On the Frontlines of the Backlog: State Health Departments and the Health Debt Programs Success Showcase 2022

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NADINE DOYLE:

Thank you all for now, joining us for our closing keynote president's challenge and closing remarks. I'm Nadine Doyle, uh, gladly serving as your emcee today. Most of us have just returned from a series of individual showcase presentations. I had the pleasure to float across all of the rooms over the past couple of hours and heard a number of themes that resonated with me and really connected back to what our opening panelists were sharing about the health debt, about rebuilding trust in public health, building resiliency, and identifying and addressing the root causes of health inequities in our nation.

Now we're going to shift to a panel discussion led by the Senior Director of Programs Marti Macchi at NACDD titled on the front lines of the backlog state health departments and the health debt. We are pleased to have joining Marti, Dr. Kristine Andrews is co-founder and Senior Director of Ideas to Impact and Visiting Distinguished Fellow at Child Trends. Dr. Jeanne Alongi, Director of NACDD's Coordinating Center for Public Health Practice.

Dr. Karen Hacker, Director of CDC's National Center for Chronic Disease Prevention and Health Promotion. And Glory Song, an epidemiologist at the Massachusetts Department of Health. Our guests bios are being shared on the agenda and the website as we speak.

And with that, Marti, please take it away.

MARTI MACCHI:

Thanks Nadine. And welcome everyone. We are so glad you're here. Um, as Nadine said, we know that you had some very rich discussion and, um, a lot more conversation, um, related to our topic, which is the health debt that we've been talking about, um, throughout this afternoon. So, um, we're going to carry on with that theme and do more, uh, sort of deeper dive into conversation about that.

Um, you know, I, I I'm, I'm just, I, the, the title of this, this panel presentation really does says it, say it all. Um, you know, we're really gonna discuss ways to address the backlog of chronic disease services that have result that's resulted from the, the health, but really explore, uh, your role, you are on the front lines of the backlog.

And so, um, we know that, um, you can't do it all. So, uh, we're excited about having this conversation and excited that you're here to join us in that. Um, in the showcase opening panel, we heard a lot about the health debt and how it only, it's not only going to have an impact on health outcomes, but it has a significant amount on your work.

And we touched on that just a little bit in that panel, uh, from a public health practitioner perspective in general. Um, you know, uh, we know that there are significant implications to the work that you're doing based on, uh, the delays in neglect in chronic disease prevention and management services. So, uh, we really want to focus on that in this particular discussion. Uh, we know that thought leaders in public health and healthcare describing the impact of delaying and neglecting chronic disease management and preventive care as the health debt and that it will significantly impact those health outcomes in the future. Um, I think we're all a little bit nervous about what that's going to look like in the future, but we know that it will.

Um, and just as a reminder, our public health colleagues and other subject matter experts to find that help debt as the accumulated impact of changes in health behaviors during the pandemic that will have long-term health effects on health. And this idea of health debt could also describe the more advanced cases of disease that healthcare providers are now seeing as patients begin to engage with their healthcare and their healthcare providers as they resume or try to resume some of the screening and management strategies that they, that they were used to pre-pandemic.

So in this discussion, I'm going to facilitate conversations and ask our very distinguished subject matter experts about the impact that the health debt has had on state health departments specifically, and ways that we can continue to prioritize chronic disease prevention mangement strategies as we deal with the demands that are due to the COVID response that we know we're all pulled in.

We also want to take some time to explore some bright spots. We don't want to just focus on, uh, some of the things that have transpired that are challenging and frustrating, but we want to focus on some bright spots in practice that could help us address the backlog of critical chronic disease care, such as delayed preventive care and screening, mistreatments. We're all familiar with those. Cancer screenings, hypertension and diabetes management, all the things that we worked so hard for many years to to move forward and really see some successes in. But we're really wanting to sort of talk about some innovations and some strategies that have been deployed and

implemented that we can leverage, um, and you know, just, just knowing very well that we've seen significant changes just even in accessing healthcare due to mitigation efforts. So we're really looking forward to having some discussion about those bright spots and those innovative approaches. I am always impressed by the people on this panel.

I can't tell you. And so I feel very honored to be with them. I feel honored to be with our colleagues on, on this, uh, this webinar today. And so with that, uh, I think we're just going to jump right in. Um, and again, please remember to post your questions, um, uh, per Nadine's, um, instructions in the Q and A button on your zoom, and we'll get to those over, over the course of our discussion.

So I'm just going to throw out the first question and the topic and, um, uh, I'll just preface it by saying that we know that chronic disease, that that the chronic disease challenge was, to quote Dr. Hacker and Dr. Briss in their, uh, one of their preventing chronic disease articles was large and is now larger due to the pandemic.

It is large, it was large. We all know that. And it's now larger, um, due to the pandemic. And as was discussed in the opening panel, we know that for many people that we, you know, live live with, work with, play with, pray with, go to school with, we know that for many people, uh, the health debt is not a new phenomenon.

We know that it's been an ongoing reality of health disparities created and perpetuated by differences in not only social determinants of health, but many, many other social inequities. So just kind of snowing that. Let's just kind of dive into this first question and, and, and, um, explore, um, some, uh, this discussion about how we make sure that the health debt accounts for debts created from previous health inequities and how they've been exacerbated by the pandemic.

And I think mostly when I think about that question, I think a lot about how we look at the data and how we tell the story. And so knowing that Glory and Kristine are deep into data and dissemination of that in innovative ways, I'd like to start with, with you, Kristine. If you could talk a little bit about how we make sure that the health debt accounts for debts created previous from previous health inequities and how we make sure that people are aware of that.

KRISTINE ANDREWS:

Well, thank you so much for your introduction and for framing this conversation. Um, unfortunately I wasn't with you all day, but, um, it does sound like it's been a very rich discussion, so happy to be a part of this panel today. Um, it's a great question because as you've already mentioned, this is, this is not a new phenomenon.

This, these inequities have perpetuated for some time and yes, have only grown larger during the pandemic as a qualitative, largely qualitative researcher, um, what's most important to me when I think about looking at data is to always contextualize data, right? And realize that we are not looking at things in a vacuum, not just looking at numbers, but realizing how, um, different, um, situations, different contexts, different circumstances really influence what we're seeing. So I one, think about the personal bias that is always baked into data and wanting to think about how was that data collected? Who was the, who was questions asked of? And most importantly, who was not asked the questions? Um, thinking about the question that's being asked and are there, um, kind of some baked in bias or inequities in the question? And then it's also in like, how am I analyzing that data?

You know, taking a very critical eye to what you see to make sure that you're often thinking about, um, historical and contemporary trauma, that you're thinking about that institutional and systemic bias and inequities that really influenced what we're seeing. So when I think about the health debt and when I think about health equity, just being activated, what's most important to me is to remind folks to, um, keep contextualizing what you read and to be critical, right? Not to just accept things as numbers on paper, not to look at the quick graph and not dig a little deeper into what's behind those numbers. Um, I think that's, what's most important to me to bring first, um, front and center when you're thinking about how do I examine critically data in front of me?

And I know Glory is more on a quantitative bent, so I'm going to like Glory chime in.

GLORY SONG:

Thank you Kristine and Marti. Yeah. When I think about this, I think, um, you know, we say that COVID has, uh, shed this broader light, right, on what we in public health have known for a very long time. And so we, in the news, like in the media, we hear like insecurities or inequities or social determinants or like structural drivers. It gets thrown around a lot, but I don't think we should, um, assume I think, uh, Liz Ruth actually made this comment in the opening panel that, you know, the key decision-makers and people who hold power across sectors, even our own have fully connected all the dots and know the solutions to move forward.

And so I think what that means is that, so for example, um, as somebody who analyzes data and has access to a lot of data, um, I, you know, echoing what Kristine said, context really matters. And because context is the actual, um, full picture, right, of what is happening with some kind of phenomenon that, you know, whether it's like spikes in, you know, diabetes hospitalization rates or something. It explains the why and takes the solution to being focused on, uh, individuals. Right? So purely around like education, you have to like eat better, you know, like exercise more to, uh, you know, the actual

drivers, right? And so, um, being really creative, um, going beyond, um, the standard or traditional data sets that we have access to, and really trying to, um, leverage data sets or even do primary data collection that, uh, really captures people's like employment experience, housing experience, you know, their, you know, ability to stay safe during COVID, right?

And, um, and really trying to, um, connect the upstream, midstream, and downstream outcomes so that we can show that, hey, you know, hey, you know, it's the same people who's living at the intersection of like unhealthy environments and food insecurity and lack of green space so that we use data and pairing that with, I think, qualitative data, as well as people's actual lived experiences to help shift the conversation to where the system solutions really need to be. Yeah.

MARTI MACCHI:

Yeah. And, and listening to you both and sort of pairing that together is really strategizing about innovative, innovative ways to be able to communicate that to the actual decision makers at the state, right? Um, that that's to me and to some of my colleagues, a challenge, um, to make sure they get that full picture for their, um, decision-making.

Yeah, thank you for that. Um, let's, let's think a little bit then in terms of, um, kind of looking a little bit broader at a lot of our public health colleagues, um, that are attending today and those that we know work in state health departments and local chronic disease prevention units as well. We know they've been pulled into COVID response, um, quite, quite often kind of, you know, back and forth and back and forth.

We've heard that quite a lot. And, and so, so thinking about kind of their role in this work, um, I'll ask, uh, um, Dr. Hacker and, and, and Dr. Alongi about how, how you think we should support this workforce. And we just heard a little bit about the data and perhaps how we might be able to help with that, but, but how do we support a workforce that's constantly being pulled from efforts to something completely different?

KAREN HACKER:

Uh, happy to weigh in on, on this. I mean, I think that first of all, let's acknowledge how incredibly exhausting and stressful the last two years have been. I'm not on the ground anymore, but it's pretty stressful at CDC. I'm not gonna lie. Um, and so this challenge of how we do what we know we must do, because I think everyone in public health would agree that when you have a pandemic of a lifetime or perhaps multiple lifetimes, you don't really have a choice.

You have to prioritize it. You have to jump in, you have to volunteer, you know, whatever it's going to mean. But it keeps going. You know? We, we call it the gift that keeps on giving, right? And I think that our workforce really needs management that is going to be as empathetic as possible, is going be thoughtful about how to arrange work days, for example, work weeks so that people can have a breather.

Not feel like they're 24 7 all the time. Um, and what does that look like? I think telework, and I know there's a huge variety of telework that's been probably going on in state health departments, right? From state health departments that are an a hundred percent telework to those that are still saying, no, you got to come in because they don't have the capability.

They don't necessarily have the, um, the technology, certainly at the local level that's. Um, but I think having that time, sometimes telework does offer people the ability to at least attend to the rest of their lives. You know, like if you have to pick up your child, if you have to, uh, help them with homework during the day, if they're virtual in school, you know, all those kinds of things.

So I think it's really, it really means for those of us in public health to think about our workforce. Not that we weren't in the past... of those stress levels on our workforce and make sure that we have the support structures in place to help them. I mean, you know, we've done some studies to look at the public health workforce and their mental anguish during this period of time, I'll call it that.

And it's, it's severe. Um, and we already had problems keeping people in the field, right? And, um, maintaining them over time. We don't pay the best salaries. Let's face it. We don't have the best benefits. People do this work in general because of the love that they have for it and the desire to support their communities and their constituents.

So recognizing all that, I think we, we just have to really be thoughtful and cognizant all the time about how to communicate openly with the workforce and how to support them. And, and just on that note, I will tell you at CDC, we're still, a lot of us are still teleworking and I got a thousand people in my center and we had to come up with innovative strategies for communicating with them on a regular basis.

We started these weekly touch-base calls, where we would talk to them and answer their questions about COVID and translate what was going on. And initially when we started them, I thought, oh, this is only because of the emergence. And we're all going to telework and everything. But people liked them so much that we have continued them and will likely keep them going, um, and I think I've even had people say, I just look forward to hearing your voice on Tuesday morning, you know, things like that.

So I think it's pushed us all to really think about our management styles.

MARTI MACCHI:

Yeah. And who would have ever thought that we could have had two hour or even day-long meetings on a zoom call and we're doing that. And, um, so those touch points that are different are very, sounds like they're very valuable. Yeah.

Thanks for sharing that. Jeanne, what would you add, um, to, to how we support the workforce and just the general demand? Um, you know, we talked, we're talking a lot about, you know, the backlog and the work, but the workforce is, you know, obviously the critical nature of the work needs to get done by the workforce. So.

JEANNE ALONGI:

Right. And you know, to echo what are our colleagues on the panel have said, I think, um, there's a lot that we have learned, um, that we can continue learning. So we couldn't just take the old way of working and all of a sudden do it on zoom, um, over the last two years. We've had to learn about how to engage at a distance, um, how to engage with our partners also. How to, um, juggle the different priorities that we have day to day and trying to focus on the chronic disease prevention work that we know really impacts risk for terrible outcomes with COVID, um, with the need we urgently pulled into the COVID work.

Um, and, um, you know, I, I am thinking right now about a conversation I had with a chronic disease director who shared, um, how we were talking about how difficult things are for her and her staff over the last couple of years. And there was a big gratitude day in their state for everybody who's working on COVID.

And as the governor was going through and thanking everyone, he left out the chronic disease folks. And you know, that's not because he, I'm sure he's grateful, um, to them, but because our communities don't really see the work that chronic disease folks are doing right now. And, um, I just, I think it's important for all of us to acknowledge for each other.

We see you, we see what you're doing. We see how hard you're working and the difference that you're making. And, um, you are making a difference. And we're really grateful.

KRISTINE ANDREWS:

I just wanted to, um, you know, I'm just listening to Karen speak and, and Jeanne, and just thinking about the importance of, um, equitable leadership is what's screaming out to me.

Right? And I keep thinking about the, how you're making this intentional. I see someone wrote in the chat intentional social connection for colleagues, right? Equity is all about intention, right? It does not happen by accident. It happens because you make a deliberate choice to do something differently.

And so, as I'm listening to you talk about adapting to a virtual environment, supporting the workforce, words like flexibility and grace keep, keep coming out for me. Um, and I just wanted to lift those up if that's okay at this part of the discussion, because, um, it really does, um, drive from equitable leadership.

And when you're having leaders that are able to, um, recognize those different differences in need for their workforce and meeting them where they are, understanding that not everyone needs the same thing. Right? That's what equity is all about. Right? Not equality, right? Not everybody gets the same. It's equity.

So really thinking about this workforce and how for this, for this particular person, it works well to do the zoom check-ins and someone else may need something different. So how do we meet people where they are, I think is going to go a very long way and kind of just that morale, that workforce needs to know that leadership is backing this.

So I just wanted to, um, I didn't mean to take you off course.

MARTI MACCHI:

No, thank you for that. It reminds me of, and Karen, you'll be proud of your division division teams. When we met with, uh, division teams at DNPAO, starting everything out with flexibility and grace, that was the motto. And so, you know, we've been living by that.

Uh, so, um, thank you for all of that. Um, I just want to pivot a little bit now to sort of talk about, um, the programming that state health departments are tasked with implementing. And, uh, Karen, I'd like to sort of start with you on this question about, um, sort of, how do we juggle the backlog and prevention programming that we've seen, and we've seen it a lot, primarily with some of the, the, the, the, the way that the work has been done, you know, completely changed.

I mean, I think about cancer screenings that public health departments are in charge of, but, you know, how do we, how do we juggle that backlog and prevention programming due to the COVID pandemic, um, in, in these health departments and among intervention partners? How do we, how do we, um, not only support staff in that, but, um, you know, also, um, just, just create, create, uh, create an environment by which the work can still get done?

Um, what would you, what would your response be to that? Knowing that the funding's very prescribed, you know, we have certain ways of doing things in public health and now we're sort of forced to really think outside the box.

KAREN HACKER:

Well, honestly, I think Marti, you sort of just said it. You've had to think outside the box, right?

I mean, you know, so how do we deliver diabetes prevention? We can't do it in person. So we've got to suddenly make this gigantic switch to virtual. And we're talking about multiple partners across multiple venues. Um, how do we touch base with them to see are you, you have that capacity, right? So we are able to deliver those kinds of programs when people want them, because it turns out people still wanted some of these things, but they just couldn't get them by going into a place-based environment.

Right? They had to get them in another way. Now, clearly talk about inequities. Not everybody has access to that. Not everybody has wifi, not everybody has a computer. And that created, I think, a lot of challenges. And so people resorted to phone calls. I talked to people in a variety of health departments, who I was just talking to a young woman who was working at MCH, um, in the health department and she was calling everybody and, you know, making times to meet with them on a regular basis. I mean, I think that we, it might not be as good as being in the home and seeing them, but I think people did make a very quick transition to these other types of modalities. And I know you're going to get into sort of what are some of the lessons learned, but I think that is one of the big lessons, which is we could do this.

Right.

You'll have a lot to learn. Um, now with that said, I think the other thing that people had to adjust to, because so many of us in chronic disease do our work through large educational forums, through convenings, uh, through, you know, bringing people together. And we were unable to do that. And I talked to a lot of chronic disease directors who were sort of like, okay, even if I'm not in the response, even if I'm not working on COVID, I can't do the things that I had put in my program plan.

We spent time working with folks to try to think about alternatives. And, you know, I think the individuals came up with lots of different strategies that they could do, um, to try to keep people's, you know, if nothing else to make sure that they weren't backsliding. Right? But that folks were able to at least maintain with their current chronic disease, for example. Now we know that we lost a lot of ground in the prevention world. And I think then we get into this question of how do we get those, how do we get those folks back in? And you know, where do they receive those? I mean, one thing we learned during this pandemic was that not, everybody's going to go to their primary care doc for everything.

Right.

Um, and I I'm a little hesitant because I am a primary care doc by nature. But the fact is we began to demonstrate that a lot of care was taking place in retail clinics, pharmacies, urgent care centers. They're doing the COVID vaccines. They're doing a lot of the testing, right? Sometimes in tents. And I think as we move forward, we're going to have to think a lot about how do we decrease obstacles to getting prevention?

And that might mean thinking a lot more strategically about different venues for preventing, which I know maybe heresy among my primary care colleagues. But I think that this is, leaning into this maybe a really good thing.

Yeah. And I think, um, you're alluding a little bit to sort of yes, outside of the box thinking, but it's going to require sort of a new level of trust also for public health practitioners and even healthcare providers, you know, to be able to expand your thinking and your thought process about what are my options as a, as a consumer of what I need?

So, um, yeah. And so that, that, that I'll, I'll look to Jeanne to see if, you know, you have anything to add to that related to some of the work that we've been doing with, with state health departments, in terms of what they're experiencing this backlog. We haven't been able to spend our money. We haven't been able to do this. You know, um, you know, how do we, how do we help them to juggle all of that?

JEANNE ALONGI:

You know, one of the, one of the things that we saw early on was it, was it wasn't just the experience of the folks in the state health department or the local health department, even when they had the capacity to move into some of these prevention activities, their partners didn't, whether because their partners had some clinical responsibility or because their partners were homeschooling kids and taking care of, um, you know, sick relatives and didn't have wifi, as Karen mentioned. All kinds of things. So we, I think this

has given us an opportunity if we, if we embrace it, to really look at how the public health system is structured and how it functions and where is the infrastructure that, um, we can leverage and where is the infrastructure that we need to focus on building?

Um, so I think that is a, uh, opportunity we cannot let slip by. I think too, our experience here is really elucidating, um, how much, we depend on access to clinical prevention to carry our prevention water. And, um, we saw lots of declines in, um, in health behavior, um, because of other pressures. And because at that, you know, that, that juxtaposition that Kristine was talking about at the beginning of what people have access to and, and, um, where inequities lie in the system.

Um, all of a sudden everybody's a lot closer to that. And now people who hadn't really understood that before experienced that before can see it. So how do we in our public health practice in states, like Liz was talking about earlier today, um, Liz Ruth, our, um, Director of Public Affairs and policy at NACDD, how do we then, um, help our, our folks influence the state policy scene to change these infrastructure things? I think that's the, that's the place where we can use our immediate experience right now, and knowledge right now to really shift how things are going.

MARTI MACCHI:

Yeah. And I'll just ask Glory to, uh, think about that from your perspective about how that might impact any kinds of juggling or changes in the way that we not, not only collect data, but how we, you alluded to it a little bit earlier, but how, how do we need to sort of pivot and, and, and think about sort of uh, data compliments to the data that we're required to collect, if that makes any sense.

GLORY SONG:

Yeah, absolutely. And I also just want to say that, um, the chronic disease funding that we got from the CDC was instrumental in keeping chronic disease on the map of Massachusetts, um, I think, um, for a lot of our health centers that we saw, that, that we were, that we subcontract with, right, through the CDC.

Um, for example, for breast and cervical screening, or for some of the innovative chronic disease work, those health centers were able to continue doing innovative and, and really like pivot, right? Like, you know, like the COVID, for example, like tele-health was always as like pie in the sky, oh, by year five of the grant, maybe you'll start having conversations. Overnight, people just like started doing tele-health and the health centers that we were able to fund through CDC funding were the ones that had the dedicated staff, that had the TA to really think about how can we optimize tele-health for, uh, chronic disease management.

And so I just, I just want to say that, that, um, we actually, we have measurable differences in outcomes between the health centers that were funded and the ones that we, we couldn't fund. Um, I think along those lines too, um, where where COVID really, um, um, I guess like gave us an opportunity to critically, um, think about, and, um, I think this was actually one of, um, uh, one of Kristi Pier's like points earlier in the panel is like, what are we doing now that can prevent, you know, another, you know, breakdown of our systems in 5 years, in 10 years?

So what, what, what can we do in prevention to, to, to prevent? Right? And so, and, and one of the things I think we're really at a reckoning point is, um, how timely is the data that we have access to and what kind of data do we have access to? Um, if you go on, like, for example, mass.gov, like the latest birth report is like two years old.

The latest death report is like four years old. Right? And, and for a long time, that seemed to have been okay, but I'm not sure if that's going to be okay going forward. And so, um, in light of, you know, these broader conversations around data modernization for public health, really, what are the opportunities to, for example, like leverage EHR, warehouses, right, for, uh, for near real time public health surveillance. I think, I think that's where the conversation needs to happen and happen soon, um, in order for us to, uh, be able to, um, be more equipped, um, to, um, respond to emergencies and chronic disease, which is not something that we think about a lot.

MARTI MACCHI:

Right. And sort of in that context, there's a question that I think might be relevant just to sort of take that in the next step, um, uh, about this sort of focus on, um, medical debt and sort of the money that's being lost, um, due to, you know, services that were stopped or, you know, um, elective, things that you know are stopped and the health debt that's focused on people and their personal health. And the question is, should we combine the two concepts or should public health stay focused on populations?

And it sounds like, you know, not worry about the decline in the sort of the funding for healthcare. Um, you know, it depends who you're talking to in terms of their perspective. If you're talking to a healthcare CEO or a health system CEO, he's, he or she is concerned about the margins. If you're talking about, you know, to public health, we're focused on this health debt, both of that is, is, is, is, is negative on your books, right?

So, so do what, what are your thoughts around public health staying focused on the health outcomes and leave the sort of of the funding issues to our, the way we've set up our health systems in America and that rely so heavily on, on funding and money.

JEANNE ALONGI:

I was just talking to a, um, a health plan executive a couple of months ago, who was embarrassed to admit that they made money, um, in the last year and a half, because they didn't have the patients coming through.

Um, and so I think there is a conversation to be had, and I can't wait to hear what Karen has to say about this, about, about funding in healthcare and in public health and what we do about that. I do feel pretty strongly that this focus on the health debt of our population though, does need to stay focused on the health of the population, in addition to whatever conversations we have about financing.

KAREN HACKER:

I totally agree with Jeanne, but I will say that I think if we completely ignore the financial implications of this, we do so, um, at our own uh, concern, honestly, because the conversation that is happening around us is still about that return on investment.

Right? Um, in fact, let's face it. The only way we really get anybody to pay attention to prevention is if we can demonstrate to them that they're going to save money, right? And they would like it to be in the next year, which makes, which is very difficult, but that's what we have been up against for a very long time in terms of the prevention world.

So I think we have to do, I know it's hard because we always end up having to do both.

Right.

Even though it's not our role, but again, I think one of our biggest challenges in both prevention, but as we start to talk more about social determinants is, and as a qualitative researcher, Kristine, you know this, which is if we cannot come up with concrete outcomes, we may, I think get some initial interest.

But two to three years later, I worry that interest will wane if we are not able to demonstrate concrete outcomes from our efforts. Now, I'm not sure that that has to be decrease in emergency room visits, you know, or it has to be decrease in number of, you know, whatever it is that you're talking about, but we are going to have to get our heads around it and our hands around it to be able to describe it.

Um, I think everyone in public health recognizes how important community activity is, community engagement, uh, convening folks from different ilks so that they can discuss

and tell, you know, create the programs that they want to create for themselves. But that is extremely intensive process oriented work. For those of us who do it, I just, I've done a lot of this in my life, we love it. We value it. But it's very hard to translate, unfortunately, or fortunately, depending on where you stand, money translates a lot easier.

Right.

And I think we're going to have to have some of these really challenging, difficult discussions. The thing that's really opportune right now, and this is, you know, on the good things that we've gotten from COVID, right?

People are listening in a way that they may not have been listening previously, even though we we're singing the same songs. Right? And we have got to use this opportunity, I think to our advantage because windows of opportunity close very rapidly and the public doesn't have much of an attention span and they'll be onto the next thing.

So we're talking about things like health equity. We're talking about disparities, we're talking about social determinants, whether you like those terms or not in a conversation that has been elevated so far about that than anything that I've certainly experienced in my lifetime. And I think our challenge in chronic disease and chronic disease directors and the state health departments,and local health departments, is now to figure out how to capitalize on that so we can get some sustainability to these kinds of issues.

KRISTINE ANDREWS:

Yes, never before did I think that there has been the permission and the pressure to lean in on health equity as it is now, right? So as you mentioned, just the short attention span, this window of opportunity. Yes and, right? So yes, we need to keep our focus on populations in public health, but we also have to be making the value proposition, making the case for why um, we may not be able to, um, what are the outcomes that we want to be able to demonstrate, right? And it's not just going to be able to count some widgets or, you know, count these numb... you know, it's not always going to be something that can be easily quantified in the traditional sense of outcomes.

What are some other very meaningful outcomes that you are going to be gathering if you are doing that process work and you are listening and you're able to tell those stories? So I am um, I am just in your amen corner over here, Karen, and just saying yes.

MARTI MACCHI:

You know, I, I was, I, like Jeanne, I spoke to, I, we have lots of partners who work in health systems and, and, you know, health intelligence and such.

And I asked somebody a question about, uh, what they think the problem is, you know, with this similar situation we're talking about. And they went straight to healthcare financing and coverage and how that just causes significant disparities. So I agree. I think we have to do both, um, and public health has been doing both, but I think it's been definitely elevated and that the financing of coverage and of treatment also is a cause of disparities. So

JEANNE ALONGI:

You know Marti, one of the, um, one of the things that we've seen in this same season is, um, uh, innovations in Medicaid, uh, funding. And how that's being used to help support, um, addressing some of the social determinants of health and even getting up to root causes. So I think of Susan Kansagra's experience in North Carolina using waivers to help pay for housing, um, for folks. And I I think, uh, the laboratory that we're in right now, hopefully will let us accelerate some of those experiments and really get them codified so that it's not a waiver that lets Medicaid do that down the line. But it's it's baked right in.

MARTI MACCHI:

Well, let's, let's spend just a little bit of time here as the time is fleeting.

And I want to hear your thoughts about, we've talked a little bit about some bright spots in practice and some, some, you know, examples of how this sort of the systems had to pivot to make sure that people were getting the care and treatment that they needed. Um, can we just talk a little bit more about, um, uh, those bright spots in practice innovation that have emerged in the last year and that could actually help us to get to the health equity outcomes we need?

What, what are, what, what have you seen? What should we keep doing? What should we stop doing? Um, what do we need to address and come up with, um, you know, some of those. Just want to kind of focus on things that, um, we should leverage.

GLORY SONG:

Alrighty. Can I weigh in on this one?

MARTI MACCHI:

Glory, please. Yes.

GLORY SONG:

Um, so, uh, one thing that I think we learned in Massachusetts is, uh, sometimes, uh, to be innovative you have to kind of set your traditional rules aside. Uh, even, uh, methodological rules or statistical rules. And so, um, the health department, uh, we rolled out a, uh, a large survey, uh, shortly, um, after COVID began. Um, it had everything from people's mental health. It wasn't just a COVID survey. It was, um, asked about employment and asked about substance use.

It was, um, the suite of, um, social determinants as well. Um, but it didn't follow any type of simple, random sampling or anything like that. It was purely a snowball, um, uh, strategy. Uh, what that means is, uh, you know, we put it on mass.gov, but only certain people, you know, visit mass.gov in English, right? We translated it into 12 or 15 languages, we leveraged all the community partners that we had to use word of mouth to, you know, get on zoom with their, with their residents to help fill out the survey. And in the end we got 33,000 respondents, uh. we got 300, um, residents who identify as American Indian and Alaska native. And just to put that into perspective, over the course of 10 years on BRFSS, we maybe got 300, you know? And so, um, you know, you can critique, uh, the methodology all you want, but it's the, it was the first time that we could say anything about a lot of the, uh, uh, populations that are disproportionately impacted.

So I, I really think, um, to be nimble and to take risks, um, especially in getting critical information and to really, um, go beyond these, whatever, sometimes invisible boundaries or walls that we, that we set up, um, within our silos is going to be really important. And I think that has that, that applies to, um, community engagement as well.

Um, I think, um, I'm, I'm guilty of this, just like in public health. Like we, we talk about the people that we're serving, but we don't talk to them. And so um really going into the communities and really thinking about, um, you know, as for me, I'm at, I'm at the state, right? Like I'm not in like local government, but even at state government, like where are the opportunities to do community based participatory evaluation? Or community based participatory research? Like community advisory boards.

If you go in and you'll listen to these people talk about their lives, you don't necessarily need like 50 data points, you know, to be convinced that, you know, they're having issues. And so I think we're, we have an opportunity because in public health, like we care about people's health. Like we care about this topic, right?

Whereas like maybe people at other sectors are not quite there yet. And so where, what is our role? Not just like speaking on behalf of the very communities that we're trying to advocate for, but being able to, um, be that bridge into like, basically connect the community with, you know, healthcare executives or like, you know, what these other sectors are, um, that should also care about the community.

MARTI MACCHI:

Thank you Glory. So changing kind of, uh, innovative approaches to better understanding people's circumstances through data collection, sounds like. What else?

KAREN HACKER:

Well, I, I think for, there's a question that tele telehealth, telemedicine, telework, tele everything, you know, we launched into it. Uh, we'd been talking about it forever.

We turned on a dime. I'm not sure we always did it as well as we could. And I'm not sure it's always useful for every single situation, but we have enormous amounts to learn from this experience, right? Everything from who did we miss because they didn't have the technology? Who did we engage with the technology?

I mean, I had a friend, um, and these aren't public health so much, but just stories. I have a friend who is involved in adolescent health and she turned her whole clinic and to tele-medicine and had a better show rate than she'd ever had because patients would talk to her on their phones. Right? Right. Um, I don't think anyone's expecting that.

In fact, I had another friend who works in adolescent health who was told, oh no, we shouldn't do that because our patients like to come in. You know, lots of different variations. So I think we really need to understand a lot more about how it works, when it works, what it's best for. I would say the same thing within public health.

There are probably scenarios where you did a one-on-one, a one-on-three, found it to be really helpful on zoom or another virtual platform. Um, and yet you can't really do 200 people as effectively. You know what I mean? As you can't get the sidebar conversations, they're are so important when you're doing community engagement, right?

Because you can't talk to each, I can't talk to Jeanne while you're talking Marti. Right? You know, we can't have those kind of sidebar conversations. So I, I really think the whole area of technology, I think it also speaks to what people can do for themselves with technology. Right? So, you know, we're really involved in self-monitored blood

pressure and we need to enhance the technology so that that can be done on a regular basis and feed right into the electronic health record.

And so your provider can tell if you need to have your medications adjusted and you never have to actually go in. I mean, what a concept, right? So there is, I just think we are going to have to dig in now to figuring out which of these techniques work for what I think, even for some conditions, honestly, there's times where the virtual strategy worked better than others.

But um, we'll be in this thinking about this for a long time. And I honestly don't think we will go back to the way it was. So figuring out what worked for us, what didn't, um, and that also pertains by the way, to people in the workplace. Right? You know, so we were starting, we were doing so much about workplace wellness.

Well, workplace wellness is going to look really different if a lot of workers aren't physically going to your fitness club, right? But fitness clubs figured it out. You can go to your fitness club, you can go online, you can get virtual training you can do in your house. So, um, I think the other thing is we have to learn from a whole lot of others who adopted all these new innovative practices and not just say, you know, we're stuck with the things that we identified.

So, you know, learning from other business communities, other community partners in terms of what they did, I think would be really helpful.

MARTI MACCHI:

Yeah, it's a whole, uh, Kristine, it's a whole new area of research that we're, I'm excited to watch. Um, I think you're absolutely right Dr. Hacker. It's like, we have to now learn from what we have seen and not go back.

Right? Because things, we have seen a lot of bright spots, so. So we only have about one more minute. So I was want to give Jeanne and Kristine, um, uh, any kind of option to weigh in on this, uh, bright spot question. What we should keep doing, what we shouldn't do, any more of?

KRISTINE ANDREWS:

We'll let Jeanne have the floor. Go ahead.

JEANNE ALONGI:

Thanks Kristine. Yeah, ditto all the above, you know, that data pilots that we've done with non-traditional data, um, we've got, uh, one with Gallup, um, where we are looking at health behavior and fears and choices and different ways, you know, seeing some of those things continue, I think is good. And, um, like I said before, I think really trying to figure out now, how do we fund and sustain, um, primary prevention work, um, in meaningful ways.

MARTI MACCHI:

Well, I have had, I have three or four more questions, which we don't have time for. So this will be an ongoing conversation. And so appreciate every, all four of you for giving us your time and attention and your perspectives and your subject matter expertise. Um, it's been a wonderful conversation and keep doing the good work that you're doing.

So thank you. So with that, I will turn it back to Nadine and we will finish out our panel, uh, session.

NADINE DOYLE:

Thank you, Marty. Thanks to everyone on the panel. Gosh, that was a, that was a fantastic conversation. You know what? I would, I wouldn't even call that a panel. I would call that a dialogue. We just experienced, um, a dialogue and really got to get a great view, uh, into the deeper perspective of, of each you guys, of each of you guys on the panel. So thank you for that. I'm sure everyone got as much out of it as I did. All right. So with that, I'm pleased to reintroduce our current board president, Kristi Pier, who's going to share NACDD's 2022 board president's challenge.

We'll then have John Robitscher close things out for us. Kristi, take it away.

KRISTI PIER:

Great. Thank you so much. Uh, welcome back everybody. Uh, this has been a really wonderful day. Uh, the insight from all of the partners has been just fantastic. It's very exciting. As we move forward to this next year, uh, if you could change the slide please.

Thank you. Uh, just a little bit of background about the president's challenge. Uh, we've been doing the president's challenge, uh, the annual challenge since 2016. Uh, it's really an opportunity for us to focus on, uh, on one, basically one focus area, uh, that we would like, uh, chronic disease directors and, uh, their programs to, um, to highlight.

And we've talked a lot about how health equity over the last couple of years. And, and so we're going to build off of that this year. And I'll explain a little bit. If you could go to the next slide, please. So this year we're going to talk about resilience. And we're really going to look at it across a socioecological model.

You can go to the next slide. So we use the Ann Masten, uh, resilience definition. There are quite a few, um, definitions around, uh, for resilience. This is, I think, really been embraced also by the brick program, if you sat in on any of the, if you sat in on the brick session today, so it's the capacity of a system to adapt successfully to disturbances that threaten the viability function or development of the system.

If you can go to the next slide, please. So we've really been experiencing a lot over the last couple of years and last year, uh, Susan Kansagra's, uh, challenge was really around equity, around racial equity. So we want to really build off of the challenge last year, the work that the chronic disease directors, uh, did last year and the challenge.

And if we look at, if we look at some of, uh, well we've been talking all day about health debt, right? And so really thinking about, about how we've been impacted, not only by COVID, but also, uh, some of the racial inequities, intentions over the last couple of years and how this has impacted, uh, impacted our ability to adapt and to be resilient.

And this is just a nice little slide to, to show that link between inequity and how, uh, the red lining and very specifically also, uh, mirrors exactly what we saw, uh, what we saw in outcomes for COVID. Can you go to the next slide please? So when we, when we look at the socioecological model and we're looking at, uh, we're looking at four different categories and I'm framing this a little bit different this year.

Um, so you'll see when we go into the individual and interpersonal kind of chain, well, we're, um, pivot a little bit. So, uh, the first, uh, the first category is those actions at the societal level. Um, that impact all of our populations, then at the next level is the community level. And that is really working very specifically in communities, um, and really targeting those specific communities, drilling down a little bit. When we are, and where we're gonna pivot a little bit here, um, isn't. When we go to the interpersonal and individual, what we're, the actions that we're looking at for resilience, we're going to actually be looking at us and our staff. And so we're going to be looking at how resilient we are, um, as staff. So we're switching a little bit here. So we're looking really at our external community, and then we're looking at our internal community.

Can you go to the next slide please? Thank you. So I'm going to go through these really fast. Um, so the societal. So just a quick little framework, if, um, if you weren't familiar with the framework that Susan used last year. Um, I really liked it a lot. Um, uh, nice, uh, checkoffs. Um, so what we're asking the, uh, chronic disease programs is to choose up

to two activities or more, depending on what they're able to do within this entire framework. So we'll walk through really fast this. At the societal level, we're really looking at a lot of, um, data, um, options and, and looking at assuring that states have the information that they need to be able to work at the societal level. Uh, so the first is incorporating the reaction to race module in your, uh, BRFS survey and assuring that you're collecting the ACEs module every two years in YRBS.

In BRFS, additionally, uh, assuring that you, um, at the state level that you're rotating, you're putting, um, ACEs, social determinants of health, and sexual orientation modules on a rotating schedule, so that you have assurance of every two to three years, that you're going to be having the data.

Uh, next is collaborating with state agencies. We talked about this a lot, um, in an earlier panel, uh, at, in that intentional way. Uh, and, um, and there's some examples here around, uh, around housing income credits and, um, and, uh, qualified allocation plan. So you'll be hearing a lot more, um, from us about this, um, in the next couple of months. And then also develop an internal strategic plan to diversify your funding streams.

Can you go to the next panel please? Uh, the next is, uh, community. Uh, at the community level, really looking at working with community agencies, such as YMCA and other local schools, clinics, et cetera, to, uh, to access community investment, to build resilience and equity and, uh, implement at least one action step, uh, in a selected community based on the data, um, that you've collected, um, at, um, from the earlier, um, uh, from the earlier work.

And then we're putting other category in here because you may choose something at your state that makes a lot of sense for you to do so. We've put that in each one of these categories. Can you go to the next one please? So at the interpersonal level, it's really about how we're looking at the resilience in our teams and really taking care of ourselves and our teams.

We've talked about this a lot today about, uh, how this has been very challenging, uh, for, uh, for our teams and, and, uh, and the folks that we work with. So, uh, looking at, um, participating in empathetic, empathetic leadership training to help support staff resilience. Uh, you heard a little bit earlier about joining the health equity council, and we really encourage that.

And there may be another activity that your team really, that you really feel you need for your team. Can you go to the next slide please? And then finally at the individual level of supporting your staff to help them become more resilient. And so you'll be hearing about additional trainings that we'll be having this year.

There's also, uh, we also have a lot of trainings available at NACDD, uh, around, uh, supporting your team members and, uh, and then implementing at least one interactive action to build, uh, resilience in your chronic disease team members. And, uh, can you go to the next slide? I think that that was the last slide.

There you go. So I'm going to, uh, move it over to John to close us out. Thank you.

JOHN ROBITSCHER:

Thank you, Kristi. I really look forward to, uh, implementing the president's challenges this year. I think it's going to be very exciting and really building off, uh, the work of previous past presidents. And it's going to be a very, very exciting to work on resiliency.

So what a super informative day, um, from our, uh, two discussion panels to hundreds of participants that have been online, the 11 breakout sessions, um, all of our guests. I mean, great conversations. It was just so great to see everybody engaged. I love this last panel we had, um, what a great conversation on how, uh, health equity, racial equity, health debt are deeply intertwined.

Um, we've only scratched the surface here. That conversation could've gone on much longer, uh, but, um, we'll be circling around and, and, um, finding new ways in which we can incorporate these, uh, ideas into our, into our areas of work. So you all have showcase contact forms. I think they've be shared online, but we'll make sure they get thrown back into the chat.

We'd love for you to uh, for you to continue to share your ideas, thoughts, suggestions about any of the topics you heard about today, uh, so that we can, um, get queued up and get working with you on, on these important areas. We're going to pause now to ask you if you would, to fill out our showcase evaluation to win 1 of 5, uh, $20 Amazon gift cards that we're going to be offering to randomly drawn winners.

Um, so it's your chance to grab an Amazon gift card, but you got to fill out that evaluation form first. And, um, don't forget to send in your showcase contact form with your program ideas and questions. A link to both of these are going to be, uh, items will be provided in email and in the chat. Finally, I'd just like to say thank you for all of you attending, especially our partners, our CDC leaders, colleagues, board of directors, sponsors, members, consultants, you know, just, it was so great.

The staff worked so hard putting this on, all of our staff and consultants worked many long hours to prepare for this event. And we wish you, uh, to be the, this is, uh, while we'd love for you, uh you know, to be in person, this was the next best thing that we

could possibly do, uh, during this pandemic. So, um, next year, hopefully in person. Uh, but, uh, want to just thank you all for your support, continued support for NACDD and have a great evening.

- END OF TRANSCRIPT -