INTRODUCTION

Welcome everyone to the United States of Care webinar - Actions to Plan, Prepare, and Prevent COVID-19 Surges.
I'm Kristel Jacobson from USofCare. Before we begin, I want to run through a few general housekeeping items.

We will be recording this webinar and the recording and transcript will both be posted to our website, unitedstatesofcare.org.

All attendees have joined in a listen-only mode.

And the format for today's call will be 5-7 minute for each of our presenters followed by an open Q&A. At the time of the Q&A we'll provide instruction for how to ask your questions.

Lastly, if you experience any technical issues during the webinar, please email user@usofcare.org. My colleague, Destiny is standing by and we'll do our best to troubleshoot any issues.

Thanks for your attention. Again welcome to this United States of Care webinar. I'd like to now turn it over to our Senior Policy Director, Kristin Wikelius. Kristin…

KRISTIN WIKELIUS

Thanks, Kristel. Hi everyone. As Kristel shared, I'm Kristin Wikelius, USofCare's Senior Director of Policy. Also on the line from USofCare is Natalie Davis our Senior Director of Public Engagement. She will help facilitate our Q&A session.

It's my pleasure to welcome and thank all our speakers for joining us today and sharing their expertise. I am honored to introduce them.

Andy Slavitt is a former Acting Administrator of the Centers for Medicare and Medicaid Services. He's Founder and Chairman of Town Hall Ventures and Founder and Board Chair of United States of Care.

Ryan Panchadsaram is a co-Founder of US Digital Response, and the creator of Covidexitstrategy.org.

Dr. Rebekah Gee is CEO of LSU Health Care Services and previously served as the Secretary of the Louisiana Department of Health. She is also a United States of Care Founder's Council Member.

Jason Elliott is Senior Counselor for Housing & Homelessness under California Governor Gavin Newsom.

We're so pleased to have all of these speakers with us today.

Regardless of where states are currently in the trajectory of the pandemic, now is the time to take stock of what we have learned in the first few months of the COVID-19 response and plan for subsequent waves. As a part of our work supporting states in their COVID response, United States of Care has compiled a State Preparedness Handbook, with 5 actions that leaders can take now to help address future waves of the pandemic.

First, listen to the needs of different communities.
In our own listening work, we're learning that people are putting concerns about the health and safety of loved ones ahead of their own and are concerned about their community and those on the frontlines. State leaders have a real opportunity to craft the next phase of their COVID response based on the needs of those most impacted-- if they listen now.

Second, Communicate clearly with people and use data to guide decision making.

- Leaders need to establish clear channels for making decisions, which will allow them to act quickly in response to future spikes.

- **Leaders also need to be creating a data driven early warning system is critical. States need effective monitoring and clear benchmarks** for action to be able to quickly identify areas when and where the virus surges with the goal of keeping any shutdowns as targeted and limited as possible. Ryan will talk more about some of the data that states can use, such as hospital and ICU capacity, as they monitor the virus in their state.
- States also need to use proven tools to respond to what the data shows, with sufficient testing capacity and the ability to trace contacts of those infected.

- **Leaders must also Share direct, timely, and accurate information** about what people can expect. Ultimately, people want clear and actionable information from trusted sources, even if the news isn't good. Effective communication in a pandemic means finding not only the right message, but also the best messengers to effectively share it with different communities.

Third. Focus on Protecting People and Places That Face the Highest Risks

We now know much more about who COVID-19 impacts most severely, and the types of settings that are most at risk. Any successful pandemic response must focus first and foremost on the people and communities that have faced longstanding barriers to accessing care, including the black, latinx and native american communities hit hardest by COVID.

This means that states must **Address disparities** using a comprehensive approach, understanding the experiences of vulnerable and at-risk populations, especially communities of color

- States should be acting now to protect and fortify the locations that have proven to have a high risk for transmission, such as nursing homes and long-term care facilities, jails and prisons and other congregate settings.

- **Future waves of COVID could bring additional school closures. As of part of planning for potential closures, officials must plan for disruptions to key services** to ensure the services and programs that children depend on, such as mental health care services and access to healthy foods, are available.

- Plans for COVID surges must recognize that not everyone can safely or effectively isolate in their home if exposed, and create a system of isolation and quarantine for those who need it. During the initial wave of COVID-19, many states and localities have established unique isolation and quarantine approaches to provide safe, temporary living spaces, often with wrap-around health care and behavioral health care. Jason will be able to discuss some California's work to meet these needs.

- As people return to their jobs, we must ensure that they are safe at work. There is much that we can do to keep both workplaces and schools safe to help prevent future outbreaks, work that Dr. Gee has helped to lead that she'll share later.

ACTION 4 is to Build a Health System Capacity to Meet People's Needs

People want a health care system that is well-resourced and will be there for them when they need it. The first wave of COVID-19 exposed the cracks in our preparation, and left people concerned that our system was not actually ready to care for them. People expect a better response moving forward, and now is the time to fill gaps that were evident in the early days of the response.

- **States need to Establish systems to be able to quickly ramp up the availability and distribution of PPE**, through regional partnership and coordination

- **Sustaining the health care workforce will also be critical to ongoing success. Workers on the frontlines will need ongoing support, and a robust mental health safety net.** New York, for example, is waiving out of pocket costs for mental health services for frontline medical workers.

- **States should also Plan a targeted approach to delaying non-essential care and procedures** if surges of COVID occur, in hopes of avoiding blanket delays to health care services that people also need.

- **And Finally, as leaders need to recognize that they may be addressing future waves of COVID on top of other external events-- most notably seasonal flu. States need to plan to maximize distribution of influenza vaccines in safe settings, focusing on the most at-risk populations.**

Fifth and finally, states should act now to build the public/ private collaborative approaches that will help them be successful. Cross state and cross sector partnerships have been an integral part of the success of the response to the initial outbreak. And now is the time for leaders to work to build the partnerships that will help succeed in addressing what comes next.

By taking these 5 actions now, the response to future waves of COVID can minimize the need for full scale lockdown and future stay at home orders.

For more information on any of these items, our State Preparedness handbook is available on the USofCare website at unitedstatesofcare.org.

With that, I will now turn it over to Mr. Andy Slavitt to say a few words.

ANDY SLAVITT

Thanks, Kristin. And greetings to everybody. First, I just want to thank the United States of Care team for the amazing work that you're doing to help figure out how to open safely. In ways that can help make sure people are both healthy and we get the country moving again.

I also want to thank everyone for tuning in today. I know people are busy. And finally I want to thank anybody, who in anyway, has supported the work of United States of Care either by bringing expertise, by signing up on the website to get emails, or financially supporting the organization and the work that they're doing. So that they can continue to do the work like put out the materials that Kristin just shared with you.

Let me just start for a second by telling you what it is that we believe at United States of Care. Our belief is that everybody, no matter who they are, no matter what they look like, no matter where they come from, should have a regular source of care that's theirThat takes care of them. Our country owes us nothing less.

The second thing that we believe is that people shouldn't have to worry about how they're going to take care of their families if someone gets sick. That there should be financial protection for everybody. Table stakes.

Third, we believe in a system that is equitable and just. And equitable doesn't mean that everyone gets the same thing. Equitable means people get their needs met, how they need to get it met.

We're fortunate to have people like Kristin who put all of those principles into actual policies. People like Joanna Dornfeld who bring those policies out to state and local leaders. People like Andrew Schwab who bring that to federal government leaders in the congress and really people like my co-founder, Natalie Davis who make sure that every bit of our work is actually grounded in solving real problems for people. And I think that's one of the things that you'll see different.

So let me spend a second before we turn it over to panelists to talk about what is going on. Over the last 24 hours, I've been having a number of phone calls with states who are more and more concerned, these are states in the south and in the west, that have for some time not believed that the virus was going to come to their communities and now are starting to see that.

And I want to just say a couple things. First of all, the question I probably get asked most frequently is, "OK, whose fault is this?" "Who do we blame?" Do we plan people who went and had barbecues on Memorial Day? Do we plan protesters? Do we blame the President? Do we blame the Governor? The truth is, if you want to blame anybody, we should blame the virus. This is how the virus behaves. This is how it behaves biologically. It goes from community to community, finding and gathering some people, then it hosts itself inside largely asymptomatic people until it finds people that it can attack their organ system, and their blood vessels. That is the true bad guy here. And, if we begin every conversation by thinking about what divides us and who is to blame. I think we'll

get it wrong. I think we won't help each other. I think we won't support each other. I think we won't come to the right answers and conclusions.

And, yes, political leaders are responsible for how they reacted. And not everyone has reacted well. And, by in large you can compare our reaction in the US to the reaction of countries overseas, whether that's in Europe or in Asia or in Oceania - our reaction has left a lot to be desired. So we're not going to pull any punches that we can do better. But doing better means all of us. It doesn't just mean our elected leaders. And it means getting into these topics in a fair amount of detail. I do believe we can live with this virus. I don't believe that we have to stop enjoying our lives. I don't believe that there aren't a lot of really great activities that we can all do. But I do believe that there needs to be the political and governmental support that allows people to do that. Things like paid family medical leave. Things that provide all types of levels of support. And that those things are the things that can be arrived at by doing the work, by looking at the data, by focusing on communities and reaching the kinds of conclusions that Kristin just laid out.

So I feel like our job is to help do that work in an impartial and trusted way. To work with people no matter who they are, no matter what their other beliefs might be. But their view is if they want to protect the safety and help their states then we are ready to dig in with them. And I'm so appreciative for those who allow us to do that.

So, with that, I'm extremely excited, like everybody else is, to hear from everybody else. I know that Kristin's going to introduce people shortly. I have had the benefit of having worked shoulder to shoulder with Ryan on many many occasions, I've had the privilege of working with Dr. Gee very closely on many occasions, and I've just met our third panelist and I'm completely blown away with the work that he's doing so I think that we're in for a good conversation.

KRISTIN WIKELIUS

Great, thanks so much Andy. And I will pass it over to Ryan for an overview of Covid exit strategy and how some of the data is looking.

RYAN PANCHADSARAM

Thanks, Kristin. Can you see this?

Fantastic. So, we started this project, Covid Exit Strategy, to help state leaders and the public better understand how their state's doing in tackling this virus. We're, as a reminder, we're a nonpartisan group with experience working across multiple administrations, made up of volunteers from US Digital Response, United States of Care, Resolve to Save Lives, and Duke's Margolis Center.

What we do is we aggregate publicly available information to track a states progress, toward reduction in symptoms, their health system readiness, and testing throughput. Our primary data sources come from the CDC itself, as well as this project called the Covid Tracking Project, which collects information from state government websites. They check them every day and aggregate that for us and we present it this way. The site that you see here is meant to be a progress bar for how the country's doing and, as a reminder, our dashboard here is only as good as what's being shared publicly by federal state and local governments. We depend of them and we can present the information in this way.

With the few minutes that I have I was going to give you a quick tour of the site, which effectively is giving you a quick tour of what's happening across the country.

When you scroll down to the main section you can start to see how each state is doing on key measures. With our working group we're surfaced these measures here, most importantly, actually when I say most importantly, these are the most important ones and you have to look at them all in context because one measure doesn't completely tell the whole story. We track what the trend of cases is looking like and so you can tell whether it's increasing, decreasing, or flat. We pull data from the CDC on what the influenza like illness syndromic system is saying. Right now actually across the board it's quite minimal right. Because we've passed flu season a long time ago.

We also track this idea that there is a target in testing that we should have across the country. And this main one here looks at the five hundred thousand tests per day number. Both Harvard and Resolve to Save Lives and the Rockefeller Center have rallied around this like as a baseline we need just this many tests to get a sense of what's happening. But there's a far higher target of 5 million a day that we need to get too. So this is tracking how a state's doing on that 500K.

We look at ICU availability, which is released by the CDC. We try to calculate out what the cases per million per day look like, right. It's an inference on what the

burden on the health system is going to look like. As well as we look at what the Covid positive rate is and that's important because it tells you how well you're testing.

If you look at this high level view and say well which states are doing really bad? I've created a quick view here that pulls all those out. You know, in the news, many of these states are there but the one that's clearly at the top with cases increasing incredibly is Arizona. They've got cases increasing over 150%. They're testing better than they were before, but their cases per million rate as well as their positivity is really high, and this piece here is on the alarming side, the case positivity, that Covid positives at 22% in Arizona. That means that for every person they're testing...sorry as you test more people the idea is that positivity rate should go down, right. You're testing more people and you're finding more people that are not positive. But if you're testing more and you're finding more positives means you're not testing enough. And so that's for Arizona.

You can see other states that are maybe on the different spectrum like Hawaii which is tagged here as red because you've got cases increasing but it's at a completely different level of cases per million, right.

In Arizona it's 375; in Hawaii it's 8.

When you look at the site use the data that's there to help you set that context. If you ask another view, well how are some of the good states doing, right. The states that are decreasing. You know, you see a consistent pattern of cases decreasing, really high testing, very low cases per million, and a positivity rate lesser than 5%. Versus the 22% in the Arizona case.

And so quick easy things, is if you just type any state name it will help you filter these things out, if you types multiple things it will let you pull those pieces out there. This tool's really helpful for journalists, or folks on twitter, or researchers, if you want to pull out a subset of states; you can do that.

A few sections to call out. There's one that tracks how a disease is spreading. This looks at the zoomed out view - what is the RT. Which we pulled from RT live. What's the doubling time. A lot of folks spend even more time on this section here which is can our health system handle the spread? Our ICU and bed availability. What do the cases per million look like. What is hospitalizations per million. As well as what the case fatality rate is. You can sort some of these

sections to get a better sense of what the state of the state is. And you can see here when it comes to cases per million per day, right this is adjusted per capita, you've got Arizona, South Carolina, Arkansas, Florida, Utah, and Texas all at the top. You know you turn that on its head, you can see places like Hawaii, Vermont, Montana, and Washington on the bottom.

The other section to call out is this one here on testing. Testing is so important, right. When I talk about this there are two targets. You can see them here side-by-side. How a state is doing towards that total five hundred thousand per day as well as how it's doing on that four million per day. You can see the positivity rate trend which is really important. You've got to look at both sides of this chart to get a sense of our we testing enough. As these increase, this number should be decreasing. And if it's not it means you have to test more. And so as a team we're working on how to help set maybe a different kind of threshold for this upper bound because if a state isn't finding any cases anymore, well then, it can test less. But if a state continues to find more of this target actually should rise accordingly to the number of cases they have.

And so this site here we update every day, every night, as soon as all the data comes out from the CDC and Covid tracking project. We've got a lot of work underway too. There's a section on the site which is us trying to fatefully assess each state on how the CDC categorizes each of the most important categories. They call them the gating criteria and indicators. If you explore this section we're working over the next few weeks to pull it into the main portion, but you can see how the CDC is looking at these things. You can see here on the category of cases decreasing from the CDC's point of view you know the states in red are not meeting their criteria. Where as the states in green are. And this uses a different way of calculating how you smoothen out cases. Most of us online that are doing these calculations do it as a seven day rolling average, or a 14, or three, but the CDC looks at it a little differently, using this thing called a three day cubic spline. So we've adopted that model, and it's a really nice model that helps smoothen things out. So you can see how they're looking at things. You can see how they're looking at the decrease in percentage of COVID positive tests. You can see which states are passing that. You can see how visits for ILI are looking state to state. You can treating all patients throughout the crisis care from their point of view. And, as well as, like what a robust testing program looks like. So, we've got a lot of work to do here. Around this part. And we'll pull it all into the main section once we're ready, but I hope this can be a tool and useful resource for you. If you have any feedback, please feel free to send it to us. We listen to and read every single

email that folks send and we try to keep improving the site because ultimately we built this for you as a state leader, as someone that can influence states in the discussions and policies they make. With that, Kristin, I'm going to hand the baton back to you.

KRISTIN WIKELIUS

Thanks so much Ryan. And just a quick reminder for the audience that we will open this up to questions, for all of our panelists, after their initial presentations. And now I'd like to pass it to our next speaker, Dr. Rebekah Gee.

DR. REBEKAH GEE

Hi everyone. I wanted to thank US of Care. It is an honor to be on the Founders Council, but also to personally thank Andy. Andy you've answered calls on nights and weekends, you've connected us to resources, I know you sprinkle fairy dust over every state in this nation and you're doing great work and you never take credit for it. You're just trying to make good things happen for the people of our country. So thank you to you personally for everything you've done for our state.

Now Louisiana is an outlier, we're a positive outlier. Why? We are a deep south state. We are the only deep south state to have expanded Medicaid and I think that that decision to expand Medicaid and the public support for that decision, explains somewhat of why we're doing better. In Louisiana, we have a culture that whether you're Black or White, rich or poor, you eat red beans and rice on Monday. We love our music. We get hit by hurricanes and when we get hit by hurricanes, they don't distinguish based on who you are, we have to pull through them together. So I do think that that culture whether it's our beans and rice or our music ties us together in ways that other states in the south are not.

And that being said, I am going to say where we are now. Where we were initially was we were severely hit and at one point in the first two weeks of the epidemic in the New Orleans region, we had an 87% increase in COVID cases. That was higher at that time than the nation of Italy or New York state. We were two ventilators away in one of our hospitals from running out. So things were incredibly serious. The virus was invisible at the very time we had Mardi Gras and other large public events and many tourists from all over the world in our state and the virus spread here very rapidly and impacted low-income vulnerable populations disproportionately.

But, we have a governor that people trust and he had a public health leader by his side, Dr. Alex Billioux , who has done a phenomenal job communicating and we had done the work when I was health secretary of communicating with the public about data and really putting in a lot of effort into those data systems so Louisiana, and I am sure there's other states that have great ones, I think ours is the best - I'm biased, some of the work that Brian just said we have for Louisiana we had it very early on. We were the first state to report for example health disparities in COVID as a state. We were the first state to have an integrated dashboard that showed ICU beds, hospitalizations, number of cases, number of tests and the data that you just saw showed that we're in the top three states in the nation on testing. We had preserved our public health capacity so we're able to ramp up testing and partnership with the private sector in ways that other states have not and I do think that local public health leadership is a part of our story as to how we got out of that initial crisis.

We, unfortunately, are looking like a U-shape now. The numbers that had gone down so dramatically are now going up and we are looking like some of the rest of the country. I call it COVID fatigue or in other words we feel like we're done with COVID, but unfortunately, as Andy so well-stated, COVID is not done with us. It is an equal opportunist, regardless of your political affiliation. But there have been success stories in terms of public action, we have here in New Orleans people are very bought into facemasks. We have been very clear about four simple messages. People. Limit the number of people that you're around. Space. Limit how close you are to other people. Where are you, inside or outside? Outside is better. And then time. How much time are you spending. Really some good messaging we have a lot of work to do and LSU is leading the way on working with LatinX communities and communities of color who understandably have tremendous issues of trust with communication that comes from the government. And so we are looking at working in non-traditional ways on communication and have made some good strides. But still a lot of work to do.

I just wanted to highlight three key challenges. One is on where are we in terms of guidance. Well, we're in a phase two in Louisiana. We're not moving forward because of how our rates are looking. There is a lot of clarity on industrial hygiene practices and how do you clean and how far do you space and what restaurant tables look like. I think there is a lot of public comfort around that. I wanted to highlight the American Association of Industrial Hygiene and their website backtoworksafely.org. In an ideal circumstance you would have had an OSHA and

NIOSH and a CDC that would have very early on put out clear common sense guidelines. That did not happen and the absence of that these organizations like AIHA have done some tremendous work and I would encourage you to look at backtoworksafely.org where you can see bar industry, at home service providers, dental and childcare guidance. And we worked very early on with them along with our restaurant association here to make sure that we were optimizing these hygiene practices.

I mentioned testing earlier. We're doing a fantastic job on testing. We remain one of the top three testers in the country and the District of Columbia as well. We still have challenges. There is a lot of disagreement on protocols whether it's for institutions of higher learning or a restaurant setting or a tennis club where somebody is teaching kids has COVID or its a bus driver, but that being said there needs to be alignment there. We are doing the best job we can, but nationally we need to be more solid on our recommendations and I have been trying to work with the National Academy of Medicine, who is putting out guidelines in July on K-12, which will be fantastic to have that level of scientific leadership.

But where we're really having a challenge at this point is contact tracing. Contact tracing is that shoe leather, classic, just need to do. It's been done for tuberculosis. It's been done for HIV and other sexually transmitted illnesses. There's a lot of problems with contact tracing and our state is one of the best in terms of our plan. We have hired nearly 700 contact tracers. Our state's office of public health is leading the effort. They are paid individuals so we're not relying on volunteers. We've got centralized calling centers. We're working across the private and public sector. However, the public trust isn't there and that's a problem we need to solve. Although about 60% of people are answering the calls, which is great, most of them are not being honest about how many people they've been in contact with. We're getting a lot of responses, "Oh I wasn't in contact with anyone" and that for most people is not the case, particularly before they knew they have COVID. So we've got to do better on our messaging and on our public trust around contact tracing.

There also needs to be alignment around common apps. Google and Apple have some tremendous, have been tremendous leaders in this space with their bluetooth technology. It allows you to see where you've been in relationship with others who have COVID without having to document where they've been using this new technology. And we're working as a state across all of our institutions of higher learning and with the office of public health to have one single app, which

will minimize the redundancy in terms of contacting people and will allow us to better translate that data into action at the state level.

So all of that's happening and more work needs to be done, but the good news is in our state we're pulling through it together. I also wanted to outline a couple of other efforts that have been very helpful and collaborative. One is on the protective equipment. Early on, and many of us were involved in looking at protective equipment, and there have been private sector or non-governmental approaches to this like Project N95 that was very helpful. And there are good COVID resources for doctors through the AMA. There are guidelines for employers and workers through the WHO and then the CDC has come out with some guidelines on how to disinfect workspaces, but arguably they're not optimal or ideal.

We have a lot of work to do as we continue to fight this epidemic to reduce disparities and ensure that vulnerable communities are those we go to first. The stimulus bill ignored some of the systemic problems, structural problems in our country that Andy mentioned. Without paid family leave, without paid sick leave, without an ability for individuals, as Andy and Scott Gotely and others have called for to have a safe place to convalesce and not to infect others, we can do many of these things that have been outlined and have created positive improvement. But without these structural factors that allow people to be able to afford to isolate, allow people to afford to get testing, we're going to have challenges. And one last problem I wanted to mention is just the cost of testing. Although Louisiana is doing great, one of the heads of our largest payers in the state said that if we tested every individual along the lines of what is being suggested, it would double premiums by next year. And so we've really got to think about governmental solutions to testing whether it's using public health labs or using stimulus funds to build public health infrastructure throughout the nation and allow for low cost tests or other solutions, looking at sewage and other ways of looking at the genetic residue of COVID in ways that allow you to have early warning signs. We've got to look at cost of testing. That's a major unmet need nationally. So I'll just stop there and hand it back to you and then to Jason.

KRISTIN WIKELIUS

Thanks so much Dr. Gee for sharing your on-the-ground experience and perspectives from Louisiana. And with that I will turn it over to our last speaker, Jason.

JASON ELLIOTT

Thank you. Good morning. For those of you on the west coast, good afternoon to the rest. My name is Jason Elliot I am senior counsellor to governor Gavin Neusum out here in California. Thanks for inviting me to participate in this seminar today. I'm here to talk a little bit about Governor Neusum's response to one particular part of COVID, which is the homeless population. So, I'll just, I know we're gonna have a broader conversation and that's important and I'm happy to chime in where I can to help move that forward, but just to zoom down and narrow down on one particular aspect of this challenge. In California, we have 108,000 unsheltered homeless people. That is the largest population. We are the biggest state, largest population anywhere in the United States. 108,000 another 50,000 people that are considered homeless, but sheltered. But, let's just focus for a second on that 108,000. When we were first learning about COVID mid-march we were all trying to figure out what this disease was, how it spread, what the attack rate would be, what the mortality rate would be and we were all learning and we were doing our best to make educated guesses and learning from our health professionals. At that point we were modeling a 56% attack rate in California. Then, in addition to that, we consulted with some homelessness and public health experts in California and they told us to assume a 40% high risk rate for homeless people meaning comorbidities, over 65 at serious risk of complications or death from COVID.

So if you take 108,000 homeless people, you put a 56% attack rate against it and you put a 40% high-risk morbidity rate against it you're looking at 25,000 homeless people in California who could become seriously ill or die. So when we were first learning about this disease and figuring out what we needed to do, the governor really quickly said alright well we gotta focus on this as one of our key pillars. Why do we have to focus on this? Number one the humanity of 25,000 to 26,000 homeless Californians demands that obviously and that is first and foremost. But in addition to that and more importantly for the healthcare system more broadly, a homeless person who needs to avail himself or herself of an ICU bed or a ventilator will receive the same treatment and access to care, sensibly, that a housed Californian will. Which means that if we have 26,000 people, an extremely vulnerable population all living in congregate settings that get sick quickly, that's going to overwhelm our hospital systems to the point, at that time we had ICU capacity between 10 and 20,000. So that was our entire ICU capacity,

was just the homeless population. So it became clear that we needed to do something around homelessness.

I'll spare the sort of narrative history of what we did, but I'll just jump to the conclusion which is we implemented something called Project Roomkey and Project Roomkey is a non-congregate sheltering strategy for homeless Californians. 75% of the cost is shared by FEMA, who has been a tremendous partner to us in this effort, and through Project Roomkey to date we've bought about 16,000 hotel rooms online and helped about 13,000, a little over 13,000 people move out of shelters, move out of encampments and be in isolation in hotel rooms where they can be safe and other people who are continuing to live in encampments can be protected from the spread of COVID. As a result, we have, and I will knock on every piece of wood in this office, we have not experienced a spike in infections in the homeless population that is dramatically different than our general population. We've had a couple of shelters here and there where you've got a 100 positive cases that have all popped at the same time. Similar thing though that we're seeing in our long-term care facilities and our prisons. So, Project Roomkey largely has worked. The question now is what do we do. Because that federal cost-share may end at some point in the future, will end at some point in the future. We obviously as every other state and jurisdictions around the country, we have access to CARES Act funding, specifically the coronavirus relief funds which expire at the end of December if they're not spent.

So I'll just speak a moment on what our strategy is moving forward and I'm happy to answer any questions. So we continue to prioritize isolation and stability for the homeless population because that's what it's going to take to protect homeless individuals from COVID. So we're going to use about 600 million dollars of coronavirus relief funding which we've supplemented with another about 350 million dollars of state general funds - so about a billion dollar program to buy as many hotels and motels and vacant multi-family buildings as possible to convert them into stable housing for the homeless. So this is a billion dollar sprint of an effort. We're looking at buying thousands and thousands and thousands of motel rooms and for those of you who are working with CRF right now in your communities, you know that this December 30th expenditure deadline is hard and fast. So we're jamming as quickly as we can to make sure we can buy as many of these hotels as possible and not revert any of this money to the federal government.

So this is going to take a significant level of coordination and effort with our counties to buy these units. The counties well ultimately, we have 58 counties in California, the counties will ultimately own the buildings and operate them and provide services. Either the county itself or through a non-profit contracted entity to provide the services. Just last point on this, we of course, permanent supportive housing in the homlessness space is the gold standard and create a permanent place for someone to live with all of the supports they need to be successful. That's the gold standard. Not all of this housing is going to be permanent supportive housing. These units that are going to be brought under control through purchase under homekey, can be transitional housing and they can be interim housing meaning let's get people off of the streets and out of those shelters, provide that safe isolation capacity, and try to continue to flatten this curve, especially when it comes to the homeless population because they're so vulnerable and they just simply, um it goes without saying, have nowhere to self-isolate if they suspect an infection or in fact infected, there's no home to convalesce in alone. So, it's just simply the humanity of the question that demands it, but also to protect our healthcare system for everyone else in California. This is the strategy we're pursuing. So, we'll check back at the end of December and I'll let you know how many thousands of hotel rooms we were able to buy, but this is our primary homelessness strategy for the remainder of this year and with that I'm happy to turn it back over and answer any questions. Thanks very much.

KRISTIN WIKELIUS

Thanks so much Jason. And I know we'll all be closely watching to see how these efforts play out in California over the coming months. And another big thanks to all of our panelists, Andy Ryan, and Doctor Gee as well. We'll now open the telebriefing up for questions, so please use the Q&A button at the bottom of your screen to type in your questions. We'll give folks a few seconds to get their questions in, and then I will turn it over to my colleague Natalie Davis to field those as they come in. Natalie, whenever you're ready we'll take the first question.

NATALIE DAVIS

Great. Thank you Kristin and thanks again to the panelists. We have been getting questions sent in this whole time, so I'm ready to start. To answer some of the

questions that have come in here, there are some links to the resources that our panelists have spoken about today. We also will be recording this and posting the video and using transcription at a later date.

So our first question comes in to Ryan specifically, but I'm sure others have feedback that they could give.

Question: Can you remind us where you're pulling this data, and can it be refreshed/can we compare state by state given the different definitions of measures in state, and does testing include nursing homes, prisons, jails, private detention facilities, homeless shelters, etc.?

RYAN PANCHADSARAM

Ryan: So the data is refreshed every night, but every data set refreshes at a different cadence. So for tests, cases, deaths, and hospitalizations, that's every day. The data that comes for [inaudible] is every week because that's updated every week by the CDC. For ICUs and beds, it's actually three times a week on a Tuesday, Wednesday, Thursday cadence, but sometimes they update it another time as well too. At the bottom of the site, you can see when the last time we pulled data from each of these sources happened. And the question from Amy around data is based on if it's normalized. Well it's not normalized. Actually, some of our columns are normalized, so you're right. Some columns aren't; things like percentages and true counts. We do have things that are adjusted per capita, per million. The whole idea of it is that you can sort by columns, but also you can get a true sense of what's happening on the ground. Like that metric of new cases per million can truly show why one state has a larger problem than another. I think the last one was around PPE. We don't currently have the ability to aggregate that information because not all states are reporting correctly, so the COVID Tracking Project does a wonderful job of aggregating the bare data that...sorry the bare data is the wrong word. The data that each state puts out, and so we really rely on them and their team, so for the moment PPE is not tracked. Contact tracing is one of those things that is really hard to track too. We have faith that as more states do this and publish it through their channels of their public health departments and their state HHS, they'll make it available on their websites, and then we can start to do something with it.

DR. REBEKAH GEE

But we still need more solutions on PPE. I mean the supply chain issues were…I mean the supply chain was very broken when this epidemic first began, and there was a lot of confusion. It was an Ebay type of environment with states bidding against states. Then with FIMA we'd finally find that we'd found a ventilator or a source of masks and then FIMA would just come in and take them. There was a lot of confusion about who would get what, and there were political factors that influenced who would get what. The good news was that our hospital systems here in Louisiana partnered together and helped share resources in ways that had never been done before. But we're still in a situation where we had to put masks in paper bags to reuse, and in some cases not have appropriate PPE. Certainly, not having our essential workers not have PPE and mixed messaging. So, we should work towards more regional purchasing collaborations, more transparency, make sure the federal stockpile is well indexed and it's communicated clearly what's in it. We did get at one point a very large shipment of things from the federal stockpile, but those things expired years ago. So all of those things need to be looked at, and we need to prepare better and not have it happen again. There are many different strategies that can be used, but I'm still not comfortable with where we are with PPE and ventilators and how we're doing with all of that.

NATALIE DAVIS

Great, thank you. Kristin, I might start with you on this one, and then others may have something to chime in.

Question: As we think about moving into the fall with vacations over, schools opening, as well as the flu and other natural disasters, what are things that state and leaders should be thinking about? After this, Jason you can speak to what this looks like from a state perspective as we prepare for this next phase moving into the fall and winter.

KRISTIN WIKELIUS

Sure, and I think it really starts first and foremost with the kind of close monitoring and tracking of the data that Ryan led us through with COVID exit strategy. States have to keep a really close eye on what the outbreak is looking like, and not just in their state but in particular areas, even at the county or the local levels, so they're able to respond quickly with the public health tools that we have if they do see spikes of the virus start to emerge. So they're able to move more testing resources to an area and more contact tracing resources to an area.

And as states are doing that monitoring, now is really the time for them to think about the challenges that they're going to be facing down the road. As we're seeing in the data right now, we're still in the early days of this pandemic. States need to be thinking about what resources they're going to need, when they're going to need them, if schools will be open or potentially partially open, and how they are going to track the spread from places like that. What is this going to look like when flu season starts? There will be potentially more strain on hospital capacity. Now is the time really for states to be thinking about how they can reach populations that maybe don't typically get their flu shots to make sure that this year they're getting those and they're protected and that's minimizing some of the strain on the health system.

DR. REBEKAH GEE

I'll just say look, we've got to be aware of this push and pull. Scientists would have us shut everything down for months until the virus is totally gone. Then you have political factors, and you have real factors of other epidemics. We've got a mental health crisis in this country, we've got millions of youth who've lost educational opportunities, and we have to acknowledge that those who don't have school or who are more vulnerable/have low income have parents that couldn't stay home and have the type of environment that people with more resources have. So there are externalities and consequences of canceling school beyond just the COVID epidemic. I think we need to be pragmatic and think about these things, and National Academy will be coming out with guidelines in July, but also, the industrial hygienics are coming with back to school safety soon. I can't give you a date, but these are things we should follow. But also be pragmatic. Let's not go buy millions of thermometers and have school nurses stand in front and wait for every child to get a temperature check before school. We have to use things like technology that uploads the data automatically and use tracking with other types of apps to be able to do this kind of public health reporting. We can't assume every school is going to have an epidemiologist, and we've got to think about that ahead of time. The issues of vaccine access are real. We just published data that says there's been a 50% drop in presentation for heart attack and stroke at our emergency departments throughout the city. The same thing is happening with vaccines. Parents are not bringing kids in, so I think the push right now needs to be to get a flu shot in the fall, get your check up, stay as healthy as possible, and let's work to make sure it can be successful as possible. The good news is that the data shows the kids are not the spreaders we thought they were, and that's promising. We also know kids do better when they get COVID. All of that is good

news and hopefully will help us with school reopening in the fall. We do know that college students are a problem. We just had a big outbreak with our kids that went to Tigerland Farm and around LSU's campus. Kids aren't as afraid of COVID as older folks, but they can be super spreaders, particularly young adults, adolescents, and people in their 20s. That's the population we really have to focus on communicating the consequences of having parties and congregating. These fall reopening plans are really going to be important to the nation as we continue to fight COVID.

JASON ELLIOTT

I was just going to add, just to put one more layer of complexity on top of this for those of us who are in government, that it's not just school that comes back in August or September, it's not just that that's when the weather gets cold and everyone needs to be inside instead of sitting out in the backyard, for those of us in the American West, we have fire season coming up. We're in the middle of a drought. How are we, as just an example, how do we think about things for Dr. Gee in hurricane season? We know what we do during fire season or during hurricane season. You move everybody out, you do evacuations, you put everybody in a high school gym. That's obviously not going to work this year. Fire season is an inevitability for us. We may or may not have an earthquake, but we are already in the middle of fire season. So what do we do? How does Calfire (our state fire department) not only prepare to keep firefighters safe but keep evacuees safe? That's just one example of five or six others that you can imagine, where, in government planning, we need to think about things because nothing can be a normal course of business. We need to rethink all of those sorts of things.

NATALIE DAVIS

Well it goes without saying, thank you both for your service and making sure that the states and the country are safe. There's been a couple of questions in looking at the changes in who is getting COVID and with the median age going down and what does that mean. You know, as we see an increase and maybe people aren't getting as sick, what does that mean? Dr. Gee, do you have insights that you would share on this?

DR. REBEKAH GEE

Well what we know is that older folks are more concerned and they've heard the message and people are staying at home more. Younger people are, well we've just had a couple clusters of graduation parties for high school students and so on, so I think this message of "we're doing this to take care of each other, it's not just about you, it's about our community" is really important and making masks cool. We're gonna have a mask brigade at LSU and do this at other campuses where people walk around in masks and if you don't have one, we give you one and it looks fun. Just making it part of being cool to wear a mask, but we've got to do a better job with young people and reminding them of why they have to stay at home. We're seeing these rates track up. I don't have ages in the data that I'm looking at, but the age range of CoronaVirus patients has tracked all across the age groups except for people under 3 in Louisiana just don't seem to be getting this virus. So, again, we really need to continue to message social pressures and positive reinforcements of good behaviors because the COVID particularly is worse for young people who have been so impacted by this. So we have to find creative ways to get people engaged and also just simple things. There are 3 simple things: stay 6 feet apart, wear a mask, and stay at home when you can. If you wear a mask and stay 6 feet apart you can do a lot of fun things. Just trying to reinforce this message. Wash your hands too. People are starting to not wash their hands as much anymore as our data shows. People just have to keep up with those three things: wash hands, 6 feet apart, masks. You can't get tired.

NATALIE DAVIS

Great, thank you. Andy, you may have something to add here, and another question that came in here.

Question: Positive cases seem to be going up but deaths and hospitalizations don't seem to be tracking, is that true? Your thoughts on this?

ANDY SLAVITT

I think I can combine those two. So, first of all, there is some good news, which is that science is working. All of the people who stayed home to flatten the curve not only took pressure off of hospital capacity, but they gave our scientists real time to start working on some of the things that are starting to work. And there's therapies now that are being used to address oxygen levels, to address blood clots, to address immune responses, and you know, when this was in Wuhan, 80% of the people that went into the hospital and were put on a ventilator died. That's

now less than 50%, and I expect that to keep coming down. So, the good news is, I think this will become less fatal in general, the more we have time with it. But here's the bad news: one is that it doesn't hit everybody equally, so it is much more fatal still in some people than others. People that are lower risk as Rebecca was talking about, are people that, if they're less careful, impact others. The other thing is that there is a pretty good reason to believe that this thing tends to circulate fast first in young people, and then eventually find older people. In New York, because we didn't have testing, we weren't able to see it. There were a lot of people, we now know about a quarter of the population in New York, that were infected early and didn't know it. And then the disease circulated and found older people, and that's when the fatality rates went up. So, it is not time to declare victory because remember, deaths are a lagging indicator, and we are starting to see hospitalizations climb. We have 7 states now that are seeing record hospitalizations. 20 other states don't even report hospitalizations, so there's probably more. And then, I expect, we'll be better than we were in New York in July, but it wouldn't be at all surprising to see death rates moving up. Anybody who believes that this is a safer disease yet is not...we're not ready to declare that.

NATALIE DAVIS

Great, thank you. And this last one is a round robin. I have the privilege as the head of public engagement of talking to people across the country about their health care experiences and during COVID a fascinating trend that we heard was high anxiety, high concern, but also high levels of hope. And so, for the people that are manning and womanning -- taking on this - what in a very short way gives you hope to keep working on this everyday? Well state with - in the order of speakers, Kristin.

KRISTIN WIKELIUS

Sure, so I would say we have already learned so much more about COVID. There is so much more that we understand, and there's so much that we can do to have better control of what this looks like going forward both in terms of our response and what we're sharing with people about that response.

ANDY SLAVITT

This is a common experience for me, during the virus, the mute function. What are we optimistic about? New Zealand, Hong Kong, Czech Republic, Greece, Singapore, Vietnam...you look around the world, and this is a virus that has a strategy. You can live with it. You can open the economy up, and people can be safe. If you don't have a strategy, and if you don't have an approach, it gets the better of you. There's still an opportunity for us to have a strategy. That strategy includes some things that we control like masks, and it includes other things that Kristin referred to that scientists will do.

RYAN PANCHADSARAM

I think the biggest thing that gives me hope everyday that we're doing this work is just seeing how much each state is really taking control of what's happening. There's states switching from yellow to green, and they have a lot of ownership over the problem and all the data they want to share and how much data they're putting out is really exciting to see. I just want and hope that that momentum continues.

DR. REBEKAH GEE

Yeah, so what Andy said about winning being possible, but also masks give me hope. As I look across a country that's been torn apart by racism and inequity, and I see people marching together wearing masks, and I walk around New Orleans and people are wearing masks. It shows that people care about each other despite the fact that we're in such challenging times. We love each other and we love our country and we want to take care of each other. The vast majority of people want to. Their masking gives me hope.

JASON ELLIOTT

I've been in government about 15 years, and I think sometimes local and state government gets a bad wrap, but I think what gives me hope is, to jump off of what Andy said, that I've seen the government and government people and political appointees do things that you never would have thought local government and state government would do. Whether it's buying hundreds of millions of masks, whether it's doing this hotel program and getting 16,000 hotel rooms, whether it's getting this feed your meals program that stood up in a matter of days and now we've served almost 2 million meals with low-income

seniors and so on and so forth. These are things that would normally take months, at best, to years, and I'm watching government people do things in matters of days that none of us would have ever thought possible. In order to have a strategy, like Andy said, and then to execute on it, we're counting on all of those nameless faces and civil servants that work on state and local governments across the country. Those people are heroes, and I'm not talking about political hacks like me. I'm talking about the folks who are doing the work, executing the contracts, and providing those services. There's a whole army of public servants out there, and they give me a lot of hope.

KRISTIN WIKELIUS

Thank you everybody for joining us this afternoon. Special thank you again to all of our speakers.

As nonprofit organization, work like we shared today with all of you is only made possible through the donations we receive from individuals, foundations and businesses. If you would like to join our important community of donors you may make a gift directly on our website at unitedstatesofcare.org/giving.

You may also find other resources in addition to what we discussed today on USofCare's COVID-19 Hub @ unitedstatesofcare.org/covid-19.

And always follow us on Twitter @usofcare.

Thank you everybody and have a good afternoon.