



**CommuniVax**

A Coalition to Strengthen the Community's Role  
in an Equitable COVID-19 Vaccination Campaign

## **Transcript from April 20, 2021: Community-Centric Public Health Practice: COVID-19 Vaccination and Beyond**

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Welcome to today's webinar, community centric public health practice coven 19 and beyond our moderator tenor vanilla will now begin.

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Greetings, everyone, and welcome to the second national webinars sponsored by the community Vax coalition, and the Johns Hopkins Center for Health Security.

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My name is Tara been Emma, and I am an contributing scholar at the Center for Health Security, and a professor of nursing and public health at the Johns Hopkins Bloomberg School of Public Health.

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Thank you for joining us today. It really is an honor and a pleasure to be here with you today to illuminate the critical importance of state and local health departments in advancing health equity, and in working together to network, a system of systems

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to help build healthier and more resilient communities, during, and after the coven 19 pandemic.

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The community Vax coalition is strengthening national and local covert 19 vaccination efforts in the United States, by putting communities of color at the center of these endeavors.

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The coalition is listening to black, Hispanic, Latino, and indigenous individuals, and how best to promote awareness of access to and acceptability of covid 19 vaccines, in their respective communities, and is also working to develop long standing local

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governance systems that enable underserved groups to exercise collective agency over their own health and wellness. during this pandemic. And going forward.

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The community of x coalition is led by the Johns Hopkins Center for Health Security at the Johns Hopkins Bloomberg School of Public Health, and by the Department of Anthropology at Texas State University.

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The coalition includes six local research teams, a central working group of national experts and a network of national stakeholders. Monica shock Spanish and Emily Brunson or the principal investigators for this project, and I would like to acknowledge

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their strong leadership in shepherding this initiative funding for community Vax coalition is provided by the Chan, Zuckerberg initiative with additional support from the Rockefeller Foundation.

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We have two panels today, our first panel, which I will moderate focuses on community centric health.

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We will discuss strategies for community based organizations and providers to advance coded vaccination, and vital conditions for health.

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Our second panel will focus on how state and local health departments can enhance community collaboration to improve health outcomes.

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It will be moderated by my colleague Richard Craig, who with me, co-chairs the community Vax coalition implementation committee.

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We will take questions after each panel, so please put your questions in the q amp a box.

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Our first group of panelists are Brian Frank assistant professor and full time clinician in the Department of Family Medicine at Oregon Health and Science University, a net are Kalyan executive director strategic programs at Kaiser Permanente Sophia Thomas,

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president of the American Association of nurse practitioners and area to Chico's principle for urban resilience strategies.

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I'm very excited about this panel. And our first panelist is Dr. Brian Frank, Brian is an assistant professor and full time clinician in the Department of Family Medicine at Oregon Health and Science University in Portland, Oregon.

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Since 2011. He has been providing care to multi generational families and individuals in all stages of life at the LHSU family medicine clinic at Richmond of federally qualified health center, outside of this clinical duties, Dr.

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Frank leads research, identifying returns on investment to businesses that support the health equity of their employees, and the communities they serve.

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He is a current member of the National Academies of Science, Engineering and medicines action collaborative on business engagement in building healthy communities.

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He also served as a member of the health equity tactic team for family medicine for America's Health from 2017 through its completion in 2019, and was the 2016 clinical innovation fellow with the Oregon Health Authority, where he led projects designed

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to identify and reduce the prevalence of food insecurity in primary care clinics, he writes and speaks nationally about food insecurity implicit bias and other issues related to health equity, Brian, over to you.

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Thanks so much better think my time is almost up after my introduction so my apologies.

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I'll give you this standard 2020 slash 21 caveats that I'm broadcasting from work, and there's apparently construction outside so apologies for that and you may or may not see any of the following running behind me naked children pets, people doing cooking.

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So now that we've gotten that out of the way.

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I really appreciate being a part of this as a member of the Oregon Academy of Family Physicians, we were really excited to have this opportunity to share what we've been working on.

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I'll take you back to this time last year.

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It was just the beginning of the pandemic we were really uncertain what was coming but what we did know was that primary care was hurting people weren't going to clinic, there was the beginning of the lockdowns, people were afraid to leave their house

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people were being advised to stay home and that meant things like a decrease in primary care visits decrease in chronic care and wellness checkups, many of my colleagues across the state and really across the country we're trying to learn how to use new

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technologies many patients didn't have access to those technologies so, along with the financial hit that many clinics were taking. There was also a lot of concern that our patients weren't getting their needs met, and working for a federally qualified

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health center as I do, that means not only that their health needs weren't being met, but there, there was social needs that were going on cared for.

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I'll give you an example of a patient of mine who came in, toward the beginning of the pandemic. He had a cough dry cough, fever, runny nose.

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He is also a patient who's on opiate agonist treatment or up north in a to treat his opiate addiction he's also homeless and living in his car. And so the day that he came to our clinic we had managed to set up an outdoor testing tent for covert, we were

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able to swap him, and then because of the luxury of working at a federally qualified health center we were also able to work with community organizations to find him temporary housing, so that he could quarantine safely, as well as some food assistance.

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That was a big win for us. We still weren't able to connect directly with public health and let them know of his situation.

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And so we started thinking, you know we have these clubs that are being underutilized these primary care providers that that need

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need to have ways of contacting their community interacting with their community. And we see that our public health system is becoming quickly overwhelmed.

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We reached out to our local public health authorities, both in the Greater Portland area and across the state, and to community based organizations to try and think about how we could create a system that's truly interactive and able to meet our patients

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needs while also dealing with this public health emergency.

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This led to a number of conversations.

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Ultimately, we found that the conversations, brought up a few things one everyone thought it was a great idea, and to nobody knew how to do it.

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We simply don't have the technological infrastructure in place to allow seamless communication between primary care, and the health care system, public health and community based organizations.

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In the interim. The Oregon Health Authority

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need funding available for community based organizations to act as context tracers. So, it helped him that we could trace where the illness was and also started to meet some of the needs of our community members, but we felt that public primary care was

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still under utilized in this, we felt that in an ideal system primary care could do daily symptom monitoring, deal with both acute and chronic disease management, help provide patients with evidence based answers and continue to provide longitudinal care

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for their family for patients and their families.

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Public Health could help with contact tracing could deal with the population level disease tracking and and help with the policies needed to slow down the spread of coping 19 and the community based organizations could help patients get their social needs

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met, build trust with communities, and also help improve the equity of the outcomes.

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So fast forward to late last year early this year, it became apparent that vaccines are going to be the answer. So as we strove to develop this new interconnectedness.

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We began to focus on vaccinations and so we're that's led us is the AFP Oregon Academy of Family Physicians is partnering with the Oregon Health Authority to develop a presentation that beacon can be given to communities, looking to be vaccinated.

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It allows us to explain what the vaccinations are, what they aren't why primary care is such an important part both of getting vaccinated and staying healthy, and that we can communicate this effectively with community community based organizations so

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that those organizations can help their, their community members, access the vaccine access care.

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We're still hoping to work more with public health to eventually build, like I said, a seamless integrated system where we can have any point of entry, whether it's at a food pantry at a public health clinic at a primary care clinic and, er, people can

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get diagnosed can go into the system so that their disease can get trapped and that they can get their social needs met. But what you've taken what I think is the first step, you know, in a road to meeting that goal.

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So I'll stop there and thanks so much for the opportunity.

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Thank you, Brian.

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Our next panelist is a net Eric Kalyan executive director strategic programs at Kaiser Permanente in Southern California.

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Currently, she is the planning chief at the southern California Kaiser Permanente coven 19 command center and co lead in vaccination readiness. She has been leading the vaccine equity efforts in coven 19 vaccine implementation.

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And that is a recognized leader in equitable healthcare, social needs strategy integrated care services, innovation, quality value metrics regulatory and legislative affairs and health care reform and performance improvement.

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She is a certified professional in health care quality, as well as an experienced pharmacist and net welcome and over to you.

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Great. Thank you and good morning and good afternoon, depending on which time zone we're in tonight thank you for the introduction and thank you to the coalition and the john hopkins Center for Health Security for the opportunity to share our story, and

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vaccine equity here in Los Angeles.



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Southern California, a few words about Kaiser Permanente.

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Before I begin, Kaiser Permanente is a large integrated HMO, and several states, with a very strong presence here in the state of California. And my discussion today is really focused around our experience here in Southern California, where we have approximately

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4.6 million members.

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And, and in many of our communities, many of our diverse communities that represents one in three, or one in four of the residents.

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And that's we realize that any successful efforts within our system.

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And by our system will make significant impact to the communities where our members live and work.

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Our mission is and continues to be to provide high quality affordable care to our members and the communities we serve. And the Kobe Kobe backpacking readiness and operations.

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Early on, included a lens of equity, and we structured it with three strategic overarching strategy.

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And the first was as early on, it really targeted towards our health care workers and our workforce to ensure that we address any equity in that in our own workforce and that included, providing competence at the vaccine competence information from printed

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material to forums, etc.

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to. to assure the confidence in the vaccine in our own workforce, and then assured that our workforce also had convenient and easy access to vaccine.

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The second was to improve vaccine acceptance and access in the communities where our member members live. We have numerous examples of that but to highlight a few and those include partnering with our city of Los Angeles on their mobile health vehicle

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program to underserved and highly impacted communities.

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We also leverage our own internal data and community based information community data to help us identify hotspots zones where we knew we have poor penetration, and also impacts about great the greatest impact by disease, to be able to strategize and

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support our outreach efforts there. And lastly we to to vaccinate all community members we streamlined our electronic appointment process system to allow for easy and convenience appointment setting, and of course our call center agents are also available

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to schedule appointments.

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And our third strategy was to prove an address vaccine equity in our own membership. And there again we leverage internal and as well as community data to support our outreach efforts.

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And to give you an example, as we were going through the phases when the 65, plus individuals became eligible, we were able to use separate neighborhoods deprivation index, and the child comorbidity index initially to be identified those cohort of patients

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that are most vulnerable and bring them in and not reach to them to be vaccinated first, and then we outreach to all members 65 plus.

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I'd like to think about vaccine confidence and it's important in all of our efforts across all of our strategies, and our physicians are trusted voices in that and they participate in internal and external forums and providing reliable vaccine information.

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According to various surveys, we know that our members trust our physicians more than any other source.

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And yes, that's more than even if actually claimed to test.

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Kaiser Permanente physicians more than the CDC So, and I share that because I think it's important to have a trusted voice again our bright spots include the Department of the appointment of our mobile health vehicle with great success and vulnerable

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communities, improving vaccination penetration rates and Latin x as well as African American communities that were so adversely impacted here in Los Angeles and I choked up because if you lived here in the fall in the winter, it was really a tough time.

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And I can't believe I'm choking here on an international call but here you go. It just tells you how we were impacted.

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And in summary, so we really expecting has been a hope we've leveraged our data we've developed systems and resources to share vaccine confidence and optimize our systems but convenient and access to our members.

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And we realized that the journey is not yet over we do continue to have gaps in vaccine equity, and we're looking forward to partner with our public health community I'm looking forward to learning from all of you today.

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As we continue to improve on this journey. And our hope is that we make a lasting impact, and the overall care delivery.

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So thank you for again for the time and opportunity to share and center back to you.

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I'm gonna go off video here for a quick second. Thank you so much and that we so appreciate you sharing that information.

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Our next panelist is Sophia Thomas Sophia is currently president of the American Association of nurse practitioners, Sofia is a certified family and pediatric nurse practitioner who really has dedicated her career to providing care to medically underserved

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families, Sofia practices at the DePaul Community Health Center, a federally qualified health center in New Orleans, Louisiana, and she also serves as a clinical preceptor as a primary care provider, Dr.

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Thomas provides her patients with access to cost effective, patient centered care. She impacts nurse practitioner education through publications and presentations on multiple clinical topics, and she has lent her clinical expertise as a legal expert

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on the nurse practitioner scope of practice and standards of care. And also, since July of 2020 as a consultant for the US Department of Health and Human Services vaccine consultation panel for operation warp speed, Sophia, over to you.

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Well, thanks so much and thank you for the invitation to participate on this wonderful panel. I've already learned so much and a net I actually got a tear in my eyes as well so I understand, you know, this has been as we all know a crazy year and a half

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and and I always try to look at the silver lining and and during times of chaos it really does bring opportunity, it's time for us to reimagine what public health looks like and really, we've taken more of a focus on public health and the importance of

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community health and and awareness.

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Really focusing on health care equity and access and yes vaccinations. We know that healthier communities will make a Healthier America. And I really is a nurse practitioner practicing in a community health center.

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I value my community partnerships and I'm so blessed to, to be in a community health centers that sounds very similar to what Brian, where Brian's practicing, where we do have community partners to help us with planning and orchestrating services for

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our patients. And for the community. Just last Saturday I went door to door in the ninth ward of New Orleans, trying to give immunizations to people who were homebound who couldn't get out to get their vaccine and we partnered with a Second Harvest Food

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Bank and so for patients that didn't necessarily need a vaccine they'd already been vaccinated which I was very thankful for.

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We gave them a food box and the food boxes contained fresh fruits and vegetables, fresh chicken, a fresh gallon of milk I mean it wasn't the powdered mac and cheese that we normally think of that comes from food banks and so I really value when we talk

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about food insecurity I really value being able to provide that to our patients. It's really important that we focus on community centric public health and and really address the social determinants of health.

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I'm so proud to be representing nursing in this webinar, you know, nursing, one of the most trusted professions, nursing really has historic roots in public health and certainly the nurse practitioner profession, was born out of the need for more healthcare

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in rural communities. we were learning in the rural Colorado when these public health nurses were the visiting nurses at the time going door to door to people's homes and into communities to provide pediatric well visits, the nurses because they understood

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assessment and and a clinical assessment and findings were finding diseases and disorders and children that they couldn't treat because they were registered nurses they needed to have a physician.

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See the patient as well. And so what Dr. Henry silver and Dr Loretta Ford learn the cofounders of the first nurse practitioner program was that with extra education and training these these nurses that were in the community already diagnosing the ear

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infections diagnosing and asthma exacerbation could be educated and trained at an advanced level to meet the needs of the patients where they are and and treat the patients, nursing is very ground in patient education and that's something that we feel

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is very very important as patient advocates, as you know, nurses in the hospital are advocating for patients and treating an educated but also in the community and that's something that I love about being a nurse practitioner is spending that extra time

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with my patients to really be sure they understand their disease their diagnosis, and what changes they can make make meeting them where they are because not all patients can afford fresh fruits and vegetables but being able to provide those community

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resources match patients up with the resources that they need.

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It's really been an amazing feat throughout coven, you know, and before and beyond I'm, I've been a nurse practitioner for 25 years and I truly love and care about the patient population I serve throughout coven nurses and nurse practitioners have really

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been surging to the community surging to areas where the need is the greatest, and we've got about 60% of nurse practitioners actively testing and treating patients as well as going to vaccination sites and and again meeting patients in the community

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where they are setting up pop ups drive through areas, going door to door, trying to get as many patients vaccinated as possible because we know in underserved communities transportation is a problem they don't necessarily have the means to get to a vaccine

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appointment.

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We know that with social determinants of health people are at higher risk of developing complications of coded, just because of nutritional and health issues.

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So we want to be sure we compile all their list of resources that we can provide to patients to make them healthier and help them achieve their wellness goals whatever those would be, you know, I think that the most important thing is that, you know,

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we, we now have an opportunity to rethink healthcare, look at social determinants of health which five years ago nobody really knew what those were.

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And really partner with the community with state and local governments to develop resources that are actually effective at improving healthcare outcomes.

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When I was a nurse practitioner school over 25 years ago, I learned that African Americans and Hispanic Americans people of color were at the highest highest risk for diabetes and heart disease and other health diseases and disorders, and those statistics

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haven't changed, so it's time for us to relook at healthcare and do something and change the statistics for the populations that are the most vulnerable in our country because again, when we have healthier communities healthier patients.

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We will have a Healthier America, and so on behalf of all of nursing I want to thank you for the invitation to speak to you today.

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Thank you so much, the fear.

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Our next panelist is area to Chico's Marietta is a policy advisor who works sign disaster resilience and recovery risk reduction and urban public policy.

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She consults with public sector groups, Lifeline firms and local jurisdictions on urban policy, and comprehensive resilience management. She was the city manager in Berkeley, California, with 18 years of public service, where she directed innovative risk



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reduction programs, she also was a research director at the Harvard Kennedy School acting in time advance recovery project focused on disaster recovery and American communities area has worked with the Federal Emergency Management Agency and the Environmental

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Protection Agency centering on work on regional resilience and developed a guide for resilience planning and implementation funding.

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As a member of the resilient America round table at the National Academy of Sciences. She advises on national level, resilience and disaster recovery policy and implementation.

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She is an appointee to the National Academy of Science Committee to advise the US global change Research Program, which is mandated by Congress to understand, assess predict and respond to human induced, and natural processes of global change over to

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you, areata.

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Thank you so much for that wonderful introduction I appreciate it. Good afternoon everyone. Um, I want to thank you all for the opportunity to speak with you an end to the other panelists from whom I've learned a lot already today.

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I'll share observations about the intersection of public health community resilience and electoral politics focusing on Northern California cities and public health leaders supporting health equity, and I just want to give a big thank you to in that and

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as my Southern California colleague at Kaiser.

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California is as a population of 40 plus million people, and it's the fifth largest global economy, the state is hit by more disasters than any other, and it's a politically dynamic and unwieldy state.

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It's a place of fast financial and social extremes. Further, as a minority as a majority minority state California really has to start to deliver on its diversity and inclusion challenges, while planning for future disasters that we will inevitably face,

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and more equitable response and recovery.

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We found on the last few years, that we have so many promising lessons to learn from public health as we apply their innovative policies and social action into other realms of community life.

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California is 58 local health districts and these hubs coordinate with a state public health agency. In addition, three cities, Berkeley Pasadena and Long Beach also have their own health districts that have really helped shape their exemplary local pandemic

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response in the last year. The California Department of Public Health, and his office of health equity, also work diligently to support local implementation of the health and all policies initiative statewide with both grant money and programs support

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in our local communities. These programs, integrate tart trusted community emissaries the public health nurses community health workers promo daughters who were put local health equity into action and both rural and urban communities so we have like this

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amazing framework that on which to build and to support us in this really difficult time that we're all facing these public agencies along with organizations such as the Bay Area health inequities initiative and the Public Health Institute really have

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grown a robust community of practice to support California. The network is long tackle challenges as Sophia mentioned, asthma, obesity, diabetes housing and even climate action with dedicated determination and we.

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Great. Greatly appreciate this sort of intervention that public health professionals bring to our, our cities and communities, the resolve of their work has really paid off for our status we've grappled with Kobe 19 and equity and vaccination processes

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in the last year as all states have in the San Francisco Bay Area though, natural disaster safety as long dovetailed with regional public health efforts, we've experienced devastating disasters in the last 40 years starting with HIV AIDS, HIV AIDS epidemic

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and followed by earthquakes landslides, massive wildfires throughout the state so that we're really a newer to the unexpected and how we all have to work together to respond and recover, as well as we can.

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The lessons from these disasters that really triggered a quick public health response in a state in the unfolding catastrophe of the global global pandemic Bay Area public health leaders helped guide regional mandates with local governments in our region

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six counties and 89 cities and towns on stay at home measures in March 2020. This was the first preemptive action in the nation to flatten the code curve and we were certainly struck by it and continue to support these ongoing efforts from public health,

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the pandemic experience for us is borne out what history in the disaster policy world shows more lives are lost and people are harmed and communities where unequal resources and social oppression, or the daily norm by pot community suffer most in disasters

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disasters always, and this is of course due to institutionalized racism and systemic medical harm over the, over centuries in our country, and the covert pandemic has shown us nothing different, but we've seen in California, I think that we can really

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work on using the lessons of public health activism to help mobilize our communities for action on social determinants of health, reducing health disparities, and continuing a health equity program and movement in the coming years as we recover from the

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pandemic.

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Another mediating factor in our regional resilience journey is the passage of voter approved taxes to pay for local resilience and equity action elections have galvanized residents in California with ballot measures to provide funds for community wellness

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and the redress of disparities, these taxes paid for upstream equity and resilience interventions throughout the state.

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Bay Area cities have really taken resilience in their hands in the last 20 to 30 years by voting to increase their taxes for improved community outcomes, our cities have a history of social activism and we supported affordable housing housing for the

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at home.

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Increased healthcare access and living wages for our communities.

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Often when I speak at conferences people are really skeptical about trying out such outlandish California practices, and I always optimistically say to them that, really, we are investment in our hometowns have to start with us, self reliance makes good

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community sense and we've seen that in the political activism in our local cities and communities.

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Studies show that for every dollar invested in pre disaster safety and resilience implementation helps reduce human suffering, protect lives, and save billions of dollars in post disruption recovery costs that \$1 that we spent ahead of time saves up to

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\$10 in recovery expenses. We in the disaster safety community have learned these prevention strategies from our public health partners so we thank all of you for that, before the next disaster strikes we can integrate community centric solutions now in

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the colon 19 recovery period. So we can begin to rebalance past and current harms to our with communities of color.

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These real world examples, really give me hope about what we all can do together, we can push for a transformative recovery ahead and commit to equity and durable change and our National Recovery.

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Thank you so much.

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Thank you so much areata. And thanks to all four of our wonderful speakers in this current community centric panel.

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Before we move to take a question from the audience. I just have one or two questions myself, because what I was hearing the thread through all of these presentations, is how critical good communication is and whether it was Dr.

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Frank talking about how can we have more seamless communication between primary care and public health and community based organizations, right up to area is recent comments, really this issue of data and communication and sharing information so that

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we can build resilience and build healthier and invest in our communities is going to be critical. My first question, I think I'll go back to a NAT Kaiser has really, you mentioned using the data that you have with your millions of members and really

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using that data to drive outreach to drive. What are traditional public health interventions for your high risk populations. Can you just comment on for a moment about the communication between public health and Kaiser and the way that you mobilized your

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data for action.

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Sure.

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Sure. Um, I'll just share, I'll just say this in a in a really simple way is that, particularly in Los Angeles County where, where we were most heavily impacted, as well as some of the other counties, I think it was really around sharing of data and sharing

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sharing the information we had, so I'll, a perfect example of this is our cooperative practice, collaboration with public health. When it came to deployment of mobile health vehicle and also sharing access and certain communities.

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We, we looked at our own hotspot zoning data in terms of understanding where there was great impact and there's poor penetration of vaccination, and also in conversation with the Department of Public Health.

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To understand how they were mobilizing in those couple of community areas that we had identified.

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And we shared our strategies and an example of that is in our Antelope Valley area community where it's, it's a desert community it's about an hour away from the metro area, we realized we needed provider access there that was one of the limitations.

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So, and also engaging with local community and public health to activate that community and provide vaccine confidence.

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And so we have a

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clinic, or a massive sort of a mass back site where we can do about 2000 doses a day. And that was established in partnership with understanding from the Department of Public Health, where there was need.

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So there was need in that community. Our local team participated with local governments and local community based organizations is trusted partners to invite the community to that ties for for vaccinations.

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And so that's an example of where we leverage their own internal data, our own internal relationships and partnered with our local Department of Public Health to meet a need in a pocket and in a community health center that answers your question of where

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we work, and when I say public health agency, it's not just we realize it's not just the Department of Public Health a part of our community, but it's also the government organizations the community based organizations that community that lives in that

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zip code to support them and bring back the nation efforts and it's, and that's just one example there's a couple of other examples of areas where we're leveraging data as well as our relationships as trusted partners to facilitate vaccination efforts

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and to bring in confidence. I think the other piece to this whole thing is also. Yeah, I heard from all the speakers is that we, we know where the gaps are we know where the opportunities are but this is an opportunity for us to, to bring competence into

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the health care delivery system, and not just stop with vaccination efforts.

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Thank you and I'm hoping that was very, very helpful and I do agree that building confidence building trust, and within our communities. And I want to build off of your response to when we think about what we've certainly one of the crystal lessons learned

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from Kobe 19, was that the public health response and building stronger and healthier communities is really a team sport. We have a multidisciplinary group of panelists with us today, and all of us to work within organizations where we draw on the strength

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of our colleagues across many many disciplines.

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I'd like to direct my next question back to Sofia.



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Sofia, I loved your comment about the roots of the nurse practitioner program, as we both are so well aware came out of public health and lowrider Ford being a public health nurse.

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And I wondered if I could ask you to comment on of the 4 million nurses and advanced practice nurses and nurse midwives and nurse practitioners this wonderful healthcare workforce that we have, how we can continue to use nursing to build healthier, more

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resilient stronger communities.

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Well you know absolutely we've got a great workforce there and and I think it's time for us to shift back into the public health nursing the public health of the 1960s and 70s, I mean there was a time when people were going to bring their children to

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the health unit to get their immunizations and well baby checks and and the health unit was the place that if if there was a disease going around the health unit we had sanitarium that would go door to door and and track the disease and the contacts and

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things like that. And you know hopefully we'll never have to live through another co that again but I think it's time for us to start looking at our public health systems, and maybe, maybe not put them back to the wayside again let's you know reinvigorate

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that but utilize nursing with, with everything that nursing can do with assessing diagnosing tracking educating patients really building a network of public health providers that can reach out to into communities.

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But, but, nurses, nurse practitioners, we love to educate patients we love to educate the public, and we have some great professional nursing associations that provide wonderful tools to our members and so I think engaging the nursing community as a whole

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and unifying the nursing community is a great first step to improving public health and then partnering with our coalition partners, whether you know on the local, national and state level to to say let's do what we can to a target these things you know

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know the US Surgeon General last year, did a call to action on maternal infant mortality and hypertension, and we need to take those those lessons and those those words from the top to say let's address these issues, we've got we've got some health care

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crises going on that were going on long before coven 19 and again the data on who's getting these diseases in diagnoses the death rates and things like that hasn't changed so now when we're really looking at public health, it's time for us to really take

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some efforts to make a change and really move that needle and nursing along with the rest of the healthcare community be involved in that door.

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Thank you so much You are so right on that.

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All right, well we have time I'm going to send this over to my colleague prior to be able to read off one of the questions from our audience members for rNq xR our question is do you think enough primary care doctors are administering Kobe 19 vaccines.

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What more can be done either by the federal government or others to make this more accessible for primary care practices.

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Wonderful. And I think I'm going to turn to Dr. Frank, to have him I answered that question if you'd be so kind, so much.

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The short answer is no.

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I think the the rollout of the vaccine process was intended to get as many vaccines into people as possible as quickly as possible.

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And from that standpoint I think it's a success. What I think is missing is the foresight to understand what's going to happen to those people down the road.

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For example, when they have side effects the next day and they need someone to call and say can I take Tylenol is this fever normal, you know, why do I have a headache.

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And then to engage them around their own health, right. So, just because someone's coming in for a vaccine especially early on, if they're part of a high risk population.

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If they don't have medical care if they don't have a primary care home by having them get vaccinated through clinic or at least get referred to a clinic, there's the opportunity to help manage those chronic illnesses.

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So I do think that that getting vaccines into primary care clinics is important, I think, possibly more important though is finding out what the community needs What does the community need to feel safe getting vaccinated What does the community need

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in order to make vaccination and option, or what do they even need to help open up and resume normality.

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We as a medical society, I think, clean very tightly to a lot of information that we need to be sharing more freely and we need to be listening to our communities, tell us what they need.

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So a long way of saying in the vaccine rollout process speed was important I think we've achieved that but I think we also need to be thinking about how to help make our communities healthier, anytime the medical community interacts with them.

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Thank you. Thank you.

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Yes, I'd say Brian and I are have the luxury of practicing and community health centers, so we are vaccine sites.

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But my colleagues who are in private medical practices private primary care practices who may not be vaccine sites that have sometimes had challenges just getting the vaccine themselves.

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And so, I really think you know as we really look at this we really need to bring in all of primary care whether it's in the public sector the private and and really making all of those vaccine sites because you know everybody needs access to care and

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so again Brian and I have the luxury of being in community health centers, but not every primary care practice has access to giving the vaccine to their own patients.

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So those patients have to go elsewhere.

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Absolutely Sophia dad has been a problem that we've heard over and over again and just looking at a recent statistic that cited that about 48% of adult Americans don't have a primary care provider, just, again, really sort of should strengthen our resolve

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about the need to strengthen primary care, and then strengthen that collaboration and coordination with public health and our community based organizations.

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It's really sort of those three legs of the stool that we really need to work together, if we're going to build healthier communities, and of course build the resilience that we need to recover from this pandemic, and any future infectious disease outbreaks.

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Well, I want to thank my panel so much again and now it's time for me to return to my colleague, Richard Creek and welcome him to the webinar.

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Richard will moderate our second panel, and it's with great pleasure that I introduce him to you all.

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Richard is the editor of the Journal of critical infrastructure policy, a peer reviewed journal

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published by the policy studies organization in Washington DC. He is also visiting professor in the Department of Political Science at Texas State University Richard's career has spanned policy development and implementation, health care and public health

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policy analysis, government, and helpful and he is the former Commissioner of Health for the city of Chicago.

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In our roles code sharing the community backs implementation committee. We work closely and a number of areas, including serving as project emissaries to organizations engaged in public health policy and practice, Richard, over to you.

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Thank you, Jenna, and thanks to our audience for joining us, tenor gave a very good description of the community banks project. I wanted to add that, I would urge people to look at the community site at the Center for Health Security at Johns Hopkins,

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you will quickly see it's a it's a unique project in terms of its geographic breath, and the number of people who are involved literally in this in this effort.

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It is a coalition, there are functioning teams on the ground and cities across the country and I think as you see today on these panels. We have representatives from the west coast the east coast in between.

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So, if you get a chance, please do look at the project. It is evolving and very exciting initiative to bring into fruition and bring it to life, some of the concepts and recommendations that are coming out of this panel.

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I do want to thank the first panel and I felt it was excellent,

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and also please get your put your questions if you have them into the, the chat box so we can get to them at the end.

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As area the mentioned in the first panel, like other pandemics this one thrives on inequality.

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And we see substantially higher rates of disease in various populations that are risk of various types, and people with chronic conditions and other health conditions that frankly are preventable and health departments, which is the subject of this panel.

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Even before the pandemic we're struggling with a number of deficits of now there are making health departments are about 3% or 4%. of the total health care budget between 2008 and 2017 about 50,000, public health workers across the country were cut from

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the health department roles for financial reasons.

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Many of us believe that, despite all of the trials and circumstances and shifting conditions and unexpected. Both unexpected environmental and community and internal conditions in the public health feel that this pandemic really does represent an opportunity

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to rebuild if you, if, if you will, how public health departments operate, particularly how they engage communities. And to do that in a way that is consistent with the evolution of public health throughout the decades.

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So I think, on this panel, you're going to get the broad sweep of state and local health departments how they've operated, but particularly innovations that we're seeing some of which are that are long standing in the engagement of communities that will

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benefit from their involvement with public health and indeed the public health sector benefits tremendously tremendously from working closely with communities, at every level, we have on our panel today, Nicole, Alexander Scott, who directs the Rhode

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Island Department of Health. Deanna Washington Executive Board Chair American Public Health Association. Rachel banks Director of Public Health, Oregon Health Authority and John Arabic president and CEO of the trust for America's Health, and I would point

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out that both John and Rachel have both a state and public health director of backgrounds, which is wonderful. And of course Deanna is up at the national level and has substantial academic and clinical background in her work so we're thrilled to have

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these leaders, join us today.

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Our first panelist is Nicole, Alexander Scott, Dr. Alexander Scott has been the director of the Rhode Island part of public health, since April 2015. She is a physician who specializes in infectious diseases for children and adults and previously worked

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in academia as an associate professor of pediatrics medicine and public health, the focus on health services policy and practice. Dr. Alexander Scott is board certified in pediatrics internal medicine pediatrics infectious diseases and adult infectious

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diseases and I know as a fact that this morning with one of our own children she was.

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She was called into some of those roles so it's it's a real pleasure to have you here. Nicole and I turn it over to you.

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Thank you so much, Richard it's an honor to be able to join with you all as well and to be on this distinguished panel, including with one of my mentors, Dr.

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our back.

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Thank you also to the community backs coalition and the Johns Hopkins Center for Health Security for bringing us together to discuss these important systems to help build healthier and more resilient communities which we know is so critical.

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When it comes to this work and especially when we want to center on equity. The best place to start is by listening authentically to our community members.



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They are the experts in what their neighborhoods need to be healthy and they have the power to drive solutions that will lead to transformative change that will be sustained in Rhode Island our model for identifying place based local solutions so advanced

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public health is our health equity zones, initiative.

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Health Equity zones are collaborative of residents educators businesses health professionals transportation experts, elected officials and many other individuals from across a variety of fields.

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The heads, the health equity zone initiative brings together all of these individuals to address the most pressing health concerns in their neighborhoods, taking a place based approach to public health recognizes that health outcomes are closely tied

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to where people live, the surrounding environment that encompasses their homes, workplaces schools and community centers, do a collaborative process for focused on active collective action together.

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Each health equity zone conducts a community based assessment and implement a data driven plan of action to address those factors that keep people in their neighborhood from achieving their full potential, the health department provides seed funding graded

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together to ensure that the communities have the support they need to implement the model in line with core public health principles. Examples of community driven has focus areas that address the root causes of health inequities include advancing economic

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opportunity through affordable housing and job training, increasing food access and supporting mental and behavioral health care. We established our first has is six years ago and now have 11 collaborative across Rhode Island, including all of our communities

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with the highest incidence of incidences of covert 19.

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More than 300 organizations participate in his collaborative representing more than 20 different sectors such as healthcare social services, education businesses and government and diverse engagement also helps bring Hass toward greater inclusive Bidy

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and more diverse representation, both of which are crucial for generating the community by in necessary for long term success. Our health equity don't have been critical and responding to the mid 19 crisis.

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For example, the Puckett Central Falls has has spearheaded response efforts in those communities, including funding a call center for conducting contact tracing and providing outreach staff into the community.

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The state has also partner with other has collaborative to expand access to testing quarantine and isolation supports vaccination, and treatment programs, Rhode Island's has initiative expands beyond responding to the pulpit crisis.

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One example is an ongoing initiative that involves Crisis Intervention Team programs for all local police departments in Washington County Health Equity zone.

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We've seen how powerful this model is it has created safer communities, improved health outcomes and increased access to healthy, affordable foods strengthened educational outcomes, decrease social isolation and linked people with substance use and with

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substance use disorder to treatments and recovery services, among others.

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We've also looked at this as a way to advance the policies and systems that have historically been used to service barriers for communities that have been disadvantaged.

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Our health equity zones continue to teach us lessons every day. This week we are actually publishing a toolkit to share the lessons we've learned along the way and help other states and organizations, implement a similar model in their own communities.

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We look forward to continuing on this discussion and many more and welcome you to contact us To learn more, thank you for this opportunity.

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Richard you're muted.

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How's that.

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Okay, thank you john.

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Thank you, Nicole. And I know community x will be contacting you soon to get a copy of that toolkit. Thank you for your presentation.

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Our next panelist is Seattle, Washington.

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she's currently Chair of the executive board at the American Public Health Association, and medical director of volunteers and medicine a free clinic.

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We're working for the work the uninsured. She previously served on the region for southeastern Health Equity Council. She is a member and founding editorial board of the journal for healthcare transformation.

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Her work in her scholarly efforts have been multi decade and extraordinary in their breath, including her University based work in teaching, research and clinical.

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So, over to you Deanna.

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Thank you so much, Richard, just so pleased to be here today and be part of the esteemed panel, both esteemed panelists, actually, and good afternoon to everyone and greetings on behalf of the American Public Health Association.

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So I just want to start off by saying, of course that a PHA champions the health of all people, and all communities all populations, and we're continuing that work as we near our 150 year mark.

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And so, as such a just wanted to start off by a little repetition of what the previous panelists said around Kobe really exposing some long standing and equities and deficiencies and service that we in the field have been aware for some for some time

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and have been writing publishing jumping up and down about Dr back for for quite some time so it's become very transparent. And it's become hard to ignore and we are pleased by that.

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We, we want to ensure though that when people are looking at the bypassed community that they're not looking at, at susceptibility with our rates of corporate infection being higher, as, as a biological entity right we really want to try to help people

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understand that the occupations in which those communities work. This the structural racism that that may surround you know how they're living where they're living, what they're doing.

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There, the fact that they need live in multi generational households, either because of structural structural circumstances or cultural circumstances.

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higher rates of coded and severe consequences. And as we continue to monitor to monitor it also lower rates of vaccination despite their percentages in each community so we we all know that as of, even as of last week.

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The CDC to say data are showing that approximately two thirds of the folks receiving vaccinations are white approximately 63% 11% around 11% are Hispanic or Latin next around eight to 9% are black and then the percentages continue to go down from there

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with 5%. Being Asian American and 1% of a Native American on our Alaska Native so indigenous.

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So we are still in that space so it's like we saw what happened delivering care with with testing and and the holes and the deficiencies, but we're still learning and there's been a lot of talk around vaccine hesitancy, especially in bypass communities

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and particularly in the African American community. And, and while that is valid and while we have suffered generational traumas, you know, within medical care and public health, as have By the way, indigenous peoples.

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I think that we just want to say to people that we understand the focus on hesitancy we just don't want folks to fail to deal with the structural inequities of access for those communities as they're talking about that.

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So I'd like to just take a brief moment to talk about, you know, I think improving the outcomes. We can see clearly within the community that community backs document and all the efforts that all the panelists are making access to care quality to care,

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health care seeking behavior, which is often impacted by prior experiences, and of course overarching all of that, again, are the social determinants of health including racism.

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So, a PHA has been engaged in a number of initiatives as a national organization and then also with our affiliates I just want to brag on a few of the affiliates for a moment in terms of what they're getting done so for instance the Maryland Public Health

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Association.

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Believe Francine Baker is the head of that association they've been working with faith based organizations to provide vaccines, so that you We are, we are in the iteration part of it in terms of providing education but also knowing that community and

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bringing that community to a trusted source so we see that happening across the nation but I just wanted to give them a shout out for that. I also wanted to give some kudos to the Arizona.

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Public Health Association for pushing back against some of the against the distribution plan that their state had initially because of the inequities for within that plan for my pop community so we definitely want to give them kudos for that.

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I'd like to bring tell everyone that our next issue of the American general public health is actually about pandemics it's prepare, prepare but predicting contain that we've been working with the National Academy of Medicine to actually encourage a blast

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to become vaccinated and to provide that education to overcome hesitancy.

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We've also joined in a letter, urging Congress obviously to prioritize communities of color, and tribal communities and we are aware that there are states that are doing so now I'm Montana and Vermont as two in particular who have decided to prioritize

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based on race.

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We understand that that may present a greater issue legally. We want to always remember people to to look strategize and prioritize based on risk and social determinants of health, those will always an effect to give you the categories in which you, you

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need to prioritize.

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In addition, we have held the advancing racial equity webinar series, all year. And along with the coven 19 conversations, that's in partnership with the National Academy of Medicine, where we've addressed issues from testing to search as to

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how to, how to effectively bring students back to universities etc and then even this year we talked about the new year of code, and our most recent one was about variance in vaccines so we invite folks to take part in that.

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We've also been very active on the hill, obviously, writing letters and support of the American rescue plan at and public health funding prevents pandemic pandemics act.

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So in the end we are dedicated to countering, what we call the info Dimmick of misinformation we feel that that is a big threat to getting to the levels that we would like to have a vaccination and safety and the ability to return to a new normal.

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And so we are pushing forward with that and then even within our own organization. We're working hard to continue to be an even more inclusive organization, making our materials more accessible, ensuring that there are a minority voices from students

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the way to leadership and continuing our partnership with our star state and regional affiliates across the country. So I'd like to just thank you.

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Thank you. Deanna thank you to the American Public Health Association.

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Our next panelist is Rachel banks, Rachel is the director of the Oregon Health authorities Public Health Division. Prior to this role. She served as the public health director field for a Multnomah County Health Department, the largest Local Health Division

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in the state of Oregon advocating for health equity has been central to miss banks career. She helped develop all normal counties first disparity focus community health improvement plan and let a unit that enacted culturally specific strategies in the

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African American black Latinx Hispanic Native American American Indian Pacific Islander, and immigrant refugee communities, Rachel over to you

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all. Thank you. And I'm like, our panelists said just very excited to be here with such esteemed people having such an important conversation. I think, you know, to lift up as folks have talked about Kobe really has has exposed these long standing and

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equities and.



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And one of the things that I see at times when the coke has not allowed us to do.

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They will that's past behaviors those inequities were based on you know, heart disease, or some

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of the professions and all of those things have laid out with these these, these disparities and inequities have come right before our eyes, any year and we all have just been much displayed to see that.

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I'll speak about a couple of lessons learned and try to talk about my experience as a local public health authority and directors well as the state level, and we do you think one of the things moving out of this just recognizing these inequities that

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And when you think one of the things moving out of this just recognizing these inequities that we're seeing that started from before. And, and we'll go into the future is that we really need to have long standing relationships with communities communities

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that we're working with as they don't want to be addressed as their disease does your, you know, at the same time let's use this crisis to double down on our on our equity related efforts, but really that that culturally specific approach or that geographic

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specific approach is needed and that holistic sense.

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A number of years ago in MoMA county we worked on an initiative still going called achieve and at that time, the you know the wisdom was that you bring Coalition's together for time stamped project based efforts.

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And that was in the working in the black and African American community where we had a health department and a community coach, and our community said to us time and time again, like, No, we don't want to work with you You're dipping in and out, based

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on what your grant is you're extracting data that represents real pain and hurt in our lives and it also represents real strategies and brilliance that that is being used to profit or to get grant dollars.

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And at that time we had to make a commitment and this was really with very few funds which I actually think ended up being much better in the long run that we weren't having transactional conversations around contracts and grants that we needed to be

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in partnership for the long term that although we thought, you know maybe chronic disease was the most important thing that people really want to talk about legacy and they want to talk about what a community look like for their grandchildren, that we

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not set community based organizations, up to compete with each other for money.

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And all of those, those things have to be fruitful. Now, that same coalition led by Miss to meet the Brazil and we certainly would be phenomenal people there has

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to talk about Kobe, they had those existing relationships they were able to really pivot to whatever the the health, health issue is that's most important to communities.

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So, you know, from a statewide perspective what a modernized public health system looks like as we talk about public health modernization, it is absolutely key at Central and key is health equity and cultural responsiveness and the state of Oregon we

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had the privilege of working with past several years with our legislature to monitor modernizing our public health system and as part of that assessment, the biggest gap we had across the state was health equity and cultural this, we've been able, through

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over 170 community based organizations, and those are really a key stool. A key legs to the stool, along with our local public health, one that needs to continue and one where once again is communities are saying what they need.

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They're talking about jobs, they're talking about decreasing institutional bias, they're talking about all of those social determinants of health so I think there's a real opportunity for us in public health.

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To use this pandemic and the relationships that we're developing for health equity to really think long term about the vision and creating healthy communities and creating health equity for all.

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Thank you.

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Thank you so much, Rachel and in terms of your last sentence I want to share up a saying that my good color colleague, 10 or FEMA has said, let's turn a moment into a movement.

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I like that.

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Our final panelist today is john our back john is president and CEO of the trust for America's Health TFH john oversees ta HS walk to promote sound public health policy and make Disease Prevention and national priority.

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During his career, he holds senior public health positions at the federal, state and local levels as Associate Director at the Center for Disease Control and Prevention, he oversaw policy and the agencies collaborative efforts with the centers of medicine

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and Medicaid Services commercial payers and large health systems. During his time as the Commissioner of Public Health for the Commonwealth of Massachusetts.

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He developed innovative programs to promote health equity and back chronic infectious disease and support the successful implementation of the state's health care reform initiative as Boston's Health Commissioner, he directed homeless, substance abuse,

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and emergency medical services for the city, as well as a wide range of public health divisions, and I would add to that that John has done the seminal work in spilling out and refining the efforts of this the many people in the beginning of the next

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level of public health. His Britain work really has been

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persuasive in terms of that we need a new stage of public health to go into the future. So it's a real pleasure to introduce John welcome John.

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Oh, thank you very much Richard and, and I want to just echo the other panelists, it's such a such an honor to be with such brilliant leaders is that the other panelists and so it's terrific to learn from you.

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Um, I would say that with all of the issues that we've been talking about, I think that we are at a critical moment, a moment that could be a turning point in terms of our history.

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But we wouldn't I think we need to embrace the need for major policy change, and for a new vision about what public health should do into the future. And to do that we have to overcome some of the obstacles of the past I was mentioned a few of those because

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they're significant. One is the nature of funding, both that funding has been going down for funding has been going down, since the recession in public health at the local, state and federal level when inflation is calculated in and we've lost 10s of

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thousands of positions. And what we've ended up with is a roller coaster funding of core funding edging downward and then an emergency happens and money gets lumped into the system that's not prepared to quickly spend money that then has a sunset to it

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so you're, you're hiring people and laying them off, it's not the way to run a public health system. And then the other obstacle like think in terms of funding is funding is categorical there's very little discretionary dollars disease specific its condition

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specific. So if you need to address the, what a community is putting forward as its priorities, you can only address that if you happen to have a line item that fits into what the community may be saying, and that ties the hands of public health, we've

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seen over the last several years, an increasing number of major federal emergencies that people mentioned, it's certainly not just Kobe but you know, we've seen.

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Katrina, a bola Zika h1 and one weather already related emergencies and we've seen new issues to public health hadn't historically dealt with like suicide and opioid epidemic vaping and climate change.

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So public health needs the resources in order to address those issues which disproportionately affect people of color, and we can't address adequately equity, if we're under funded funded in a way that ties our hands or only always just have to respond

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to whatever emergency is the one in front of us. Now, on the other hand there's some real opportunities, the existence of the ACA the expansion of insurance access means public health needs doesn't need to do as much safety net primary care is that historically

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good we can begin to move away from that and if we're expanding insurance coverage now that will increase that allows public health to focus its attention upstream.

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We also are seeing some real attention now at the federal level in terms of policy and proposals, as well as many of the state and local levels to think differently about public health, and on mentioned some of the things that I think would be necessary

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if we're going to be able to carry out what the other speakers have said is so important for us to do.

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Certainly one thing is just funding we need core funding in public health. There's a proposal now that has been Congress is considering to add 4.5 billion a year to the CDC budget that would mainly go out to local and state health departments to pay for

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infrastructure, not disease specific work but the generalized capacity of health departments that would that would help in terms of having the resources to address equity social determinants.

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We also are proposing more line items that aren't necessarily about a disease, but allow for greater flexibility. So for example, for the first time last year, Congress passed a social determinants of health line item at CDC, and this \$3 million in it.

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President Biden just proposed increasing that to 153 million, that would channel funds to the local and the state level that would allow them to hire people who have expertise in housing or transportation economic opportunity, and public safety so that

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it's possible for public health to work in a more active way, and with greater varied expertise to try to address this, the issues that need to be addressed as communities are elevating what their priorities are.

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We also need to put a lot of money into data, we need a data modernization and part of data and modernization has to be overcoming the persistent and long term problem of insufficiently capturing data on race and ethnicity.

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I mean it's embarrassing that we're at a stage of the coven crisis where we only get about 54% of the reports on vaccines and cases that indicate race and ethnicity.

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They it 90% 90 plus have age and gender, why aren't we capturing race and ethnicity if we can capture it we can highlight all of the where the need exists and allow the resources to be targeted.

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And the final thing I would say is that unlike in the past, we need to channel funds to organizations that are at the community level agencies of color, community based organizations, we can't allow the obstacles that an excuse excuses of the past to

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continue that say, they, they don't have they're not large enough they can eat in the federal kids, we've got there are ways of overcoming those issues.

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And I think a good example of that was when it was announced, just a few weeks ago that \$2.25 billion in covert funds were going out to address the pandemic, and they had to be targeted towards populations of color.

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Even then, though the challenges, will they get small they stop at, say a state health department level or will the state health department, be able to contract those out and ensure that the resources are available, where they need to be a couple of quick

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story from when I was h1, when I was dealing with each one in one at as a state health commissioner, we were doing vaccinations across the state, in the large places that could handle a AF community vaccination drive easily, and what we realized in the

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first few months is, there was a great disparity between the percentage of the population that was white and the percent of the population that were people of color that we're getting vaccinated.

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And when we investigated that it had to do with access, and it had to do with welcome this to the communities that they felt they felt they could trust the people that were there and they felt welcome.

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And so we redirected the money to community based organizations in each of the communities that were that were underrepresented.

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And they were grassroots organizations that had never done anything like a vaccination campaign but they were happy to host it happy to, to have their leaders, encourage people to come in from the community and in a matter of months, the disparities that

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had existed.

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Were were eliminated in terms of vaccination. And that for me was a reminder, we've got to get the money to where it's going to do the most good. So, having funding streams that allow us to do that will help with that, I will end my comments.



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And with that, I will end my comments. Thank you so much John, and thank you for this panel for really illuminating the whole sweep of issues from a very local level, the most local level right up to the national level in terms of some of the factors

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that will be necessary. If headway is going to be made on the very important issues that we discussed today.

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We're a little over in our time and I did have one or two questions I wanted to put to the panelists. Deanna you mentioned, what the American Public Health Association is doing and what we're all contending with in terms of misinformation is out there.

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You know, it's, it's, it's almost like a Post truth environment in many respects, and pandemics require that honest direct truthful communications occur at every level of the public health system within the community.

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Do you have ideas in terms of how do we go about neutralizing this if this is not an easy question but what's your sense of how we grapple with this. Over time, particularly at the national level where you are situated.

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Yes, um, I think that my answer is going to sound similar to many other experts as we're trying to grapple with this.

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Certainly, trust trusted messengers with consistent messaging makes a difference, and whether that's at the national level and or whether that's in our community organizations.

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So, for instance, I in my volunteers and medicine clinic.

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We are working with a local community pharmacy.

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That is trusted by the community we are trusted by the community and so we've just been giving consistent messages for about two months before we received the vaccinations to give them and now we are providing vaccinations every day and they are the community

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is responding to that and so the ability to provide the information consistently from people, again, who, who are trusted who are known, is, is, at least one, one step of it.

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And then, of course, utilizing across all of our partner agencies at the national level trying to also provide that messaging to Congress, and with the alliance that we formed in December, to try to look at how we are impacting services and how we can,

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we can increase equity and services across the United States.

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Thank you, thank you for that.

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And Rachel a question for you based on your comments. Obviously we've got a continuum among both local and state health departments in terms of relatively more community involvement and relatively less community involvement.

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And I'm wondering, for those in the latter group that those that have relatively less involvement, for whatever reason, whether its financial cultural based on the particular department or any other factor.

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Some ideas or thoughts you have for those sorts of departments to start re engaging the community.

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Oh, thank you for that question. I appreciate it I think there's a number of things that can be done.

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One is thinking about the entry points and who community would be engaging with and creating those types of positions and valuing lived experience in within the staff that you may already be working, working with often I see that's one of the barriers

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that there are people that come to work every day and do, perhaps some other job who are community leaders and and who go home at night and they're talking to their neighbors and whatnot so I think it's building the capacity in in our organizations in

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local and state health departments to have folks that can engage with the community is definitely one star, I think, you know, always, as it was said, kind of listening and hosting sessions are just really being honest and you know it's it's relatively

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cost effective to set up a zoom call with leaders to go out and show your face that vaccine events, those sorts of things. So I think, you know, those are ideas as well, and other folks have mentioned community assessments.

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If whereby you have a community health improvement plan coming think there's a radically different way to do that to think about asking community what that looks like.

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I know when we did that in both at this in my county and Portland and at the state level in Oregon when we focused our community health improvement plan, not just on the top disease categories, but on in equities or on a community based process we got

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drastically different results back so whereby before we had, you know, community health improvement or State Health Improvement Plans it really focused on maybe it was opioids, or increasing breastfeeding rates or diabetes or, you know, all important

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things when we engage different stakeholders and said, Actually we want to use this health improvement plan to achieve health equity, we got back things like a, we know our communities we want to value cultural and lived experience and that brilliance

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that community has, you know I mentioned talking about institutional bias and adverse childhood events. It's a much longer picture it's a much more holistic picture, and it allows that continual engagement with community so those are some of the ideas

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and, you know, one other thing I guess I would say is, with all of the investments coming through. Soccer our box point is a prime time to be funding community based organizations, and building out culturally specific strategies within our organization

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so that that as we're listening we're able to take that take the feedback, do something with it and most importantly, continue to go back out and talk to community about what we're doing with what we've heard.

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Well thank you very much for that. And if if priors here, my colleague, or maybe we could do a question, we're very mindful of the audience's time today So, are you there and, and might you have a question for us.

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Thank you Richard I have one question. And that question is, how are by pop communities involved in developing solutions solutions are being created for this, for these communities, but how are intervention, being created with these communities.

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I can give one example it's a recent one and conversations that we've had with the Latin community here in Oregon who's rightfully brought a lot of attention on the vaccine inequities really highlighting that the Latinx community has over, been overburdened

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and has a disproportionate share of the state's coveted cases that they are fine.

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Because, because of their efforts to and things like agricultural work and a variety of other fields that have kept society going but but are under vaccinated.

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And really, I think, in that and i and i don't want to use this example to say it's a shining success. It's a lesson learned and it's too much of a gap that we're seeing, but communities came forward and said these are the strategies we want to see.

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And what we did with that is said, based on what we heard here are the things that we think are possible and here are the continuing questions for community dialogue.

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So it's a bit of listening to what community say this is what's needed us doing our homework and showing up and taking accountability and responsibility, pausing and saying, What do you think, did we get that right, and then working together on next steps.

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Well, thank you, thank you so much. And we are at the time, Mark, I will tell you that.

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For those who did ask questions, we will look at them and try our best to get back to people. I want to thank my co chair turnover edema, and thank the audience, in particularly thank our panel members today for sharing their ideas, their thoughts, and