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 America 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.
[Applause]

>> 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 don't have a car.
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 server 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're 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.
Sorry, Miss Valentine.
>> Just Jo.
>> Yeah.
>> 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]