Written Testimony House Select Subcommittee on the Coronavirus Crisis
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Good morning, Chairman Clyburn, Congressman Scalise, and members of the Subcommittee.

My name is Jennifer Bacani McKenney, and I have been the local health officer for Wilson County in Southeast Kansas since 2011. I was born and raised in Fredonia, Kansas, a community of 2500 people, where I am also a family physician who owns and manages a private medical clinic. I have been practicing medicine there for the last 12 years with my 77-year-old father who has served our community for 42 years. I am also the mom of an 8 year old son and 10 year old daughter.

In rural communities, public health professionals, health care providers, and staff are feeling great strain. My health department has four full-time employees and serves a county of approximately 9000 people that has historically had some of the worst health rankings in our state. COVID-19 has hit our region hard and in multiple waves. Our employees have worked days, nights, and weekends to detect COVID cases, conduct contact tracing, educate the public, all the while still attempting to provide the high-quality services we have provided for years.

All of us at our local health department were raised in southeast Kansas. We care deeply about our community members as they are literally our friends, families, and neighbors. Although we are a small health department, our goal is the same as larger health departments – to protect and promote the public's health.

Our local health department has employed extremely dedicated staff and professionals, but the pandemic has stretched them beyond their limits. We have now had turnover of three of the four employees employed at the start of the pandemic. We are still in the process of hiring a new health department administrator after the last two have resigned in the last 6 months. There is no doubt we need national programs in place to support the training and retention of public health professionals, both now and for the future. Without pipeline programs and resources to support the public health workforce, we will see continued attrition and be ill-prepared for the future.

95% of our county's COVID vaccinations and 100% of routine childhood vaccinations are given at our local health department. Unfortunately, since the beginning of the pandemic, we have seen a drop in the number of children coming in for their routine vaccinations. Our health department staff strives to keep up with the Women, Infants, and Children (WIC) Program services, infectious disease investigations, and environmental health programs, but these and other activities have taken a backseat to the pandemic because of our limited staff and resources. Throughout the pandemic, we have worked

diligently to coordinate our local efforts with those of our state and federal public health partners. But we do not always feel supported, and we need additional resources to continue to care for our communities both now and long after the pandemic.

In rural communities, our experiences are unique. While I have been busy nearly full-time as the local health officer, I have continued to work every day as a family physician in addition to my other roles. In rural counties like mine, we often serve our communities wearing many hats. My colleagues and I staff the emergency department, round in the hospital, care for patients in nursing homes and others on hospice. We see patients in the clinic, in the hospital, in the parking lot, in their homes, through telehealth. Anywhere they need us. We're swabbing noses, we're treating people at home with monoclonal antibodies and we're admitting seriously ill unvaccinated adults to the hospital in record numbers. We're putting on PPE and taking off PPE every day. We are encouraging our community to get vaccinated with each opportunity we have, and we are vaccinating them ourselves. We're educating others and keeping ourselves educated on the latest data and science.

Every public health or health care professional I've spoken with is discouraged and exhausted. They're working impossibly long hours to care for patients who are mostly unvaccinated, and they're reaching a breaking point. Southeast Kansas has seen a huge surge of COVID Delta variant cases as has much of neighboring Missouri, Arkansas, and Oklahoma.

Kansas has seen one of the highest rates of public health leadership turnover in the nation. I co-lead a bi-weekly zoom call for Kansas local public health officials, and many of my colleagues have privately shared their stories of harassment, not only by the general public, but by friends, neighbors, and local officials. Many health officers and health department administrators have resigned because of this; some have been fired for promoting interventions we know will save lives, such as mandating masks and vaccinations and enforcing public health strategies like quarantine and isolation.

In addition to staff shortages, our overall public health and medical resources are extremely limited as well. My hospital does not have an intensive care unit (ICU). Recently, I had to call 40 different hospitals in our region to find a hospital bed for a patient critically ill with COVID-related respiratory failure. While working for many hours to transfer this patient to an ICU, my medical team and I managed the struggling patient before finally being able to transfer her to a larger hospital with medically necessary ICU resources.

This scenario is not unique to hospitals in southeast Kansas. Because our public health guidance and recommendations are not being followed by many in our rural communities, our hospitals and local healthcare providers are being overwhelmed by COVID cases. Many hospitals, including my own, are experiencing staffing shortages, an inability to transfer patients to larger hospitals, the need to care for sicker patients than we normally would, shortages of life-saving medications, and inadequate beds and supplies to care for routine but significant medical conditions because we are overwhelmed by the number of COVID cases.

We are being stretched thin in our health department, clinics, and hospitals as COVID continues to spread and we care for more and more sick patients. We are nearing a crisis point with our capacity to take care of routine conditions and provide routine public health services that have been neglected during the pandemic. We need to invest in public health now and into the future with the kind of supports that stabilize the profession and fund implementation of interventions that we know work for advancing health.

We will have an uphill battle supporting rural public health in future years because of the battle scars of COVID. Many rural citizens and community leaders have chosen to adopt a very "anti-public health" stance through this pandemic. When COVID-19 arrived in Kansas in early March 2020, I did what I've always done as a doctor. I studied the emerging science, communicated with my public health and medical colleagues, and cared for people in my rural community. I stepped forward not knowing exactly what I needed to do. I did not have access to more information than anyone else, but I tried to soak up all the credible information I could. I knew our community would need leadership, teamwork, and appropriate care.

I began my health officer work on COVID-19 by convening a countywide meeting with leaders from local schools, hospitals, businesses, churches, and governments. I would not have been able to gather these stakeholders had I not spent the last decade building trusted relationships. These meetings became a weekly exchange that brought key community members together.

My health department administrator and I started weekly Facebook live information sessions in mid-March. We knew that our community was scared, uncertain who to trust, and in need of data and reassurance. We promised the public transparency and an open dialogue from the beginning.

While a majority of the people in my rural community are supportive of my work in health care, unfortunately, some individuals have attempted to make my public health work more personal than professional. Some of the rural citizens we are working so hard to protect distrust government as well as public health institutions and the science of public health. Even though the virus is the enemy, their anger and frustration are often directed toward public health officials like me.

In speaking with my public health colleagues around the state, I know many have experienced worse harassment than me. But some have not been able to speak up for fear of retaliation and more threats, so I hope to share my own examples of harassment to give a voice to those who are unable. The following are some examples of the challenges that I have experienced during the pandemic:

- Business owners have expressed anger toward me for requiring employees to quarantine after close contact with a patient who tested positive. Some have refused to let quarantined employees stay home.
- I have been a member of the local school board for the last 6 years, and the president of the school board for two of those years, and even the local school board has gone against my advice and has voted against keeping students masked. The same science that we are teaching our children in school is being ignored by those making decisions for them.

- A person drove by my house filming my property last summer because I hosted an outdoor dinner for my small clinic staff, using appropriate social distancing and masking, to thank them for all of their hard work. Shortly after, someone on social media posted about the video that I was having a huge party and that I "don't think the rules apply to me."
- After the county commissioners decided to have a public mask mandate hearing, the local sheriff's deputy asked if he could escort me and my health department administrator out to our cars because he was nervous about the angry people in the crowd. The following day, I asked my cousin, who was helping care for my children while in remote learning, to keep my kids away from the front of the house because I just didn't know what might happen that next day. This was the first time I remember feeling unsafe and nervous for my family in my own hometown.
- Our health department staff has been lied to repeatedly about close contacts, onset of symptoms, or whether the person is following quarantine and isolation requirements. People who have tested positive have been seen unmasked in public places like the grocery store or restaurants during the time they should be in isolation and then deny this later.
- People have called for termination of my appointment on social media for continuing to encourage mask use and vaccinations.

Because the Kansas state legislators passed legislation restricting traditional public health powers during the pandemic (HB2016 and SB40), county commissioners are now empowered to make most COVID related decisions. They have been told that they, as the board of health, may consult with health officials but that these consultations are "optional." Nearly 100% of the public health officials I have talked with across Kansas have seen their county commissioners make decisions based on political beliefs and anecdotal stories rather than on the scientific facts. Over half of the states in our nation have passed laws that limit the authority of public health and medical experts to implement proven safety interventions. Some of these laws prohibit mask and gathering mandates or ban quarantine and school closures when clusters of cases are detected. They erode any confidence the public may have in public health professionals and will make it harder for us to control other highly infectious diseases like tuberculosis in the future[1]. We need a common framework to make decisions and quickly act to prevent outbreaks and disasters; and that framework must be based in medical and public health science. Right now, most COVID decisions are being made by individuals without any medical or public health training or experience.

State and county-level politicians in Kansas have made decisions that have poor scientific backing and are deleterious to our public health efforts. We are trying to save lives with masking, testing, contact tracing, quarantining and isolation in the same way we attempt to save lives in local hospitals, clinics and emergency rooms. But policy decisions by local and state elected leaders make it clear they don't believe we should be respected or listened to. The following examples from my county are similar to

[1] NACCHO and the Network for Public Health's New Report Proposed Limits on Public Health Authority https://www.naccho.org/blog/articles/naccho-and-the-network-for-public-healths-new-report-proposed-limits-on-public-health-authority-dangerous-for-public-health-highlights-proposed-state-laws-detrimental-to-public-health 2021.

what scores of others have faced, and they are curtailing our ability to contain the spread of this virus and prevent death and debility:

- My county health department was informed that there would be no county governmental support for enforcing quarantine or isolation requirements.
- I was told during a public meeting that a commissioner did not need to wear a mask because he was a Republican.
- When I proposed mask mandates last year to our 3-member county commission that serves as our board of health, I asked them to support the mandates and I would take the blame from the community, but instead they voted the mask mandates down 3-0 on multiple occasions.
- Late in the fall of last year, they informed me that my job would be opened up for applications, even though they'd never expressed dissatisfaction with my job performance over the prior decade. When I asked if I did something they didn't agree with, I was informed that I focused too much on health and not enough on business. The community wrote letters and came to the next commission meeting, and the county commissioners decided not to open up my position for applications after all.

We need more support from local, regional, and federal leaders. This needs to be borne out in policies that recognize our expertise, and new resources must be made available to assist in COVID efforts and beyond. We need a much stronger rural public health infrastructure. We are being asked to work harder in a much more difficult and controversial work environment. We need enhanced resources to continue to battle COVID and prepare for future pandemics.

I and many of my colleagues have contributed thousands of in-kind hours and have worked many hours of overtime because we have promised to continue to protect the people of our communities. But this is not realistic for everyone in public health. Funding needs to be sustained over time and used as an efficient complement to routine and emergent medical care. This funding should support training for those with an interest in public health careers as well as those at risk for leaving for other sectors of the economy. The funding must also be there to provide these workers the tools they need to succeed. From enhanced testing resources to improved data systems, the public health sector needs cutting edge technology to improve health and ward off future pandemics. Robust funding for tools and intervention delivery scientifically shown to improve health will help public health professionals prove their profession can have population-wide impact. Public health professionals across the nation have been wounded in this pandemic and they need backing now. Healthy communities are good for everyone, and in rural communities, like mine, we all see clearly that we're all connected.

The COVID-19 pandemic has challenged the entire nation. It has produced miraculously effective vaccines as well as resistance to time-proven public health strategies. We have seen extreme selfishness and we have seen heroic altruism. We have a great opportunity to turn a new page and elevate public health with resources and strategic policies. COVID has highlighted vulnerabilities public health professionals knew existed but couldn't address. We need to address them now, and we will need a re-

invigorated system for the future. With the support of this Congress, we can have the human capital and resources needed to point public health in the right direction for all communities.

Thank you so much for your attention to these issues. I am happy to answer any questions.