It's a pleasure to introduce our presenters and our discussant for our second panel this morning.

Our first panel member is Dr. Daniel Dodgin. Dr. Dodgin currently directs the Office of Policy and Strategic Planning for the assistant secretary for preparedness and response at the US Department of Health and Human Services. This encompasses national health security, health system policy, mental health, community resilience and at-risk individuals.

Dr. Dodgin served as executive director of the White House, directed a national advisor group on disaster mental health and led the nation's mental health response to hurricanes Harvey, Erma, Maria, Katrina, Sandy and others.

Also, the H1N1 epidemic, the BP oil spill, the Boston Marathon bombing, multiple mass shootings and other natural and manmade disasters.

He was one of the lead authors for the Impacts of Climate Change on Human Health in the United States: A Scientific Assessment.

Dr. Dodgen also served as an advisor to the government of Greece and the State Department for the 2004 Olympics in Athens.

Before joining HHS, Dr. Dodgen was senior federal affairs officer at the American Psychological Association following his AAS fellowship with the US House of Representatives.

With the Red Cross, he responded to the Los Angeles riots, the North Ridge earthquake, the Oklahoma City bombings and the September 11th Pentagon attack.

He received American Psychological Association 2005 early career award and was elected a fellow of APA in 2012.

He is on the board of directors of the International Association of Applied Psychology and as a Harvard senior executive fellow.

He is also a licensed clinical psychologist in Washington DC.

Our second panel presenter is Dr. Sachiko Kuwabara. I hope I got that right.

Who currently serves as the director for the Office of Risk Management and Operation Integrity and the Division of Emergency Operations here at CDC.

As director, she provides overarching strategic leadership, centralized management, coordination and guidance to identify and mitigate risk inherent in public health emergency preparedness and response operations.

This program is committed to addressing the various aspects of emergency operations that can impact personnel, processes and performance, including the characteristics and processes for evaluating and implementing risk and operational integrity and management systems.

Prior to serving as the director, Dr. Kuwabara served as the deputy for the Deployment Risk Mitigation Unit. In this role she relied on her training as a psychiatric epidemiologist to help guide the development of support programs to meet the needs of agency staff working on the front line of the Ebola outbreak.
The DRMU was set up during CDC's 2014 Ebola response and was tasked with addressing concerns related to respondent wellbeing. The unit supported CDC's mission of ensuring safer, healthier people by addressing the needs of the deployed CDC staff and their families. Then our discussant is also going to be co-presenting alongside Dr. Kuwabara, is Julio de Santali Pierre. Julio is currently team leader for the initiatives and partnerships team at the CDC Office of Minority Health and Health Equity. In this capacity, he provides technical leadership for the agency on the development of health equity programs and agency language access capacity building initiatives. He also oversees several agency-wide initiatives related to national public health pipeline programs, public communication efforts and binational health equity collaborations with Brazil. Please join me in welcoming our panel presenters and our discussant.

>> Thank you for the nice introduction and the nice welcome. And thank you for inviting me to be down here. I always love coming down to Atlanta and seeing the great work that happens at this marvelous organization, as well as seeing this beautiful campus. It's a lot nicer than the building that I'm in. Oh, I'm in a nice building, but we don't really have a campus environment like this. So thank you for allowing me to come.

All right, well like I said, I'm really thrilled to be here. So I wanted to start just by talking to you a little bit. How many of you are familiar with ASPR, the assistant secretary -- all right. We've got a lot of hands up here. So I'm not going to talk a lot about what ASPR is. I think if you've heard Dr. Catlick or any of our leadership talk, you've probably seen the four priority areas and what those are. So I won't spend a lot of time on that. But what I do want to do is spend a little bit more time talking about some of the specific things that we do at ASPR that I think are most relevant to our conversation today.

And of course one of those is the specific mandate that we have that actually all of HHS has to address the needs of at-risk individuals in disasters. At-risk individuals are defined in the law as children, pregnant women, senior citizens and other individuals who have special needs in the event
of a public health emergency.
Now what we decided to do back when the law was first passed in 2006 was just say, "You know, it's great. We absolutely need to be paying attention to children and pregnant women and senior citizens."
But there are a lot of other people who have specific needs during a disaster that may not be addressed if we're not consciously thinking about them when we're doing all aspects of preparedness response and recovery. So we really decided, let's take a little more expansive view of this.
And that's when we developed the concept of access and functional needs.
Now are most people familiar?
Raise your hand if you kind of know what access and functional needs are.
All right, so we saw a fair number of hands up. Basically, if we were to boil it down, what we're really saying is access needs, as you see here, people who must have access to certain resources or function-based needs that refer to restrictions or limitations.
But really think about it as during an emergency needs to be able to access healthcare, right? We're HHS, that's our main focus. What are the things that are going to make that a challenge? It could be a functional limitation.
You don't have a car. You could get to it if you had a wheelchair or if you had your service animal but now you don't so suddenly maybe you're at risk.
You know, unlike the people in Atlanta, a lot of people in DC, including myself -- New Yorkers will understand this -- don't have cars.
I haven't owned a car since I moved to DC in -- well, the bio already spills the beans. So more than 20 years ago.
So I could actually be one of these people, right? If there's an evacuation scenario and we need to get really far out of town, maybe a plume scenario or something like that, I'm going to fall in this category. So the reason we focused on the need rather than some particular category you might fall in to, because your need may not map onto the traditional things we think about when we think about who's at risk during a disaster. Because let's say for example someone with a service animal who has a visual impairment. Now most people would automatically put that person into a need category, right? Like, they're blind, they've got to have special preparedness. But often people with mobility and visual impairments actually have given this a lot of thought. They have a plan and they may have a service animal.
They may have a plan in place, a neighbor that will transport them. So that person actually is going to be okay. And we also don't want to stigmatize or disempower people by saying, "We're going to take care of you in a disaster because you have a visual impairment," when in fact maybe you don't need extra care. So it's about the need. What do people actually need in a disaster? Which of course means we have to know our communities, right? Because otherwise we're going to make the assumptions that if you fall in one category -- they're going to look at me and say, "Well he isn't going to need any assistance." While I sit in my condo and get nuked or whatever because I couldn't get out of town. So it could be any of us. And I think that's the important thing to remember. And in fact, it could be all of us, right? Because there's probably not a scenario where one of us might not discover that we're at risk. For example, there are a lot of people who take medication all the time, right? Different for chronic health conditions or whatever. All right, but most people who are taking medications for chronic health conditions may not actually be known to the people who plan for special needs or vulnerable or at risk. And yet you could quickly become at risk if you don't have access to that medication over some period of time. So all of us have some vulnerabilities, and I think we start from there. Because I think that allows us to start from a position of humility. Then to begin thinking about where are the needs in my community? Where are the needs going to be and how can I better plan for that, which is really the first step to resilience, right? So there's lots of great models and lots of great definitions of resilience. I don't want to go through all of them because that would take all of the time that we have remaining and the rest of the week too. But this is just a simple one, and I think that this framework from Rand is actually really, really helpful. Community resilient requires building neighbor-to-neighbor alliance and organizational connection. I want to focus on that because I think when we think about resilience in terms of how does it build connection, I think that's how then we can start to think about how we integrate it into our disaster preparedness and response. And one of the things I think particularly as health workers we have to be aware of is sometimes we're a little bit too humble. Sometimes we are willing to defer to, "Oh, well, we're not building roads and we're not doing the power grid. We're not bankers."
And I think sometimes we defer to others in terms of thinking what does a community first need in a disaster. What does a disaster community first need in terms of thinking about preparedness, response and recovery? And I think we need to recognize that healthcare really is the node through which so many other systems that we need in a disaster are connected. And we as healthcare are connected to all of those things, whether it's supply chain and infrastructure as it relates to that, roads, buildings, refrigeration, you know, as our esteemed colleague from Puerto Rico was talking about. All those things connect through health. And the argument that I always make, you know, when I'm at meetings on climate change or whatever is like people care when it affects their health, their wellbeing, right? That's when people become involved. So for example, we have wildfires and there are wildfires all the time in the west. You know, I'm from the west and the southwest. And we care and we look on the news, but it's when homes are threatened, lives are threatened, that's when we become interested and involved. So it turns out that people's health and welfare is a critical part and it really is the node I think through which community resilience has to be built. So how do we do that, right? I'm going to just talk very simply and basically because I want you all to be thinking in terms of where you work, where you're at, how this might play out. And I'll just go through these steps. So the first step, there are strong relationships between organizations. Okay, that's a sign of resilience. Well, what does that really mean for us? At ASPR we've already talked about the HPP, the hospital preparedness program, a little bit.

Which builds coalitions, right? We have these coalitions that are comprised not just of hospitals, but of everyone involved in the healthcare system. And in fact, we're really working to make those more inclusive so it's also nursing homes, mental health facilities, home-based care facilities, et cetera, or organizations so that when we think about the coalitions of healthcare providers in a community that we're funding -- that's what the HPP grants do -- that it truly is a coalition of members of the community who deliver not just direct healthcare services but also the auxiliary services around that.
Obviously, we have partnerships with WHO and ASTHO. But I think there are other ways, and each of us can think about, okay, how do you build strong relationships with these organizations in your community? I think it's particularly true of the topics that we're talking about today, because often the most vulnerable members of our communities, whether they're ethnic minorities, people with disabilities, other people who we know might be at higher risk during a disaster, often are served by community-based organizations, faith-based organizations, et cetera, which often are not part of the traditional public health coalitions and the traditional emergency preparedness coalitions, right? They often don't even have a seat at the table. So if we have strong relationships between organizations, that means the organizations that are serving the members of our community in direct ways like for example home-based care services, are part of that organization. So that's a sign of resilience. How do we ensure organizations are ready and prepared to respond and recover? I think this is as particularly important one because we really do have these two worlds, right? We have this world of people who provide direct services to some of our most vulnerable members of our communities, right? They're often community-based organizations. They frankly often function on relatively low budgets and often advanced planning and sort of taking on new things is a real challenge. You know, I come from the community mental health system in terms of where I started in my professional career. And community mental health systems cannot even meet for the most part their basic need to take care of the severely mentally ill or children with severe emotional disturbance, right? Which is kind of the basic mandate of community mental health. And then when you come to them and say, "And I expect you to do emergency planning and I expect you to show up at all these meetings I'm going to convene downtown in the Public Health Agency. And I expect you to give me regular reporting on the status of your facility when something happens," it's overwhelming because they're already overwhelmed. They're already not able to meet the needs of their community. It's not because they're not passionate. It's not because they don't care. So first up we have to figure out how do we help people who serve our most vulnerable members of our communities. How do we help them think about emergency preparedness in a way that helps them do their job better? Right? And then the other thing is the emergency preparedness community, right, emergency managers, first responders, et cetera, how do we get them thinking about their community in a different way?
So we have these two worlds that don't often intersect until after an emergency has happened. And one of the things I think that if you want a truly resilient community, we have to think about ways to do that. And I think there are some ways. I think certainly the more we can take responsibility for providing free trainings, web-based trainings, capacity-building tools, things that actually give people resources that don't cost money. But then I also think we need to help people think about how emergency preparedness also benefits the everyday work that you do. Certainly I worked in the community mental health center where I started my career. You know, we had a walk-in crisis center. People could come in and receive free immediate care for crises. And we definitely had people walking in who were suicidal, walking in who were having psychiatric episodes where they were really beginning to decompensate. I had a client run out of the office and try to run in front of a bus on the street one day because he was actively suicidal. So there are a lot of people in our community who serve our most vulnerable who actually deal with crises every day. They do. And I think there's a knowledge that we can tap into, but I think there are also linkages for them so that you can begin to see how the everyday work you do dealing with crises, there are maybe ways that that can be tweaked without adding a huge burden to you. So you can think about how that could be leveraged for emergency preparedness and response. And I think we who are in the emergency preparedness and response field need to be better at helping our community-based, faith-based organizations do this work, right? We can't just keep telling them, "Oh, you've got to do it, you've got to do it." But there are actually things that they bring to the table, things that we can help them figure out how their skills and what they do every day can actually help them to be better prepared. All right, so how do we promote disaster volunteering? Again, the third step here in the resilient communities escalator here, enough volunteers to help in a disaster. I think all the things that we've already talked about -- Mitch mentioned and I think all the panelists have talked about the importance of involving people from the community. And I think one of the things that we need to do a better job of is also recruiting people into volunteer programs that look like the members of their community. And that requires extra effort sometimes that we haven't always been willing to do in the past. And I think we talked about why that's important.
Some of the examples of things that happen at ASPR, the National Disaster Medical System, Medical Reserve Corps, these are the worst acronyms in the universe, the Emergency System for the Advanced Registration of Volunteer Health Professionals. But those are just three ways that people can volunteer. But I think again if we're serious about having enough volunteers to help in a disaster, we need to also be thinking not just about numbers but about the skills that they bring and the sensitivities that they bring by recruiting from more diverse members. How do we dissociate individual helping behavior, right? As we know in many, many of the kinds of emergencies that we're talking about -- I think it's less true in hurricanes, but in many situations the people who can help you out in the first few minutes actually turn out to be the most crucial in a lot of scenarios. Certainly if you're talking about a mass violence shooting event, which sadly we're all experiencing more and more. But also potential terrorist attacks. Even a hazmat incident, chemical incident, et cetera, often the resources the official resources in your community may not be able to get there in time, right? So one of the things that a resilient community can do is it enables people to rely on each other, right? It's the whole neighbor-to-neighbor concept. So I think one of the things we need to be thinking about is how do we facilitate that individual helping behavior. And again, I think we have a lot of resources in that regard, but whether we're actually doing it and really training our communities, I mean I think CERT training which is available in a lot of communities is an example of that. I think first aid training -- I think a lot of the things that we used to do more of and kind of as we've sort of become better at relying on -- not better. We have come to rely more and more on government to come in. And even when you do polling on sort of people's expectations about what will happen after a disaster, there's a lot of expectations around sort of outsiders are going to come in and help us. But that isn't necessarily true. And so I think we have a responsibility to help people figure out, how do we make our own communities stronger? And then finally, which is really the bottom line, how do we help individuals and families prepare and respond? And again, I list some examples here, but I think this is really sort of where the rubber meets the road, right? How are we going to ensure that all the members of our community
at the individual and family level are better prepared?
And I feel like I'm saying,
"We ought to do this, we should do that."
There are programs in place that are doing this, but I think all
of us in this room, we're in this room for a reason, right?
We care about this stuff.
I think it's up to us to begin to make these linkages,
because I think we focus a lot on response.
We focus a lot on recovery, but I don't think we focus enough
on the linkages that build resilience
that enable our communities to be stronger
when something bad happens.
Because you know, as I was telling Admiral Redd earlier,
but we all know it, every one of us, our community is going
to face a catastrophe at some point in our lives.
And every one of us on an individual level is going
to face some kind of catastrophe in our lives.
That's just the reality.
Whether it's a cancer diagnosis or a mass shooting
in the community next to you or a train derailing or a hurricane
or an earthquake or whatever, it's going to happen to us.
And I think we too often sort of live our lives
in a bubble thinking not us, it won't be us.
And I think because of that we fail to take advantage
of these opportunities that are there.
And also I think as public health people --
again, I talked before about how we're unnecessarily humble
sometimes when it comes to disaster response.
We tend to differ to the other folks in the room.
I think we need to be a little bit less humble and we need
to really be more proactive in our communities about saying,
"All right, we have a role."
Health is critical.
Wellbeing is critical and it's critical
for every member of our community.
So how can we do these things that build resilience?
Because if we can build these resilience factors in earlier,
it won't be a problem later.
One final thing that I wanted to say, just listening
to all the remarks, I don't know if any of you are familiar
with the ISC guidance on mental health and psychosocial support
in emergency settings.
It's a WHO document.
But I strongly encourage folks to take a look at it.
And I'm going to -- I know I'm almost out of time.
I'm almost out of town actually, because I have a flight soon.
But I just want to read one section of this guidance.
Remember, this is about psychosocial
and mental health assistance in a disaster.
And this is under the core principles section
on page 12 of the document.
"Humanitarian aid is an important means
of helping people affected by emergencies.
But aid can also cause unintentional harm.
Work on mental health
and psychosocial support has the potential to cause harm
because it deals with highly sensitive issues.
Also this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as participating in coordination groups to learn from others and to minimize duplication and gaps in response, designing interventions on the basis of sufficient information, committing to evaluation, openness to scrutiny and external review. Developing cultural sensitivity and competence in the areas in which they intervene or work, staying updated on the evidence base regarding effective practices, and developing an understanding of and consistently reflecting on universal human rights, power relations between outsiders and emergency-affected people and the value of participatory approaches.

So again, take a look at this document. And mostly I just want to encourage everyone to keep thinking about all of these issues. This conference is a great start and a great way to get this conversation going and to keep it going. So I just want to encourage us all to do that, and thank you for your time.

[ Applause ]

>> So thank you for that.
And good morning and thank you for allowing me to be here. I just want to start by saying what a wonderful forum this is. I think the opportunity to speak honestly about some of these topics, you know, and talk about some of the structural inequities. And when we think about disparities in health in particular, I think sometimes it can make us a little bit uncomfortable and so we can be afraid to talk about some of those experiences. And yet I think it's having those honest conversations that is really the most important. That's actually going to move us forward. So what I've been asked to come and share a little bit about today -- and again, I appreciate the opportunity not only to share some of our work, but also to learn from our colleagues as well. I'm certainly going to walk away from today with a lot to think about. It's really us moving towards implementation of some of the concepts that we've talked about and heard about this morning. Thinking about it too from the role of the responder. So taking a slightly different perspective and looking at it through that lens. When we look at the intersection between emergency response and cultural humility and our role in response, specifically as responders, I think it's important for us to consider our own personal biases and how that impacts our interactions with, our communication and our ability to build those trusting partnerships. That sort of mutually respectful relationship that will help us
to ultimately achieve what I think we're all on the ground trying to recover from and focus on rebuilding our communities in the event of an emergency. When we think about emergency response too, we think about the environment in which we are sending some of our responders, and the environment in which many of us have deployed into. And it's an often chaotic sort of stressful environment. It's usually unfamiliar in some ways to us. And sometimes we don't think about how that might make us feel and how we cope with those feelings.

And when we sat down and talked with a number of our responders during the 2014 Ebola response, that's really what they expressed to us. And it was sort of expressed as this desire for some kind of cultural training. And again, really more around that internal acknowledgement of how cultural norms and behaviors influence our actions on the ground. And so we started looking into cultural humility, concepts of cultural humility and concepts of cultural competence. And I really think it's more than just gaining factual knowledge. Again, it's about that ongoing attitude, right? That attitude towards our communities and our attitude towards ourselves. And for us, thinking about cultural competence not as an end goal but as a process. And thinking about cultural humility as one construct for thinking about that sort of process approach. We then had an opportunity to work with a number of experts here at the agency. In particular I want to thank Dr. Arlene Edwards who really sort of led the development of and helped us think through frameworks for thinking about cultural humility and emergency response. I also want to acknowledge Commander Bourneman and her role in this. And then of course our colleagues in the Office of Minority Health and Health Equity really for their leadership in this space. So with that I'm actually going to turn it over to Julio for a more in-depth discussion of the training itself. Thanks again.

[ Applause ]

>> So for this part I'll just sit here and then I'll switch to discussant later at the podium. So one of the -- oh, actually, you know what?

>> Want me to go to the next one?

>> No, no. I'll do it from there.

>> Okay.

>> So we really appreciated the opportunity to work with CPR in doing this activity. Particularly because our office has had a longstanding
relationship on issues of emergency response operations, either by providing technical assistance and support. But we also understood that there were a number of issues coming up in terms of what were the lessons learned with responses that we wanted to provide some input. And we thought that the best way to provide input was to be a closer partner. So we were very encouraged by this opportunity to work more closely together with CPR on a project that really will -- the intent is to touch the work of the majority of people who go out, if not all of the people who go out on a deployment response. And so the objectives of the training, and again this is based on the previous work that was done by Edwards and Bourneman. Was to recognize the value of reflectivity in one's own cultural norms, values and behaviors, engage in self-examination and exploration, examine potential biases and assumptions and develop strategies to avoid imposing individual cultural norms and values on others in specifically the deployment setting. So the objective was to not only go through this exploration but to really come up with concrete strategies. One of our driving principles of the training is that people were imminently assigned to go out to do a deployment. And so while we understand that this is very broad and can often be a lifelong endeavor for any particular individual. We wanted to get very concrete about what you're going to do in the next two weeks to prepare. And what do you plan on doing while you're in your deployment? We made sure that that was a driving principle for this training because we heard very much from deployers and from CPR that this had to be actionable. It had to be something that they were going to be able to do in real time. And so as part of the work of looking at the literature on cultural humility, and there is quite a bit of literature in the social sciences, particularly in the context of healthcare and healthcare settings. We wanted to look at those in the context of deployment. And so we then started to frame those competencies of cultural humility in the context of a response. For example, under attributes, there is issues of openness. For actions there's providing available, accessible and detailed information in a timely fashion. In terms of skills, it identifies problems and when and how to follow up on the identified problems. So we want to get very specific and granular about not only what does it look like, but what kinds of skillsets would you need. And that way perhaps provide the deployers a pathway to start building those skills as they are either getting ready for that immediate deployment, while they're at that deployment or even after they come back from a deployment.
It's a very concise training. Again, another parameter of this endeavor is that they would be able to get it in one shot prior to a deployment. And so the training agenda includes a statement about what is the strategic imperative that the training provides, the objectives related to the training, a pre-test to help people assess where they are. We then provide definitions, go through the map of the attributes, actions and skills, go through a participant-driven exercise around the use of a planning tool for deployment so they can really start thinking very concretely about what's going to happen once they land, wherever they're going to be placed. We go through a series of scenarios based on scenarios that were provided by previous deployers that of course have been blinded for issues of protecting the individual. And we have a strategic planning session where all of the people in the room talk about, "Okay, and what does this mean now that we're moving into uncharted territory in this new response?" And then there's a post-test. So we are in the process of collecting the feedback from the material review and the training will be piloted. It's been constructed as a 90-minute training for a multidisciplinary group of responders, behavioral scientists and cultural competence experts. Some of them will have seen the material and some of them will experience the delivery of the material. And that starts in February. So immediately after this week we start looking at those dates. Any questions we'll hold until we open up the floor.

So I want to appreciate this slide and I'll keep it up. But I do want to go back. Now I'm switching hats here as the discussant. I want to go back and make two observations and then I have one question for Dr. Dodgen and one question for Dr. Kuwabara. So what struck me in terms of, Dr. Dodgen, your presentation about ASPR's role, is given our previous panel that really talked about, as Mr. Stripling mentioned around structural racism. And often we have to build better, not build the same. Because we're often then reinforcing a structure of inequality. You identified this issue of building resilience intentionally. And I'm wondering, what are the inherent challenges of that kind of dynamic at a national level with so many dynamic underlying factors that drive some of these access and functional needs that you spoke to? If you could speak a little bit about that. >> That's a nice, easy question to address, and I'll try to be brief.
In terms of I think what the challenges are, I think first off of course the programs that are designed to address the needs of people who are at risk. For example, all the programs for our administration for community living for people with disabilities, for seniors, et cetera. And then we have a separate administration for children and families that does a number of programs aimed at welfare system, Head Start, et cetera. And then we have other great programs at CDC and of course we have World Health, HERSA. So a lot of the places where this kind of activity can be engaged in are siloed right from the get-go by the way that Congress appropriates their dollars and authorizes their programs. So I think there are a lot of incumbent challenges. And then of course the added complexities are that many of those programs don't have the funding and the resources and the personnel that they would like to be able to address the real needs that are happening across our communities. So that's the challenge, right, is that you've got sort of under-resourced programs that are already siloed. And as we all know, collaboration pays off big time in the long-term. But it's really labor- and resource-intensive at the beginning, right, to make all the contacts, to get to know everybody. But I think that's also an opportunity and I do think that's where disaster response is an opportunity, because it is the one time when you can actually pull people together. Think about the RACs, which are the regional advisory committees in all ten of the regions of the US. And the HHS regions and the FEMA regions are co-located, right? They're always the same headquarter city. Those folks convene much more frequently during a disaster, so all the people who lead a lot of programs are getting together. That's also happening at the national headquarter level too. I think what we need to do a better job of -- it's a great opportunity but we need to do a better job of leveraging the collaboration, the collegiality, the let's all pitch in and help attitude that happens during a disaster. We need to do a better job of leveraging that into how do we collaborate all the time better to build the kind of strength so that the next time a disaster happens we'll be able to do that. It's challenging, right? It's challenging because the funding and the authorities and all that aren't set up for that. But I think disasters as horrible as they are do provide an opportunity for us to convene and to start talking about how do we do this better all the
time so that in the next disaster we're better coordinated and better prepared?

>> Great. Thank you.

And so for Dr. Kuwabara, Dr. Dodgen just mentioned this issue of silos. And I just wanted for you to perhaps provide a little context for -- CDC is very known for its silos among us, right? We were very happy to collaborate with you all. But what led your office to reach out to us for this kind of collaboration? Could you give some context to that?

>> Sure. Yeah, so I think unfortunately yes, there are times where we can be siloed. I think where we have been able to be really successful though is when we've been able to leverage I would say the really broad, rich, expertise that exists here at the agency. And so having that opportunity to collaborate with the Office of Minority Health and Health Equity, with our partners and NCHHSDP as well as with our partners in the Center for Global Health around this particular topic. As we think about preparing our staff -- and as you mentioned, who represent themselves in a broad range of areas of expertise too. So I think that in part that comes with the recognition that we don't necessarily each individually own or know or have the full subject matter expertise. And where we can, find ways to collaborate and come together to sort of piggy-back off of each other's experience and knowledge, that that ends up being a really rich and powerful opportunity.

>> Great. I have follow-up questions on my end, but before my end are there any questions in the room? Because I can keep berating them, but if there's anyone in the audience. So Dr. Valentine.

>> Yeah, please.

>> This question I've been sitting there struggling with and it may not be for this panel. It may be for the synthesis panel. But I was trying to figure out -- I mean I understand what we're saying about preparedness and things we can do to sort of build relationships to be more effective in our response. What I was thinking about was sort of the nature of like responders when you're in an emergency situation and there is no time for some of these processes that we're describing. And people sort of have their mindset, is "Oh my God, the house is on fire. We've got to put it out." And nobody's thinking about partnerships and collaborations and all of these nice things that are really,
really important if you had time to prepare for fire prevention. But not exactly when you're in the fire. And so I was thinking when Mr. Stripling spoke about this whole notion about taking the time and sort of pumping the breaks and creating these kinds of relationships that honor and respect the communities that we're seeking to provide services to. But there's this sort of rescue mentality that kicks in and I think that's very real. And overcoming that in the provider's head is really important as well as people who are sort of being helped expecting to be rescued. So I just wondered, maybe again it's for the synthesis panel, maybe it's for this panel. But how do you balance out a situation where you've got a time problem? You don't have the time to do these very important kinds of sort of preparatory kinds of activities. And moreover you have people coming with a mindset that's not about partnership; it is about me swooping in and saving you from this disaster. So really how do we tackle that and really move forward to get to a point where we can sort of build it back better with an improved set of relationships? Because once you start off wrong, it's also sometimes very difficult to correct that and get the right balance again in the partners when they're coming together.

>> Thank you, Jo. Anyone on the panel?
>> Okay, well I have sort of two responses to that. I think the first one is really you are so right. I think it's a great question and I think it's one that we all struggle with in emergency preparedness and response, is once the buzzer goes off or whatever metaphor you want to use, everyone wants to run into the burning building, right? Everyone wants to help. And that sort of heroic phase of disasters is really valuable, right? The community comes together, great things happen. I do think we can leverage some of that positive energy to get people to the table that otherwise wouldn't be there. But I think the challenge that you point out is a good one. There is the second part of my answer, is my office actually, or my old division, actually did develop a training called Psychological First Aid for Leaders. And it is a training specifically on how to use sort of basically psychological first aid skills which is kind of listening to people, helping people keep calm while they're responding to disaster. But this is a training that takes those basic psychological first aid skills and teaches leaders how to use them when you are leading in an organization during a crisis. How do you take those same skills to support your workforce and the people around you so that they don't get caught
up in sort of the high energy to the detriment of the long-term goals?
And it's actually a really great training, I have to say. It's free, anyone can take it and it's modular so you can stop and start and do whatever.
And you can access it from the ASTR website. I can't remember the URL right now.
But if you look up psychological first aid for leaders, you should be able to find it.
But I think it's one potential tool that people can take. Of course, they still have to take it before the event happens, right?
I mean, so I think part of it also is for people like everyone in this room, including us up here, to be at the table and not to be reluctant to say, "You know, I notice that we're really focusing on this, but we've forgotten something."
Particularly when addressing the kinds of concerns that we've been talking about today actually does help the long-term response, right?
Because if you've got a pocket of people who aren't being helped, you're still going to have to go back and help them eventually.
So there are things that our presence can do.
So I think it's also part of that --
I keep saying don't be humble which is contrary to everything I've learned in church growing up and everything else.
But I think we often let ourselves be overridden by events.
We don't bring up -- you know, you can't always be the thorn in the side.
I mean, sometimes you've got to go with the program.
But I think we need to be a little bit more bold about saying these issues are important.
>> Dr. Kuwabara?
>> Yeah, I would just add, as I mentioned, I think forums like this where we can have those honest conversations and we can start to engrain that into our way of thinking so that we are shifting the dialogue even before the event happens.
And I think that's the intention too with the training around cultural humility.
How do we help our responders think about their own biases and process that in real time?
You know, we've talked about making the training something that we can provide to our responders in real time, just-in-time type of style training.
But we've also talked about what are other forums or platforms in which we can provide this type of training and that we can continue this conversation.
>> And just to add and then we'll go to Dr. Rodriguez Mercado, his question.
But one of the things that I think this panel is about is that there needs to be an institutionally lifelong commitment to these issues where it cannot be episodic.
Because then we're always just being responsive, right?
And so that's why I wanted to have Dr. Dodgen talk about --
there are operational challenges to doing that,
particularly at a national level.
And that at the individual level, that's also true, right?
So the course is really about those who are going
on deployment while the time interval
in which we're reaching them is two weeks before they go
on a deployment.
We really want them to leave the training knowing that this has
to be their lifelong homework, right?
That it's not going to happen in a 90-minute session.
They have to become much more mindful and intentional
about building those skills over time, because they're not going
to happen in one shot.
Dr. Mercado?
>> Yes. One of the big problems that we have during emergencies,
especially with the elderly population and the people
with mental discapacity, is that sometimes --
and I don't know if you can give me advice
about how we can address this.
In terms of the elderly people, the Department
of Health only certifies those centers
where the elderly people live.
You know, nursing home, nursing, that's it.
But the main responsibility is under the agencies
like Family Department and Housing Department.
So that was a big problem during the emergency
because they had the data, they don't share
with the Department of Health.
It was a mess at the early beginning.
Then we bring over everybody and we work as a team.
But I think that they should decide
that when they assign resources to that type of population,
maybe sit down with all of the people that are involved
in the care and make sure.
And maybe work out as a team or maybe make like a committee
that can sit down and establish a plan,
a master plan for an emergency.
I think that that population, the mental incapacity
and the elderly, they are the most of the groups
that people miss and forget that they exist.
You know, only when they are involved in a major disaster
or natural disaster, then they remember about them.
But I think we should establish a way that we can work together,
the state and federal agency, with that kind of population.
Because I think that those are vulnerable too.
There is a lot of problems because most of these people
in terms of the elderly,
their family members just put them there
and they forget about them.
So that creates a problem.
People with mental discapacity, sometimes their parents are
so old that they reach a point that they die, both parents.
And then the people are on the government maintenance.
So I think that we should do some alliance
or maybe brainstorming about how we can deal
with these two groups.
I don't know. You're the expert, so you tell me.

>> All right.

So this is a great comment I think for a lot of reasons. First off, I think it's really important, the comment that our colleague from Puerto Rico made, is that often the elderly and people with mental disorders are the most vulnerable. And in fact that's actually borne out by the research. If you look for example in extreme heat incidents, heat waves, et cetera, the highest like exponentially the highest mortality and morbidity is seniors and people with mental illness.

Far and away. Now a lot of that actually has to do with medications that people are taking that dehydrate them and they're not getting proper messaging from their physicians and pharmacists about the need to hydrate when you're on these meds. Because people never read the packets, you know, the little instructions that come with your medications, right?

So first off, that's a real, real issue in terms of people with mental illness and seniors exacerbated by income level and by other things that create further disparities. So I think it's a great point. I think in terms of things that we should be thinking about to try to address those challenges, first off actually my team is developing or has developed -- it isn't published yet -- a web tool specifically for home- and community-based organizations that serve people with disabilities and seniors in their homes. It's a training on emergency preparedness. Because again, the folks who are doing those kinds of projects or services very often are not very engaged with the emergency preparedness world, right? Their hands are full already. They don't want to be dealing with that, but they want to be thinking about it, as we've learned from Hurricane Maria and going all the way back to Katrina. But everything since then. So I think that's a really important one.

I think the third thing though that you mentioned is that we do need to do a better job of collaboration at the federal level and also of course at the state and regional level in terms of the agencies that serve people with disabilities, seniors, the elderly, children, ethnic minorities. I mean, again all those silos. And I do think that we are doing a better job of that than we used to during disasters. But I do think that we do have a long ways to go. And I think one of the critical things in a disaster is very quickly to get set up a workgroup or whatever you want to call it that is specifically aimed at addressing the needs.
And you may have to have more than one group. You may have a children group here and a seniors and people with disabilities group over here and low-income, medically indigent. You know, you have to figure out what your community needs. But it's very important. But it's also important when those groups are set up that they are integrated into the incident command structure. I know at CDC -- I don't know if we have -- well, obviously Admiral Redd, but I think there are others in the room who've been involved in some of the special working groups. You know, there's a children's working group that is always set up. Georgina Peacock used to lead that for years. But if those groups are stood up and aren't feeding constantly back into the larger system, it's still wasted effort. So I think A, we've got to pull together the people who have expertise in disasters and in the specific group that you really want to work with or target your activities on. But then you've got to make sure that that working group is integrated into your incident command. Otherwise you're going to have parallel work going on and you've already talked about how that didn't serve in your -- so those are just some of my responses. Sorry. >> That's okay. >> Any comments? No. Last comment in the back. [ Inaudible ]

Right. Do you want to take a stab at that? >> Sure. Yeah. Thank you for sharing that experience. And yes, so when we think about cultural humility, we also think about it in terms of different work environments, different working cultures, not necessarily just some of the different environments that we might experience in terms of working in different communities or other cultures that we're not familiar with. And the EOC is a culture in and of itself. And so we absolutely recognize that. I do want to say that I think it's important to hear that kind of feedback when it comes to thinking about our response work here at CDC. It's really important for us, and in fact that's how this training was born, was to hear the feedback from our responders and the people who are involved in response so that we can continue to try to make improvements and find areas and opportunities where we can work together as an agency to identify solutions and try to make our own operations a little bit stronger. So thank you for that.
Also, just to clarify, there are a number of initiatives that we are in conversations with the emergency response operations teams regarding issues of not only cultural humility, but what other kinds of trainings for the entire response community within CDC that go beyond the epidemiological approach or the epidemiological lens, right? In terms of what traditionally CDC does in terms of a response. We are invested particularly in our office of folding in more underlying and causal issue considerations in terms of how responses are planned for, what kind of preparedness we do, and how we train. So there are a number of discussions that are happening at multiple levels with various members of the office, with CPR. And we look forward to having continued discussions about that as we've been reorganized to be part of Captain Redd's division regarding emergency response and also preparedness and communities of practice. So I want to give a round of applause to the panel. [ Applause ]