at the same time. An important feature of our annual report is looking at state-by-state indicators across a range of areas that give the state a baseline from year-to-year. As well as actions that states could take to improve their readiness for emergencies.

Some findings from this year's report are included here; a notable increase in the number of states that are participating in the nurse licensure compact, which allows hospitals to search their capacity during emergencies. That is excellent planning for this across public health laboratories, and most states are credited in Iva public health emergency management and 29 states are accredited in both.

In the other hand, in areas for improvement - and all states and the nation as a whole can take states to improve in-depth opaqueness - 11 states would use the public health budget over the prior year. We have seen a reduction in vaccination rates for flu. And the use of paid time off for workers -- varies across the states.

We have seen the approval of vaccinations and immunizations to prevent RSV in older adults, pregnant people and young children. The White House stood up the office of pandemic response and preparedness to coordinate across federal agencies.

There have been new extreme heat of resources from multiple federal agencies to help states and communities identify residents who are most activist and help them to prepare for extreme heat. And funding from the American rescue plan act has been invested across the country to strengthen public health infrastructure and workforce.

What remains a significant challenge is that public health infrastructure funding is an important illustration of what we call the boom and bust cycle of public health funding. The chronic underfunding of public health is put our nation at risk by failing to invest in foundational capabilities such as disease detection systems, modernizing data systems, enter the workforce. When a crisis hits, but we often see is short-term emergency funding which is indeed a vital for the emergency response. But once that crisis has receded from the headlines we return to a period of 70.

Already, Congress has ascended aliens of dollars of public health funding that was intended to extend beyond the acute phase of the COVID 19 pandemic. One recent consequence of this is that a scheme providing the vaccines to people who are underinsured and uninsured will be shut down months ahead of schedule.

As I mentioned earlier, this year's report include a special feature devoted to the impacts of extreme heat. Why focus on extreme heat? It is the leading cause of weather related deaths in the US. And yet heat related deaths and illnesses are preventable. We noted an increase of frequency and intensity hasn't reached a broader range of the country, and some proportion to bear a disproportionate risk including people who work outdoors, older adults and young children.

I will report include recommended action for the federal government as well as state and local governments to better prepare. I look forward to hearing from the experience of one of our speakers today, Jane Gilbert, a chief officer for Miami County.

I will report also importantly include policy recommendations for a variety of different audiences including Congress and federal agencies. I will just mention a few here, and I encourage you to review the report for additional information. Many of our recommendations for Congress could be a copy through annual appropriations, passage of the pandemic all hazards prevention act and other mechanisms.

To build a strong foundation for the nations preparedness we must invest in public health infrastructure, workforce, and continuous modernization in a sustainable manner. Not the cyclical pattern of boom and bust. What we also see is that the recent outbreaks of measles, Ampex, and avian (indiscernible) continue to illustrate the lack of resources, especially the CDC immunization program.

We hide that as well the importance of job protected paid leave to prevent workplace outbreaks and perfect the health of workers and customers. This really demonstrates how all sectors have a multiply in the nations and states the Patmos.

It is also critical did equity and the meaningful engagement and partnership with communities be prioritized throughout readiness and instant management. As we have long son, the health and economic disparities that are exposed and further exacerbated for emergencies and disasters. We should not be planning for populations who are at increased risk only after disaster strikes.

In our last area of recommendations, we support increasing investments of healthcare readiness and response, programs administrated by the administrative and strategic preparedness and response, including building readiness for pediatric patients and emergencies. Continuity of care during disasters inquires planning and coordination across facilities and we know that the nation's healthcare system is also understrength.

Finally, recognizing the serious and probing facts that environmental hazards have a health. We call for improved indoor health quality standards and funding for environmental health and extreme initiatives to protect communities from the different hazards that they may face.

So here you can learn more about our report, as I measured we have a link to the report in that. As well as our other public health research and policies. Please do not hesitate to reach out to us. And with that overview of our 2024 report I am excited to introduce our panel.

We will save questions to the end, please submit your questions in the Q&A box, not the chat. We will get to them after the presentation.

Our first speaker is Jane Gilbert, the chief officer for Miami-Dade County. She needs Saturday developments to increase the risk of (indiscernible) associated with extreme heat. Prior to that she was the chief resilience officer for the city of Miami, in partnership with Miami-Dade County, and Miami Beach, and the greater Miami Beach in.

Doctor Raynard Washington services Director for public health, responsible for leading more than 900 interdisciplinary public health professionals who work daily to protect and promote health at Bosque County residents with an emphasis on in proving health equity. He is also the chair of the Board of Directors of the big cities health coordination, (indiscernible).

Our photo speaker is Doctor L. Brannon Traxler, who served as Director of services and chief medical officer for the South Carolina Department of Health and environmental control. In this capacity she provides direction for public health, leading it's more than 2000 public health employees. She ensures that the delivery of imported services in 74 public-service sites located in every county in South Carolina.

It is now my honour to welcome our first speaker, Jane Gilbert, chief heat of the Miami-Dade County.

JANE GILBERT:
Thinking the dean, it is really a pleasure to be addressing all of you today. As in the Dean has said, I am the chief heat office of the Miami-Dade County. I was appointed to this role 3 years ago, to address the increase in health risks and economic burdens associated with extreme heat and to work not only across the county, but with our various stakeholders within the state County. The health department, National Weather Service, universities, community-based workers, municipalities, we have 54 appendages within Miami-Dade County.

So I have told you a little bit more about the why of a chief heat officer, and of the what. I should say a little bit about the wife. And I am also going to talk about how we assessed how extreme heat is specifically impacting people in Miami-Dade, just to give you a sense of how it might be happening in other cities across the country. But some of the unique aspects in Miami-Dade as well. And then an overview of how we developed our plan and some of the components of that plan.

So, Miami is known internationally for its risks to sealevel vice and hurricane risk. And we have been working on those for quite some time. But when a group of community-based organizations went into our lower income and more vulnerable communities, free focus groups and surveys, to find out what their top concerns were related to climate change, it was not hurricanes or sealevel rise. It was extreme heat. Because that is what they were living day in and day out.

Really, it is for that government awareness of how extreme heat is impacting people's lives and livelihoods, that my position was born.

So we have had an increase of over 70 days, with temperature over 90° since 1970. And our average minimum temperature advice of 2.2°F, going forward, we are going to see a dramatic increase in days with heat and disease, over 100 and hundred and five, in the fifth National climate risk assessment it was found that Miami-Dade County is act within the county to have the most increase in dangerously high heat days defined as 100°F or above.

I should say that last summer we had over 42 days at or above 105. So even though historically it has been about a week, we are well on our way to get into that flea months out of the year. Or could be, anyway.

And we saw that with last summer's extremely hot summer, and an increase in our emergency department visits. That is, peaks from the Summit last year, and then the previous six years. You can see that we had a much harder peaks. This is from our state health department.

It is getting hotter in cities globally, not just because of climate change, but because of how we develop our open development pattern. More asphalt, and buildings, less vegetation, less trees,

more heat from those buildings, from vehicles, all of this contributes to urban areas being at least a 10° hotter than other areas.

That is distributed unequally. On the left, you will see area median income, the white areas being the lowest medium income. On the right, open tree canopy, Dwight being less than 10% of the tree canopy. You could see how unlined they are.

And we have the compound vest. We have chronic high heat in Miami, not the extreme heat waves but with a hurricane and extended power outage, that is our disaster. When it really comes to heat. That is our episodic disaster. Because people do not have access to air condition, and we saw that with Hurricane Amber in 2017 when we lost 12 people in a nursing home in the county just enough of us.

So we did an assessment, looking by ZIP Code of heat related emergency department visits and hospitalizations in the county, and the highest correlating factors were high poverty rates and high land surface temperatures. So our open heat islands, low income, other social determinants of health, high proportion of outdoor workers, the high proportion of families with children.

So we have a map to this, and this is really informing how we intervene in our action plan. Very much above the types of populations that are at risk and location. And I can speak more about that.

So we pulled together a task force including healthcare professionals, National Weather Service is, all the different stakeholders did a series of public workshops. Use the data from our vulnerability assessment, and created a highly collaborative workplan.

I always say that if you want to go fast, go unknown. But if you want to go far, go together. And it really was a critical aspect of our action plan. It is a collective action plan. While I have led to the creation of the planned, all these different players, from local, state, national, international, ivory leading or supporting some of the actions on the plan.

So it is split up, our plan is split up into three main goal areas. Inform and prepare people, help people stay cool at home affordably, and make sure that we have site for backup power and cooling capacity for that hurricane risk. And then the third is to cool our neighbourhood. Primarily through treeplanting efforts, but over open heat island mitigation efforts as well.

Since we have a public health group here, we do a lot of trainings, education, we can get a lot into this in the question and answer, because I know that my time is limited. So we have updated our heat advisory and warning thresholds to an outdoor worker protection, and formed a partnership with local universities on ongoing research.

And with that, I will turn it over. Thank you.

NADINE GRACIA:
Thank you so much, I am looking forward to hearing more about the skeet response plans and how you prepare for populations that are disproportionately at risk for extreme heat. So I look forward to talking about that in our discussion. We are now going to hear from Doctor Raynard Washington, from North Carolina public health. I will turn it over to you.

RAYNARD WASHNGTON:
Thank you, and just in advance of the
it is really my privilege to be here this afternoon. As an epidemiologist by training at a local public health official I am very pleased to join this critical conversation about preparedness.

At what team here as has already been said, I am really proud of the work that we have done to protect and promote good health for the 1.1 million North Carolinians and it is also my honour to serve as the chair of the health coalition. We delete 35 of the nation's largest metropolitan health departments. Together we serve about 61 million Americans, or nearly one in five residents in the country.

It is really great to be a part of the coalition because we get to have a the sorts of conversations with each other and also champion how our governmental public health system can improve to better protect our communities and closed some of the persisted We experience as relates to have equity. Into many of our communities across the country.

Like many of you I have got firsthand experience of the really critical vow that emergency preparedness plays in our job as public-health team members. After serving as deputy health commissioner in Philadelphia, I came here in March 2020, and as you might imagine I was tackling a global pandemic that was really kicking off on March 2020. And I went for my new (indiscernible) to our emergency operations Centre to join our local pandemic response activities.

My position is really focused on devoted public-health plays in emergency response. Local public health department of really on the front lines of the preparing for and responding to and supporting residents doing all kinds of emergencies. Very often we are at the beginning, the middle, the end and in between. There are very few if any unbudgeted to do not have some impact on the public's health. And because of that it is really important that we maintain at the local level coordinated efforts, and that we have to prepare our partners on the ground for emergencies before they happen so that we can be able to respond quickly and in an impactful way.

This is really the unique local public health. Local public health departments across the country in big cities are responding to both acute crisis like the weather related issues in the Texas area to infectious disease like the avian influence that is all doing better today. And this is all while we are still maintaining our routine surveillance and response activities and of course provided those vital critical public health services including it and schools across our communities. Public health departments are ready to respond because of the work that we put into maintaining

what we called the true all hazards preparedness. Which is so critical to our nation's health.

As we are seeing or experiencing the resurgence of diseases that we fought that we had eliminated like a measles and polio, and even here locally we are experiencing an outbreak of (unknown term), it is clear that all hazards preparedness must be at the forefront of our priorities our public health system. We have to be prepared to search up for unexpected infectious disease emergencies which requires us to have funding for both staff and infrastructure, and as we have already said, this boom or bust disease specific funding has become the norm for us in public health over the last several decades.

As we all know, public health emergencies do not just arise out of infectious disease. We currently are dealing with a drug overdose crisis which is extreme. We have gonna violent epidemics across the country, and we live in a nation where in about 7/10 deaths arise from preventable chronic conditions. Our emergencies are not sporadic. They do not come and go, they are ongoing and ever present. And with that in mind it is so important for those of us who work in local public health to focus our efforts not just on our communities, but on pushing for policies at the state and federal level that support or at least do not detract from the work that we are trying to do underground.

I would like to just highlight a few things that I believe we should be pushing for at the federal level. In order to make our preparedness for emergencies better and make our local level welcome more efficient and more prepared. It is essential first and foremost that federal agencies have clear preparedness and response goals well in advance of an emergency. At the same time, but I appreciate and we all know that federal research and (indiscernible) is vital, it is also important to recognize a top-down approach is (indiscernible), to truly prepare our function as a system public health leaders must be involved at every level of government, local state and federal, and information data and resources need to be able to flow quickly and efficiently from each of those levels. And until that happens I argue that we will remain unprepared for health and health security challenges that we face.

Consider for example the public health preparedness program that was created after 9/11 to support preparedness infrastructure and in response MIDI workforce at the local level. Despite the increase in emerging and reemerging infectious diseases and all the other emergencies at local health departments are tackling, Congress continues to cut the funding by nearly 50% of the last two decades. In (unknown term) we have had to increase our public health opaqueness staff from one FTE to 3 since 2020 really because of the neatest we have experienced over the pandemic.

(indiscernible) to host preparedness that is our community partners, and really maintain a local response plan for every type of hazard is so vital to our success, when emergencies of ice. But with federal funding for emergency preparedness dwindling, it is really difficult to sustain even the basic level of staffing and local health departments, not just in big cities but also in the medium and small cities and will part of our country.

That is why as a combination, we are taking a leadership role and really urgent, as was mentioned already, the reauthorization of the pandemics preparedness act. Which really enables so much funds to help us for preparation.

I firmly believe it is time for our country to activate adult vaccine programs. As we learned from COVID 19 reveal the need a comprehensive vaccine infrastructure in order to protect Americans from both known facts and emerging infections. During the MPOX researchers, we did not receive any funding to deploy vaccines to our area throughout the outbreak but we were able to at the successful level mobilize partnerships on the ground without community organizations, LGBT plus social organizations and others to really work diligently to get vaccines out to the community to help us to contain the situation.

We have seen very situate similar situations happen if the measles outbreaks with the Department of health has really had to take the leadership role in mobilizing underground locally to get vaccines out to thousands of families with no additional resources available to them.

Finally, and really important to me as an epidemiologist, it is really critical that we have timely, accurate and actionable data at the state and local and federal levels. (indiscernible) still badly need significant upgrade and modernizing. We are really a pleasure to to our federal partners for the investments that are been made recently at the local, state and federal level, but from the perspective of local health department the CDC absolutely must have the authority to not just invest in the sectors but also collect the information so that we can have a coordinated response and share data across a variety of partners that includes both local, state and federal. And actually make timely decisions with information that will help us to make those decisions as best as possible.

It is a shame that right now because of the fragmentation of our system we are collectively tasked to make decisions that cost trillions of dollars, but the framework for connecting in showing public health data that is really fragmented result in inconsistent reporting to both the CDC, the state and local public health partners. Expanding the authority for local state and public agencies will allow us to have data sharing in a more timely measure and allow us to be able to translate that information much more quickly at the federal state and local levels.

In closing I want to emphasize that a well-functioning public health system must prioritize the pandemic and all hazards preparedness, and it has to be well resourced at all levels of government before, Joe Vick at active outbreaks. Diseases and disasters do not recognize city county or state boundaries, and across the nation every community is only as compared as the nearest community. So with that I will pass it onto the next speaker.

NADINE GRACIA:
Thank you so much. Thank you for so many points of awareness. The preparedness that happened in addition to the day-to-day work. Looking forward to speaking to you more about that. And also noting the importance of mental policy recommendations both to state and

federal levels of how we actually strengthen public health preparedness across the nation. Thank you so much.

We are now going to hear from our next speaker, Doctor L. Brannon Traxler from the North Carolina Department of health and environmental control. I see the audit is already putting questions into the Q&A, please continue to do so and we will move to questions after we complete the presentation.

L. BRANNON TRAXLER:
Thank you so much. Two Doctor Washington and to TFAH. I am L. Brannon Traxler, wanted Deputy Director's at the South Carolina (indiscernible) of health and environment control, a member of the health development and services division which would pull variously known as public health. We are undergoing some renaming.

I also serve as the chief medical officer and the vice chair of the patent committee for the Association of State and territorial health officials.

It really is truly an honor to be here with you all today.

So some of the things that you are going to hear from me at the state level are very similar to those that you had from Doctor Washington, at really the local level. And I think it really emphasizes the point that he made at the end of that emergencies do not know boundaries. And that response is not limited to one geographic level or even one organizational level. It really impacts everyone and every entity.

In South Carolina I will note we are a centralized public health system. So local is a state for us. Our local health departments are part of our state health department. First I want to touch on this broader nature of emergencies. Really any significant emergency you are going to have happen out there in the water that is affecting anyone beyond the individual level, that is really affecting any population or subpopulation, is going to have a public-health component to it. Some of those are going to be much more obvious, such as the COVID 19 pandemic. Others will be much more subtle. But they're all going to have a public-health component into the need for preparedness and response capabilities.

I think that one of the big categories, certainly that we face in public health emergency preparedness and response, if the wife of related emergencies as we have heard from Miss Gilbert and Doctor Washington. You know, the wife of related emergencies are only getting worse. They are only getting more unpredictable and they are only getting more severe. The diversity of them is increasing. In South Carolina we are very familiar with hurricanes. We unfortunately see hurricanes not infrequently. And have gotten to be fairly adept at responding to them.

But it is those unknown unknowns that bother me and that concern me and keep you awake at night. And that includes things like extreme heat. Wildfires that we are seeing, nobody would

have ever really felt that Louisiana would have some of the wildfires that they have experienced in the last few years but there they are. And again that is somewhat we traditionally think of hurricanes.

Earthquakes and tornadoes, that is not the anticipation, that is not the knowledge, that it is coming the way that there is for I have a cane for things like of quick and tornadoes. We also as Doctor Gracia mentioned early on in her introduction, we are seeing an increase in the intensity of hurricanes. NOAA released their predictions that there is a 50% chance of an above accurate chance of hurricanes. The intensity and unpredictability of the models for those as we have seen, different models even changing as we go, more than we used to, really put a strain on the system and our ability to respond.

We also have to be prepared, as was noted, for all hazards. We have to be prepared for infectious disease outbreaks. We are seeing a increase in those and increase in global travel. We are only going to see that continue. We are going to see things that only let COVID 19 that can spread very quickly and easily but also things like Mpox which has come over from Africa and cases of hemorrhagic fever. And ebola, things that do scale most Americans.

We have to be prepared to respond to those because it is truly one plane flight away from the United States. Bioterrorism is something that is still present as a risk. In any mass casualty situation has a increased chance of illness, such as the complete collapse in Baltimore, which could have been a lot worse were it not for the quick thinking and quick actions of emergency workers on the bridge. Not only in terms of the direct casualties and direct victims of the impact and the collapse, but also in terms of potential releases that could have come from the ship's cargo and its impact on the Baltimore community about there.

Things that that really do have the potential to have a significant public health response component.

So to be able to respond to these broad, diverse and unpredictable unknown unknowns of emergencies, we really have to have sustainable and flexible funding. It is critical for public health to be able to do what it does, that only on that day-to-day basis, but also during the emergencies are doing the unexpected. We need to be able to adapt, we need to be number, able to adapt very quickly and not to have delays related to appropriating money or procuring supplies, etc.

An example that was alluded to with vaccines, an example is having COVID 19 funding during the pandemic. That really, you know, could have been a more flexible, could have an out for a quicker response. We were able, with the assistance of many federal partners, to be able to use it in ways to help this bond. But having those abilities from the startlingly can help and it did.

The public health infrastructure Grant is a great example of a very flexible funding. We certainly hope that it will continue, I would need for funding such as this to continue and not to get more prescriptive as we go.

Another challenge that is facing us at the state level for public health emergencies is the need for a robust and really this elite supply chain. We also are examples and heard about them job in COVID 19. The testing supplies and kits and the engines early on, as well as the personal protective equipment, the PPE. But also drugs and medications. We are seeing antibiotics which are in shortage, and which when we have antibiotic shortages, it is only causing people to potentially have to use more potent antibiotics than what is necessarily used for a condition. And this is contributing to resistance, it is contributing to antibiotic resistance when we have shortages of the novel spectrum at biotics that we need.

We need supply management and majestic capabilities also to be able to handle the supply chain. And to be able to handle the supplies and medications, and make sure that we are cycling through them appropriately and not causing any wastage during emergencies, or in anticipation of one.

Again, I want to touch also as others have on the importance of partnerships. We cannot in public health respond to population level emergencies unknown. It just is not feasible. No matter how robust our workforce is and the matter how strong our infrastructure is. When there is a public health emergency, we need to have partners available and standing beside us who are willing to help. We depend on them and we greatly appreciate them. I know that our organization, the Association of State and territorial health professionals, one thing they do is really help organize partners, especially at a national and state level to come together.

TFAH is another group who in this webinar have brought together partners. We need not only does partners within the government and within the different levels of government, we did them externally.

I think an example right now with the avian influenza is the need for animal and human health partners, as well as the Department of agriculture, in states and in cities, and counties as well as at the national level, to be able to come together to respond and to be able to share information so that we are all working together in a coordinated effort. And I do believe that is one thing that South Carolina is doing well, we are communicating with those partners, and so I figure it does put us in a good position as we prepare and hopefully do not have to experience but are prepared for potentially fix in our state.

With that, I leave you with my contact information and I am happy to answer any questions when the time comes. Thank you.

NADINE GRACIA:
Thank you, for really showing the breadth and depth of what public health does each and every day in terms of preparedness and response. We really appreciate your presentation. So this now includes upper panel presentation period, we are going to open it up for a Q&A period, so I am pleased to be joined by my colleague who is going to help motivate the Q&A.

I am going to start it off and then I will turn it over to them. I will start off with a Jane. We have seen it in the Q&A, you talked about in particular with your work as chief heat office of Miami-Dade County, when you look at your heat response plans and how you really think about the communities and populations using the data, to identify populations that are going to be at disproportionate risk for extreme heat, can you expand on the points that you started to raise in your presentation about how you prioritize actually protecting and giving outreach to the communities and populations that are most at risk? As you have probably seen there is interest around outdoor workers in overpopulation.

JANE GILBERT:
Perfect. So just to highlight, the ZIP Codes that you saw in the darkest bed, they are experiencing emergency department visits and hospitalizations at x4 times higher than the other lighter colours. So the disparity is quite significant between those. So, all our targeted messaging and media, outdoor media, in healthcare clinics, in stations, everywhere we go, in multiple languages, is targeted to those difficult. And in English, Spanish and Haitian Creole. We do radio, Haitian Creole radio, Spanish radio, specific messaging for pregnant people, outdoor workers, and then we do a series of heat safety training etc. I've in person or virtual, for summer camp providers, for people who are providing assistance, to people experiencing homelessness. We do heat safety training for the outreach and response.

You also talked about building that capacity in our vulnerable communities. So we started in partnership with our emergency management to do heat safety training. This year it is extreme weather training. So we are looking at the trifecta of hurricane, flood, and heat season and partnering out of our community-based organizations to revamp up the recruitment to those trainings. And we are training people not only to protect themselves and their families, but their neighbours, their communities, with ideas on how to do that and with equipment.

So we actually have the first of six in a series tonight about that. Any community he was interested in that kind of training, I am happy to share the resources you have shared on that. And we have partnered with healthcare practitioners to do trainings in the healthcare community as well. To make sure that they understand the questions to ask in terms of exposure, and how to connect them to keep resources.

NADINE GRACIA:
Thank you so much for that and that we handed over for the public questioned.

SPEAKER:
Thank you very much. Let me apologize, it is a very active Q&A so we will look at all of these questions. Doctor Washington, you talked about data modernization. Could you please go and little bit more into what implementations might be for local health and for our ability to detect outbreaks and diseases, if we were able to better modernize our data systems?

RAYNARD WASHNGTON:
As a tangible example, most municipalities do not have to own disease reporting system. They

were like I've on a state or maybe a regional sort of entity. To kind of manage the data system itself. So what happens in that case is we are wholly responsible overlying it on a state system to allow us to be able to know what is happening. And so I think one of the benefits of COVID 19 is that our ability to be able to receive an electronic lab reporting really expanded across the country, both for maps as well as other healthcare providers, so that was a positive. So the time it takes for a lab results to get from law to result is much shorter.

But if that report is going to the state, and I do not have real-time access to the back end of the state system, I have to wait until it gets released to me at a legal jurisdiction level, which can…

** Audio issues and break-up **

B optimal to have systems to receive those reports simultaneously as well as to allow us to manipulate the data on the backend. One of the things we are also unable to do because of technology is we cannot do -- sufficient bio analytics…

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So we have to use I for the hospital healthcare system so I think there is an opportunity to both improve and enhance the technology that we give that the local and state level as well as federal because it also has to get to our federal partners. And that is just on the infectious disease site. I think that is even greater opportunity on the noninfectious disease site, whether it is so much data flowing, and across various systems, both in private practice healthcare systems, that could help us to understand the true burden of chronic conditions in our communities for example, that we are not able to chemically been like him. We are relying on survey data as opposed to being able to use things like healthcare exchange information, or relying on variety combinations of electronic medical record to help us inform what is happening on our day-to-day.

SPEAKER:
That chronic disease data -- has huge imprecations showing pandemics as well. So we have gotten questions about what policymakers could do to improve the recruitment and retention of the public health professionals, as well as preventing burnout in the public health workforce.

L. BRANNON TRAXLER:
Traffic this is a problem that we face at all levels and as we face in healthcare as well as in public health. Unfortunately these days public health is not always the most popular field to go into. So I think, you know, removing any divisiveness from any topic about health certainly is one thing that personally make us can do, that would increase interest across the spectrum of all workforce applicants who would want to go into it.

We do need sustainable funding, is one thing I think, for building that infrastructure that is our

workforce. I tell our team they are our most valuable resource out of all the resources that we have.

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In our policy that we put into place, things like paid time off his efforts in the TFAH report, not only making it available but encouraging staff to take it. Making sure the people feel supported in using benefits that are available to them. We know that the workforce nowadays is looking for flexibility, and so any way that we can do that, be it telecommuting foot jobs and those that are eligible, where that is attainable, is certainly encouraged. In addition, I think that making sure that our staff feel valued, I think that is one finger at the workforce IQ repeatedly from the team, that they are looking for.

Our agency Director has the same (indiscernible) "People first", which I think is a very strong motto and shows our staff that they are valued. And in addition, any way that resources can be put into place for staff to support really a worklife balance is another aspect of work that the workforce nowadays is looking for, be it childcare, even helping assistance get spots in childcare, as we know that that can be a challenge nowadays. Or even subsidizing childcare. But I take that people first a step further and say family first because we know our workforce cannot dedicate themselves wholeheartedly to the job as well, if they have stress and are concerned about things in their homeland.

I think that that is a way that you can combat burnout. By really supporting a worklife balance, and not just saying that the words, but truly walking the walk.

NADINE GRACIA:
I want to add those are some excellent points, and the public health workforce is so vitally important when we think about our nation's health security and promoting health and well-being for communities across the nation. You raised so many important points about the importance of sustained and flexible funding to be able to meet those foundational capabilities and having a workforce to do so for both chronic disease, (indiscernible) of advocates, and I think that some of the emergency legislation which is provided funding into infrastructure is imported, and the challenges we often return to that and we do not see that sustained. And I think legislation like the public health infrastructure save lives act, many of our public health partners who have been championing that bill to support sustained infrastructure investment which includes the workforce, and also recognizing the public health is competing with other sectors, with regards to the same workers and being able to actually provide the salary and benefits that will attract and attain workers.

So the importance of yes, the fact that this has been off of I need to be not appropriated in order to move that into implementation, I think is also a critical measure for the public health workforce. The: we have time for one or two more questions. So for Jane Gilbert, can you

expand a little bit more on what outreach to outdoor workers looks like in Miami? And also what are the perceptions that the workers or perhaps that employers have, as relates to heat safety?

JANE GILBERT:
That second one varies. But, so, what we have done is offered free trainings, that we have promoted, to our higher risk and industries have a higher number of workers exposed to heat. And for the safety officers and the business owners themselves, we have done again messaging to those communities that link them to a website with all sorts of resources for how to create heat safety plans.

One of the things that we really try to message is that by having water, electrolytes, by providing shaded rest breaks you actually can maintain or improve productivity and reduce your Worker's Compensation claims. You are not just protecting your work. It also go bottom line by doing this work. It really is the obvious, the level of awareness, we have faced awareness are not in our construction and agriculture industries, but those small scale businesses and the landscaping property, moving, that may be not for in the speakers, those are the harder ones to reach that we are not sure. And we know that there is a lot of pride in work is that they think they can handle things that sometimes, it is often not the case.

But we are doing our best to again, message that through multiple different channels. And get more targeted in that messaging.

SPEAKER:
Thank you. And that such with Doctor Washington. Where have you discovered the greatest bottlenecks or barriers to coordination, perhaps across agencies or with partners?

RAYNARD WASHNGTON:
Sure. I think what I would say of course, what happened so often in emergency response, even with a well-made plan, is that we are continued to be content with the emergency but also the competing events we must also (indiscernible) so having the human resources enabled us to be able to mobilize quickly for a response underground as well as continue our ongoing responsibilities as a local health agency can be a challenge.

I think in terms of just coordination, that can also be a challenge for us locally, in North Carolina all of our departments have a health department like South Carolina, so we are left to… There 85 health directors in the state and so we have to work together and of course we have an association that brings us together, but again fitting about today not being any… You know, infectious diseases do not think about and are not aware of our boundaries. Even the state boundaries we have so many of our veterans ago between North Carolina and South Carolina very often, we do not have a great tool to coordinate across state lines as a local health agency and so I think that is one opportunity for us to think about again just ignoring geographic boundaries and thinking about how people operate and making sure that I will responses are seamless across even state and county lines. Nazi---

NADINE GRACIA:
Thank you to you and to all of our panelists. Really just incredible feedback and resources, that have been included in the chat for our audio. Clearly this is really is such an important issue and one that we face each and every day.

We will have a recording along with a slight and additional resources that be mentioned in the context of this briefing available on our website at tfah.org in the coming days, so we encourage you to tune in. We will also send out an update about when those are available. Many thanks for joining us today, and thank you for all the work that you do.

Thank you, take care.

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