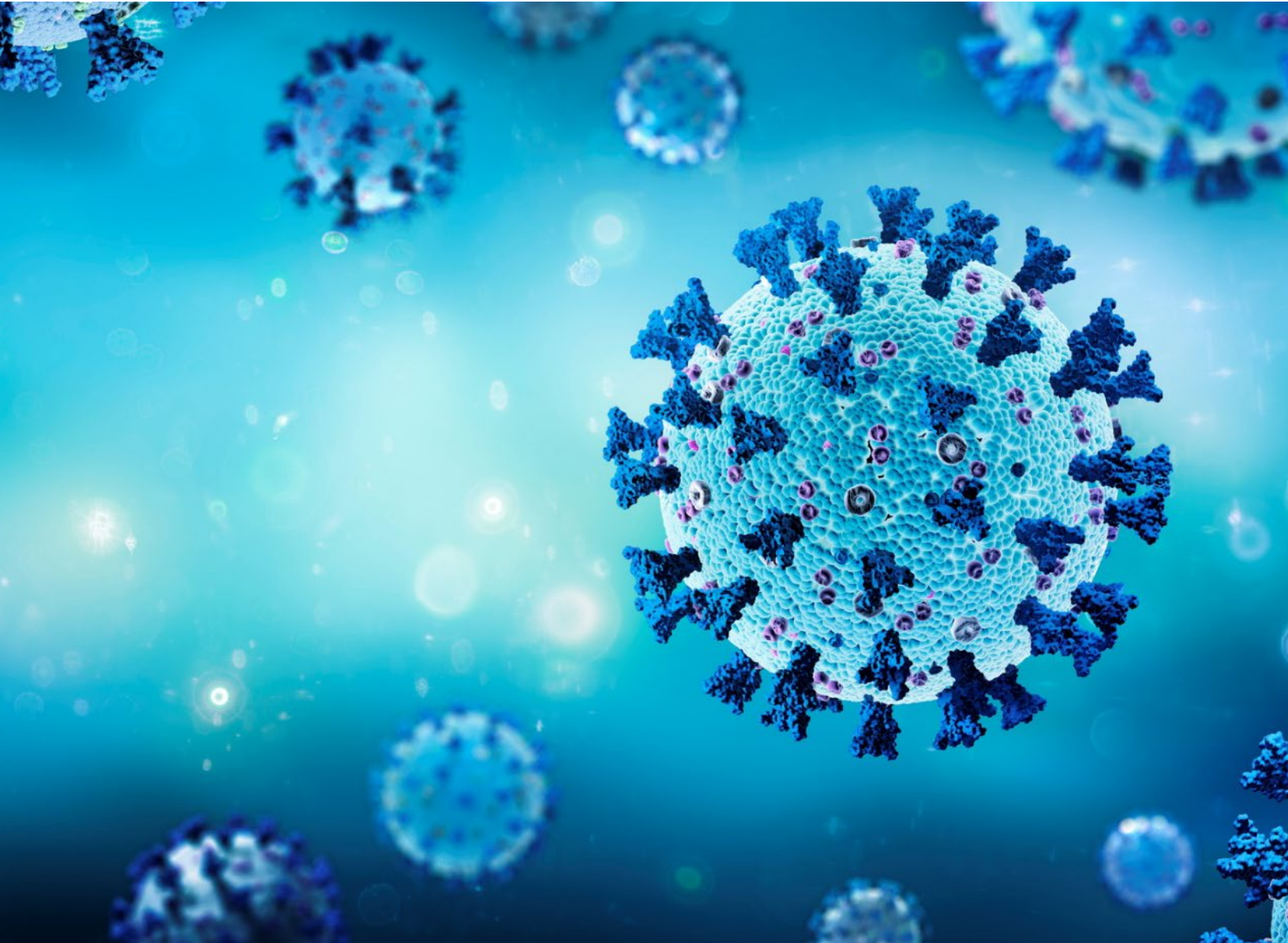




Leading During an Emergency

Prepared for: CSTE LEAD program

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Council of State and Territorial Epidemiologists

Learning Objectives

This case explores common leadership issues often experienced during public health emergencies, from the eyes of epidemiologists. The case is specific to the realities of local/state public health departments and is set during the COVID-19 pandemic, though the content and application is relevant to many types of public health emergencies. Analyzing the case will require applying leadership theory as well as a basic understanding of emergency response, crisis communication, change management, data translation and communication, health equity, workforce planning, data governance, and data sovereignty. The goal of the case study is to provide epidemiologists an opportunity to think critically about how they can best lead during a real-life emergency situation.

By completing this case, participants will be able to:

1. Develop solutions for creating a coordinated and collaborative vision to an emergency response
2. Identify leadership strategies to influence change at all organization levels
3. Identify strategies to meaningfully convey data for different stakeholders
4. Apply principles of health equity to emergency response
5. Identify workforce planning considerations
6. Apply strategies of self-reflection/evaluation to past and current emergency response

*While parts of this case are based on a real-life situation, other parts are expanded upon and fictionalized. Names are not real.

Description of the Case

What are the key tenets for leading in an emergency?

Leading in an emergency requires skills you have learned about general leadership up to this point, as well as additional skills specific to responding during crisis or emergency situations. As you think about the scenario presented here and what actions you would take and how, keep the following things in mind:

1. Crisis leadership requires making a transition from being a tactical responder to a crisis leader.
2. Utilizing skills in change management are critical throughout the response.
3. More so than ever, coordination and collaboration across the organization and multiple levels of organization (federal/state/local) may be necessary for effective response.
4. Crisis leaders must communicate effectively across multiple levels of stakeholders (internal, external, public).
5. While in the midst of responding and protecting the public's health, crisis leaders must also take steps to ensure a healthy and supported workforce.
6. In moving data to action, not simply presenting data, but effectively influencing stakeholders is often critical.
7. Decision-making is a balancing act, but taking action is absolutely necessary.

What is COVID-19?



According to the CDC¹, “COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. Because it is a new virus, scientists are learning more each day. Although most people who have COVID-19 have mild symptoms, COVID-19 can also cause severe illness and even death. Some groups, including older adults and people who have certain underlying medical conditions, are at increased risk of severe illness. COVID-19 is thought to spread mainly through close contact from person to person, including between people who are physically near each other (within about 6 feet). People who are infected but do not show symptoms can also spread the virus to others.

Long-standing systemic health and social inequities have put some rural residents at increased risk of getting COVID-19 or having severe illness. In general, rural Americans tend to have higher rates of cigarette smoking, high blood pressure, and obesity as well as less access to healthcare which can negatively affect health outcomes. They are also less likely to have health insurance. Rural communities are also becoming more diverse racially and ethnically. Racial and ethnic minority groups including, African Americans, Hispanics and Latinos, American Indians/Alaskan Natives², and Asian/Pacific Islanders, are at increased risk of getting COVID-19 and having severe illness.”

¹ CDC. Coronavirus 2019. Accessed April 21, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Basics>

² Arrazola J, et al. (2020). COVID-19 Mortality Among American Indian and Alaska Native Persons-14 States, January-June 2020. *MMWR*: 69(49);1853-1856.

Background



May 2019

Tia Smith works as an epidemiologist for the Communicable Disease Branch of the Histogram State Health Department. She started her career over ten years ago as a data analyst for the Department and has gained many years of valuable experience as a mid-level epidemiologist there. However, recently, amongst multiple recent retirements of other epidemiologists in the Department, she has been asked to take more of a leadership role within the Branch. Given her passion for epidemiology, not leadership, she is somewhat hesitant, but wants to continue to serve her state where needed. And, after all, we just had our 100-year influenza pandemic back in 2010, right? Nothing big could be on the horizon...

May 2020

Well, it's not an influenza pandemic. But COVID-19 has surged across the globe, including cases starting in Histogram in mid-March of 2020. The state has more and more cases every day with a concerning healthcare system surge and resources for contact tracing outstripping available capacity. Coupled with this tactical response is increasing pressure from the Governor's Office and the media to release up-to-the-minute data on cases, hospitalizations, and deaths. Due to recent media coverage in the state on the disproportionate effect of the opioid epidemic in Native American communities, there are also underground — yet visible — social media campaigns

maligning Native Americans and concerns that stigmatization may increase for this population if they experience a COVID-19 outbreak.

The Governor's Office has asked Tia — now acting head of the Communicable Disease Branch as the State Epidemiologist is out on medical leave — to provide data and stand-up visualizations of COVID-19 cases, hospitalizations, and deaths by gender, race, and county. The Governor's Office has given Tia a three-day deadline.

State of Histogram's American Indian Population



The state of Histogram lies in the Pacific Northwest of the United States. Its population is 4.5 million, with 70% of residents being Caucasian, 10% African American, 10% Asian American, 5% Latinx, 2.5% American Indian or Alaska Native, and 2.5% Other. Histogram has the largest American Indian population (~112,500) in the Northwestern United States. Among the 112,500, 70% report specific tribal affiliation/community attachment and 50% live on a reservation. Tribal affiliation in the state is diverse, with reports of seven different tribes. The three reservations in the state represent three different tribes and cross county boundaries. Additionally, their “community” often extends beyond the reservation borders. While 72% of the state is rural, reservation communities are almost totally rural in nature with residents often having to travel great distances to secure needed resources, including healthcare.

The Pac-West Region of the U.S. Department of the Interior's Bureau of Indian Affairs is located in the capital of Histogram. Their office works closely with the tribes in the state, especially the reservations. Part of their role includes assisting with social services and tribal operations. Though the Bureau assists tribes as well as reservations, the tribes within reservations in Histogram exhibit strong self-determination and provide many services traditionally provided by the government.

Data Systems



With investments in data systems from 2004-2008 when public health preparedness infrastructure was strong, Histogram — despite being a relatively small state — has a robust data system and good relationships with the healthcare community across the state. COVID-19 testing is becoming widely available in the major cities and laboratories are reporting results to the state with little lag. Hospitals are likewise reporting information promptly through their existing reporting systems to the state. Though there is certainly a lag in death reporting, classification of COVID-19 deaths seems to be consistent and appropriate.

The Department has a strong data visualization program within its State Center for Health Statistics, housed and co-led with the state university located in the capital city. Vital records data are displayed on a public access website and able to be queried and presented by many strata including age, gender, race, and ethnicity and down to the zip code level. Because many conditions are rare and some areas of the state have very small populations, data are not displayed for

numbers less than ten. Data are usually at least one year old upon release due to reporting lags and necessary data cleaning.

What to Do?



With the elevation of social justice issues in the state after a number of police shootings of BIPOC in 2018, the Communicable Disease Branch has developed strong relationships with a number of other organizations, including the Pac-West Regional Office for Indian Affairs. From those interactions, Tia is aware that the tribal reservations have strong concerns about sharing health data, especially if it could cause further stigmatization of their community. Therefore, before taking any action on stratification of the data visualizations by race, Tia decides to speak to her contacts in Indian Affairs.

Within an hour, Tia is on a call with Pac-West staff and the tribal and health leaders from the three reservations. She thoughtfully asks the leaders what health information they feel comfortable being released about their populations. They answer that their communities — including persons off-reservation — are often small, and can often be easily identified when small numbers are released. Due to the recent opioid coverage, they are feeling especially vulnerable to racist attacks and are fearful about being labelled with another disease. Then, one leader surprises Tia by stating and asking: “We appreciate you reaching out to us about this and you protecting our community’s data and people. In return, we will ensure that we do all we can to provide data to you, if we have it. But, you haven’t asked us what else we might need. And what else we need is to have the all of the data that you also have available for our efforts to protect our people. While we may not be

comfortable sharing it widely, we need it to prevent disease in our communities, which we are committed to do.”

Tia responded that she appreciated their feedback and that the Department was always open to the tribal and health leaders’ suggestions, questions, and concerns. She concluded by stating that she would be back in touch with Pac-West within 24 hours to share information on the data dissemination plan.

At Tia’s suggestion, the state health department ended up creating data visualizations stratified by race. These were shared with tribal leaders so they could take action within their communities as well as shared with the Governor for informational purposes. The public-facing website visualization was broken down by race for the larger proportionate races of Caucasian, African American, Asian American, and Latinx. However, in order to preserve confidentiality for the American Indian population of Histogram, break down by American Indian or Alaska Native was not provided on the public-facing visualizations.

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Case Questions

Discussion Question #1

The Governor has requested public-facing stand-up of COVID-19 data visualization, including breakdown by race by county. The tribal reservation leaders have asked that that data not be publicly released, but be released to only them.



Would you have done the same thing as Tia/Histogram State Health Department? If yes, why? If not, why not?



How would you explain your decision to both the Governor as well as the tribal leaders?

Discussion Question #2

Tia is acting in an “Interim” role as Bureau leader.



In what ways does this role complicate the situation?



What specific things should she do to assure that her team is on board with her decision? Why is that so important?

Given that working during a pandemic is stressful for public health staff in and of itself, dealing with complex political issues are all the more trying and challenging — yet part of the job.



What things can Tia suggest for her staff to do to maintain their own health and wellness?



In what ways can Tia model self-care?

Discussion Question #3

Recovery is the period whereby restoration efforts occur concurrently with regular operations and activities; an example of recovery is preventing or reducing stress-related illnesses or excessive financial burdens after the COVID-19 pandemic or a catastrophic hurricane. Mitigation, on the other hand, is the phase of emergency management where actions are taken to prevent or reduce the cause, impact, and consequences of emergencies/crises. An example of mitigation from the COVID-19 pandemic might include addressing the vaccine distribution system for future pandemics or revising emergency powers legislation to be more responsive.

Recovery and mitigation are often overlooked and minimized as part of the emergency management process. However, recovery/mitigation work done post-police shootings in Histogram with the Bureau of Indian Affairs certainly impacted the COVID-19 response.



Regardless of how the data visualization is ultimately handled, what suggestions would you have for recovery and mitigation actions to take post-COVID-19 to address health equity issues in Histogram?



What lessons regarding working with American Indian populations around data can be translated to working with other populations you serve around data?