

Written Testimony for the House Select Subcommittee on the Coronavirus Crisis

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Statement of Mysheika W. Roberts, MD, MPH Health Commissioner, Columbus Public Health

Good afternoon Chairman Clyburn, Ranking Member Scalise, and members of the Subcommittee.

I am Dr. Mysheika Roberts, the Health Commissioner at Columbus Public Health which serves the cities of Columbus and Worthington in the great state of Ohio. I am here today with an extensive 20 year public health background at the local, state and national levels, including serving as Health Commissioner since 2017, working for the Centers for Disease Control and Prevention investigating outbreaks in Ohio, leading sexually transmitted disease clinics in Baltimore, and serving as the medical director and assistant health commissioner in Columbus.

My health department serves over 900,000 people in central Ohio. Columbus is the second largest city in the Midwestern United States, growing over 16 percent from the previous census. Our city is 46 percent minority, with 29 percent of those residents being non-Hispanic African Americans.

Over the past 20 months, my colleagues and I have worked tirelessly to keep our community safe during this once-in-a-lifetime pandemic, and doing all we can to ensure equitable access to the COVID-19 vaccine. Local health departments are the boots on the ground that are tasked with bringing this pandemic to an end and serving in partnership with our state and federal public health partners. But the experience we bring is unique and we need support to be successful, both during and long after the pandemic.

Our work goes far beyond the current pandemic. Columbus Public Health is responsible for protecting the health and improving the lives of all 900,000+ of our residents, as well as responding to routine health threats and emergencies. We know our communities block-by-block, neighborhood-by-neighborhood, fielding the many concerns and questions that families, local decision makers, and health care providers might have about COVID-19 or any other public health issue. We know the community's concerns because we live within the communities we serve and have a pulse on emerging issues.

This is not easy work. I sit here before you today as an exhausted, overwhelmed and overworked public health official. I am not alone. After 20 months of COVID-19 testing, tracing, vaccinating, working long hours, and working weekends to protect the health and safety of our community, my staff is burnt out, overworked and underpaid. Some are leaving the field entirely, unable to contribute any more to the work they once loved. Their tank is empty. As reported in the CDC's Morbidity and Mortality Weekly report, public health workers are at risk for negative mental health consequences because of the prolonged demand for responding to the pandemic and implementing an unprecedented vaccination campaign. The report found that 92% of the public health workforce reported working directly on

COVID-19 response activities and 59% of respondents said they worked more than 40 hours per week in a typical week since March 2020¹.

At Columbus Public Health, our staff turnover is up 5% over normal years as we continue to respond to the pandemic. Without question, the pandemic has taken its toll on all Americans, but its impact on public health has been often overlooked, undervalued and left in the shadows. Nearly all of my staff has been called to respond to this infectious disease effort, including restaurant safety inspectors, rodent and insect mitigation teams, breastfeeding specialists, dieticians, injury prevention investigators, drug and alcohol counselors, birth and death certificate clerks, and so many more. These are people hired to do jobs that had nothing to do with infectious disease containment, case investigation, contact tracing, isolation or quarantine. Yet, they wake up, work the worst parts of the pandemic, leave the office to go home to the pandemic, sleep thinking about the pandemic, and then they do it all again the very next day.

Additionally, local health department staff are tasked with combatting unprecedented levels of mis- and disinformation that divides communities and allows the virus to flourish, eroding trust in the public health system. Public health officials and their staff also have been physically threatened and politically scapegoated throughout the COVID-19 response. A recent count by The AP and Kaiser Health News found that over 300 health department leaders—colleagues just like us—have left during the pandemic. Many have lost their jobs for trying to protect and defend the health of their community. Many other career public health officials have stepped down, interrupting their careers to protect themselves and their loved ones from actual or perceived threats of violence. These untimely departures create a leadership vacuum that is not good for the communities they serve, their colleagues in neighboring areas, and the public health field as a whole.

Here in Ohio, we have had our share of harassment and intimidation targeting public health officials. Our previous director of the state department of health was subject to threats and anti-Semitic slurs at her home. Her designated replacement never assumed the job after her contact information became known and she was subject to harassment. In January of this year, the state Department of Health's assistant medical director had shots fired at her home. We are not immune.

The bottom line is, the largest health crisis in over 100 years has created an unprecedented challenge for those of us working in public health and we need the support of lawmakers and leaders now more than ever. Unfortunately however, lawmakers in many states are actively working against public health and our authority to protect the health and safety of the communities we serve. Laws that challenge and undermine public health authority have been proposed in all 50 states, with 26 states passing laws that hinder our response to COVID-19 and ultimately lengthen the pandemic. Examples of these new and unnecessary laws include: the prohibition of mask mandates, including cases of active tuberculosis; banning the use of quarantines for those exposed to COVID-19; setting arbitrary time-limits on emergency orders; and giving unilateral power to legislatures to stop public health actions². These new

¹ CDC MMWR, Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic – March – April 2021. https://www.cdc.gov/mmwr/volumes/70/wr/mm7026e1.htm?s_cid=mm7026e1_w

² 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->

laws will also impact public health agencies' ability to protect the public from serious illness, injury and death both during and long after the COVID-19 pandemic. Local health officials make decisions based on science and evidence that protects the health and safety of their communities, whether popular or not.

Additionally in Ohio, the General Assembly recently passed a law, over the objections of the governor, which completely undermines the theory of infectious disease containment which public health has successfully practiced and managed for decades. My authority as Health Commissioner is now limited to matters of isolation only. I can only issue orders for those with diagnosed with the disease, not case contacts. That change alone, without input from the public health community, demonstrates ignorance and lack of understanding of the basic underlying science of infectious diseases. Sadly, that change was made despite the protests of hundreds of medical and public health experts, meaning it was a willful act that will prolong suffering and pain in Ohio.

My colleagues at local health departments are leaving the public field every day due to burnout, fatigue, retirement, challenges to our public health authority, and harassment from the public on social media and in-person. These vacancies alone would be challenging enough, but we entered the pandemic after years of disinvestment that made the COVID response even more challenging.

According to the National Association of County and City Health Officials which represents and surveys all local health departments, local health departments began the pandemic with fewer dollars and fewer people compared to a decade earlier.

Nationally, small LHDs have seen median per capita spending remain essentially unchanged in the last decade after accounting for inflation, while medium and large LHDs report 14% and 22% declines in median per capita, respectively. However, as we are being asked to do more, any increases have not been sufficient to keep up with spending, especially for medium and large LHDs. Population increases and an aging population put a further strain on scarce dollars. And then the pandemic hit.

These budget reductions directly impact the workforce and people available to do this complex work. The workforce is such a critical piece to pulling us out of the pandemic and building a strong public health infrastructure for the future. Local health departments began the pandemic down 21% of their workforce capacity since 2008, with the number of full-time equivalent employees dropping from 5.2 per 10,000 people in 2008 to 4.1 per 10,000 people in 2019. Moreover, our employees are older, nearing retirement, and burnt out from the pandemic. Others are being offered more lucrative careers outside governmental public health in order to leverage the experience they have gained with us.

LHDs have long been asked to do more with less, and this approach left us vulnerable. In order to reach our federal public health goals, we need your sustained, predictable and robust investment in our work – not just disease-specific program lines – but resources to support the broad infrastructure needed for a successful health department. We also must ensure that those dollars get to the local health department level in a meaningful amount to help improve capacity. Public Health infrastructure legislation, including provisions in the House Build Back Better plan if well resourced, could make a meaningful difference in the future of public health.

[on-public-health-authority-dangerous-for-public-health-highlights-proposed-state-laws-detrimental-to-public-health](#) 2021.

While infrastructure funding can help support needed positions, we also must do more to help recruit and retain the workforce of the future. Local health departments are unable to be competitive in today's job market and attract the fresh talent needed in the field. Salaries often fall significantly short of the private or healthcare sector. Low pay often makes it difficult to retain graduates for the long-term, especially in locations that might not be as attractive as a thriving metropolitan area. Public health needs a workforce loan repayment program, modeled after the National Health Service Corps, to help recruit, retain and retrain a public health workforce for the future. This is particularly relevant now, as new staff and volunteers are being brought into the field for the COVID-19 response on a temporary basis. Bipartisan legislation has been introduced in the House to do just that (HR 3297).

To compliment strong investments in workforce, we also need to fully modernize our public health data systems not just at the federal level, but all the way down to the local health department level, so that we can have a timely, comprehensive data picture to educate the public, inform policy making, and target programs. The federal government made large strides in this area for health care in the American Recovery and Reinvestment Act in 2009. We must continue this effort on the public health side now.

The pandemic has been life changing and hard, but it is not over and challenges remain. The pattern of boom-and-bust funding cycles to tackle a crisis places American lives at risk. Short-term solutions to the pandemic will not provide long-term success and readiness of our nation. But with your help, we can set up and enhance the system to get through the pandemic and be better prepared for whatever comes our way next.

Thank you for your time and attention to this critical topic. I now look forward to answering your questions.