University of Illinois Chicago, School of Public Health Interview

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SPEAKERS

Wayne Giles, Jocelyn Vaughn, Ronald Hershow, Jessie Knoles, Devangna (Guddi) Kapadia, Natalia Lopez-Yanez

Jessie Knoles 00:02
All right. My name is Jessie Knoles, and I'm a Project research associate representing the University of Illinois archives. Today's date is Friday, November 4 2022. And I'm meeting over zoom to discuss the responses put in place by UIC School of Public Health during the COVID 19 pandemic, for inclusion in the University of Illinois system COVID-19 documentation project. This is a group interview. So I'm going to go ahead and let all the interviewees introduce themselves. Name and Title, please.

Wayne Giles 00:40
I'm Wayne Giles, Dean of the School of Public Health.

Ronald Hershow 00:45
And I'm Ron Hershow, I'm the Director of the Division of Epidemiology and Biostatistics at the School of Public Health.

Devangna (Guddi) Kapadia 00:54
Good morning, Guddi Kapadia, I'm the assistant director at the School of Public Health.

Natalia Lopez-Yanez 01:00
I'm Natalia Lopez-Yanez, I'm the director UIC COVID-19, Contact Tracing and Epidemiology Program.

Jocelyn Vaughn 01:08

I'm Jocelyn Vaughn. I'm the Research Data Scientist of the program.

Jessie Knoles 01:14
Great, thank you all, I'm going to start off with a very base question. And that is, at what point did COVID-19 come onto your radar? And what were your first thoughts on that? Anyone can jump on in.

Wayne Giles 01:29
In January, we starting seeing the first cases, we did have some faculty, I'm thinking about Michael Cailas, in particular, who was tracking cases and doing some data visualization, tracking what was happening sort of across the globe. we were sort of watching, I think, initially, we underestimated some of the impact, didn't realize the enormity of what was going on. I'll let others jump in as well.

Ronald Hershow 02:18
Yeah, I, I can jump in as well. In spring semester, 2020, I was teaching a course on terrorism as a public health issue and had just really started the course. And in that course, we always make the point that nature is the best terrorist, that as much as the idea that some perpetrator might intentionally release an infectious agent to damage the world, that nature is very adept at doing that. So and it seems like every, every time I teach this course, there's a new emerging threat that makes that point for me. And so in January, when we opened the course, early on, really, maybe by the second week of the course, we were already noting that there was this virus spreading in China, out of the city of Wuhan. And it really didn't take us long to have our first lecture on that. We were very fortunate in that there was a Chinese PhD student in the College of Pharmacy, who was in close contact with colleagues in Wuhan, who was able to really give us an insider's view of what was going on in that city. So, I think I can say that maybe we may have had the first UIC lecture on this new emerging threat back then. And that's really how it came on to my radar screen.

Devangna (Guddi) Kapadia 04:01
I would just add, I know for a fact, or I know that, you know, the first cases were in January, we we work closely with the Chicago and state health departments. And so, we were aware that the first case in Illinois, in Chicago happened. You know, and I think the reports that we were getting was that the systems were being burden, and we were feeling pretty confident that the US systems would not be as burden. And so, I you know, I know that there's a lot of conversation around those elements and that piece, but yeah, I think everybody at the School of Public Health was pretty aware fairly quickly. And conversations were happening, you know, internally to the school public health as well as, you know, amongst our, our peers.

Jessie Knoles 04:51
What did those conversations look like?

Devangna (Guddi) Kapadia 04:53
I think we're just trying to understand, I mean, Dr. Hershow mentioned you know, I also have a lot of family Oh, Um, across the globe, and so there was a lot of best guesses or what was playing out that was that was coming out, you know, and fear clearly from from those that were closer to China, and how to how to really put a handle on something we knew so little about.

Wayne Giles 05:21
The other thing, that happened in February, March, is we were getting increasing numbers of questions, both from IDPH [Illinois Department of Public Health] from the city, and then also from businesses, etc. The news media as well, asking what do we do? How do people stay safe, etc. So. So the number of requests began to skyrocket asking for information, technical assistance. and we realized we needed to develop some sort of system to handle all these requests, because they were coming to individual faculty, staff, etc., myself. And we didn't have a way initially to handle all these requests, but everyone was looking to the school. And I should say, in addition to in addition to outside groups, staff at UIC, we're also looking at the school for expertise as well. So there was a lot of demand that moved up quickly for expertise.

Ronald Hershow 06:44
And all of that interest, I think, was generated by evolving events. And one of these seminal events was the identification of the first COVID-19 cases in the Chicago area. First, a couple in Hoffman estates developed COVID-19. And actually one of our alums Jen Layden, who was a PhD student of mine, and, then stationed at IDPH, fully evaluated those first cases and published her findings. And all of that, I think, attracted the public's attention to the fact that this was coming close to home now.

Jessie Knoles 07:29
Great. So as the School of Public Health, how did you determine what your primary roles would look like for UIUC, or sorry, UIC and the Chicago communities?

Wayne Giles 07:47
So, I think we divided things up into three different buckets. March 13, was the day when, everyone decided we'd start spring break early a week early, we'd have two weeks in sort of break, then go to totally online. And so the first bucket was how do we handle classes? moving online, we had several faculty who had never taught online, never used zoom, etc.. So, pivoting all of that over two weeks was a Herculean task. And I will say, we have a number of programs that are entirely online. And so we relied on faculty and staff, in many of those programs, to mentor faculty. So that was one bucket. The other bucket was the UIC resource bucket component that I mentioned previously. There were a number of really early meetings about what campus should do, etc. And so that was sort of a second really important bucket. And that's how the UIC contact tracing work, we'll talk about that a little later came to be. And then the third bucket was we were getting lots of requests from IDPH, the Chicago Department of Public Health, businesses, etc., for technical assistance, So with the requests we decided to create the incident command structure so we had one email address that all the queries could go into. And we had Guddi and Antoniah [Lewis-Reese, Administration, School of Public Health] managing all of the requests and made sure that when a request came in within 12 to 24 hours, they got some an initial response. Creating that structure really helped us. There was a group of us that initially met, I think was twice weekly and then weekly to start dealing with all of the inquiries. Later in the pandemic the meetings became less frequent. I'll let others add

Ronald Hershow 10:21

Yeah, I think maybe Guddi should add to the discussion because she was at the center of our command structure. But I will say that part of that was also creating opportunities for faculty, to work with news media, to get good information out to the larger community. So we were forging connections with news media, they were approaching us, and that was also channeled through the incident command structure that Guddi is, is I think, best positioned to really discuss.

Devangna (Guddi) Kapadia 10:58
I think you've gotten the gist of it. You know, I, one of the things, I remember that that initial meeting, like it was yesterday, when we all sat down across, you know, across campus, College of Medicine also have has a lot of expertise, you know, there were a number of people. And as, as we mentioned, it was not just about healthcare, right, we were talking about schools being shut down, businesses being impacted, and you know, all the components. And so how best, and at that time, I know, we made a conscious effort to say that we are going to try to be experts and put out valid, you know, pertinent information, you could already feel the hiss, like hysteria starting, and the only way to control that is through communication. And I think that's why one of the reasons of, you know, managing all the requests that were coming in, and being as responsive as we were, was to try to make sure that we were getting good information out quickly, efficiently, effectively. And so that, you know, the levels of of requests, there were definitely our partners that were in public health, that we're managing the actual, you know, boots on the ground, addressing the disease, then we had a lot of media messages, or media requests, as well as and then and then supporting this external, you know, businesses, schools, community, you know, how do we deal with XY and Z, and we reached into all of the resources that we had at the school, public health to best address all of that.

Wayne Giles 12:29
The other thing, on top of this, we were also getting requests from students who were interested in volunteering for these efforts, we had alums who were interested helping out with the response as well, so the other part of the command structure was a means for students and alums and others to volunteer to be resources. all of this was handled through that structure.

Devangna (Guddi) Kapadia 12:55
Right. And so when we're talking about content expertise, we're actually we were also talking about physical, you know, placement of individuals as needed, or as appropriate, or at least pushing out the asks to groups that would be willing and ready to respond.

Ronald Hershow 13:11
You know, some of it was very ad hoc. Much of our work was really inspired improvisation. In one case, I can remember getting a call from one of my students who happened to work at Trader Joe's. And she was concerned, as many people in service industries were concerned about exposure on the job. And she wanted my advice, and wondered if we could talk about how to protect the clientele and the workforce, at supermarkets against this new threat of COVID-19. And I just remember, you know, having a two hour conversation with her, where we, you know, said things, well, let's see, we should probably space things at the checkout line, you know, and maybe putting little x's with tape on the ground to show people where they could stand while waiting to check out. A lot of the things. that later became sort of second nature, came about by us just thinking about common sense approaches on

calls like that, and those kinds of calls were going on - not just with me, but with many faculty, I think we were being asked to improvise and comment on ways to best protect different kinds of communities against this new threat

Jessie Knoles 14:32
and was, as a school of public health, I'll probably abbreviate that to SPH there were external partners like the IDPH Chicago Public Health media news media were you also were their internal partners within UIC. Were you working with other departments like associated with UI Health or, or any other medical or departments within UIC for this?

Wayne Giles 15:09
Yeah, we had a number of partners that we worked with. we worked a lot with College of Medicine, particularly the infectious disease unit, for a number of the requests that came through later on when we did a lot of work with CDPH [Chicago Department of Public Health] on vaccines, and there was actually an vaccine advisory committee to the CDPH that reviewed information on vaccine approvals and included on vaccine and vaccine hesitancy when they were releasing the first vaccine because there was a lot of concern about rushing the vaccine. And it included myself, colleagues in the College of Pharmacy and a colleague in nursing as well. The other thing that happened, in the spring 2020, with George Floyd, which was sort of part of this response as well, is there was a group that came together called UIC PACT partnership for anti racist campus/community transformation. PACT included colleagues both on the east and westside including colleagues in UI Health, Liberal Arts and Sciences, Business, etc. Interested in how we can do more impactful work with the communities that we served, and so that that partnership came about as well.

Jessie Knoles 16:58
Great.

Devangna (Guddi) Kapadia 17:00
I would just add, I know that, we've definitely tried to keep lines of communications open. So if we were not the experts, or if we were not able to meet a request or demand, we had others that, you know, that we could ask and say when volunteer requests came in college, you know, all the health science colleges, students were willing and ready and, you know, I'm sure you're gonna reach out and talk to some of them as well. But, you know, they also lead some great efforts.

Jessie Knoles 17:28
Great.

Ronald Hershow 17:30
I would also like to mention that if we talk about developments at UIC, how our response evolved by the summer of 2020. So again, the first case occurred in late December 2019. And then by that summer, I and a bunch of other faculty were asked to convene by Chancellor Amiridis, on the UIC campus. That group and that effort was headed by Rick Novak. Rick Novak in the Director of Section of Infectious Diseases. And the Chancellor's charge to that group was, you know, fairly simple, please develop a plan to keep our campus safe was sort of the broad, the broad deliverable of that summer's work. And

so we met very intensively over that summer and did develop a detailed plan for campus and how to keep it safe. And it was really out of that planning, that a lot of the key components of our safety plans for the campus evolved. One of the decisions we made in that group, for example, was to set up a COVID-19 surveillance testing program across the campus and that's different than diagnostic testing. Diagnostic testing is what you would get or what you would receive if you develop respiratory symptoms and wanted to make sure you didn't have COVID-19. This was different. This was an effort to periodically and routinely check for a COVID 19 infection among people without any symptoms, recognizing that COVID-19 is often asymptomatically acquired, and those people who have either mild or no symptoms are in a position to spread the infection to others. So the only way to identify them is to test them, and then to move them promptly into isolation and so forth. Once we made the decision to have that testing program in place, we realized early on that we also needed a contact tracing program, because we needed a way of, again, contacting the people who tested positive, in order to move them into isolation, and then importantly, to ask them about people that they may have been in contact with who might be incubating COVID-19 And in a position to develop the disease and then spread it forward to others. And it was toward the end of that summer that a decision was made to start a campus contact tracing program, and we debated a few options for that. One of the options we debated was simply to ask Chicago Department of Public Health to do the contact tracing for us on our campus. That was an approach that was used at Urbana-Champaign, the UI campus at Urbana-Champaign. We decided eventually to go a different route, and to develop our own, if you will, homegrown contact tracing program. And to, very importantly, staff that with students who became the contact tracing workforce. We made that decision quite intentionally thinking that students would make great contact tracers. First of all, our students are whip smart, they learn quickly. They're very tech savvy. But perhaps most importantly, they're able to establish rapport with the people that they would be performing the contact tracing with because they are derived from that group, they are students themselves and understand the stresses and the particular stresses that COVID-19 is placing on the campus, on students, faculty and staff, and, therefore can empathize with the people they're working with. And that empathy will be communicated in a way that will establish strong rapport and enable us to gather really high quality data to gauge where the disease was occurring on our campus, and to effectively isolate and quarantine people accordingly. So two of the people on this zoom call are central to that effort. We came up with, I came up with the name, the COVID-19 Contact Tracing and Epidemiology Program, which is a really long name with a really long acronym CCTEP. But anyway, I think it would be maybe valuable at this point, because both Natalia and Jocelyn were in on the ground floor, Natalia as one of our first seven contact tracers, and Jocelyn as a leader of the program, so I'm going to turn it over to them to comment about those early days and a little bit about just how crazy it was to stand up the program.

Jessie Knoles 22:57
That'd be great.

Jocelyn Vaughn 23:02
I was lucky to join the program in August of 2020, about ten days before the first week of operations. I had previously been working at the Joint Commission, which is a hospital accreditation agency, so was very much involved in COVID-related work, mainly handling inquiries from hospitals and health systems. I was also working as a volunteer contact tracer at the Skokie Health Department and a

contractual epidemiologist for IDPH. So, when I came on board in August, we were really building the program as we were implementing it, and I was working closely with Ellen Stein, who was the director at that time. The major focus of those early days was building the infrastructure for contact tracing. We did most of that work in REDCap [Research Electronic Data Capture] as an alternative to Salesforce, the platform that IDPH was using. We were developing all of the scripting for case and contact interviews, case investigation and contact tracing protocols, the training plans and procedures for newly hired contact tracers, and phone systems – truly building everything from the ground up.

Ronald Hershow 24:45
I'd like to focus on one aspect of the Contact Tracing program development that might bear particular mention because, you know, one of the exciting parts of working on this program was that you know, UIC can sometimes move sort of slowly and bureaucratically, but everything in this planning was streamlined. And I, and we would meet with Dean Giles weekly and give him updates. And on one of those updates. He said, Well, what else do you need? What else can I do for you? And we said, well, we're really having trouble setting up this phone system, we need a way for our contact tracers to call out and ideally with a caller ID that identifies them as contact tracers. And, you know, literally within 24 hours, Dean Giles had connected us to the exactly the right person. I can't even remember that person's name. Do you remember anyone?

Wayne Giles 25:41
I don't remember. I think I reached out to John Coronado [Vice Chancellor, Administrative Services]. And then he connected you, it was just amazing.

Ronald Hershow 25:49
What's amazing is how quickly, resources came to us how strong the partnerships were that we were forging that enabled us to do this work. But I want I want Natalia to also weigh in because she was, as I said, one of our first seven contact tracers, but has now transitioned to become the director of the program. So she has some interesting insights, I'm sure as well.

Natalia Lopez-Yanez 26:16
Yeah, thank you. I'm an alum of the School of Public Health, and I was in that bioterrorism course that Dr. Hershow was speaking to earlier. We knew very early on that this was going to be an evolving situation. I've always had a very strong passion with infectious diseases. I remember me and several of my classmates, were looking for opportunities to become involved and serve the UIC community. I had remembered very clearly that contact tracing is this essential "boots on the ground" epidemiologic component to infectious diseases. When I saw that announced, I really jumped at the opportunity. I remember in those early days, there were only seven of us, as Dr. Hershow was saying the team has evolved over time to as many as 40 contact and we were working independently. In contrast to now have a larger teamand multiple people working together. Previously, each of us manned the phones and were doing intakes and providing this feedback and public health guidance and answering any questions individuals would have. We worked very closely with Ellen and Jocelyn, we were always on the phone trying to get some guidance andit was very much so a collaborative effort to really ensure we were getting the correct guidance out there. And , training had been fantastic and we'd covered this incredibly comprehensive number of topics.But I remember just the number of different scenarios and

the number of different kinds of situations that came up or the different questions that were asked wasn't anything that you could ever plan for, it's something that you pick up and gather with time,how to address these questions or what type of questions are going to be asked most commonly by employees or by students.. But I can, I can pause there but I just remember those early days, it was very much so learn as we go and really making sure that we're getting that right information out to our community particularly to individuals who are exposed, what to expect and really calming those fears.COVID was very taboo, as many of us remember at the beginning and it was really quelling those misconceptions and really helping people get through isolation, quarantine providing them with resources and really just being a listening ear. Dr. Hershow speaks a lot on the importance of having students who are empathetic and compassionate. A lot of times individuals just really needed to get their fears out to feel safe, isolating, or to be able to kind of get through that period. Another kind of big thing we were saying was people were just concerned about their household members and like, how do we protect them and with campus housing.

Jessie Knoles 29:53
Great. Yes, yes-

Devangna (Guddi) Kapadia 29:56
I'm just gonna, so I want to say that, you know, as we were doing this internal effort, or on campus, there were many individuals that were doing supporting contact tracing at the same time across the state. So we had faculty that were called in and working directly with IDPH, the city of Chicago, Cook County, and many of our surrounding partners. So as Jocelyn, you said, you were already volunteering with the health department. You know, there were many individuals that were already placed, actively helping respond. And then, you know, we at the School of Public Health also partnered with many, many organizations. So for example, we were one of the ones that were selected to support the city of Chicago's efforts, we also, the School of Public Health was also contracted to support cook County's efforts. So there were a number of parallel things that were happening as internal and external, was being supported.

Wayne Giles 31:06
Yeah. So just to add to what Guddi just talked about. One of the big things was that CDPH, Chicago Department of Public Health decided that they were going to hire 400 contact tracers, these were going to be people from the community who would do the tracing work. And then later they those individuals pivoted to do work around vaccine hesitancy. But it was faculty in the School of Public Health who took a major leadership role in training, those contact tracers. And so and now what we are seeing as part of that effort, is the a program called Life Scholars and many of those contact tracers are now students at UIC, either undergrads or master's students. it's nice to see how faculty in the school and staff as well played a major role in training these individuals giving them a taste of the importance of public health. And now there's a nice pipeline to the public health workforce.

Jessie Knoles 32:15
Great-

Ronald Hershow 32:17

I think one of the great challenges when you mount a response like this, and when I say you mount I mean, when Illinois or the city of Chicago mounts a response is what to do with all that energy and infrastructure and dedicated workforce as things transition to a more endemic phase of COVID-19? Not sure where there yet [to the endemic phase], we're still anticipating a winter surge. But eventually, we have, through all these programs that Dean Giles was just talking about, we really engaged a lot of community members in this effort - contact tracing and vaccine promotion. And the question is what you know, where are the pathways for that workforce, it would be a crying shame, in my opinion, to let it all dissipate. So that Life Scholars program is a way of getting that workforce involved in public health, career development. And, we're constantly thinking of new challenges to move that workforce into. And as I said earlier on this call, there's never a dull moment. You know, there's always something new happening. Now we're in this triple, triple threat phase with three circulating viral pathogens, COVID-19, influenza, and respiratory syncytial virus. Monkey pox happened as an intervening event and fortunately, seems to be decreasing at this point. But the point is that there's a lot of ongoing work and thinking about the next pandemic is, you know, part of that. How can we use this workforce to take on new health challenges and do better next time?

Jessie Knoles 34:22
So, with the contact tracing, were you working directly with a testing program, the surveillance testing program that had been initiated?

Robert (Ron) Hershow 34:32
With our campus contact tracing program? Yeah. Yeah. Yeah, I'll let Natalia or Jocelyn weigh in on that. Jocelyn you get the data feeds, so maybe you take that question!.

Jocelyn Vaughn 34:45
Yes, we worked closely with the surveillance testing program. And it's funny to think now that we were getting positive results directly from the head of the Pathology Lab as they were being resulted. I had forgotten about that. We would manually enter those positives in our database and from there, contact tracing ensued. Later, we, of course, became more sophisticated in the way we extracted data and now obtain results in real-time from all types of COVID testing on campus through several electronic health records (EHRs). From the beginning, we also received self-reported results from community members, which I think was an important decision. Self-reported testing, including home testing, accounts for a substantial portion of cases who we serve. We designed a REDCap survey to enable any student or employee to self-report a positive test that they obtained at an off-campus site; they could also report an exposure to a COVID-positive person—for example, if they were exposed to a family member—and even travel (which was included later). We believe that it's one of the most important parts of our infrastructure that because it directed anyone on campus, regardless of their university affiliation or reporting need, to the right place.

Ronald Hershow 36:41
You know what, one of the realities I'm sorry to interrupt but one of the realities of COVID-19 Currently, is that incidence data about new cases of COVID is very suspect at this point, because so many people are doing home testing, and that home testing often doesn't get reported through our normal disease reporting system on our campus. Thanks to this universal reporting team tool,, we have a pathway

whereby people can report those home test results to us and get them into our system. So UIC in a sense is an island where we're doing, I would say, more complete case ascertainment than many other jurisdictions when one thinks about the COVID-19 landscape.

Natalia Lopez-Yanez 37:34
There's one note that I wanted to make about the program that, as I was hearing Jocelyn speak, I realized we had never really clarified. Something that's very unique about our program is that we're dually trained as case investigators and contact tracers. In traditional contact tracing models atcounty or state level public health departments, they're usually split. So one group will do the case investigation component. And then once they figure out anyone who was exposed, they pass it over to the contact tracing group, and then they speak to anyone who was exposed and provide them with guidance. This program was very intentional in of training us to do both. So we not only would be able to take those positives that Ellen and Jocelyn would put into the system, do the case investigation, but then also be able to reach out to their contacts at the same time. That's a feature that I wanted to highlight about our program that's quite unique, and it maintains the case to this day.

Jessie Knoles 38:51
Great. And with all of the contact tracing that was primarily over phone calls, are we also texting, phone phone calls. Yep. Okay. And then just going back really fast to the reporting tool that is separate from REDcap, or is that REDcap?

Jocelyn Vaughn 39:15
Yes, that's a great question. REDCap is a data capture and reporting tool that was initially designed at Vanderbilt University, and it's used by a many different universities for research purposes, as well as quality improvement and other program administration purposes. As I mentioned, it is the platform that we used to build the database that contact tracers used to conduct case investigations and contact tracing. The contact tracers would be logged into the REDCap system as they were speaking to someone and documenting their responses throughout the interview. Because it is such a flexible data collection vehicle, we were able to rapidly create a project in REDCap when a new need arose. One of Guddi's comments reminded me that Ellen and I were both working for IDPH for about six months before coming on board and starting this program and had observed challenges that Illinois health departments were dealing with, specifically with data management. That experience also informed the design of our program.

Wayne Giles 40:51
The other thing I wanted to just mention, about the student component of our contact tracing is, it's not just the empathy that the student contact tracers have, which I think is vitally important, of course, but they also had sixth sense, a little bit of intel, when they didn't think they were getting a complete story. They knew when things didn't exactly sound right, because of biases in reporting, and stigma, etc. And they would say, you know, "I really think we need to go back to person X", or "I think we need to do some more queries as part of Y" and that intel was really invaluable, I think, to understand that sixth sense that many of our students had, as they were following up on cases was really valuable. And It was a level of intel others might not have had. And that was really important. The other the last thing that I will mention is that when we saw surges in the city, we would see follow up surges on campus as

well. it's important to remember that those two are very connected. And many of the initial cases we saw were cases that weren't necessarily happening on campus, but the initial spread etc., happened in the community in the city. And so, being able to sort of link all of that, is vitally important as well.

Ronald Hershow 42:36
Yeah, when you lay the incidence curve of the city of Chicago side by side with the incidence curve on the UIC campus, the curves are shaped very similarly. But the magnitude of of the numbers of cases are much lower on UIC and our watchword or our tagline became, "UIC is where COVID-19 comes to die". Our faculty, staff, and students are members of the Chicago community, and we are 80%, commuter campus. But we all worked effectively to prevent forward transmission of COVID-19 on our campus. And really, in the last two and a half years, we really haven't seen the type of propagated campus outbreaks that have occurred in other campus environments. So part of that, I think, is an advantage we have because we don't have as many dormitory students as some residential colleges have. But part of it is, I think, directly attributable to the work of CCTEP.

Devangna (Guddi) Kapadia 43:50
I'm going to add one more, because I know you look like you have another question. I just, I want to, like commend the fact that all of this, you know, it was it was quick, fast moving. But as Jocelyn just said it, you know, as we learned, things evolved and changed and shifted. And I was really impressed. And you know, I have to give kudos to them about how, how responsive because we were all learning, right? And so the fact that we were able to apply the findings of things that they were just doing, you know, six weeks or six days before really showed how people were willing to be flexible and really, you know, learn from what was still playing out. So

Jessie Knoles 44:32
Yeah, that's great. I was actually just going to start asking about the challenges with with an outbreak that has so many different ebbs and flows and surges and different variants, how contact tracing and the School of Public Health as a whole How did you navigate those those searches and possibly a little lull at some point, but mostly like different variants coming onto the, onto the horizon and different surges. And different guidelines. I mean, we had in Illinois, we had the different phases. So how did contact? How How did contact tracing evolve with the evolution of the pandemic?

Ronald Hershow 45:27
Well, in in the broadest possible terms, we flexed up at periods of high incidence. So we would, you know, I think Natalia already mentioned that at our apogee or our peak, we had over 40 Contact tracers, and we flexed up to that number precisely because there was a lot of disease occurring both on our campus and in our surrounding communities. And so we kept our eyes on Chicago and Illinois data, and flexed accordingly, in response to fluctuations in incidence. And so that's in the broadest sense, how we did it. The other thing is, by having our own opportunity to modify our scripts and our approaches to contact tracing, we were really able to incorporate some of the latest epidemiologic occurrences and findings that were occurring out there into our procedures. You know, when monkey pox started, we were able to add questions regarding possible exposure to monkeypox cases. In the beginning, we sort of regretted the fact that we couldn't simply tap into Salesforce, which was the platform that was being used by Chicago Department of Public Health for their contact tracing, certainly

upfront it would have been easier to do that, to utilize that existing platform. But it wasn't quite ready for primetime. When we were trying to stand up our program, Salesforce hadn't been fully launched by the city. So made it necessary for us to develop our own homegrown systems. And looking back, that was such a lucky break. Because it gave us that flexibility to change our approaches, incorporate new information, new questions that were worth asking at various junctures in response to new variants that were emerging and things like that, that, in the end, was what I consider a key ingredient of our success - the flexibility in our system.

Wayne Giles 48:10
I think the other thing with the ebbs and flows is, I can remember, there was a time during one of the ebbs when people were thinking it's over. And we can shut all this stuff down. And so making sure and advocating for not, moving too quickly and shutting things down is important as well. Because, you know, with the expertise that you've got sort of in the school people knew, the virus, unfortunately, is what's in control. And, and the virus can mutate, pivot, change, etc. And so making sure people are aware of that, and being cautious about sort of moving things, shutting things down, etc, really quickly. We also need the ability to quickly surge when needed, so continuing to have a core staff who are doing the contact tracing, is really important. And the other thing I will say is that contact tracers did identify a number of other student needs that were occurring, issues around student isolation, particularly when they moved from one dorm to another, mental health, and well being for students. The contact tracers were identifying these topics before others on campus were aware, being able to communicate some of these student needs were really important because now we have additional campus efforts around mental health. That I think are vitally important. But that was another really important value of the of the contact tracing effort.

Ronald Hershow 50:08
That's a great point. Thanks for saying that.

Devangna (Guddi) Kapadia 50:14
I would add all resources. Right, I think there were food pantries that were set up. I think there were, you know, there were, there were other elements. And I think we learned a lot about what was happening within communities that that the students were living into. So we could connect to various resources. And I think that was happening across but, you know, was hyper localized? Definitely.

Jessie Knoles 50:39
That's great. So were there any identifiable biggest challenges with creating a contact tracing program?

Jocelyn Vaughn 50:56
I would say that one of the main challenges that we've had, which is unavoidable when you have excellent student staff, is that there's high turnover. They're always graduating on you. So, we were consistently hiring, onboarding, and training contact tracers while implementing the existing program, which was challenging. Additionally, a major challenge was rapidly adjusting to constantly evolving guidance, as Guddi was speaking about. We would have to modify our database nearly every day; there was some sort of tweak that was needed. Consistently updating those tools, communicating updates to staff, and making sure that they understood what the up-to-date guidance and knowledge

was on that day when they came on shift was demanding. Natalia, you could probably speak to this from the early days. You probably had to be briefed before every new shift because something had changed, even if it was just a three-day lapse. Those are two things that come to mind immediately.

Natalia Lopez-Yanez 52:32
I think part of the challenge as well, from the contact tracer standpoint, is I remember when we got our first few cases, we were really. And then all of a sudden, we were in double digits. And then in October, we were in triple digits. And that's when we were still kind of a pretty small groupstill doing it single handedly. At that point, our procedures looked very much different. But Ellen and Jocelyn really found ways to streamline our processes to ensure we maximized the resources that we had. And then, as the team grew, we were able to, , be able to serve the community better and trace for large clusters. And then later on, we had program supervisors, so individuals that were directly overseeing the call center, rather than only Ellen and Jocelyn. Once we had those supervisors, I think that was a large component to really streamlining our processes, because they really were there to provide assistance, epidemiologic expertise and troubleshooting So I think that that's one large component, of course of the program is it as Dr. Hershow was saying it constantly evolved, and it strengthened over time, and we found new ways to serve the community better.

Ronald Hershow 54:11
The other thing I would say is, in addition to talking about the challenges that we faced, there were, I would say unexpected rewards of standing up and performing contact tracing, and part of it was, you know, that contact tracing is a very intense and challenging type of work. People can sometimes be rude and you're talking to people who are under a great deal of stress who just found out that they have a COVID diagnosis. So it's stressful work and we quickly developed some systems, try to develop a sense of community within our contact tracing core, all kinds of crazy things, some of which worked, some of which didn't, but things like virtual happy hours and trivia contests and other things as well. And we had a logo-designing contest to develop the design to be used on the CCTEP official sweatshirt and T shirt. Well, those things I think, enabled our workforce to develop a sense of community, frankly, at a time when it was difficult for students to develop a sense of community, because so much of Education had pivoted to virtual, not in person approaches to education. So we didn't see that coming. But we, came to recognize that that was part of what was good about contact tracing and that it did provide that sense of community for our workforce.

Natalia Lopez-Yanez 55:55
On that note, it was especially important as time went on with the first year students because they had never been on campus. So their only interactions with each other, were purely virtual. This really did provide like Dr. Hershow, saying, a community. And it was just an added benefit. No one truly understands, what we were going through except each other. So not only did we have these really great friendships and this community was formed, but we had each other for support, particularly when, it got really crazy in the call center, which I think was really important.

Jessie Knoles 56:38

Going back a few steps, CCTEP that was a contact tracing just for UIC. And then did it CCTEP work in conjunct in conjunction with external partners who are contact tracing the Chicago community? Or did they did CCTEP evolve into more community based contact tracing practices?

Jocelyn Vaughn 57:09
I can speak to that. Our jurisdiction, if you will, is limited to UIC students and employees, and we are an extension of the Chicago Department of Public Health. We do not conduct any contact tracing with unaffiliated community members. After several months of implementing our program, our jurisdiction narrowed slightly. Initially, we were handling people with clinical duties in addition to campus employees. We were working very closely since day one with the occupational health arm of the health system, University Health Services (UHS), to ensure that there was full contact tracing coverage for all campus members. Later, we moved to a model whereby they handled people with clinical duties or who worked for the health system, and we managed all nonclinical students and employees. Of course, we also collaborated with CDPH. For example, if we identified a cluster that met the definition of an outbreak by CDPH standards, we would share that information. We've also coordinated with them when we have had case investigations that involve substantial mixing with non-university individuals. There's one more recent example from April 2022 when there was a large student gala in which roughly 150 non-UIC affiliates were in attendance. Another good example is when we had a cluster in a large congregate setting that was not a dormitory, but still housed a large number of UIC students and was the sort of setting that very much encouraged communal living.

Ronald Hershow 59:25
Did you also want to mention the coordinating role we played with other UI campuses like Peoria and Rockford and so forth?

Jocelyn Vaughn 59:36
Sure. We also worked directly with UHS to offer case investigation and contact tracing to other non-Chicago campuses like Peoria and Rockford. We've worked with leads from each of those campuses to assist with the design and implementation of their contact tracing programs and attended meetings together on a routine basis. Also, going back to the reporting tool, part of the function of that tool was to ensure that individuals from any UI campus were routed to the appropriate location. Depending on whether they were from Springfield, the Quad Cities, or Peoria, and even sometimes which college they were from, there were different protocols, so that tool really helped us direct the diverse group of people we were serving to the right place.

Jessie Knoles 1:00:39
Great. And I do have one, one more clarifying question about that reporting tool. What did that look like from the user end? Was that just going to a website or calling a specific number? Or was it like an app that they use? What was that? What did that reporting tool look like?

Jocelyn Vaughn 1:00:54
It's essentially an online survey. So there was a link that we would disseminate broadly and when someone needed to report to us, they clicked on the link and completed a series of questions including which campus they're from (again, because we had different procedures depending on the campus

they were affiliated with); whether they were a student or employee; and what they needed to report (for example, symptoms, a positive test, etc.) Then, once they hit the submit button, a record would be created in our database, and we could proceed accordingly, which at that time was normally reaching out by phone.

Ronald Hershow 1:01:42
Thank you. Natalia, I think put the link to the reporting tool and the chance. Great,

Jessie Knoles 1:01:49
Thank you, Natalia. And I do have a question specific to Natalia as someone who was public facing calling students, what was the general reaction to people who called with contact tracing? Was there any sort of maybe frustration for changing guidelines or just immediate fear, stress? Was there any like hesitancy, maybe pushback to give information? What was the general? Or like, what sort of what sort of situations did you encounter as a context tracer?

Natalia Lopez-Yanez 1:02:26
That's, a really great question. I think, part of this stems from, whether they already knew they were positive or not. Part of surveillance testing is, , that we were finding people a lot of times were asymptomatic or that had not yet become symptomatic. And so a lot of times when we reached out, there's a little bit of disbelief, , they weren't sick, because they hadn't checked and seen that they had positive results. They hadn't really realized that they were positive and the initial shock of that.. , Particularly early on there was just kind of the stress associated with it, like, what does that mean, for my family? What does that mean for me, am I going to get really sick, and before the vaccine was provided for the public, and it walking people through and being able to help them like this is what's going to happen over the next few days, here's how we can support you and support others. So, I would say that there, was always a little bit of fear, and needing to explain to people and support them throughout that process. I think our team has been really fortunate in the entirety of its existence, that we've had really fantastic engagement with the community. I mean, even today, where a lot of our processes are automated, there's a lot of buy in from the community, we have really high levels of people that we're able to reach and that we're able to retain over time. I think that that's just something very unique about our community that's worked to our benefit. I think another component that Dean Giles also mentioned early on, was that there was this kind of fear of getting in trouble from kind of what they would reveal and what their activities were, particularly if, you know, they weren't campus members. So I think a lot of our work early on was really building this trust with the community that like, look, we're not here to get you in trouble. We're really here to make sure that everyone is afforded the chance to get public health guidance, and, remain confidential. We reveal as little information as possible The bottom line is we want to protect our community, it's not about individual getting you in trouble. I think early on, that was something that we had to learn to navigate. And, we had a sixth sense, as Dean Giles was saying, when people weren't being completely honest, so we were able to tap into that. And I think, being a student, and kind of being able to say, you know, I'm a student as well, I know what you're going through, I understand you have these challenges, or I understand you might have been hanging out with your friends, and, from a peer to peer standpoint, I think it really played to our advantage.

Jessie Knoles 1:02:29
Thank you.

Wayne Giles 1:03:33
The other thing, I would say, I want to just hit on what Natalia just talked about, there was a lot of pressure from campus and others, to know who in our classrooms or who in our college tested positive, and, and there was a lot of, and there was also pressure to be punitive. And I think that the contact tracing team did really did a good job of saying, listen, we've got to get student's trust, etc, being punitive is not going to help us here. And so that really helped us make the case to campus, about the importance of keeping things confidential and not be punitive in terms of reactions, etc, not reporting people. that was an important aspect of all of this work.

Ronald Hershow 1:06:37
And I think I would add to that by saying that our program took great pains to explain contact tracing to the campus. As you know, we were heavily burdened with work. But we felt that contact tracing would only work well, if people understood what it entails and what its goals are, and so forth. So particularly early in our existence, we made the rounds; we connected to various units on campus. And we'd give presentations on our program, about why we do what we do, what contact tracing basically is. And the other thing was that as part of that work, we also acted as student advocates, in some respects, because one of the sources of anxiety for students who get infected is that they're going to have to miss school, and that will lead to work that they have to catch up on. And we advocated very early on that our faculty should be very proactive in assuring students that there would be pathways for them to catch up in the eventuality that they had to be isolated or quarantined, for example. And we assured them that we'd meet them more than halfway in that regard. So I think all of that ended up making us more effective because students started feeling that advocacy, faculty started understanding why we had to maintain confidentiality in our work. And it came together very nicely.

Natalia Lopez-Yanez 1:08:32
A lot of decisions that are made for the program to this day are data driven. So, when there are changes in policies, we're able to explain it to the campus. We're doing this because we're seeing this in our campus or we're doing this because this is what's going on in the community. And this is how it's affecting us. And this is why we're trying to keep the community safe so- [Cuts off]

Jessie Knoles 1:09:14
Natalia. Think we lost Natalia. Can everyone else hear me? It's not my computer.

Jocelyn Vaughn 1:09:24
Maybe I can help to finish that because Natalia was saying something I wanted to comment about too, and it speaks to one of your earlier questions about how we handle the ebbs and flows in incidence. I completely agree that maintaining data transparency was very helpful in fostering trust with our community, and one of the things that we measured in addition to incidence was timeliness and the proportion of people who we were able to reach among those who we attempted to contact. One of the key measures that we were tracking, and continue to track consistently, is the time it takes us to reach a case from the time they provide the specimen for their positive test. The benchmark is 48 hours,

given the incubation period of COVID. We measured that consistently and communicated the information on a weekly basis to stakeholders throughout the university. We met with them very frequently in the early days because there were so many questions about how to handle certain investigations. Welcome back, Natalia. I was just trying to expand on your thoughts about the importance of data. When we knew that we were creeping up on that 48-hour benchmark, we implemented changes to procedures. For example, we started using more email-based outreach to make initial contact with people and reduced the intensity of case outreach when we experienced a significant surge that first fall. We were making daily phone calls to most cases initially, and then reduced that to three periodic checkpoints. To Natalia's point, we were able to use our data, not only to explain to community members why we were making decisions, but also as a signal that we needed to initiate changes to procedures. Is there more that you wanted to add, Natalia?

Natalia Lopez-Yanez 1:11:57
No worries, and apologies, I'm not sure what happened. But I think that communication with the community is just a piece that I really wanted to highlight, you know, the presentations that Dr. Hershow was referring to, they continue to this day, whenever we have a unit that we feel, you know, the Children's Center, or Facilities or the Faculty Union, like we continue to do these presentations over time. And we continue to get as much information out and public health education out to the community as possible. And I think that that's really made us kind of the resource for campus, and that they know that they can turn to us for information. So I think communication is just a really essential component to our program.

Ronald Hershow 1:12:44
And I would say that communication is bi-directional. We don't just give information, we also receive important feedback at those sessions about the particular stresses that some departments are under, peculiarities to that specific unit that we need to think about and integrate into our approaches.

Jessie Knoles 1:13:11
Great. Yeah, I think I would love to talk more about outreach and engagement efforts in relation to health information. I noticed on the School of Public Health website, there's a free virtual COVID-19 course. I'm wondering like what other efforts were put in place to just give resources to UIC and community members who didn't either know, what was going on or didn't know how to find good information about what was going on? Like, what did those sorts of efforts look like?

Devangna (Guddi) Kapadia 1:13:50
I will take a go at it. It looks like everybody was ready to go. So I think that was one of the biggest things that we were, you know, wanting to get as much information and, you know, continuing to state that this information is evolving, and we are trying to stay on top of it. But we wanted. I know that the Collaboratory for Health Justice at the School of Public Health made a valiant effort to ensure that whatever basic information we had, it went out in multiple languages and in multiple ways, so not only did we get it out on our website, but we know we worked with community partners to make sure it was you know, printed and out, you know, in the community as best as we could. We tried to keep all of our information on our website as up to date as possible linking to, you know, CDC [Centers for Disease Control and Prevention], and WHO [World Health Organization] at that point, Hopkins was one of the

ones that we really relied on. They were, you know, getting some great data and pushing that out and right from the get go. So we were trying to, you know, not only be the source of information, but ensure that people were going to sources that we found credible as well. And so I think that and that also You know, layered on top of all the information that our experts were sharing, you know, out media wise, we made sure we linked all of those pieces as well. So you know that it was like kind of a full package and looking around. So

Wayne Giles 1:15:17
a couple of other things that I'll mentioned. Linda Forst, who is faculty in environmental occupational health sciences, created a COVID course, we had, we had a great group of speakers in that core. it included our own faculty, leadership at Illinois Department of Public Health, Cook County, Chicago Department of Public Health, all of those folks who did our community outreach, centers like Community Outreach Intervention Project, which focused on substance abuse issues, and today talked about some of their outreach efforts on the west, and south side to the substance abusing community. We had Marcus Betts who does community outreach, talk to students as well, the mayor's office asked us to create a street ambassador program. So these were, again, similar to the contact tracing work. These were individuals from the community, who were would go out and distribute PPE and information about how to stay safe. Marcus Betts and I were asked by the mayor to be on her racial equity rapid response team. This was community based organizations, UIC School of Public Health, the mayor's office CDPH, we met weekly, to talk about what we were seeing across the city, and help to make decisions about where to place testing sites, what that might look like how we were doing in terms of distributing PPE. And then that work pivoted to some of the vaccine work that that happened. But that was another really important source of one getting accurate information out there was a communications team that was part of that, that Marcus Betts helped to co-lead. But also us getting feedback from the community. So we knew we could hear directly from leaders about what they were seeing, where they were struggling, someone mentioned earlier about food. one of the things that was really hard with COVID was, there were places where people couldn't get Uber Eats to go to in their community. And so how do you how do you deal with those issues, a lot of issues around seniors, etc. But it was really enlightening way to deliver information and get feedback. And this worked highlighted the importance of having hyperlocal data. Because we were able to go Census Tract by census track and see where we were seeing spikes in COVID. or later on with vaccine, where were the communities where there was higher rates of vaccine hesitancy and then say, Okay, this is where we need to target vaccine distribution and some of those high impact communities. This was really valuable. And that work continues to this day. But really valuable resource in terms of as having an impact, not just in the school or university community, but citywide.

Ronald Hershow 1:18:56
Yeah, it was, it was very rewarding to be part of that. Because this is, of course, an epidemic that is rife with health inequalities. And we were able to use that hyperlocal data to identify the socially vulnerable communities that were being impacted most severely like the Dean said. And this wasn't just the School of Public Health; For example, there was the Protect Chicago Plus Initiative that in a very grassroots way, tried to move vaccine into the 15 community areas that were most affected by COVID. And, I think we all take a great deal of pride in the success of that program. And we're watching the surveillance data as proof that it worked. Early on the disparities were crazy with death rates that were

disproportionately elevated in African American communities - so much higher than white communities. And over time, we've seen those gaps narrow, we still have a situation where we can do better, and where we still haven't vaccinated our African American communities at quite the same rate as the white communities and other communities in Chicago. But we are making progress. And that's been rewarding to be part of.

Jessie Knoles 1:20:40
Thank you. Great. Before I start winding down the interview, I just wanted to ask quickly, what the context tracing CCTEP looks like now in fall 2022. And also [through the whats] my notes what to the incident command structure, if you're still using that what that looks like right now as well.

Natalia Lopez-Yanez 1:21:08
I can go ahead and get us kicked off. CCTEP today in age, continues to have the staffing model where we have leadership overall with Dr. Hershow, Jocelyn, and I and then we have someone who oversees the call center. And then we have our cadre of contact tracers, it is a little bit smaller than our peak point of 40. I believe right now we're at approximately 20 contact tracers, however, we have incorporated a number of measures that are automated to really ensure we're still providing this really high level of service, it's still very rapid service, but to be able to serve, the larger needs of campus. So we're able to serve anyone who test positive, anyone who's exposed and requires guidance, with the with the changes, and then we do continue phone outreach. So that automation occurs over email and survey, and then we do continue the phone portion. Our phone portion is very deliberate, it is targeted at those at highest risk for severe illness, or death. And so, we make sure that they are receiving the most hands on guidance. We do still handle a lot of inquiries from the community, either by phone, or by email from students or faculty. We have had the opportunity to really forge these very strong partnerships across campus, within schools within administrative units to be able to provide them the support and guidance as things change.

Ronald Hershow 1:23:17
Just to extend that a little bit, as was mentioned earlier, one of the big things that we're dealing with, in general with COVID-19 is what's next? When this begins to settle down and hopefully transitions to a more endemic and reaches a more controlled equilibrium in our societies. What to do with all this infrastructure and public health energy that has built up around this health challenge, and I think we in our own microscopic way on campus, we are undergoing the same kind of soul searching and thinking about that. What's next for our program, when things do settle down. We're extremely excited because…. what is Raphael's last name?

Natalia Lopez-Yanez 1:24:21
Florestal-Kevelier

Ronald Hershow 1:24:22
Yeah, I'm sorry, I've been calling him RFK or Raphael. I always lose track of his full name, but he's like a breath of fresh air. He's… what's his title.

Natalia Lopez-Yanez 1:24:35

He's the assistant vice chancellor for student health and wellness. This was a position that was created over the summer to really unite our student health and wellness efforts on campus and be able support to the student experience.

Ronald Hershow 1:24:56
We have been meeting with him fairly often. He comes to some of our regularly scheduled meetings. But we've also had separate meetings to discuss what role the School of Public Health and, and our contact tracing program in particular might play in that general campus wellness arena. And what we might pivot and transition to. The health challenges that have been mentioned at those meeting include mental health issues and stress and other infectious diseases, the most recent additions being monkeypox. In addition we have ongoing issues with sexually transmitted infections on our campus. The periodic scare that happens when a student comes in with mumps or chickenpox on our campus, all of those things are things that are potential roles for our program and we don't want all this to dissipate, we want this capacity to be maintained over time. So I guess that's where contact tracing is right now, contemplating the next stage.

Wayne Giles 1:26:06
Just before Guddi starts, I just want to add a couple more points. I think one of the things we've learned is one, the value of having students in this role that I think is really important in terms of empathy and other things that you've heard. Second, I think is the ability to surge and to surge quickly, I think is really an important aspect. And so, you know, how could we have a core group of students who might pivot to different areas, depending on what the issue is? Student ambassadors or whatever, but be able to surge quickly when the next pandemic happens. I think just being able to utilize them as a resource, important as we move forward. As we think about the broader Chicago community, how could we have a corps of public health community workers that might work on COVID, and then vaccines, and then there other issues that are happening in the city, but could quickly surge if needed, and have them as part of the public health workforce.

Devangna (Guddi) Kapadia 1:27:33
So as far as the incident command structure ICS is usually stood up during emergencies. So no, I totally agree with Dr. Hershow, we are not out of the woods. So there is still a form on our School Public Health page that you can still, you know, contact and if you need an expert, or if there's media requests that are specific to COVID, etc, it is not front and center as it once was. It is not being pushed out, it is more if you know, you know, they've come to us, then we will continue to respond. The standing meetings have been have been dropped. The team itself, you know, the individuals that we pulled together, not necessarily even the individuals but the the units that we were leading on, are aware that if there is another event, or if we need to pull this structure back, you know, it again, it's it has now this, we've tried it, it worked, we'll go back to it, if and when we need it, and that's what incident command is all about. So it's it's it's there, and my hope, but it will continue to stay as you know, part of our infrastructure at the School of Public Health.

Jessie Knoles 1:28:53

Great, thank you. Okay, now I'm going to ask a few line down questions. Overall, how has the pandemic affected the operations objectives, including research and outreach efforts of the School of Public Health?

Devangna (Guddi) Kapadia 1:29:15
Say that say that one more time? How has-

Jessie Knoles 1:29:18
How has the pandemic affected the overall operations or objectives, including research and outreach efforts of the School of Public Health?

Devangna (Guddi) Kapadia 1:29:29
Well, I think this actually, there's one thing that I wanted to, like, make a comment early on, we at the School of Public Health really, you know, proactively, we wanted to be. We wanted to set the example. You know, we kept saying that from the beginning, like, people are going to be looking at us as public health experts and and we at like, unsure of what broader communities were doing, you know, Dr. Hershow said it like he was already thinking about some of these mitigation efforts way before they were, you know, publicly announced, or, and the like, I will, you know, I will say that, you know, we still mask at the School of Public Health, if you come in, you'll see that most, you know, everybody walks in with a [mask], you know, like, there are things that we are, you know, we preach, and we practice. And I think that the pandemic really highlighted all of the things that, you know, we are here for the community, and we were there for the community, we are here for our students, and our students are ready to be engaged. And you know, that when I was trained in public health, it was, you know, you are-, you know, back in my day, it was a 911. And, you know, we are first responders in a sense, and you were trained to be a first responder and you, you kind of ingrained that in you. And I think the the students embody that very much so as well as the faculty. So I think the pandemic, you know, did highlight some of our strengths. And really, there's more to do, right, there's now a lot of data that we have that needs to be reported on and share it out and published on there's a lot of lessons learned things that we, you know, we have shared some really great highlights, we definitely, you know, as we evolved, we definitely learned things and, and so how can we document that and make sure that it gets passed down to for future efforts.

Ronald Hershow 1:31:27
Wayne, I'm wondering if you wanted to talk about the Collaboratory for Health Justice more generally, and how, in a sense COVID has been the paradigm that has proven the value of that initiative.

Wayne Giles 1:31:43
Yeah. so thanks. And I'm happy. Yeah. And I think that's really good. So the Collaboratory for Health Justice is our the community engagement part of the school and, and so as part of that, it was the Collaboratory that was part of the leadership team around that city wide contact tracing program. They brought an understanding and value of community voice. Having community members help us to set the agenda, they did a whole source of research scholars that were from the community, and we did training for them. And I should say, even before COVID, we had a strong community focus, but it was strengthened as part of the work that we do within the school during covid. The other thing I did want to

mention really quickly is that, during COVID, we had people who were also suffering from heart disease, cancer, diabetes, etc. And so as we're looking at sort of the impact and the data from COVID, understanding the impact that COVID had on cancer screenings and treatment for hypertension, and issues of access to care is really important. And the intersection between many of these other conditions and COVID, I think is ripe for research. As we move forward, We're seeing this huge surge in substance abuse that's happening, we're seeing a huge surge in mental health issues as well in our community, and we're seeing, unfortunately, a surge in violence, as well. But understanding how all of these things come together, is important research and intervention opportunities for not just us in the School of Public Health, but I would argue, folks across the university as well. But, but really strengthening that research, I think is important. And I would say through all of this, our faculty have been amazing and have been really resilient when I think and staff as well, in terms of pivoting to online, but then coming back in a safe way and continuing those other research efforts that have continued and, if you look at our research expenditures, they've gone up fairly substantially during this time, partly from COVID, but also because there are other really important centers and other activities that we're getting funding for as well so the school continues to thrive.

Jessie Knoles 1:35:00
Great that kind of-

Wayne Giles 1:35:00
Ron was that. Yeah. Was that what you wanted?

Ronald Hershow 1:35:02
That was great. Yeah. No, thank you. That was terrific. Thanks.

Jessie Knoles 1:35:06
And that kind of leads into my next question, which is the field of public health uses data to understand facets of health and adjacent topics. For example, environmental health health inequities, occupational health. What are some examples of perhaps, realms that we don't typically think of that the COVID 19 pandemic has affected in terms of health and health care?

Wayne Giles 1:35:43
So I talked about in my previous response, I think about delay, and delay in screening because of COVID. I think it's important. I think the other thing, we tend to think about is geography, we think about social vulnerability, etc. But I think the other thing is thinking about different occupations. when COVID started, we were thinking about the health care occupation being at risk, right. But also, we need to be, think about other essential workers as well. workers in the grocery stores, CTA workers, these are the essential workers as well, and how do we ensure that those individuals are safe, And then the last, the I would just mention, is having a strong, dedicated, highly trained public health workforce. And the school did receive from the Health Resources Services Administration, $1.5 million to provide scholarships for public health students, MPH students, who will be working in medically underserved areas. So it's a nice, as COVID is becoming, hopefully more endemic, it's useful to see now sort of at the end, we're able to replenish the public health workforce, and really with a target on those communities that are most medically underserved.

Ronald Hershow 1:37:49
I also think that one of the outcomes that will come out of all this is the realization that when COVID-19 broke across our country, our data systems were severely underdeveloped and antiquated. Reflecting on the way things evolved, people were relying on John Hopkins data. Really, that should be CDC data. And, and there's now a whole initiative at the CDC, the DMI, the Data Modernization Initiative, that's seeking to catch up our data systems, to meet the needs that these kinds of health challenges pose for public health systems. So I think that an excellent legacy of COVID will be the upgrading of our data systems, and I think there are other innovations that will carry over. For example, I think telemedicine is here to stay. I think it's been put on the map by COVID, or established very firmly by COVID. Also, I don't think Zoom is going away. I think it makes meetings more accessible. In many cases, I still feel like something's lost from not having in person meetings, but having an option to attend virtually, I think, is not going to go away. And I think it's a good thing overall, to make those meetings accessible to people who can't physically be there. So those are just a few thoughts on that.

Devangna (Guddi) Kapadia 1:39:47
I would kind of reiterating so apologies. But I think I would call out. So as, as the Dean said, you know, work and the importance of work and what constitutes healthy work really was highlighted, we have a NIOSH [National Institute for Occupational Safety and Health] funded center for health and work at the School of Public Health. And, you know, they stepped up a lot to help with, again, just, you know, those that those workforces the the cleaning services that, you know, that were not, you know, first in mind, as far as you had your food workers and you had, you know, but still deliveries, etcetera, etcetera. So, I think work and, again, healthy work in terms of not just safety at workplaces, but fair wages, you know, hours, the ability to, you know, schedule and be safe, as needed, all these things were really highlighted and, you know, brought to attention, and I think they're going to continue to be, you know, at the table, and hopefully, it'll be addressed. So I think that's important. So, and I know that, you know, everyone talks about health disparities and health equity. And I think just equity and disparity overall, was really highlighted throughout the pandemic. And, you know, we have the Collaboratory, and I think we're doing a lot to really think about it even PACT [Partnerships for Antiracist Campus Transformation] is, you know, an effort to really think about and see how it can be addressed. But those disparities not only is, you know, access to health care, access to information, but the things that we're talking about, right, like, when we went to zooms, you know, Chicago public school systems had to think about how to make sure people, you know, every student could get back on Zoom, how those that were getting, you know, breakfasts and lunches, and things like that, how they could still access that. And so again, those disparities were just magnified. And I think, you know, it's, it's a growth in crisis. Right. So.

Wayne Giles 1:42:02
The other thing I just wanted to mention, you know, Ron mentioned the importance of data. And, and, and I want to add in addition to data. You know, I think communication is key. And there's all this disinformation and misinformation. And so just as we're thinking about the public health workforce of the future, and particularly with social media, being able to communicate effectively is going to be really vital and important, and being able to combat misinformation and disinformation, and using trusted voices in the communities all that sort of another sort of really important future activity that we've that we've got to address.

Ronald Hershow 1:42:57
I think the other challenge that we all face is that often public health is managed in panic neglect cycles, and that we marshal a lot of resources in the middle of crises, and then frankly, let them dissipate.

Wayne Giles 1:43:19
Yeah,

Ronald Hershow 1:43:19
And it's really a well documented fact that public health was at a low ebb of funding, when this pandemic broke, that we were roughly spending 2.5 cents on every tax dollar on public health, which was lower even than the proportionate amount we were spending during the Great Depression on public health. And after the 2008 economic collapse, the US lost 55,000 Public Health jobs. So now, of course, we've seen a rush of resources in in response to this crisis. But if we're really going to learn our lesson, then we won't let all that dissipate, right? We're going to learn that lesson and keep our workforce strong and active and give it the data management tools it needs to be effective. And I think those are the great challenges we confront.

Devangna (Guddi) Kapadia 1:44:26
Yeah, so the infrastructure is not just having the humans but the humans that are knowledgeable and the systems to support them.

Jessie Knoles 1:44:36
Great, that leads into my next question, which is how has the COVID-19 pandemic affected how public health professionals and epidemiologists think about and prepare for future pandemics?

Devangna (Guddi) Kapadia 1:44:57
You want our voice to represent all a public health professional cuz I don't know if anybody wants me to be that person.

Wayne Giles 1:45:04
I mean, I'll start. So I think there are a couple of things. one would be having strong data systems, that are in particularly data systems that are timely, that can identify and track future pandemics or, or outbreaks, etc. Being able to communicate effectively and, and having the trusted messengers that can deliver that information in a timely manner. And then thirdly, public health can't do this by itself, but they've got to be collaborating across multiple sectors. And so being able to collaborate with, healthcare, in the delivery of interventions, and the messaging, etc, is important. being able to collaborate, but education is important.

Ronald Hershow 1:46:27
Yeah,in the broadest sense, to prepare for the next pandemic, we need to address the inequities that were the subsoil in which this pandemic flourished. I mean, COVID-19, broke on an unequal world, and disproportionately affected, socially vulnerable communities. And some of that vulnerability maps to race, ethnicity, with communities of color being severely affected, And I think we have to take the steps

in our society to really get serious about addressing those health inequalities. The stark reality is that people of color live in more polluted environments, engage in risky service jobs that expose them, potentially to infectious diseases, and other hazards, as Guddi was focusing on work environments. Admittedly, reversing structural racism and generations of disinvestment in thee communities is a tough fix. But that doesn't mean we can ignore them either. And we have to fully engage with that process. Id if I were to construct a wish list, it would include the availability of national health insurance for Americans and moving beyond the Affordable Care Act, to a more universal form of health care provision, so that we don't have people on the outside looking in for health care and, and not always bumping up against these terrible access issues. When we compare ourselves to the other wealthy countries of the world, we're just not doing that well, in that regard. P prior to the pandemic, we were rated the best prepared country in the world. And yet, when you really take a careful, look at our response to the challenge of this pandemic, we did worse than many of our comparator nations that have universal health care systems and things in place that act as a safety bulwark for those societies. So I think we have a lot of work to do. And we at the School of Public Health are very excited about that work in general. Health, social justice, justice and health equity is at the center of virtually every faculty member's work. So those are the challenges that we look forward to contributing to overtime.

Devangna (Guddi) Kapadia 1:49:31
I'm just gonna, you know, for making kind of wish lists are I think one of the things that the pandemic really is, is the cultural shift of having public health as experts, as responders, as you know, I'm not sitting on the sidelines. And I hope that that's the case into the future and Maybe we won't have pandemics anymore if people are listening to the data and the science and, you know, we can we can be in the prevention modes that we want to be. So it's the first time that my family knows what I do for a living. So hopefully, you

Ronald Hershow 1:50:23
I hope they know you're a rock star, Guddi.

Jessie Knoles 1:50:29
Okay, I think that's the end of my questions. If there's anything that anyone would like to add before we say goodbye, feel free to do so now. Otherwise, I'll thank you all for joining me and this very important project that the university is tackling and I really appreciate your input and your experiences. They're very valuable to us. Thank you very much. Appreciate your time. Bye bye. Bye bye