Healthcare Ready is a disaster preparedness organization working to make communities more resilient to emergency situations, with a health equity focus.

With Healthcare Ready Executive Director Tom Cotter, MPH.

From COVID to Katrina to soaring temperatures, when disasters strike it is our most vulnerable communities that are on the emergency frontline, and it's our underserved populations who experience the most disproportionate impact – and widening health disparities.

The mission of Healthcare Ready is to help build resilient community health infrastructure that is prepared for, can respond to, and able to recover from disasters and disease outbreaks. One of their specific goals is to ensure historically underserved communities and medically fragile populations can access medications and medical care during a pandemic or natural disaster.

In this episode, Healthcare Ready's Executive Director Tom Cotter shares some of the ways that the organization goes about helping to prepare communities for disasters, and how these approaches target the drivers for better health equity.

With host Rolf Taylor, Founder & Executive Producer, Health Disparities Podcast

---

Full Transcript

Rolf: You are listening to the Health Disparities Podcast from Movement Is Life. On today's episode, we're discussing how to ensure patients have access to healthcare during times of crisis. That's important because the health of all, especially those most impacted by crises and disasters such as Hurricane Katrina, depends on resilient infrastructure, a seamless emergency response and supply chain coordination to ensure continuity of care. What we may hear about on the news when things go wrong are stories about shortages of medication, the disproportionate impact of infectious diseases on vulnerable populations, or perhaps serious conditions going undiagnosed when access to care breaks down. The mission of the Healthcare Ready nonprofit organization is to build resilient community health infrastructure that is prepared for, can respond to and recover from disasters and disease outbreaks. And one of their goals is to ensure historically underserved communities and medically fragile populations can access medications and medical care during a pandemic

or natural disaster. As we discussed recently in an earlier episode, it's always the underserved communities that pay the highest price during natural disasters just as they do during an economic downturn. And that is because weathering the storm tends to favor those people and communities with the most resources. Building resilience and equity into the healthcare infrastructure is therefore vital in preventing the widening of health disparities as a result of crisis and disaster. So, joining me today on the Health Disparities Podcast is Healthcare Ready, Executive Director Tom Cotter. He has a Master of Public Health degree from Boston University School of Public Health, and a certificate from Johns Hopkins Bloomberg School of Public Health. And over his 15-year career as a public health and emergency management professional, Tom has piloted and launched innovative international strategies to localize emergency response operations and build sustainable response functions worldwide. So, Tom, welcome to the Health Disparities Podcast. We're looking forward to hearing all about healthcare ready and how the work that you do supports health equity.

Tom: Thanks, Rolf, and I am so excited to be here. And thank you for that introduction. Even beyond public health and emergency response my undergrad degree was in public and community service studies, which is basically a community organizing and understanding socioeconomic determinants of health. So, this is a conversation I love having. I'm always happy to do it. Thank you.

Rolf: Very good alignment. Thanks. So, let's just start with your origin story, your prequel if you like. When and why was Healthcare Ready established?

Tom: So, Healthcare Ready was founded after Hurricane Katrina in the early 2000s to support the coordination collaboration between healthcare infrastructure, public health, private sector, public sector, and all of the myriad actors within the healthcare supply chain. From there, our mission has grown to be making sure that there is unimpeded access to testing treatments and healthcare in general to any given person, any given community, especially during disasters and crises. And as we know, the disasters and crises have not gone away and in fact have become more complex and lying over each other, these compounding disasters. So, our mission is really important, especially in an age of pandemics, in an age of frequent outbreaks. And with the effects of climate change, more and more natural disasters as well. We always try to keep patients' lives and treatments from becoming disrupted and try to mitigate that through various different mechanisms. But the partnerships between the public private and now we're including more and more in the nonprofit and NGO sector is key to our identity as an entity. And we do that through careful analysis, through facilitated conversations and any other things.

Rolf: It's really interesting that the genesis was really Hurricane Katrina because it's an event that's kind of imprinted on everybody's minds, a bit like Covid really. It's kind of everybody knows about it. How did that happen? What came after Katrina that created a framework where people got together and thought, we need an organization to do this?

Tom: It's a good question. Essentially what it came down to your point, there's been these very easily identified inflection points in the history of, especially this country, Katrina, 9-11, the pandemic, Hurricane Sandy, Joplin, Missouri, when the tornadoes hit, lots of them. And Hurricane Katrina was unique because of the scale of it and the scope of it, I think. And because the communities that were affected were so chronically and historically underserved that it was a particularly arduous and difficult task to get things back to where they needed to be. And so, what the conversations were that kind of led to our inceptions were around, listen, there's all these needs that the government knows about, and they have limited resources or limited technical ability to actually solve all of them because there's so many, they're so detailed, they're so nuanced. There was a need to go to the private sector and say, listen, you do warehousing, you do logistics, you do healthcare access if you're, for example, a healthcare distributor or healthcare manufacturer. But there was no easy way to interface between government entities and these private sector solutions. And that really hampered, I think, the progress of recovery, the speed of response. And what Healthcare Ready does is because we're a 501c (3), we're a non-lobbying organization. We're not an association, we're not private sector. We're a nonprofit and that allows us to move really easily between government and private sector and try to connect dots where we can better solve problems in these crises.

Rolf: And the dots being the organizations, the resources, the capabilities that could be public, could be private, but it's how you bring them together. That means you have a solution.

Tom: And sometimes identifying the problems. So, we talk to the communities themselves, we talk to the hospitals, the federally qualified health centers, the FQHCs, the community health centers, and we say, what are your deltas here? What are you missing? Whether it is during a response or when we're building resiliency pre and post disaster. And so, we find that and sometimes we identify those solutions and then we can present that either as a method of advocacy, whether we just kind of put it out there and say, hey, there needs to be more investment here and now and for this reason. Or if it's a problem that we think our partners and our members and our network can solve, we can bring that directly to the members to find resources to solve a particular issue. But absolutely it is

these dots are all of these various stakeholders and connecting needs to resources is a core of what we do.

Rolf: So, you're very much a membership organization, which means you're a large national coalition of organizations. Could you talk a little bit about what is your process for convening all those different organizations? How do you share knowledge? How do you share information? How do you educate? How do you consult?

Tom: That's right. It's art and science. We use both of those. It's hard to tell on which day, which is more prevalent, but essentially our members allow us to provide that critical information around supply chain disruption, access issues, and the potential thereof. And to your question, the way we do this is a couple different ways. And there is no one way in which we can best coordinate, collaborate, and communicate across all of these different sectors. But the most common way is we send out situation reports, and we gather all of this data. Some of it is open publicly available data that we curate and put into this document. Some of it is we talk to our members, we talk to our government partners, we talk to the hospitals and the hospital associations, and we put everything in one place so that if you're a decision maker in the healthcare sector or even in the public health sector, you can best allocate resources, make your decisions, identify problem areas in communities that are underserved or have issues that are not being at the top of the list where they might need to be.
And so, we get all that data in one place for decision makers during disasters, we also do threat as assessments. So, a little while ago, Acorn Pharmaceuticals went out of business suddenly and ended operations within eight hours of notifying their folks. We did an assessment. We said, here's what they manufacture, here's what is at greatest risk of being disrupted and here is where we think that the industry and the private sector can actually just absorb this sudden shortfall in production. And that allows people to anticipate. And the anticipation allows providers at the end of the day, who needs this information the most. It allows them to navigate around and mitigate that the way any particular patient would feel that disruption. And again, I talked about our matching resources to needs. That's a big, big avenue of how we can do this. And to get a little bit more specific, a lot of the ways that shortages, medical shortages, for example, are recorded is from the distribution or the manufacturer side. And what we like to do at Healthcare Ready is get it from the actual providers themselves, so that even if it is not a disruption manufacturing, not a distribution disruption, there's a lot of different places where something can happen that will prevent a patient from getting the medicine that they need when they need it. And so, we try to work backwards rather than work forwards through the supply chain. And we work from the end user upwards as well as from the manufacturers downwards so we can better identify where the issue is. And at the same time, we do a lot of

policy advocacy and research and our membership, our members fund these initiatives. Things like for healthcare disparity podcasts, things like pharmacy deserts and how that impacts health outcomes and what we can do to mitigate that. How can we extend and have nurses, NPs, PAs, pharm techs and pharmacists operate at the top of their licensure to provide better access where maybe a hospital is not nearby for a particular community. So, a lot of that research helps us to advocate for these policy initiatives to advocate for these planning and investment opportunities in the public sector as well.

Rolf: What are a couple of examples of more recent activity that Healthcare Ready has got involved with?

Tom: It has been obviously like many healthcare and public health entities; it's been a real sprint/marathon. It's been a marathon of a sprint during Covid 19 and the times afterwards. In the later stages as Covid 19 waned, as the vaccines came out and the treatments more readily available, we did a study, we did a study of the impact of Covid 19 on communities of color. And what we looked at specifically was what were the specific barriers to access in underserved communities? How did people perceive the resources that were given to them and how did that relate to health outcomes? And what we found really specifically was there are very specific and nuanced, but very much real and felt access barriers to healthcare felt by black and brown communities in communities of low income and chronically and historically as I like to say, underserved communities where we could say a barrier to access for Hispanic folks that we interviewed and we polled were really hesitant to seek care because they weren't aware that they could get treatment for free and they were afraid of having a financial burden to go get a Covid 19 test, to go get a Covid 19 vaccine. And so, this research was very clear and allowed us to present a framework of how do we introduce more concepts of equity into the rollout of something like a pandemic response. Other initiatives that we're working on, we have a community disaster resiliency tool that integrates noncommunicable disease data of a particular community with the social vulnerability index, with their vulnerability and proclivity to natural disasters. Going back to Hurricane Katrina, this is a recent effort, but a lot of the communities still are very vulnerable to the effects of hurricanes, and if we overlay that with diabetes data, additional morbidity data, as well as what is the concentration of hospitals, clinics, pharmacies, we can really pinpoint communities that are really in need of investment and really in need of more resources during an emergency response. And I'll give a couple more, but a lot of our work kind of flows around a lot of this. I'll talk a little bit about the PAHPA report. Now, I think a lot of your listeners may be familiar with the PAHPA reauthorization. This is the bill that funds ASPER and it funds our pandemic preparedness. It's the Pandemic and All Hazards Preparedness Act. And so, this is being

renewed in September. Healthcare Ready was tasked by Congress to do an analysis for the last time this was renewed in 2019, and we produced this really lengthy detailed report based on key stakeholder interviews, polling, research, and one of our key findings that I think will be relevant here is there was a lack of equity planning and understanding in the last time we renewed this and built this whole pandemic preparedness infrastructure. And we saw this, right? We saw this even beyond our IC3 impact of Covid 19 on communities of color report. We saw this with the monoclonal antibody treatments and the lack of access and awareness, even awareness in how we communicate public health to certain communities was not planned for. So that kind of gives you a bit of a scope of you know, we do congressional reports that advocate for change and how ASPER and HHS approaches these pandemics and also, we take a deep dive to see what went wrong and make recommendations for how things went and go further.

Rolf: We recently had on the podcast a group from a hospital on the southside of Chicago, and they were talking about some of the challenges that they were facing right in the heart of Covid, where in a way, as a consequence of all the additional work that they had to do because of the pandemic, they were then surveyed and given a very poor safety grade. And one of the things they mentioned was that getting approval for something like remdesivir during the pandemic required really burdensome paperwork. So, putting all of the extra resource into having to go through burdensome paperwork, they suspected that the hospital up the road probably didn't have to do that, but because they were a safety net hospital, they had a higher bureaucracy burden, which was affecting their ability to provide care. Does that kind of align with what you've been discovering happen to that kind of organization?

Tom: A hundred percent. It's no secret that when any disaster happens, whether it's a pandemic, a hurricane or tornado, we all look to large secondary and tertiary care hospitals for the solution of providing healthcare to an affected population, right affected community. What we really leave out of our thinking and of our planning, and by we, I mean the emergency management, emergency response and public health community is these lower level, more accessible safety net clinics and hospitals that really are the main touchpoint for people to get healthcare. Most people don't go to a hospital when they need to see a doctor for whatever reason. They go to their primary care clinic, they go to a pharmacy to get their medicine, they go to the safety net hospital like the one you spoke to, a free and charitable clinic if they're underinsured or uninsured, and we're really hurting ourselves, I think in response by not inviting these key stakeholders to the table when we're starting to have conversations around preparedness. And I have a couple examples of that kind of illustrate this point. If you think of the RSV/Covid 19/flu outbreak that

affected pediatric hospitals nationwide last winter, this was an event that was unusual. The pediatric supply chain, not as robust as the adult supply chain for many different reasons because it's so specialized. For example, the pediatric hospitals were inundated, inundated with children and their parents seeking healthcare, and we saw this play out in their emergency departments where the wait times were so long patients left without ever having being seen and what could have been prevented or what could have mitigated the effect of this is engaging primary healthcare, pediatrics, engaging these safety net hospitals, engaging these rural and community hospitals that are probably a better fit for a good number of those patients that are waiting in a tertiary or secondary level care emergency department. But that conversation was never had on the calls I was on the coordination calls and the back and forth as we all tried to navigate this new type of outbreak that was affecting children predominantly after we were so practiced on adults during Covid, we had to pivot to do pediatrics, but that was never brought up as a potential solution. It was never acted on to say, hey, listen, let's figure out how we can communicate to parents that there's a long wait at the ED and here's the reason you absolutely should come to the ED of this big hospital or of this hospital coalition, and here's everything. If you want to see a doctor tomorrow, we've got all of these clinics in rural and community hospitals and safety net healthcare facilities that are going to be a better fit for you. And that conversation didn't happen, and I think it was much to the detriment of the response to this. Likewise, let's talk about Mpox. The Mpox response focused on distributing testing treatments and vaccines through public health departments. Not a bad model, but there was a huge disconnect in the trust and the communication between the LGBTQIA community and this mechanism that is trying to provide them testing treatment and information around vulnerability, for example, and their own personal vulnerability. But there's a whole host of clinics of FQHCs, community health centers that specifically cater to the LGBT~Q community that were never engaged in the early stages of this rollout. That would've been a really good place to have a trusted entity reach out to a community that has been historically underserved and mistreated and who may have really ingrained mistrust of the system, and that didn't happen. Instead, we had these kind of popups that were much less effective in forming that relationship with the community. At the end of the day, that's really important when you're getting healthcare. People trust their doctors, people trust their pharmacists, and if we think that the solution is always to go towards these big hospitals, we're stepping over a lot of providers, healthcare providers that already maintain these relationships that people are comfortable with, that people trust that people are used to. And in some cases, if we look at pharmacy and hospital deserts are very geographically and physically close to, and so I think that's a big deficit. And so, to speak to that safety net hospital, I can't speak to the specific paperwork and

bureaucracy that they had to go through, but it is consistent with what I'm seeing and hearing from a lot of different places around the country.

Rolf: Is there just an information vacuum or a barrier to good communication between the people needing healthcare in both those examples you just gave? Is it that we lack a channel of communication to actually interface with the people that we want to say, don't go there, go here.

Tom: All of that exists. We just need to use it. We need to find those local partners. We need to find those community-based organizations. And instead of rallying them or saying, here, do this, let's start asking questions. Let's say, what do you need? My background is in international humanitarian efforts, and you never come in and just implement a program. Tom Cotter, executive director of Healthcare Ready should never walk into a community in, I think this safety net hospitals in the south side of Chicago where I've been, but I don't have that lived experience and start saying, here's what you should be doing. Instead, let's say here, what do you need? And then that way we can say, okay, here's what you need. Here's the resources I can give you for you to help solve this problem as a trusted member of the community. I don't think we're missing those pathways. I think they're under resourced, they're underutilized, and they're just not tapped into, and they're very effective. They're so effective. Right now, we're doing a project with the city of Baltimore to build in resiliency planning and resourcing into community-based organizations in Baltimore, so that they're more resilient when there's a disaster. And we didn't come in and say, here's the checklist of all the things you need to do to be more resilient. We said, hey, what do you think? You need to be more resilient. Here's what we can bring to the table in terms of our expertise and experience. What if this looks aligned with that and what are you thinking of that is not on this list? And let's build a really bespoke and customized plan based on what you know, because at the end of the day, there's no central emergency management or public health entity that knows a community and will know every community around the country, but by engaging with local partnerships, we have that intact pathway. And so, to get very specific, how do we resource this? How do we create and tap into these channels? I think again, it's just resourcing. Send money. Literally it's funding community-based organizations. It's funding safety net hospitals. I think it's also developing more of a reflex in our emergency managers across the country, especially in the health sector, to instead of saying, okay, we're sending bottles of water, we're sending buses, etcetera, to say, reach out and say, what do you need? How can I make this easier for you? I'm working right now with a healthcare group in a specific state so that the association can gather all of the needs from all of their members across the state, safety net, free and trauma clinic, FQHCs. It doesn't matter who the association is. And then that's a really good mechanism to be able to elevate that to

the state EOC, to the county EOC, to FEMA, need be, right? Again, those mechanisms are no cost, low cost, but very effective. So, I think we've just got to build that into our thinking of making sure that A, we're planning to engage these folks and B, and I think this is most important, we have enough seats at the planning table that we're capturing their lived experience through disasters, their lived experience of what their needs are going to be and ensuring that we're including that in our thinking.

Rolf: I'm sure we have listeners to the podcast who are thinking, this sounds great. We need to be part of this network. We need to be a member of Healthcare Ready. Could you talk a little bit about what kinds of organizations you are welcoming as members and how our listeners could actually engage with you?

Tom: Yeah, absolutely. So, for right now, our members are largely manufacturers and distributors and large healthcare associations. What we're leaning into though is doing a lot more bespoke work and making sure that members who maybe have less than a billion dollars of revenue B with a B are able to access our services on an ad hoc basis. So, if somebody's interested in this, you can contact us through our website and tell us about your problems. We'll talk it out and see what we can do for you as it relates to healthcare supply chain and access during disasters. I think what we'll be doing in the very near future as an organization is creating more opportunities for direct membership and direct partnership. Right now, our situation reports, and other intelligence products are largely what we call traffic light protocol whites, which means or clear we can distribute it to anyone at any time. And that makes sure that we're erring on the side of getting the information to people who need it the most because we need to pay our electrical bills at Healthcare Ready, just like any other organization and make sure we're providing good health insurance. By the way, we'll be changing that in a bit, but we want to make sure that becoming a member of the financial aspect of that is never a burden to getting what you need for your community. Other than that, our contact information's on our website. I invite people to take a look at our website. A lot of the resources that I've spoken about today are available for free on our website, including a tool that I forgot to mention, which is RXopen.org, which is a web tool, web-based tool that allows you to see what pharmacies are open or closed after a disaster so you know where to send your patients or your patients know where to access their medicine. So, there's a lot already that you can get, and if you're interested in more, give us a shout.

Rolf: And then for our listeners, just as a kind of closing summary of some of the kind of key findings that you would pass on to them to have them think about disaster preparedness, what would be some of the key things you'd suggest that they consider and think about?

Tom: I think the key thing is to make sure that you have the input of all the stakeholders. Doing this halfway is not going to cut the mustard here. I think the other thing is, and especially I think for your listeners, is view your planning through the lens of health equity where these disasters as they come through, again, whether it's a pandemic or anything else, we'll expose the vulnerabilities, identify them, name those vulnerabilities, and invest in them by providing more resources or planning around those particular vulnerabilities. Ensure that you are engaging through a diverse team of stakeholders to influence your planning and your thinking. And then make sure at the end of the day people are aware of the plan, they know how to contact you if they are looking for additional resources. Say if you're at a county level or a large healthcare facility, make sure that you're creating avenues that are effective for communication, for people to communicate with you and asking questions and ask for resources and that you're communicating outward. If you look at that example that I gave for the pediatric surge event, that two-way communication between communities and you as a public health actor is absolutely critical and I think is overlooked or maybe it was overlooked and now we're getting a lot better at it after Covid 19. So, I think between making sure there's enough seats at your table for preparedness efforts and trainings and exercises, making sure that you are including a diverse opinion and a diverse lived experience in your planning to ensure that you're not leaving anything or anyone out. And then make sure that you're creating good and solid communication pathways, so that you can be agile and ensure that you're meeting the needs of your community.

Rolf: It's been really interesting hearing your overview. I hope you come and talk about this at our annual caucus sometime. It seems like this is information that needs to be discussed more, that more people need to know about, but it doesn't get discussed that much in the context of health equity until there's a disaster. And the key is its preparedness not being reactive. That will actually help with health disparities.

Tom: Agree a hundred percent. And I can't wait. I can't wait to participate. Absolutely.

Rolf: Thanks for joining us on the podcast. It's been really interesting discussion.

Tom: Thanks very much. Absolute privilege to be here. I appreciate it.

Rolf: And thanks to our listeners for joining us today for this episode of The Disparities Podcast. Check the summary for links to resources discussed during this episode. And until next time, be safe and be well.

146 MIL Healthcare Ready 2023