In the April 23, 2020, Prioritizing Equity webinar, leaders from the nation’s public health institutions illuminate ways in which COVID-19 may uniquely impact public health, the health of minoritized and marginalized populations, communities of color and patients that are historically and contemporarily experience inequities.

Featured speakers

Moderated by: Aletha Maybank, MD, MPH, chief health equity officer, AMA

- Lori Tremmel Freeman, CEO of the National Association of County and City Health Officials
- J. Nadine Gracia, MD, MSCE, executive vice president and COO of Trust for America's Health
- Regina Davis, MD, PhD, associate executive director of the American Public Health Association

Transcript

April 23, 2020

Dr. Maybank: Good evening, everyone, or afternoon depending on where you are. Welcome to our next session in the series of prioritizing equity. My name is Dr. Aletha Maybank, and I am Chief Health Equity Officer at the American Medical Association. The Center for Health Equity, which I oversee along with my team, its role is to help embed equity across the entire organization of the American Medical Association. So since the COVID crisis has started, we have been playing roles in figuring out how to advocate for better data, how to help support physicians across the country. And we always think that, what a good opportunity for us to do, is to really bring together folks and partners that we have been in conversation with to have conversation around what are the priorities and what are the issues, especially as it relates to equity in our COVID response, which we know translates pre-COVID and it will translate also after COVID is here with us.
So today I'm really honored in our public health session. Public health is, for those who don't know me, is that those are my roots. I spent a long time in governmental public health, and I have lots of passion and respect for the space of public health and what it does to really promote and protect the health of all people across this country. So today I have with me Dr. Nadine Gracia, who is of the Trust for America's Health. I have Dr. Regina Davis, who is from the American Public Health Association, and I have Ms. Freeman who is CEO of NACCHO... which a lot of people like to say nacho, and I'm like, It's not. It's NACCHO, the National Association of City and County Health Officials. I've worked with them very closely over the years.

So thank you all for being here with us this evening. So I just, really quickly at first, want to go around the Zoom room or the YouTube room and just hear from you each; kind of your role in the organization and what are some of your current priorities as it relates to COVID-19 and public health? So, Dr. Gracia, do you want to start?

**Dr. Gracia:** Sure, and thank you, Dr. Maybank. It's really a pleasure to join you for this important conversation. So our organization, just to share a little bit about Trust for America's Health, which is also known as TFAH. We are a nonprofit, nonpartisan, public health policy research and advocacy organization that's headquartered in Washington DC. We have a mission of promoting optimal health for every person and community and making the prevention of illness and injury a national priority. Our vision is that we will have a nation where prevention and health equity are actually foundational to policy-making at all levels of society.

So for many years our organization has actually focused attention on advancing an evidence-base public health system that's really ready to meet 21st century public health challenges. Sadly, as we all know, what we're seeing now with this unprecedented COVID-19 pandemic is really a consequence of years of chronic underfunding of public health, which has put our country to be more vulnerable and puts lives at risk. As this pandemic, as you know, is really shedding light on, and further shedding light on I should say, is the disproportionate impact it is having because of long-standing inequities that it's having on communities of color, low income communities, and marginalized communities.

At Trust for America's Health, we are actively engaged in the COVID-19 response efforts. One advocacy effort that we are doing through federal law makers and policy makers, is to really get emergency funding to states and localities to address the immediate public health crisis. We're also engaged in calling for data disaggregation to identify populations and communities that are disproportionately being impacted and also calling for directed resources to communities that are at greatest risk and that are being disproportionately affected.

Now, while we're focusing on the immediate and pressing issues, we also are doing a great deal of advocacy and calling for long-term solutions, in particular; the long overdue investment in our public health infrastructure for the nation as well as dedicated funding and resources to public health to be able to work across sectors in addressing social and economic conditions that largely impact health.
I’m looking forward to the conversation this evening and, again, thanks for the opportunity.

Dr. Maybank: Absolutely. Thank you. Laurie Freeman, do you want to go ahead and talk about NACCHO?

Ms. Freeman: Sure. So NACCHO is the organization that represents the nearly 3,000 local health departments across the country. Our mission is really to improve the health of communities by strengthening and advocating for local health departments. We have been on the front lines of this response now for—going on 12 weeks and since January. It’s been a long time for us. Our members and our local health departments, as I said, are on the front lines of the response, working in their communities and in being conveners in their communities of sectors within their communities to really have a coordinated response effort at the local level. They have been actively getting people connected to care, making sure that they, in the early days of this response, are still in the active mode of doing contact tracing and follow up and really just preparing in responding to the COVID-19 virus.

We at NACCHO have been supporting them by making sure that they have the latest guidance and everything that’s coming down out of the federal government on a daily basis. We have been advocating very hard to ensure that the federal monies that are flowing out of emergency response to this disease are targeted towards state and local governments and really trying to make connections for them in as many ways possible to other parts of the governmental public health system and other systems in place that are in response to this disease.

So very, very busy. I'll talk more hopefully about how we’re looking at the health inequities associated with this response as we get more into the discussion. It’s of serious concern to us. This is a space that we live in, and we’ve worked in the health equity space for a quarter of a decade trying to make a difference in communities to ensure that everybody has an equal chance for healthy communities.

Dr. Maybank: Thank you. Thank you for that. Hi, Dr. Davis.

Dr. Davis: Hi.

Dr. Maybank: Hi, I know Dr. Benjamin was going to be here tonight, but he had a last minute switch, so we very much appreciate you being able to speak with us this evening.

Dr. Davis: Yes, he sends his regrets. He was called into a press conference. So it’s my pleasure to be here and to talk to you about the American Public Health Association. APHA, as we are affectionately called, is the oldest and largest public health association in the world. We have about 50,000 members and we’ve been around for nearly 150 years. So when you think about most public health achievements in the United States, we’ve been there at the forefront. Quite frankly, I mean, our mission is to improve the health of the public and achieve equity in health status. While we may be
having physical distance that may change the way we're conducting our mission from day to day, it really is not changing our mission.

We are still very focused on the United States being the healthiest nation, and we've got a lot of experience with regard to previous epidemics, whether that be H1N1, SARS, Ebola, but people don't tend to think of is HIV, AIDS, chronic disease. So we're focusing on what we do best, which is bringing the best science. We're really redoubling our efforts. We're calling for robust data collection. We're calling for access to quality care, calling for funding, the public health infrastructure, and addressing those social and structural factors that we know are making these minority groups more vulnerable, so that we can move towards health equity. So I'm looking forward to this conversation about health equity.

Dr. Maybank: Awesome. Thank you very much. So Dr. Gracia, I'm going to start with you. As I explained to everyone beforehand, you all are more than welcome to jump in at any point in time. I wanted to ask a question because, in February 2020, I believe the month was, you released the report "Protecting the Public's Health from Diseases, Disasters and Bio-terrorism." It wasn't totally before COVID was here in present, but it definitely was before there was a lot of media attention and just attention in the way that it is now. It's almost like you all knew something was coming and it was headed our direction. Can you talk a little bit about the report and why you all were in the process of putting this report forward anyway?

Dr. Gracia: Certainly. Thank you for that question. So one of Trust for America’s Health's primary efforts is indeed in publishing evidence-based, science-based reports that provide evidence-based policy recommendations on key and pressing public health issues. We have actually been focusing on the issue of public health preparedness for many years, actually since September 11th; in recognizing the importance of public health as part of our nation’s infrastructure and public health preparedness as an important part of our nation’s health security.

This report that you mentioned is a report we call "Ready or Not: Protecting the Nation's Health" and specifically with regards to disasters and bioterrorism and outbreaks. We release it annually, and we did release the report in February. What it showed was that, while the nation has made progress since September 11th with regards to infrastructure for public health preparedness, it is still uneven and that there was much more that needed to be done.

For example, we have seen, with regards to public health emergency preparedness, grants and funding going to states where that funding has been cut significantly over more than a decade and a half, nearly 50%. We’ve seen, for example, that funding for the hospital preparedness program, which is the only federal funding source to health care delivery systems to be able to prepare for disasters and outbreaks and other public health emergencies, has been cut by over 60% since 2003. When we look across a series of indicators—we include in the report about 10 indicators that really can serve as a checklist in a way for states to assess their level of preparedness for these types of
emergencies—that there was an unevenness across the states. So it serves as an opportunity and a tool for states to be able to improve their readiness.

That also ties strongly to the level of public health funding. We also recently released a report on the state of public health funding for the nation and have found, again, that really the nation has underinvested in the public health system. Why that's so important to states and localities is that federal funding really provides about 55% of public health funding support for states and localities. So when you have cuts to federal funding, you're going to see cuts as well that happen at the state and local levels.

So our recommendations included bolstering funding for public health, bolstering funding for these emergency preparedness systems; having, for example, increased funding for emergency response funds so that there's not a delay when an emergency happens, that funding can get directly to states and localities to be able to address this. We also saw that this is not just a responsibility of public health. In the recommendations, we also talk about policies like paid sick leave and paid time off and how only 55% of employed workers had access to paid time off. When you talk about an infectious disease outbreak and people have to make a tough decision about whether or not to work or stay home and lose a paycheck or potentially even lose their job, it just demonstrates how this is really a multi-sectoral issue, not only for public health and health care to address, but for policy makers and businesses in education, transportation, and housing, that everyone has a role in really bolstering the nation's health security and preparedness.

**Dr. Maybank:** So you actually answered my next question that I was going to open up to everyone. I've spent a lot of years in the public health space, and now I'm more so in the health care space. I get asked this question and I'm sure you all do too. People ask, "So what is public health?" It seems obvious to us because-

**Dr. Davis:** It's everywhere.

**Dr. Maybank:** It's everywhere, right, but we can't say that to folks because that's just not even really helpful either. I think in the description that you just provided, Dr. Gracia, and how you described all the different pieces and elements of policy and advocacy that you're engaged in, it kind of demonstrates the breadth of protecting the public health and what's important to do that.

Anybody can speak to this. How else would you describe public health and the importance of the public health infrastructure, just so that people really get that if they're not in the public health context? Health care, there is a great divide as it relates to health care and public health, and so how would you describe the public health infrastructure, and why is it so important? Lori, do you want to start with that?
Ms. Freeman: Sure. The public health infrastructure provides communities, states, and the entire country with the capacity to prevent disease to promote overall health, to prepare and respond to emergencies and threats like the one that we're having right now, and also, to deal longterm with chronic ongoing challenges to health. The infrastructure itself includes health departments but also federal agencies that rely on the presence of health departments at all levels to support and implement health programs and policies that respond to these areas that I've just talked about.

I do like to talk about them in terms of some of the overall arching programs and services because that can be more meaningful for people, so things that infect broad parts of our population like immunizations and vaccinations and infectious disease monitoring and what we’re doing now and things like cancer and asthma prevention, water quality. It’s a broad expanse of things, but when you start talking about it in that way, you begin to understand that these are areas that impact more than one person. They’re not just treating one person for a specific ailment or disease or an injury. We’re talking about implementing services and programs that can impact more than one person: populations.

Dr. Maybank: Thank you. Then just to go back to my statement about the divide, during this response, has that hurt public health departments in terms of just not having a system of health really overall in this country, but having really too—we have a health care system and a public health system—and I would imagine that divide is really also amplified during this response. Has that hurt health departments at the local level in any kind of way or hurt their response?

Ms. Freeman: It depends, and I hate to use those words, but our health departments are well-trained to work across every sector of their community in a response like this. One of the first things they did, and I had the good fortune of actually in early March being in Texas when this was first starting, and I actually was in two communities where this was just coming about and they started community meetings.

The health department called together all the sectors of the community, including hospital systems, the health care providers, fire, EMS, police, education. This is what they do. This is what they’re really good at. They pull together all these groups, and they are the convener, and they say, “This is our preparedness and response plan. This is your role. Let’s talk about how we are going to continue to work together throughout this response and share information,” and when it works well, it’s really beautiful to see in action because there’s a constant exchange and sharing of information and data and resources among those.

That’s not the case perhaps in every community across the country and every health department, but it is what the public health is based upon in a large sense. Now, where it begins to break down in my mind is—especially in something like this—we haven’t been in a situation like this for a hundred years. This is new to us, and just the sheer volume and extent of what we’re dealing with can overwhelm any system, any preparedness plan, and so you can see things begin to break down.
I think when we begin to talk about the data and the disparities that we're seeing, that could be part of
the breakdown too and how we're tracking that and who is tracking that and how it gets reported.
There could be more coordination in my mind between public health and health care at certain times
that would help us to open up the exchange of information and data and sharing in responses like this.

**Dr. Maybank:** Thank you. That was really helpful. Dr. Davis, do you have any comment in regards to
the public health infrastructure and public health and how you frame and talk about public health and
what it means, but then also the infrastructure itself?

**Dr. Davis:** When I talk about public health and try to explain it, I like to start with the WHO's definition
of, or the World Health Organization's definition of health, which is "complete physical, mental, and
social wellbeing and not merely just the absence of disease." When you start there and you—that's a
great, I think, foundation for how we think about public health—so we are thinking about those threats
that complete health, and we're thinking about it from a broader perspective, so we're talking about
population health, and so we're looking at how we can improve health. I talked about being science-
based, and so how we're using that best science to improve health or prolong life for a group of
individuals, so whether that be minority populations or whether that be a defined area such as a city or
a national level.

In public health, we know that there are many factors that influence health. We refer to some of the
highly-cited studies that talk about 60% of determinants of health. Determinants that lead to early
death in the United States are largely outside of the doctor's office, only about 10%, and that's not to
note that health behaviors, they absolutely play a little role, but it's really hard to be healthy when
you're in a neighborhood that doesn't provide the resources or the opportunities or you just don't have
the basic essentials to be healthy.

We really do try to focus on, as we like to use, going upstream, talking about and addressing those
social determinants of health. I think some of the ways that we could work together in terms of public
health in the clinical world is really trying to bring that experience or that knowledge into the clinical
experience. We talk, I like this example, of a student that was being cared for by a doctor, and he was
trying to understand the asthma compliance, but then when he asked a couple of questions like, “Do
you have running water? Do you have electricity? Do you have a support system?” and then
answering questions like that helps you have a better appreciation for how you're going to care for this
particular patient and how you're going to provide the resources and support around them so that they
could have their best health because everybody wants to be healthy.

I can't imagine anybody that doesn't, but it's these other pieces that have an impact, and so when we
think about the public health infrastructure, we're thinking about the public health workforce, we're
thinking about the health care sector, we're thinking about the laboratories that all work together to try
to improve health, and quite frankly, we can't be successful without all of us working together.
Dr. Maybank: Thank you. Anybody have anything to add because that's great. To slide into the other important context from being in public health, again, is the conversation around health equity, health inequities. Public health embraced the field of health equity a while ago, a long time ago. Nadine, you were at the Office of Minority Health, which around 1986, I believe, Margaret Heckler’s report came out and started the Offices of Minority Health across the country and really declared a statement in a sense for this country that we need to focus resources, people, and attention to address a health inequity and public health definitely did that. I just am curious to your reflections on how in the public health context and the science of public health and the methodology of public health—why is that really critical as it relates to health equity and how you've been able to address it during the COVID experience? Any of you are more than welcome to answer that question however you choose fit.

Dr. Gracia: I'm happy to start, and I actually would build off of something that Lori said earlier with regards to the expertise of the health departments at the local and at the state and federal levels in utilizing the data and science to really help drive programs and interventions, policies that are determined, because you want to ensure that what you are doing is both effective as well as safe, that it's reaching the communities that you are intending to serve.

I think that is such an important role when you think about responding to any level of a public health crisis, including a pandemic, is drawing on those existing kinds of relationships that public health is a convener, bringing together different sectors, and as Regina indicated, that these are based on many systemic and structural inequities that have existed for decades, but having those existing relationships with other sectors and importantly, with community—community leaders, faith leaders, others in the community that can help with regards to the outreach and education and utilizing that data to identify where are communities at risk—how do we ensure that we are partnering together so that we can get information to the community in a culturally and linguistically appropriate manner? How do we ensure that we get access to resources, whether it's testing, whether it's access to care and services, health care and services? And also addressing social needs that may be needed, for example, if we are implementing, for example, mitigation measures like physical distancing and ensuring—are there communities that might have more difficulty with those types of mitigation method measures, whether it's housing security or food security—ensuring that their kids are still able to get education virtually in their homes.

Public health, as you said, Dr. Maybank, really has understood the importance of equity; equity in all policies, equity in all measures, and I think providing greater resources to ensure that communities really can... that these types of measures actually reach all communities is critically important. I think because public health has understood that, that that's important for ensuring that everyone can reach their optimal level of health. That's why they're such a leader and so much at the front lines of this.

Dr. Maybank: Absolutely. Lori or Regina?

Dr. Davis: Yep. She said perfectly.
Ms. Freeman: Yeah, I would agree, really, and just back to the previous question too about how we can bridge the gap with health care. I think public health really is uniquely positioned to address the health and equities of this disease. We know a lot about that space, and we can bring all of the tools and resources that we have in our toolbox to bear to help educate the health care side about this where they might not be as focused on that, and we could definitely work collaboratively in a better way to make them aware of the important stuff not overlooking that in this response.

Dr. Maybank: Thank you. Just a quick break. Folks who have questions, please feel free to post questions so we'll start getting to those soon. The other part, just Dr. Gracia mentioned the report of Ready or Not. We put the links to some of the reports that were mentioned. If anybody else has any links or anything that they would like for us to post in the chat box, the team will do that as well.

Continuing on with the health equity conversation, and we’re going to root ourselves there, so I guess all of you, I believe, have been advocating for the data and the disaggregation of the data, but the disclosure of the data, better collection of the data. I would love to hear the work that you’ve done in that area as well as what’s the status update of what we know to be the latest in terms of what we’re doing as a country. Lori, do you want to start?

Ms. Freeman: Yeah. Sure. I can start, and of course, others can chime in here too. First of all, I am particularly ashamed that this caught some people by surprise in terms of the impact to the African American black community. We should have known just because of how our communities are positioned to understand underlying conditions in chronic disease in these communities. When we were first hearing about this and about its impact on those with underlying conditions, we should have known and acted sooner. I do not understand why we did not do that. But now that that data is emerging, and once it came out, to me, it was like, okay, that should not be surprising to anybody. However, that data now, we can use it as a pivot point and input a lot of resources and efforts into targeted efforts and to educate and to get people connected to care and get them tested and to mitigate exposure to these populations that are really being impacted particularly “non-white” or “Hispanic” is what that category is called in a lot of the reported data. I will also say with regard to the data is it’s not quite clear yet why there are such gaps in that reporting. As I was thinking through this earlier today, I was thinking back to how we do this normally with case reporting, when that information is gathered it’s a health department responsibility. But people are coming from different places into the health department to facilitate that reporting.

They're coming from health care providers, they're coming from hospital systems and other areas. So somewhere along that chain we're losing data or it's not getting put into these case reporting mechanisms. So we have to find out where that breakdown is and we have to fix it. And the issue with the demographics also are that there are systems within systems within systems of this reported data, all going to kind of different places sometimes for different purposes.
I was looking at hospitalization data today and struck by another piece that I hadn't heard anybody say, that in a category of five to 17-year olds, once again the nonwhite group was much larger than the white group in that young category. So we should be looking and focusing in and honing in on these little pieces that we're learning even as we learn and even as we developed the data further to try to figure out why that is and to warn these groups of the population, that they might be particularly vulnerable and might need to shelter a little bit differently and avoid contact a little bit differently.

Dr. Maybank: Thank you. As we build on that original question, I also want to bring in the question of, and Lori you mentioned, I don't know why we didn't pay attention to it, and I think from my perspective, the why relates to how equity just isn't a priority really for many institutions across this country. And I guess as, Nadine and Regina, as you both talk, can you speak to that why? But also then what is it that will potentially make people pay attention? What do we need to do differently that will make people pay attention? What have you done that has made people pay attention in a way that potentially they haven't before?

Dr. Davis: So I'll start. I would agree with Lori in that I'm not surprised because these issues are longstanding and we're not, to be frank, this is what the first time we're calling for these types of things around data collection. If you think back to the Affordable Care Act, we were asking for better data collection. So that's honestly the million dollar question, why aren't we better about data collection? I guess there's a number of reasons, but I do think that, I have two points I want to make. One is that it's not just collection of data because we can collect data all we want, but we've got to act upon it. One is that it's not just collection of data because we can collect data all we want, but we've got to act upon it. So the data is going to be really rich and helping to reveal those populations that need it, the resources and most. But then we've got to act on getting those resources to the population.

So there's two parts of that. There's collecting the data but also acting upon that data and getting the resources and the programming and the support around what that data is showing us. And then I think we have a real opportunity here because now it's not just minority populations that are experiencing the frustrations that minority populations have felt for a while. So now other populations know what it's like to be uncertain about your health care, to have rushed care, to have non-optimal care. So hopefully this experience is going to help us move in a place where we want to make some changes that are going to improve our system.

Dr. Maybank: Thank you.

Dr. Gracia: The main thing I would just add to that, and you referenced, for example, the federal government report from 1985, the other report of the secretary's task force on black and minority health, which as you noted you described it was the first time the federal government had actually issued a report documenting the disparities among people of color in the United States. And before that there were many researchers and academicians and clinicians who had long been describing and documenting those disparities. And it did lead to important developments; the creation of the office of minority health at HHS and offices across the country and the Affordable Care Act as Regina said, it
has also been instrumental in this work and did indeed a call for even further disaggregation of data, not only by race and ethnicity but primary language and disability status and sex in order to address exactly what we're talking about, which is recognizing where we are seeing poor health outcomes and be able to address them.

So absolutely, and acting on them. I think something that we need to really do and something we're doing at Trust for America's Health is we are advocating to Congress, we're partnering with other organizations in calling for this data disaggregation and recognizing, as we've gone through the process, that it's not only the public health departments and laboratories, if you will, that are gathering and collecting this data, but recognizing it and to that opportunity to really strengthen linkages is that the data we also need to get from commercial laboratories and clinical laboratories and really have a strong understanding of the importance of the entire surveillance system.

And that's health care, that's public health and that's so many different entities and the importance of having that data collection is to be able to have robust data analysis. Because even as we are having these data now being reported, much of it is still going uncollected if we look at the actual reports. And so this is an opportunity for us to focus on this in this immediate crisis, but really to now lead to that systemic change of data infrastructure, providing additional funding and resources to build the data surveillance systems, the interoperability of those systems, but also the accountability of all who partake in that surveillance system to contribute that information so that we can have the type of policy and programmatic change and investment that's needed to address disparities.

Dr. Maybank: Absolutely. Is there one thing at this point in time that would, if you all had a choice that would really help improve the data collection piece? I've heard folks talk about the importance of having a short form, different suggestions being put forward. Anything in your mind that at this moment in time, like what's kind of the critical priority to help improve the data collection pieces? Dr. Gracia, you did a great job at kind of outlining in totality what's needed and I think that's absolutely critical. But I just wanted to kind of get a sense, is there anything that's like really immediate that would help with the data collection aspects of COVID?

Dr. Gracia: We've been having conversations I think with each of those sectors and components of the surveillance system. What we're hearing is the quality of the data that's actually being sent into the laboratories and the public health departments, that if we can have improvements at that interface, then the public health departments at the local and state level will be able to actually report out and have—and at the federal level—we'll be able to report out that information, we have to ensure one that the actual forms have that as a requirement for completing that information. And then beyond that it's ensuring that whether it's the providers or whomever is requiring and requesting the testing, that there is some way to make that connection, that that data is completed by the time that it's actually getting reported into the localities in the states. And Lori, you may have other experiences certainly from what the local health departments are saying as well as far as data quality and data access.
Ms. Freeman: I think it's all of those things. But also to an earlier point that you had made, it's also the modernization of our data systems and we are at a complete deficit at the moment with the size of this response and the lack of infrastructure that we have in place. The combination of those two things are causing our capabilities, diversity to teams, and we're seeing the vulnerabilities of our weak systems that have been now weakened over time by further defunding of governmental public health and just a lack of paying attention to keeping up with modern technology.

So we really do need those investments to be in place and to have that level. We don't live in the confines of a communist government where there's one system for all. We have many different states, many different local systems all feeding in. So interoperability, again, there's a lot involved to this and it's going to take a very large infrastructural investment in order to get it up to speed. And what we're learning from this response is, one thing that we can learn from this disease, that this is a weakness and that needs to be addressed.

Dr. Davis: Yeah, absolutely. I think it's worth noting that even in the data collecting that we're doing now, is not in real time. So we're often getting data the years following. So I mean you have to factor that into how are we going to shore up our systems and then these health systems are overrun right now. So you could have a short form all you want, but you've got to have the staff that has the time to complete the form completed accurately and then transmit that information to state and local health officials. So there are several pieces to that that we have to make sure are working.

Dr. Maybank: Absolutely. This past weekend, I have a member in our family that actually passed away from COVID. In a sense I had an exposure and we all went through a drive-through testing station here in New York City, called up the health department, the state health department, got our appointments and went through the drive-through. And of course me as the public health person, I'm looking at every aspect of what's happening and what was really clear because you're not opening your windows, you're only really cracking your window. You're putting your driver's license on your windshield so that they can look through the glass to fill out the form. And they weren't filling out a form, they were really just checking a box through the call that you made and number and just making sure the name matched up.

But I've realized through the process, and even in the calling of the appointment, there was no space or opportunity—or there could be an opportunity—but no one had asked about race and ethnicity. And there are a lot of people going through drive through testing and maybe in other places it's different. But it became very clear to me very quickly how we're not collecting that data and how it's definitely not prioritized. And I get that it is an extra step, but I just feel that we can't do public health well into it's excellent space if we don't collect that data. It helps, us all the data, all that social data is really critical and important. So let me get to a question-

Dr. Gracia: Dr. Maybank, can we just all say to you we're sorry for your loss. Thank you for sharing.
Dr. Davis: Yes.

Dr. Gracia: Thank you for sharing. We’re very sorry for your loss. While we’re doing so much in public health, this can impact us directly through our own families and friends. So we certainly want to acknowledge that.

Dr. Davis: Yes.

Dr. Maybank: Absolutely. And that’s what’s real and what creates a sense of urgency in all of this, is oftentimes our lived experiences connect us to this work. But I thank you for that. Let me get to some questions before folks get upset with me this time because I didn't get to them the last time because I got so caught up in the conversation, I could see it happening now. Let’s see. So this has come up a lot, of the news and media attention has focused lots on African-Americans and blacks. However, we’re very clear that there are inequities or folks who are experiencing or definitely that and next communities, immigrants and Native Americans. And so can you speak to any work that you're doing—and the question specifically was about Native Americans—but you can also broaden it to include other specific racially marginalized populations in the country, and anybody could take that question.

Dr. Davis: So I'll just weigh in to say that The American Public Health Association has a long history of working with native populations, and we have a tribal think tank where we are working, as been stated earlier, that public health, we’re natural conveners. So we are working to bring the best science in terms of how do we best serve the population? We are in conversations with those tribal leaders in terms of how do we raise awareness to their issues. We are preparing resources, fact sheets that you can feel free to go back to our website at www.apha.org for more information on that. But it’s certainly an issue for us that we are aware of and we’re working on.

Dr. Maybank: Okay, we'll make sure we put that in the chat box.

Dr. Davis: Yes.

Dr. Maybank: Anybody else?

Dr. Gracia: I would say for Trust for America’s Health, you absolutely identified an important issue, which is being inclusive as we talk about the populations, and certainly recognize the disparities we’re hearing. For example, in Navajo nation with regards to the disparities there with regards to COVID-19. And again addressing structural inequities that have existed in many tribal communities. As we’re advocating on issues like data disaggregation and federal resources going to communities that are disproportionately impacted, we’re ensuring that we are talking broadly about not only black Americans, but Latinx, Asian American, native Hawaiian Pacific Islanders, and American Indian Alaska natives. We’re finding, too, where certain States are able to do even more granular data
disaggregation and identifying, for example, communities of native Hawaiian and Pacific Islanders that are showing disparities again that, as has been earlier said, shouldn't necessarily be surprising in the sense of when we think about the chronic medical conditions, like diabetes and hypertension, that exists across these populations.

And so that's the importance, too, of having that data to saying these communities are being disproportionately impacted. And we have to target and really focus resources, and outreach, and services. And doing so as well in a way that is culturally respectful and responsive to the communities. Because all of these communities, even when you think about native American communities, if you look at federally recognized tribes, there's over 560 federally recognized tribes that are all different and unique. And so it's really being respectful and working with the communities to address their needs.

**Dr. Maybank:** Absolutely. And I have to give a shout out to Dr. Winston Wong from the National Council of Asian Pacific Islander, probably not going to say that right, Council. I see the acronym, but I'm probably not getting the words right. But Dr. Wong, who we've been in communication with, pointed out the data in Washington state of 0.7% population of native Hawaiian and 1.7% of the deaths. So I think that's important for us, being connected to one another, and leaders also, within this space of different backgrounds, but different positions in different organizations or amongst different organizations, to make sure that we're talking and sharing information amongst each other. And that's what I see as the value of these conversations. So that we could learn something more for ourselves and kind of take that back, and adjust it for ourselves and for our organizations.

Another question has to do with the root causes of inequities. It seems there isn't political will to address systemic racism which cause health disparities. Programs and resources help but don't address the root cause. Do any of you want to speak to that? And it was mentioned a little bit at the top of the program, but I would love to hear some more voice around that.

**Ms. Freeman:** I would just hop in here and say that we are particularly attuned to the potential for things to get much worse as a result of this crisis that we're in. And that more the aftermath of this is something that we have to acutely pay attention to, because there will be deepening poverty, deepening homelessness, inability maybe to complete your high school education. All of the social determinants could be impacted even further from this crisis. So by us thinking about this now and trying to get ahead of it before we get to that point, we're hoping to come up with some ideas on how to lessen that impact and address it ahead of time.

**Dr. Davis:** Yeah, I would add that the individual that posed the question is correct. It is a difficult conversation to have, the word is polarizing. And for that reason, when we begin to have those conversations, they often don't go far enough. And because of that, we don't always see the political will that we would hope. But we have to be better about being open to the conversation and not, just because the word is used, not taking it so personally, because it exists. It is absolutely a contributing factor. The science has proven that, and we would serve ourselves best to address that. Because if
we want to continue to be a successful country, it is essential, especially as the demographics of the
country are changing, that we are going to have to address this issue.

Dr. Gracia: And I would just add that it's important to, as the person who sent that question in said, it's
not solely about programs, it's also recognizing structures and policies that perpetuate and exacerbate
these inequities. When we look at those root causes, that's really important to truly advancing equity, I
think not only in the short term, but how we do that in the long term. And to not underestimate the
power of advocacy, because these advocacy movements have been critical. Whether it's looking at
the provisions in the Affordable Care Act that really address equity. That was through a great deal of
advocacy of organizations across the country that had recognized the longstanding structural
disparities that existed in health care and in health, and how to try to deconstruct those inequities.

Having the power of of that advocacy, and certainly what what we did a lot of work in at the Office of
Minority Health when I was a director there, was also looking at governance and leadership, and is
that a priority of governance and leadership? And how do you make the case using data and using the
power of story and the power of advocacy to really affect change? But it's something that we have to
continue to pay attention to because as we transition, as we shift through phases of the pandemic, it
can be easy to lose sight of that and return to how we were before in the sense of how the systems
operated before. And instead we need to push even further to ensure that there is change.

Dr. Maybank: Absolutely. We probably have time for about two more questions. I will say, and most
folks who know me, that I am of the school that definitely says it's critical that we name racism and
structural racism as a fundamental cause of why health inequities exist in this country. We have
evidence at the interpersonal level, that's what unequal treatment was all about, that all of us are very
grounded in, and we have evidence at the institutional level. We think about J. Marion Sims and all of
these other historical contexts, and also more recent contexts, of segregation of our health care
systems, and how that impacts health. And then we have the structural context as well. So while
discomfort is exactly that, there are many more people who are living in discomfort due to the
inequities that they experienced. And I feel it's absolutely our responsibility as leaders and as health
equity leaders to name and call racism, and then also figure out the action that we have to do behind it
that aligns with addressing that context.

I have a question about—have you heard any success as it relates to addressing health equity in
COVID either in the United States or globally? As an example, I've heard about Chicago, our own
base is there. Mayor Lightfoot put forward the recommendation to start racial equity response teams in
which they're engaging local residents in an asset that they have already in the strength of a
community organizing group, West Side United, in building off that strength to help create a racial
equity response teams. Are there any other successes or opportunities that you have heard being put
forward? You talked a lot about the policy at advocacy level, but any other programmatic level, folks
are asking.
Dr. Davis: I haven't heard about success in specific cities, but I will say that there is a better understanding of the value of community health workers, and how critical they are in these types of pandemics or situations, in terms of they're often trusted purveyors of information in the community. And so how essential they are going to be, not only now but afterwards, in terms of if we fortunately have a vaccine, or providing information. So that is one thing that we've been talking about is how critical community health workers are and are going to be going forward.

Dr. Maybank: And I know APHA and several others have asked for funding. NACCHO, think you all are part of a similar coalition of $45 billion if I'm correct. And part of that is the support a hundred thousand folks to help do contact tracing, which could be community health workers or other folks. But please correct me if I'm not saying that exactly right.

Ms. Freeman: Yeah. We are advocating for three and a half billion dollars.

Dr. Maybank: Oh, three and a half billion. I upped it to 45 billion.

Ms. Freeman: We'll take the 45 billion for public health infrastructure. While I have a moment here just to address that, I haven't heard of anything specific. However, to this point about contact tracing, a lot of people want to put technology behind this effort and call it a day, but we are advocating very much that you still need the human element of working with people that you are asking to isolate in quarantine. I think it's been mentioned a little while ago. But particularly with an eye towards equity here, because you do not want to keep people in their homes if they're food insecure, if they don't have a good living situation, or are being subject to violence or abuse in their home. All of those things are something that we are particularly concerned about as we work through this next phase, and particularly that isolation quarantine phase, making sure people are are safe and healthy, and have what they need if they need to isolate or quarantine.

Dr. Maybank: Absolutely. So we're nearing the hour. I still have more questions I'd like to ask, but I know I can't. So one, I want to say Dr. Wong is from the National Council of Asian Pacific Islander Physicians. So I just want to make sure I make that correction out of respect of the organization and Dr. Wong. And then I did get a comment that said, "Dr. Maybank, it's not just race ethnicity data. We need to be collecting data on income level, education, and neighborhood." And that's absolutely correct. I completely agree with that as well, and so just wanted to read the statement.

Dr. Maybank: But I want to thank all three of you for joining me on the conversation today. I know it was valuable for folks who were listening in. It's always valuable for me to hear you all. And I know we all tend to be on the same circuits and definitely hear each other a lot, but I appreciate it. I feel like I'm in community when we can come together this way. And again, thank you for your time and energy, and continue to be well, and I wish you and your loved ones well as well.

All: Thank you
Dr. Davis: Stay safe, stay healthy, stay inside.

Dr. Maybank: There you go. Yes.

For more information and resources about COVID-19, like our new Health Equity Resource Center, please go to ama-assn.org/COVID-19. Thanks for being with us today.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.