

We now have our closing synthesis panel,
so I'd like to invite Mr. Stripling and Secretary Mercado
to come back up, and Dr. Walken.
And while they're coming up, we have a couple special guests
that I just want to quickly recognize for being here.
They were part of the delegation that travelled
with the secretary from Puerto Rico.
Catherine de la Cruz Duran who is assistant secretary
of planning, development and federal affairs.
She just stepped out?
Okay. And then Jessica -- help me with the last name.
Your last name is?
Okay. Program manager and principal investigator
for crisis hurricane supplement.
Glad you could be here, and then
of course Commander Caralina Pinto.
So now I'll turn it over to Dr. Walken
for closing synthesis panel.
Thanks you.

>> Thank you.
So the synthesis panel,
we're going to open it up for questions.
We also have a series of questions that we've come
up with that we can answer.
First I just wanted to kind
of summarize what we've heard this morning.
I started with the framing talk and now I want
to pull together all the various pieces that we've heard.
Initially, Dr. Liburd kicked us off this morning by stating
that the purpose of the forum was to monitor CDC's progress
in pursuing health equity.
And she stated that some of you hold health equity
as an aspiration and others as an achievement
of best possible health for all.
And that CDC sits at the intersection
between this aspiration and the actions.
So that really gave us a charge to think
through what our responsibility is
and how we can apply this to emergencies.
And then Admiral Redd talked about his quote,
"The rising tide does not rise all ships."
And that health equity really must be intentional
and deliberate.
And Mr. Stripling also stated the intentionality
and the importance of that,
and that in emergency response we're going
to reinforce our structural racism if we're not careful
to be very intentional in the work that we do.
Because emergencies tend
to magnify the inequities that exist.
So we must use this health equity lens
to assess our strategies, our policies, our programs.
And then we heard from Dr. Rodriguez
who emphasized the importance
of understanding the historical backgrounds of the communities
that we're deployed to,

understanding their government structure and their unique vulnerabilities and the strengths in that area. And how important it is to work within the community. As my colleague recently shared a quote that she heard recently at Moore House, is that you don't do change for people. You do change with people. And then we heard from Dr. Dodgen and he pointed out we actually have a very specific mandate, HHS does, to protect at-risk populations. And he highlighted steps to resiliency which included neighbor-to-neighbor resilience and how to facilitate helping behavior. And then in our final talk, Dr. Kuwabara talked about the importance of knowing one's own cultural influence and understanding that we bring to the table our own personal biases. And Julio talked about the training that will be available to deployers and hopefully to a broader CDC audience to address that. And so with that, I think that we can move on. Do we have the questions on here? No? Okay. So I'm going to start with a question and anyone on the panel can answer that question. And then certainly if you all have questions, if you're not in front of a microphone, you can head to a microphone or use the one in front of you. So the question is, what are some barriers you've had to address when serving at-risk or vulnerable populations in public health emergencies?

Anyone on the panel?

Dr. Rodriguez, I don't know if you wanted to talk about -- I know during the response

with Puerto Rico there was disenfranchised populations that had historically not had trust with the government and maybe that was a barrier.

>> Yeah. I think that the most problematic situation that we have is that we never thought that we are going to have a category 5/4 hurricane.

You never can be prepared for that because you cannot fight nature, you know.

You don't know what is going to happen.

Also the problem that Puerto Rico had was that before the hurricane, Puerto Rico was in a very bad economic constraint.

We have a bad electrical grid that was totally inefficient.

And we know that if a natural disaster comes to Puerto Rico, that will be the first challenge that we will have.

But I think that to criticize and to say that we were not prepared for a natural disaster -- because you don't have control of the nature.

Only God has.

So I think that the other thing that maybe we could be doing different is the combination between the federal agencies.

I think that is something that has to be addressed.

Like I mentioned before, maybe we meet a coordinator

or inter-agency director that knows everything about how FEMA works, HHA works. All of the federal agencies, maybe that is going to be like the start of preparedness and response. And in that way, that can coordinate more efficiently in case of a natural disaster. I think that that is the lesson learned. And I hope that if you agree with what I said, hopefully you can take that message to Washington and make it happen. I think it's not only going to help Puerto Rico; it's going to help any other emergency around the nation. So I think that could be a good study. Maybe that director can have help from different federal agencies that work together with him. And everybody knows what to do in a natural disaster. Because I think that it is going to eliminate the red taping that always occurred between when you ask for help, is going to be the response faster. And people can be prepared, they can also give seminars to different federal agencies to teach them how to react to a natural disaster. And let me tell you something, the natural disasters are going to happen. You know, each year this can happen. So we have to be prepared in order to know how to address the situation. But I feel that the most important thing is to be prepared, everybody coordinated and work as a team. I think that that is the most important message that I can talk about.

>> Let me hit a couple of things on there. Because I was going to raise three points and I think you hit the first one beautifully. Which is that the structures we have are themselves a barrier. And my experience in the Virgin Islands was that there were four different coordination centers that were in play. The federal center, the official local emergency management center, the unofficial one that was like in the governor's house that was the real locus of power that was separate, and then Mike Bloomberg had one set up himself because he's a billionaire and he can do that. And there were these four centers that were separate from each other all running separate cycles, all coordinating different things. And what that led to was the second point I would make, is the blindness of the response, our inability to see these issues because of the tunnel vision we have, because of the urgency. And my argument would be emergency management literature outside of health equity -- and I could do a whole 20-minute rant on this -- shows that that adrenaline is a bad idea generally, right? That tunnel vision gets in your way. So the more that you can -- now that we have these tools, the vulnerability indexes, the visualizations,

the job is to hold leadership accountable for using them.
I think that makes leadership less blind;
that's the second thing.
And the third thing I would raise is the other thing we've
got to talk about is data.
Because when we're going out there,
there are assessments happening.
Everybody and their brother
and their sister are doing an assessment in the field,
whether it's a CSPR, whether it's the Red Cross knocking
on doors, whether it's a FEMA assessment.
But what's happening is some doors are getting knocked
on 12 times and some doors are getting knocked on zero times.
Because it isn't unified.
So if we had a way to have a unified shared data collection
platform that everybody would agree to use,
that all those assessments would come into one place.
Then we can target that entire universe
of networked resources towards where the needs were.
Nobody wants to do that because everybody wants to brag
to their own funders, right, "Hey,
look at the mission we did.
Hey, look at the good we did here."
But as a result, there are these pockets of vulnerability
that are invisible left unhelped and dying,
because you're not networking all of these resources together.
We have that technology now,
if we could develop the political will to get it done.
So I think the structures are in our way,
we have this innate blindness
and then we don't have an integrated data
collection mechanism.

[Inaudible]

>> I think we do speak
in different languages too each other.
And in disasters, when everybody has their own lingo,
it might not be an official language but it's something.
We all have a way of speaking and I think again,
sort of that lack of self-awareness
of our own culture, where we're coming from,
creates those barriers right off the bat.
We're not really bothering to explain.
Between that and the EOC,
you know it's an alphabet soup, right?
It is just acronym after acronym after acronym.
And nobody tells you -- I'm sorry, thank you.
If you're a community-based organization and you're invited
to the table and you finally sit there,
and then the people just start talking in this gibberish
of alphabet that you have no idea what they're saying,
how sincere of an invitation is that, first off?
But how much are you going to be able to participate?
So I think communication is critical in terms of barriers.
And I think the other thing, you know, we've gone through a lot
of the barriers already, so I don't want to repeat myself.

But I think one of the things we have to remember is disasters expose the fissures that already exist in our communities. Whoever's most vulnerable, in a disaster they're usually worse off. Where are disparities in terms of how resources are allocated to different parts of the community as well as to different programs that are designed to serve the community, all of those things emerge tenfold during a disaster. So I think one of the barriers is, as I think Mitch has been saying, the systems that have created some of our inequalities and some of our challenges are in many ways reinforced during a disaster unintentionally. But nevertheless, I think part of it is we have to be sort of aware that the same sort of inequalities are going to surface in a disaster, and we have to be extra conscious of the need to address those. And I think that's a barrier because of course we all come to the situation with our adrenaline packing and everything else and we want to dive in and do what we've always done and what we were trained and exercised to do. And it's very difficult I think to step back and say, "Wait, there are some problems perhaps in our communities." Not problems, but challenges that we need to be thinking about. And so I think that often is as barrier, just that ability to step back and look at some of these larger issues.

>> Yeah, so I would echo everything that's already been said, and then add to that too just sort of that idea of being able to empower our responders to be able to integrate a lot of the ideas that we're talking about here today, and to carry this forward in our work. In the emergency operation center as well as the field, and in our interactions with our partners and our colleagues on the ground. I think to the comments earlier, that if we are able to begin these conversations now in a preparedness stance, so we are starting to shift our way of thinking and talking about and approaching response now before we get into those moments of almost panic and how are we going to handle this. It at least frames the conversation from a different place from day one. So I would say that that's our intention as well, is to really think about how do we empower our responders with the tools and the knowledge in order to be able to most effectively respond.

>> I just want to point out that part of this project of doing the cultural humility training is that it points out two things. One, from our office's perspective, we're very invested in supporting initiatives that increase processes that advance a diversity and inclusion consideration within the agency, right?

So for our deployers, we want to create an environment that really builds their skills not just with external partners but with each other as team members. As was said earlier in a comment, that they can acknowledge the diversity contribution that's in the room of their peers who they're working with during a response. So this issue of cultural humility, while it's very apropos in the context of external partner engagement, it's also very critical when we work with each other as colleagues, because of that alphabet soup of skills and perspective and terminology. The other issue that it raises for us, given that this is a new project, is that we understand in the office that there are new skills that we as CDC-ers need to have if we're going to advance a health equity approach. It does mean that we have to do things differently. It may not mean that our roles change, but that the way in which we approach our roles change. And so that's going to require some discussion, some training and some contemplation.

>> Thank you.

So all of your responses dovetail nicely into the next question.

You know that you have great leaders on the stage when they talk about a barrier, they also talk about a solution, and we heard solutions from each of you.

So I just want to ask if you can share other examples of strategies or programs that have reduced social, economic and health disparities to address the needs of at-risk populations in public health emergencies and how you're able to achieve this.

So we don't necessarily have to go down the line, but if anyone has anything they want to add to the previous question, it would be great to hear.

>> I'll buzz in.

Okay, so the first one is -- and I want to brag on CDC for this. I don't know where this idea came from.

But of all of the federal agencies, the CDC idea of sending long-term assignees into these jurisdictions to coordinate recovery work, or CDC employees for years, I think is incredible.

And I am so proud of you guys.

Whoever in CDC came up with that idea made the decision, supported that to give some of your blood and treasure on a long-term basis into these places, is meaningful.

And it advances capacity in a real way.

So I just want to thank wherever that came from.

I just want to thank you as a person that sees the impact that that's had in those jurisdictions.

So I think that's one.

And the lesson there is long-term commitment.

And I say that because for us, New York City, we deployed folks

to Puerto Rico, we deployed folks to Virgin Islands.
And then you know, we're out.
We're done.
You know what I mean?
And they call me still, my VI partners.
A couple times they've said, "Hey, you were here.
You were great.
Help us. Come back."
And I can't, right?
I don't have that ability.
And that is a violation of equity principles, right?
Because I did not establish long-term partnerships,
and that's not the way it should be.
I would love for a long-term EMAC commitment.
The two others I'm going to say are
in Ebola there were two things that we did
that I think were helpful concretely.
One is that City Hall did say -- and I alluded to this,
that we wanted to track travelers coming back
from West Africa.
And that mission was initially assigned
to the NYPD's Missing Persons Bureau to make sure
that they had a bead on these folks.
And what that essentially meant was that NYPD would go
around tracking a bunch of African American men in a lot
of the most vulnerable areas of the city.
But initially the Health Department was cowed by this
because we're humble, right?
And this goes I think to the definition of humility,
and I think this is important
because this has come up a lot today.
The definition of humility from my Sunday school days, Dan,
is that it is
about understanding the unimportance of you personally.
That does not mean that you cannot fight
like a tiger for your mission.
And what I saw our commissioner do was go to the head
of the NYPD and go to the highest levels of City Hall
and say, "We're not going to do it this way."
You know what I mean?
We're not going to make this a police operation.
Because if we're going to have to do this,
we're going to do this
in an unintrusive partnering way with the community.
And the third thing that we did in that response was
that we had a doctor on our staff who was from West Africa,
who had family connections in some
of the Ebola outbreak areas.
I didn't know that person.
We brought that person into our incident command system.
We anointed them, you know,
"You are now part of our inner circle."
And that person with our health equity staff coordinated
outreach to the West African community.
They didn't have ICS training, they didn't know
from emergency response.
But they knew that community.

They had expertise in that community
and they very strategically designed outreach mechanisms
that led to the EPEC frameworks,
these kind of engagement frameworks we're using today.
And that was a controversial decision, right,
because the commissioner didn't know that person
and City Hall didn't know that person.
But we gambled on it and it paid off.
And I would encourage all responding agencies
to do the same.
Trust people.
Just trust them.
They know their communities.
They are smart folks that work in public health.
Give them power, decentralize your decision making
and it will pay off.

>> Just out of curiosity, how many state
and local people do we actually have in the room,
or is it pretty much all feds?
Any state and local folks?
[Spanish phrase] okay.
And Mitch, all right, okay.
Well, never mind.
So I won't talk about a lot of the tools that we have other
than we do have some great tools for how to build coalitions
and how to integrate more diversity
into your coalitions, et cetera.
But let me give you another very, very specific example,
because I think these concepts are challenging, right?
We can't even agree on what cultural sensitivity is,
what resilience is, what's the difference
between cultural sensitivity and cultural competence.
And we can't even agree on this,
and it gets very big and very complicated.
And I think sometimes we need to be better
about making it simpler and more specific.
So let me give you a specific example.
We have these things called federal medical stations
which are kind of deployable, almost like a MASH unit.
A hospital that you can set up
and you can serve people let's say if you have some place
where your hospital is down like in Puerto Rico.
So you bring them in and you bring in BMS people --
we've got some great PHS officers in the room --
to staff it and to provide the medical services.
So when the FMS's, federal medical station --
got to explain our acronyms -- were first set up,
nobody had thought about the fact that the aisles have
to be wide enough to accommodate wheelchairs.
So I, because I was the lead for at-risk individuals at the time,
I just basically did a brief education
for our people doing this.
I'm like, "Okay, here's some basic minimal standards
that you have to meet when you're setting
up a temporary hospital facility that will allow it
to accommodate everyone who's going to come

in and need services."

Also we had to set up a policy for people who had service animals, who had typically a guide dog, but it could be something else.

Being able to say, "Okay,

let's talk about the width of your aisle.

Let's talk about what your policy is on service animals, what's your policy on where you're going to put the caregivers or next of kin who are still going to be wanting to visit every day -- where are you going to accommodate them?"

Being able to break it down into simple tasks that are doable, that you can literally in terms of a width of an aisle, you can literally measure your progress, right?

That was really helpful for people.

And I think often we get sort of enmired in these very complex concepts that none of us even really agree on the definitions for.

And then we turn it over to emergency responders who tend to be very concrete, right, because they have very specific tasks.

And we expect them to figure out how to implement the stuff that we can't even figure out.

So one thing I would just say is I think sometimes where we've had the most success is where we can be very specific and concrete on what it is we expect people to do.

Because if you can turn it into a checklist, they'll do it.

You know, first responders, the EMS folks, whatever.

But we're not always so good at that.

So I would say it's a success, but it's also something we could work on.

>> Okay, we'll move to our last question just because we're a little short on time.

So this question is both for the panel and for anyone in the audience.

We want to know, what are some takeaways from today's forum that you can apply to your work?

Okay.

>> Great question, thank you.

I appreciate that, because really I don't have a question for the panel.

I do want to thank the organizers for putting this together.

It's been a really interesting morning, and there's a lot of thoughts going on in my head.

And thank you for the secretary and the delegation from Puerto Rico for being here, and our guests here also.

We've talked a lot about the time crunch and the adrenaline and the cultural humility piece, and we've talked about a lot of this.

I'm a person who thinks that words matter.

So one thing that we've talked about --

and we keep saying preparedness and response --

I think what we really mean is a broader picture.

So we're not just talking about preparedness and recovery.

We know that's in there.
But I think that we'll always need those things.
I understand that.
We need to have the ability to respond and recover
and so on and so forth.
But I do think that when we're having these conversations,
what can the feds or the states do to support communities
and individuals to have a better understanding
of their actual circumstances and potential for being at risk?
And I think this is part of what public health does.
We had communications -- this is a strong capability at CDC.
We were able to convince many people
that smoking cigarettes is bad,
because they understand what the risk is.
We got people to wear seatbelts --
not we alone, but these are the communications and so forth.
So we're looking at this as sort of a prevention piece
or helping people understand what they can do
to take protective actions.
Most people are not in this world that we are in.
Most people do not think about this stuff
until the thing is barreling down on them or it just did.
And then you spend a lot of time thinking about it.
So how do we support people
in understanding a little bit better
about what their own risk profile might be,
or what protective actions address those specific things
that make them disproportionately affected
potentially by the disasters?
Is it a matter of -- you know,
we talked about neighbor-to-neighbor.
So it's like a neighborhood watch like you do for crime?
Is it more communications?
I understand the need for having champions?
Do we have more information and courses in school
from elementary school age up through college just
so people have some familiarity and sort
of literacy around these topics?
And maybe even specific to the community they live in.
I don't know the exact answer, but I know that there are a lot
of communities that are not engaged in this conversation
and we can't necessarily reach all of them.
But I just think we should add this --
so Dan showed that RAND ladder for resilience.
And at the bottom it said teaching individuals
and families to prepare for and respond to.
I would say, can we add avoid?
You know, don't be in the place or don't be in the circumstance
where you'll be injured, where that turns into a disaster.
There are some things we can do.
And then we will inevitably respond and take care of folks
who were not able to protect themselves adequately.
So that's my two cents.
>> I want to make a comment about that.
I think that sometimes the federal government needs some
important detail.
And we saw most of the NGO's

and nonprofit organizations receive federal funds for prevention, for education and all of that. So let's use it.

>> Yeah.

>> Let's add to that and use it, because you are spending the federal money to those organizations.

>> Yeah.

>> You know, when they receive that money, they have a commitment of prevention, information. Go to the community and all of that.

>> Yeah.

>> And when I become aware about that, I am using it right now in Puerto Rico.

>> Yeah.

>> You know, I am here using it in everything. If I have a problem for prevention or information, I call them first.

>> Yeah.

>> It's not their responsibility, but I use them as a partner.

>> Yeah.

>> Because I don't have the resources to do it alone. And let me give you an example. About two weeks ago there came an organization that deals with HIV patients and they give them medication. They run the clinic and all of that. You know what, the federal government gives the money for the medicine, for everything. So you know what I'm going to do now? Maybe we are talking about to see if I can give all of my HIV clinics to them and they can run the program completely. There are certain states that are doing the same. And I save money, get better service and I become a partner of that organization. And we join in effort for the better care of that population.

>> Yeah.

>> That's what it's all about.

>> Yeah.

>> Dan, you and I have talked about this before.

>> The only thing I would say is I do think the concept of disaster risk reduction, which is perhaps not as popular as it was a year or two ago, but I know there are folks at CDC obviously working on it as well. But if any of you are not familiar, just look up disaster risk reduction. There are some really nice materials, particularly out of the UN. Most countries in the world have sort of adopted it as a way to think differently about this whole concept, which is what you're saying. Which is we want to help people to avoid being in harm's way in the first place. And there are some things you can do, right, which mitigate people's risk. Because as we know, lower-income communities

for example are much more vulnerable in a hurricane or an earthquake because the building standards are often different or not enforced.

You know, there are other things that happen.

So I do think disaster risk reduction is a concept that if you're interested in this question, Google it and you'll get some good information.

>> I only have one short comment on that.

So that terminology is not really used in the US much, although the rest of the world uses it.

But ASPR and CDC and some other folks are part of the mitigation framework leadership group and have been able to sort

of put health conversation into this discussion.

So about six months ago I was in a room full of feds who were saying, "DRR.

DRR." And they were relating it to health.

So I mean, all of this conversation is around that.

We're just not using that terminology.

So just be aware that we're all working on this.

And as HHS and CDC, we are in the prevention business.

>> Okay, well I think we're out of time and so we're going to close this session.

So I thank all the speakers for speaking earlier and for the questions.

[Applause]

>> Well, we started out at 8:30 this morning and it is 12:30 and I think it's been a rich day here at the Centers for Disease Control and Prevention and in our efforts to advance health equity.

I wanted to just make one comment, that the Office of Minority Health and Health Equity exists to strengthen CDC's capacity to protect the health, safety and security of diverse and vulnerable populations.

And we cannot achieve our purpose without the kind of collaboration that we have experienced today.

And I was reminded again that we are our best when we create spaces to learn from each other and explore the difficult and arguably the impossible.

But today's forum leaves me believing that building equity and community resilience

in public health emergencies is a mission possible.

And as a result of this meeting, Captain Wilkins along with the planning committee will be tasked

with creating a synthesis article

that will pull together the lessons learned from today that will highlight those issues that we need to bring from the invisible to the visible.

And actually put forward some suggestions that our colleagues within CDC as well as in states, locales and jurisdictions, the Caribbean, the Pacific, can glean from strategies that they can use toward advancing health equity in this area.

Before we adjourn, I'd like to ask Captain Wilkins to come up.

We have certificates of appreciation for all of our presenters.

Please join me in giving them a hand,

and I'm going to call their names.

[Applause]

We want to thank Dr. Amy Walken
who I discovered today is a Tarheel.

Go Heels! I knew there was something about her
when we first met her.

I want to thank Mitchel Stripling.

I mean, I'm just like buzzing.

Thank you so much for your presentation today.

And Secretary Rodriguez, we are so honored
that you are here with us.

We know it was a sacrifice and a huge commitment to be here,
but we really appreciate it.

And Captain Funk, thank you for the work that you do,
for being our discussant today.

Dr. Daniel Dodgen, thank you for your passion and insight
and experience and the work that you're doing at ASPR.

We hope we can call on you again.

>> Thank you.

>> Dr. Kuwabara who was our colleague here.

Thank you for reaching out to the Office of Minority Health
and Health Equity and really stimulating the development
of the cultural humility training.

And our own ace Julio de Santali Pierre.

I consider him like one of our health ambassadors.

We send him out a lot to do the kind
of diplomacy that's important as we look
around the globe at health inequities.

And I get excited to see that we're not
in this struggle alone, but that we share this space
with people around the world.

So thank you.

Your time here,

I know everybody's email screen is probably clicking off.

But these are times that are very important
in our own continued professional development
and then our ability to push our agency forward.

So thank you again, everybody.

Have a good rest of the day.

[Applause]