Summary: Written Testimony of Joneigh S. Khaldun, MD, MPH
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U.S. Senate Committee on Health, Education, Labor, and Pensions
June 23, 2020 Hearing on "COVID-19: Lessons Learned to Prepare for the Next Pandemic"

COVID-19 has and continues to ravage communities across the country. As of June 20, 2020, Michigan had 61,084 confirmed COVID-19 cases and 5,843 deaths. While we have made tremendous progress in slowing the spread of this disease in Michigan, we recognize that now is not the time for victory laps. COVID-19 is still very present in Michigan and we continue to respond to outbreaks across our state. Nationally, this destructive virus has killed over 120,000 people so far with no end in sight and has left under resourced public health departments scrambling to provide a coordinated and robust response in the absence of federal leadership. It has also further unveiled the tragic injustice of racial inequality in our society. But it is not too late. With strong federal leadership and strategic policy, we have the opportunity to turn this crisis around and prevent additional suffering and death.

Health Inequities
Across the country, communities of color are disproportionately being infected by and dying from COVID-19. For example, despite making up only 14 percent of Michigan's total population, African Americans represent 31 percent of COVID-19 cases and 40 percent of deaths. This cannot be explained by genetics and has everything to do with institutional and structural racism that has consistently left communities of color without adequate resources and opportunities for prosperity and optimal health. Strategies to fight COVID-19 and future pandemics must focus on eliminating policies that perpetuate inequities and should ensure equitable access to health care, vaccines, education, employment, and housing.

Consistent and Accurate Messaging
Since the beginning of the COVID-19 outbreak, Michigan has been challenged by the lack of a consistent, science-based federal strategy and message about the true threat of the disease, mitigation strategies, and potential treatments. A clear, accurate, and consistent message is needed at the national level alerting people to the risks of the disease, how and when to get a test, the importance of contact tracing, and basic public health messaging relaying the benefits of wearing masks and practicing social distancing.

National Testing Strategy and Infrastructure
As a country, we were not prepared for COVID-19. We did not have the testing capabilities, testing supplies, or personal protective equipment needed to adequately respond. Governments and hospitals have had to compete for resources, often against the federal government. Combined with delayed and sometimes unusable supplies from our federal partners, this created unneeded uncertainty in an already difficult situation. While things have improved, many of these issues continue to be a concern. We need a national strategy and leadership to ensure a smooth supply chain that makes sure the right supplies are arriving when and where needed.

Public Health Investment
Nationally, less than three percent of the annual $3.6 billion spent on health is dedicated to public health and prevention, and this proportion has been decreasing since 2000. COVID-19 has shown the problems with this disinvestment. To ensure the U.S. can continue to respond to COVID-19 as well as the next emerging threat, we need to invest long-term in our public health departments and programs.

WRITTEN TESTIMONY

OF

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HEARING ON

"COVID-19: Lessons Learned to Prepare for the Next Pandemic"

Committee on Health, Education, Labor and Pensions
United States Senate
June 23, 2020

Chairman Alexander, Ranking Member Murray, and members of the Committee, thank you for the opportunity to speak with you today about Michigan's response to COVID-19, what steps need to be taken to protect the public health from this devastating disease, and how we can prepare for future pandemics.

COVID-19 continues to ravage communities across the country, and Michigan has not been spared. Michigan identified its first two cases of COVID-19 on March 10, 2020, the same day that our Governor, Gretchen Whitmer, declared a state of emergency. By April 1, 2020, Michigan had identified 9,334 confirmed cases and 334 deaths from the disease. Governor Whitmer has taken a series of appropriate and decisive actions to protect the health of Michigan residents, including restricting gatherings and travel unless they were necessary to sustain or protect life, limiting healthcare activities that were not time-sensitive, and aggressively building up testing and contact tracing to contain the disease.

As of June 20, 2020, Michigan had 61,084 confirmed cases, and 5,843 deaths due to COVID-19. It has tragically killed people of all ages in our state, from as young as 5 up to 107. While our road has not been easy, we have made progress. Due to the Governor's actions, the sound judgment of most of our businesses and residents, and the work of our local health departments, Michigan has seen a significant decline in cases and deaths over the past several weeks. Our hospital systems, particularly those in southeast Michigan who were hit hardest during this pandemic, are now stable in bed availability, supply of personal protective equipment (PPE), and resources available to take care of their sickest patients. As of last week, Michigan was one of four states in the country on track to contain the disease, according to the public health experts at Covid Act Now.[1]

Because of this, Michigan is cautiously reopening the economy with robust safety protocols in place.[2] But let me be clear: this is not the time for victory laps. COVID-19 is still very present in Michigan and we continue to respond to outbreaks across our state. There is no vaccine and

[1] https://covidactnow.org/?s=53768
[2] MI Safe Start Plan. May 7, 2020.

much of the population has likely not been infected, meaning most people are not immune to the disease. There is no FDA-approved antiviral treatment. And many states are still seeing increasing numbers of cases. In Michigan, I am preparing for the real possibility of a resurgence of cases in the fall during influenza season, which would be devastating for the health of our residents and could stretch our hospital capacity once more.

For these reasons, we cannot let our guard down now on COVID-19. The COVID-19 pandemic is not over. As we move forward with fighting this disease, federal, state, and local leaders must be laser-focused on protecting our communities from COVID-19 and addressing the inadequacies in our public health infrastructure.

Health Inequities

The greatest tragedy of this pandemic is how it has ravaged communities of color. Michigan was one of the first states to release data on cases and deaths by race and ethnicity. In Michigan, a state where just 14 percent of the population is African American, 31 percent of COVID-19 cases, and 40 percent of deaths, are African American. Governor Whitmer swiftly responded to this information by establishing the Michigan Coronavirus Task Force on Racial Disparities, chaired by Michigan's Lieutenant Governor Garlin Gilchrist.[3] I have the pleasure of serving on this task force alongside several other community, academic, and government leaders, and the task force has moved swiftly to identify causes and promote solutions to address these inequities.

The racial disparities in the effects of COVID-19 are not unique to Michigan. African Americans, Hispanics, and other racial and ethnic minorities across the country are disproportionately being infected by and dying from COVID-19.[4] This is no surprise. Health disparities and inequities have plagued this country since its inception. To be clear, these disparities cannot be explained by genetics. Instead, the disparities exist because of institutional and structural *racism* that has deprived communities of color of adequate resources and opportunities for prosperity and optimal health. Indeed, racism is a public health crisis that must be met with urgency, funding, and the elimination of policies that perpetuate health inequities: policies like redlining, lack of investment in schools, and both implicit and explicit bias in the healthcare system.

These policies have caused communities of color to be more likely to live in poverty, have inadequate housing, have poor access to healthcare, and work in lower paying jobs.[5] This means that due to the nature of their employment, people of color have disproportionately been deemed "essential" during the COVID-19 pandemic, needing to leave their homes and interact with the public instead of having the privilege of safely working from home while maintaining health and other fringe benefits. Homelessness, multi-generational households, or unsafe living conditions make it difficult to effectively self-isolate and quarantine, allowing COVID-19 to rapidly spread. People of color are also more likely to have underlying health conditions that are often

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[3] Executive Order 2020-55

4 Garg S, Kim L, Whitaker M, et al. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:458–464. DOI: http://dx.doi.org/10.15585/mmwr.mm6915e3.

[5] US Bureau of Labor Statistics, Report 1082, Labor force characteristics by race and ethnicity, 2018. October 2019. https://www.bls.gov/opub/reports/race-and-ethnicity/2018/home.htm.

undiagnosed or poorly treated, putting them at higher risk of being severely affected and dying from COVID-19.

Strategies to fight COVID-19 and future pandemics must focus on eliminating barriers in access to healthcare. No one should worry about paying out of pocket for testing or treatment of COVID-19. Everyone should have access to health insurance, and our healthcare safety net which cares for the most vulnerable must be adequately funded. Vaccine distribution strategies should be data-driven and focus on those who are at highest risk of severe disease, with clear guidance in place to ensure communities of color have equitable access. Strategies should be employed that embed testing and vaccination distribution in communities — not only in doctor's offices or hospitals. The strong partnerships that state and local health departments have cultivated with communities over the years should be leveraged to address ongoing challenges with access to care. These partnerships will also be critical to overcoming the mistrust of the healthcare system that often exists in communities of color, fueled by historical inequities in treatment.[6]

We also have to ensure access to adequate housing. Housing policy is health policy. In the short term that means safe places where people who have COVID-19 can self-isolate and longer term making sure people have access to affordable, healthy housing in safe neighborhoods.

Finally, we must address implicit and explicit bias in our healthcare system. Research has shown that, once care is accessed, both implicit and explicit bias by healthcare providers contributes to health care disparities.[7] One of the factors associated with implicit bias is how we are socialized. We all have implicit biases but often do not realize that they exist – assumptions about individuals and groups can cause medical providers to not use a patient's individual circumstances or objective data to guide clinical management. Explicit biases include those that are more explicitly racist, that may also not be fully recognized. This bias is known to impact health outcomes in communities of color and COVID-19 is no different. Implicit bias training should be a mandatory part of all health professional training, and medical schools and residency training programs should accelerate efforts to increase diversity in their classes.

Consistent and Accurate Messaging

I have the utmost respect for my colleagues at the U.S. Centers for Disease Control and Prevention (CDC), and I have been grateful for their support since we first began building up Michigan's response to COVID-19 in January 2020. However, we have been challenged by the lack of consistent, science-based strategy and messaging from the White House. I am a practicing emergency medicine physician and have had the honor of serving as Baltimore's Chief Medical Officer, Detroit's Health Commissioner, and now as Michigan's Chief Medical Executive. As frontline clinicians and public health leaders, we rely on swift, scientifically sound guidance and messaging from our nation's leaders and federal public health experts during a crisis. This has not been the case since the beginning of this outbreak, with inconsistent and inaccurate messaging from the White House about the true threat of the disease and potential

[6] Armstrong, K et al. Distrust of the Healthcare System and Self-Reported Health in the Unites States. J Gen Intern Med. 2006 Apr; 21(4): 292–297. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484714/

[7] Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington (DC): National Academies Press (US); 2003. Available from: https://www.ncbi.nlm.nih.gov/books/NBK220358/

treatments. There should be a clear, accurate, and consistent message at the national level alerting people to the risks of the disease, how and when to get a test, the importance of contact tracing, and basic public health messaging relaying the benefits of wearing masks and practicing social distancing. As with previous outbreaks such as Ebola, or H1N1, we must make sure our nation's top public health leaders are the face of this pandemic and are given full authority to swiftly implement the most scientifically sound practices and to communicate this information to the public.

National Testing Strategy and Infrastructure

As a country, we did not expand access to COVID-19 testing quickly enough. In the early stages of the pandemic in Michigan, individuals had to meet strict criteria, including having severe symptoms, or a clear history of travel to an impacted country, to access testing. Once they met that strict criteria and were tested by a healthcare professional, state and local public health leaders had to subsequently arrange for packaging and shipment of the patient's sample to the CDC lab, where the CDC then prioritized which samples were run. By early February, Michigan was working through the process to be able to run samples in our state laboratory, but that process was then halted as the CDC had to work through unexpected inconsistencies in the testing platform.

By the end of February, Michigan's public health laboratory was the only laboratory in Michigan able to perform COVID-19 testing. On March 10, 2020, when Michigan confirmed its first case of COVID-19, our laboratory only had enough supplies to run a few hundred tests a day for a few days. Weeks of delays and restrictions in testing meant we were not able to identify cases at the level and speed needed – with tragic consequences – as there were likely hundreds, if not thousands of cases in Michigan well before they were identified by testing.

Since that time, through painstaking work, Michigan has built a testing system that now conducts about 14,000 tests per day. We are working towards a goal of 30,000 tests a day, or about two percent of Michigan's population per week, in line with recommendations of national public health experts. Nearly 70 laboratories in the state have validated testing for COVID-19, and about 250 test sites are currently operating. With this expanded capacity, Michigan has broadened testing criteria significantly, and we are focused on testing anyone who has symptoms, may have been exposed, or is most vulnerable to disease. The assistance of Michigan's National Guard and funding from the Paycheck Protection Program and Healthcare Enhancement (PPPHCE) Act as well as the Coronavirus Aid, Relief and Economic Security (CARES) Act have been vital supports in the state's testing strategy.

I have greatly appreciated the support we've received from our federal partners including, but not limited to those at the U.S. Department of Health and Human Services (HHS), the CDC, the Assistant Secretary for Preparedness and Response (ASPR), and the Federal Emergency Management Agency (FEMA). They have consistently answered our calls and Michigan is now regularly receiving testing supplies. However, we still struggle with the lack of detail provided on the timing, quantity, and type of supplies coming to the state, and often the supplies we receive are not compatible with the laboratory systems that exist in the state. This makes planning and coordination challenging.

Early identification of cases and testing should have been an early priority at the federal level. When it was clear in other countries that the disease could rapidly spread, the U.S. should have swiftly established a national testing strategy and set up clear testing criteria and infrastructure for state and local governments to easily obtain testing supplies. Instead, state and local governments were left to compete for limited supplies and people who likely had the disease were turned away from testing, resulting in the disease spreading like wildfire in our communities. Even today, Michigan is unable to meet its testing goal of 30,000 tests per day. Laboratories still struggle with a fragmented and inconsistent supply of test kits and laboratory reagents. Our hospital laboratories frequently run low on reagents and are still only able to test the sickest patients. Going forward, the federal government should institute a national supply chain strategy to resolve bottlenecks that no state alone can address – and ensure an ample supply of test kits and reagents.

Invest in Public Health Infrastructure at the Federal, State, and Local Levels

In its 1988 report, "The Future of Public Health", the Institute of Medicine expressed concern that, "this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."[8] Despite this grave warning, our public health systems continue to struggle for the support and funding needed to ensure there is a robust, versatile, and flexible system available to protect and promote the health and wellbeing of our residents. Public health departments across the country are continuously asked to do more, with less. Between 2008 and 2017, more than 56,000 local public health positions were eliminated, which accounts for almost 25 percent of the workforce.[9]

Nationally, less than three percent of the annual $3.6 billion spent on health is dedicated to public health and prevention, and this proportion has been decreasing since 2000.[10] Funding from the CDC for public health preparedness and response has been cut by over half in the past decade.[11] In FY2016, Michigan's per capita state funding from the CDC was $18.80 compared to the national average of $21.31.[12] This places Michigan 43rd in CDC funding.[13] These cuts have had a significant impact on our ability to adequately fund and respond to public health threats.

I have experienced this first-hand. As Detroit's Health Commissioner, I led the city's response to the largest Hepatitis A outbreak in modern history, pulling my limited staff and funding away from other critical public health work to quickly set up pop-up clinics, and worked with Federally Qualified Health Centers and hospitals to make sure patients were appropriately screened and those at highest risk were vaccinated. In my role as Michigan's Chief Medical Executive, last year I had to quickly respond to the state's worst outbreak of Eastern Equine Encephalitis (EEE) ever recorded. This debilitating mosquito-borne illness infected many and ultimately killed six people and dozens of animals across the state. I had to scramble to set up a

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[8] Institute of Medicine 1988. The Future of Public Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/1091.
[9] Trust for America's Health. What we are learning from COVID-19 about being prepared for a public health emergency. Issue Brief, May 2020. Accessed 18 June 2020 file:///C:/Users/HUdsonn2/Downloads/TFAH2020CovidResponseBriefFnl.pdf
[10] Trust for America's Health. The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2020. Accessed 17 June 2020 https://www.tfah.org/report-details/publichealthfunding2020/
[11] Ibid.
[12] Citizens Research Council of Michigan. An Ounce of Prevention: What Public Health Means for Michigan. Report 403, August 2018. Accessed 17 June 2020 https://crcmich.org/wp-content/uploads/rpt403_public_health-2.pdf.
[13] Citizens Research Council of Michigan. An Ounce of Prevention: What Public Health Means for Michigan. Report 403, August 2018. Accessed 17 June 2020 https://crcmich.org/wp-content/uploads/rpt403_public_health-2.pdf.

surveillance and mitigation strategy coordinated across 45 local health departments in a matter of weeks.

My experience with COVID-19 is no different. Since March 2020, our state and local health departments have had to take aggressive and extraordinary measures to expand contact tracing infrastructure – the bread and butter of any communicable disease response. We set up a new technological infrastructure that enables more effective management of contacts. We built our own contact tracing army – over 10,000 Michiganders have volunteered to be contact tracers, approximately 500 are deployed today, and we are moving quickly to hire surge staffing embedded in local health departments, using funds from the PPPHCE Act and the CARES Act.

But the ability to respond to crises like these should be built into the public health system, not jerry-rigged as a global pandemic spreads like wildfire. We should not have to rely on volunteers or take staff away from other critical public health work to respond to emerging public health threats. Lack of ongoing investment in technology, surveillance, and staffing infrastructure means that state and local health departments are constantly improvising and building these systems *during* a response, resulting in dangerous delays in understanding disease spread and swiftly controlling it. To ensure the U.S. can continue to respond to COVID-19, safely reopen and sustain our economy, and respond to the next emerging threat, we need long-term investments in our public health departments and programs.

Public health experts have been gloomily warning of our lack of preparedness for a global infectious disease pandemic for years. Unfortunately, COVID-19 has turned those warnings into a real-life public health nightmare, killing over 120,000 people in the U.S. and leaving under-resourced public health departments scrambling to provide a coordinated and robust response. It has further unveiled the tragic injustice of racial inequality in our society. But it is not too late to save the lives of hundreds of thousands more. We have an opportunity to make the next chapter in this crisis a success story brought about by strong federal leadership making serious and sustained investments in public health infrastructure.

Now is not the time to celebrate or turn our focus away from COVID-19. We must still aggressively fight this pandemic and if we do not redouble our efforts many more people will unnecessarily die. As a country we must urgently address health inequities, expand testing and contact tracing, and make sure our public health infrastructure is strong. We must remain vigilant, hopeful, and committed to protecting the public's health.

Thank you for the opportunity to share Michigan's experience.