# *Reflections from the Front Lines*

Members of the White House Fellows community report on their involvement battling the pandemic

**Cynthia McCaffrey (1995-96)**

I am UNICEF's Representative to China, where I lead a team of over 100 people to design and implement programs providing children with health, education and protection.

My husband (Michael Hatchett, also class of 1995-96), our two daughters and I live in Beijing, China. When Wuhan locked down on January 23, 2020, we saw coronavirus shut down other cities, including our hometown Beijing. A city of 25 million deserted. Sidewalks empty. Few cars on the road. Every storefront shuttered except for grocery and liquor stores. While we could get most anything we wanted, the only things not available were masks and hand sanitizer.

Beijing's deserted streets were an early signal of the isolation coronavirus brings. In China, the advent of Chinese New Year compels tens of millions to leave their cities and the country, traveling to celebrate the new year together with friends and family. The year 2020 was no exception and, as always, UNICEF staff were among them, taking well deserved breaks. Few — very few — of us remained in Beijing for what was to be quiet time to catch up on work, reading, and simply rest.

Wuhan's lockdown triggered an abrupt shift. The UNICEF office closed, I convened our Crisis Management Team and UNICEF China staff began marshalling an emergency response from our individual living rooms, kitchens, and bedrooms around the world. This was the first time that any UNICEF team responded to an emergency without anyone being in the same room. Within days of the lockdown, UNICEF delivered essential supplies to Wuhan. Through Zoom meetings and WeChat (China's WhatsApp), the UNICEF team crafted health messages to reach children, youth, and parents and created online activities and learning guides to engage children from 3 months to 18 years old. From our own isolation, we tried to address and reduce the impact of the coronavirus isolation on hundreds of millions of children and their families.

While we mounted the emergency response, we cared for each other. That is an important lesson of COVID19 — caring for each other. Similar to the evening applause and singing for health workers in Italy, Spain, and the US, a spontaneous support system linked us together from Beijing to Bangkok to Delhi to Copenhagen to New York. Attendance soared on our weekly staff Zoom meetings. Phone trees, diet tips, and exercise links flowed to and from each other.

As the shut down and crisis persisted, my team in China pivoted to help UNICEF offices around the world. Handling late night calls and long hours is one thing, but the isolation everyone on our staff was experiencing and how to mitigate the effects weighed on my mind. Our staff was isolated from each other and often from their own families. This was another new coronavirus phenomenon. Those implementing the emergency response were dealing with their own personal emergencies including caring for elderly relatives, home schooling children and finding safe places for family trapped elsewhere. My family was also caught in the wake of cancelled flights and closing borders. Separated from each other and unsure when we would see each other again, we navigated three time zones for regular Facetime calls.

These new family and work routines remain, but at work and home I find ways to address isolation. UNICEF China's support to the national back to school campaign, for instance, urges safe hygiene as well as safe physical return to school. The human interaction maintained by my team, family and friends (including fellow Fellows) both online and carefully in person continue to sustain me. Looking ahead, I am and urge others to use all channels to reach, support and care for each other. We

## *Covid-19 Reflections, continued*

can and must usher out coronavirus' attempt to isolate us from each other.

### Thomas Fisher (2010-11)

I met the leviathan on New Year's Eve. "China Investigates outbreak of atypical pneumonia that is suspected linked to SARS" Agence France-Presse tweeted the morning of December 31, 2019. At the time, I was following foreign press for signs that a swine flu that culled a third of the hogs in Asia had leapt to humans. But this was not swine flu. Epidemics are routine for emergency medicine. The 2001 Anthrax scare filled the waiting room with terrified, but healthy patients. Thirteen years later Ebola swept the world, and I practiced donning and doffing head to toe protective equipment. As the number of new cases of pneumonia bloomed, a curiosity became a threat and we were introduced to the conoravirus. By the second week of January, The New York Times took note and I forwarded the article to friends along with the caveat "this may not be a pandemic, but when one occurs this is how it starts."

I knew one day the virus would appear and the day that it did a pall fell on the emergency department. Unmasked nurses with long faces spoke with hushed voices and laughed nervously as they directed the patient to a room. The red-faced middle-aged businessman was placed in room 41, a negative pressure room designed in 2015 to contain Ebola. It isolates patients from the air in the rest of the department and provides the ability to communicate through a window. The monitor showed his heart was racing and his coughs were audible from the hallway. Before I entered the antechamber between the hall and the room, I fumbled with an N95 mask shaped like a duck bill, donned a yellow gown and a placed a disposable plastic eye shield over my glasses. The nurse, Brad was similarly protected, and together we leapt from the safety of the boat into the dark abyss.

### Travis Matheson (2007-08)

As a WHF I was assigned to USDOT as a senior policy advisor and safety portfolio expert to Secretary Mary Peters. I am a 28-year veteran of the Washington State Patrol where I currently serve as the Captain of the Property Management Division (Fleet, Supply, and Facilities). My previous command assignments include HR, Special Operations, and Internal Affairs. I have been the Incident Commander of the WSP's Incident Management Team for eight years.

The Washington State Patrol turns 100 years old in 2021 and to celebrate we've been collecting our biggest 100 stories. They include the 1980 Mt. St. Helens eruption, prison riots, presidential visits, the World's Fair, WTO protests, the first female state police chief in the United States (Chief Annette Sandberg in 1995), and 30 officers killed in the line of duty. Due to a tragic and unprecedented series of circumstances, in terms of duration and impact, we experienced four events that will be at or near the "top" of that list in just four arduous months (March-June) of 2020.

Washington State was at the forefront of the COVID-19 pandemic in the United States. The WSP activated the Incident Management Team on March 5, 2020, and I was named Deputy Incident Commander. We were challenged with preparing our agency of nearly 2,500 public safety first responders and support personnel for the developing pandemic. Much of our energy was spent determining what and how to communicate to our employees and developing policy for dealing with evolving scenarios. This development incorporated, and was complicated, by federal, state, and local guidance and restrictions. Most of our remaining time was dedicated to PPE acquisition for a statewide workforce, many of whom were on the front lines. Most of our traditional vendors for gloves, masks, hand sanitizer, and other disinfectants were immediately overwhelmed and unable to fulfill our standing orders. We had to research and discover new and creative sources for these vital supplies. For example, we ended up ordering 500 gallons of hand sanitizer from a local distillery.

On March 24, 2020, while still in the early days of our COVID-19 response, Trooper Justin Schaffer, a seven-year WSP veteran was assisting fellow officers with a high-speed vehicle pursuit of an armed robbery suspect. Trooper Schaffer was placing spike strips in an attempt to deflate the tires of the suspect's vehicle when the suspect intentionally struck and killed Trooper Schaffer. The suspect proceeded to intentionally strike a second trooper's patrol car, injuring that trooper, before he was apprehended and charged with the aggravated murder of Trooper Schaffer. The WSP activated a second IMT and I was again appointed Deputy Incident Commander.

Traditionally, we dedicate resources and a massive effort from around the state to create a memorial that is worthy of our colleague's ultimate sacrifice. Not this time. We have completed much of the planning, but due to COVID-19 restrictions we were unable to hold a memorial.

Like much of the rest of the nation, following the tragic murder of George Floyd, the Pacific Northwest experienced widespread peaceful protests and destructive, violent riots. Local agencies were quickly overwhelmed and the WSP was tasked with supporting local law enforcement in cities across the state. On June 3, a third IMT was activated to support the WSP's response to these protests and riots and I was named Incident Commander. We had never experienced two concurrent IMT activations and now we had three. The demonstrations continued for weeks and included the now infamous CHOP (Capitol Hill Organized Protest) and the death of a protestor on I-5 in Seattle by a motorist. All of this further exhausted and exasperated our employees who were finding themselves assaulted and demonized by a very vocal section of the communities that they had taken an oath to protect and serve.

And then finally (hopefully) on June 17, Governor Inslee announced temporary furloughs for state employees due to a forecasted massive budget shortfall. Over 900 WSP employees were required to take one unpaid day per week off during July (20% pay cut) and then one day a month for four months (5% pay cut). This was essentially all of our civilian staff except dispatchers. So while still in the midst of recurrent and often violent protests and with the backdrop of COVID-19 we began the unprecedented administrative work of massive furloughs. Now our hard-working, dedicated employees who had been decidedly taxed by the COVID-19 response, Trooper Schaffer's death, and extensive demonstrations against their presence would be expected to continue doing more work, in fewer hours, and for less pay.

Unprecedented seems to be the word of the year and we all joined a career in public safety knowing that we don't get to choose our emergencies. These past four months have challenged many of us like never before. However, every challenge presents an opportunity that we would not otherwise have. We have grown individually and collectively. Like much of the world, we have adapted to our COVID-19 environment even though it continues to rapidly change. We were finally able to hold a memorial (more than four months after his death) for Trooper Schaffer and provide closure for Trooper Schaffer's family, the WSP, and the community in which he served. We continue to assess, learn, and improve our service to our state with racial equity at the forefront of our approach. And our employees largely weathered their first round of furloughs still feeling valued and passionate about their public service.

### Mark Hagerott (1991-92)

Reflections from one White House Fellow helping battle COVID on the High Plains: The year of 2020 will certainly go down as an historic flex point in the arc of history... and my White House Fellow's experience working interagency government projects was crucial as I was now called to work with multiple of our state and federal government entities as I led the university system of North Dakota into uncharted waters. Students and the campuses they inhabit, because they constitute a high-density concentration in which the virus may propagate, are especially problematic in this existential pandemic battle. By mid-February, I was watching the news coming out of China with alarm. When the virus began to race thru Italy, a modern industrial state, in late February and early March, quietly I began the preparatory actions needed for my system of eleven campuses to respond. My wonderful cabinet of presidents and their faculty and staffs began to prepare to shift almost 50,000 students and 11,000 courses to an "online only" format. In partnership with our Governor, and the Chair of my Board, we suspended classes and phased the move out of students. As the virus began to build, the National Guard asked that eight of our eleven campuses prepare to become field hospitals, and it was a surreal scene to watch one of our storied stadiums, home to a football team that won a record number of National Championships, fill with hospital beds. We safely and smoothly pivoted all students and classes, and experienced NOT A SINGLE CAMPUS INFECTION, or lost a single faculty or staff member, in the initial onset of this plague. As I write, we now make preparations to return to campus, which again, will be an interagency government effort, building as before on the insights I gained as a White House Fellow.

### Jeffrey Kang (1994-95)

My experiences battling the COVID-19 pandemic are both personal and professional. I am an internist and geriatrician with a public health

## *Covid-19 Reflections, continued*

background; and post my White House Fellowship, I was the Chief Medical Officer for the Centers for Medicare and Medicaid in the Clinton and Bush administrations.

As a physician and as a public health expert with a health policy background, this coronavirus pandemic will undoubtedly be the most memorable and impactful period of my life.

On the personal front, my wife and I were among the early US COVID-19 cases in late March. She had mild disease and I had moderate disease with shaking chills, total body aches, and fevers reaching 104 degrees, but luckily no shortness of breath or hypoxia (low oxygen) requiring hospitalization. In between the episodes of fever, I wrote an email to friends and colleagues, entitled "Lessons from a COVID-19 Patient," sharing my experiences with and understanding of the disease. Putting a brave face on my condition, I noted that my likelihood of dying at my age with no other risk factors was 1.93%. "Greater than 98% chance of survival," I joked, "I'll take those odds!"

Professionally, this was occurring while leading the launch of a new, private equity backed healthcare company, WellBe Senior Medical. The company is focused on home-based, geriatric care, for the frail, disabled, disadvantaged, polychronic elderly patient — the same population that is at high risk of death due to COVID-19. The pandemic accelerated the interest amongst insurers in our care model, so much so that within two months of contracting with one plan we opened in Atlanta with 5000 patients. That health plan, Aetna, would describe our joint implementation as the fastest clinical program they've ever stood up in the history of the company.

We have been up and running since July 1, and it has been absolutely rewarding to see the reception we are getting from patients. These patients had been deferring care because they were afraid to leave the safety of their home and go to a hospital or clinic where they might be exposed to the disease. The surprising truth is 90-95% of the care that a patient receives in a primary care office can be performed in the convenience and safety of one's home. Furthermore, medical professionals can bring the needed COVID-19 testing directly to the patient. As of writing this, we have one patient diagnosed with COVID-19 that is being cared for in their home. Whenever the COVID-19 pandemic ends, I believe the new normal for adult health care services will be a movement away from office-based care to telehealth for the relatively healthy adults and house calls for the frail, polychronic patient.

While the political debate on how to handle the pandemic and the economic and health consequences of the pandemic rages on; I am blessed to have survived the disease and to lead a company that provides real world solutions for the most needy, high-risk patients during this crisis.

### Robert G. Marbut Jr. (1989-90)

I have been serving as the Executive Director of the United States Interagency Council on Homelessness (USICH), generally known as the Federal *Homelessness Czar*, since December 2019. USICH is an independent federal agency within the executive branch charged with coordinating the federal response to homelessness. Since the onset of SARS-CoV-2 (COVID-19), USICH has led and coordinated the overall federal containment and mitigation response to the COVID-19 pandemic for families and individuals experiencing homelessness.

Our mantra has been to “save lives and not crash the medical system.” USICH has been deeply concerned that medically compromised residents of homelessness facilities and encampments could overwhelm emergency rooms and departments.

USICH has worked directly with a multitude of federal agencies, direct front-line homelessness service providers, public health authorities, health care providers, emergency response organizations and the White House on the COVID-19 response. At the outset of the pandemic in the United States, USICH took a proactive “emergency management incident command system” approach to the COVID-19 response — which was informed by the unique characteristics of the homelessness community. USICH's strategies and tactics have relied on information from data, doctors, epidemiologists, and the scientific community.

Through the guidance of the U.S. Department to Health and Human Services (HHS) Centers for Disease and Control Prevention (CDC), the work of front-line emergency homelessness service providers and the support of many federal agencies, the incidence of positive COVID-19 cases and fatalities due to COVID-19 within the community of homelessness has been

significantly lower than had been originally projected. The rate of COVID-19 for families and individuals experiencing homelessness has been lower relative to respective general public rates as well as lower than the rates of other congregate living cohorts. Within the community of homelessness, the data from the first six months indicates there have been 4,845 positive COVID-19 cases, and unfortunately, there have been 130 individuals who have died due to COVID-19 as of June 30, 2020.

### Raul Perea-Henze (1993-94)

*The most powerful army in the world*

I was fortunate to be asked to become the Deputy Mayor for Health & Human Services for the City of New York in December 2019.

I could never imagine that 30 days later I would be confronting a triple crisis never seen in New York City and certainly not ever imagined by me and most Americans. Since February and for 100 days now, we've been immersed in a citywide response to understand, control and go beyond a new virus that has toppled governments and shaken economies. We never thought that an army of the smallest organisms will remind us that globalization is real and it can bring advantages and disadvantages to the world. We got to see the best and worst of people. We protected our seniors and children, delivered a million meals a day, converted 140 hospitals to complete COVID19 care, cared for over 100,000 patients and buried 20,000 New Yorkers.

I saw health professionals sacrifice their time and potentially put their families at risk in order to take care of their patients. Millions of workers went to work from home and proved that productivity didn't suffered. Long hair and Zoom backgrounds became the new normal and New Yorkers found ways to isolate but remained in touch with their loved ones. Families got to spend quality time. Domestic Violence took a deadly and quiet form.

The restart after the cases got under control brought the second crisis. The economy is severely affected for years to come: out of 8.6m New Yorkers, 1.5m are unemployed; 5m receive some government assistance, 1m seniors are in need of home services; 1.1m children out of school and the city is facing $9B budget shortfall. Tax revenue has dramatically fallen, and people are moving out in droves.

To top it all off, the third crisis of historical racial inequities is now compounding what the virus started. The 27 hardest hit neighborhoods by COVID19 in the city, are also the same most seriously affected by housing shortages, lack of health and social services and lower economic opportunity.

At the end, the most powerful army in the world should not be a virus but the strong resilience and spirit of our fellow citizens. I'm confident that New York City will rise again stronger and better like it has done so many other times. We just need to believe that unity not division makes for a mightier force in pursuit of our great American agenda and our ability to uphold our values regardless of any enemy.

### Mario Ramirez (2014-2015)

As an emergency medicine physician who came up through medical school in the years right after the US anthrax attacks, my professional interests have long been shaped by the intersection of clinical medicine, national security, and health policy. Just prior to my Fellow year, I served on active duty with the Air Force and practiced airborne critical care in the skies over Afghanistan. As luck would have it, my time as a Fellow at the Department of Health and Human Services came during the 2014-2015 Ebola epidemic, and I was fortunate to serve as a member of the Secretary's core response team for the first six months of my Fellowship. During that time, I had an inside look at how our nation should respond to an emerging disease threat. At the end of that first six months, and somewhat presciently, I was asked to serve as the Acting Director for Pandemic and Emerging Threats in the HHS Office of Global Affairs for the remainder of my Fellow year, and that experience included extensive interface with the World Health Organization around two other coronavirus outbreaks (MERS and SARS).

Shortly after my Fellowship, I left Washington, DC and returned to Nashville where I started working clinically in the emergency department again until one of my co-Fellows, Andrew Buher (2014-2015), and I decided to start our own consulting company, Opportunity Labs. Prior to the pandemic's arrival, most of our work had been in education and workforce upskilling. As things became more serious here in the United States, however, we combined our backgrounds in education and emerging disease threats to create an open source strategy guide for education leaders that went on to

## *Covid-19 Reflections, continued*

live at Returntoschoolroadmap.org That strategic level guide spread quite broadly and then led to work directly advising the governors and state education agencies in six states, two large cities, and several charter school and nonprofit organizations around developing return to school guidance and understanding how to interpret public health guidelines. Today, we are continuing to advise several organizations that impact thousands of schools and hundreds of thousands of students across the U.S on a daily basis.

In addition to my work at Opportunity Labs, however, I continue to work nearly full time as a practicing ER doctor and have had the chance to care for dozens of COVID patients. I've been up close and personal with this virus and It's been a truly humbling experience as any clinician caring for these patients would attest, I believe. I've taken care of young, old, sick, and not too sick, and each of these experiences has shaped my view of this outbreak and what it will take for our country to get out of this mess. I've been fortunate to share many of these views through television and printed work with a focus on helping the general public understand how to best protect themselves and our fellow citizens. It's been an unconventional career, to say the least, but I'm grateful that I've been able to leverage the unique set of experiences I had as a Fellow against this terrible disease.

### Shereef Elnahal (2015-16)

After transitioning from being Commissioner of Health in the state of NJ to leading the state's only public hospital in the city of Newark, I never imagined having to manage through the worst crisis the hospital has ever faced. In mid-April of 2020, almost every patient in our hospital had COVID-19, and our front-line health care heroes were challenged with managing scores of extremely ill patients. I quickly realized that we had to reimagine all of our roles on the executive team: we existed, primarily, to support the front line. I remember carrying PPE into patient units, taking employees aside for brief moments that allowed them to express their fears and frustrations, and celebrating times when we were able to discharge patients who unexpectedly recovered after long bouts on a ventilator.

As we consoled our front-line heroes in the midst of their battle against this disease, we also could not help but notice that almost every patient in the hospital at that time was a Black or Brown resident of Newark. We do serve a majority-minority community, but even here, minority patients were never more over-represented in our hospital census. Our EMS services also saw a fourfold increase in deaths-on-arrival of our ambulances, and unfortunately, we found the same troubling demographics in this group as well. There has been much reporting of national studies that showed a disproportionate impact of this pandemic on people of color. But we saw it firsthand, and I will never forget it.

One of the most rewarding experiences involved working with the US Army Reserves, who came to our hospital after we experienced critical staffing shortages in nursing and other critical roles. The worst of our staffing crisis happened in our emergency room one weekend in April. Nurses were assigned to an unprecedented number of patients as call-outs skyrocketed due to illness, family illness, or childcare needs. Our EMS team heard calls for help in our emergency room, and almost every off-duty nurse or clinician, including our helicopter team, descended on our own emergency room to assist our staff in a time of incredible distress. That story was heard throughout our state — including the incredible military leadership who had been assisting NJ with staffing field hospitals and other critical responses. They heard our call for help and assisted our staff, side-by-side, across many functions where we were short-staffed. My sense of patriotism and appreciation for these heroes has never been stronger. I will never forget our sisters and brothers in the 332nd medical brigade. They will be part of our University Hospital family forever.

### Anthony So (1995-96)

*Searching for the Light in the Darkest of Times: Charting a More Equitable Path out of this Pandemic.*

Every generation has its defining moments. Particularly for those of us in public health and healthcare, these are very dark times, but also an opportunity to become our better selves. Searching for the light in the darkness can help give us the compass — and the strength — to finding a more equitable path out of this global pandemic.

As the picture of COVID-19 took shape early this year, I was reminded of the outbreak of SARS in 2003. Then as a young program officer at the Rockefeller Foundation, I was pitching in at a regional tobacco control meeting in Hanoi, unaware till later that Dr Carlo Urbani had seen one of the early victims of the disease there in another hotel in the city at the time. He contracted SARS and later died. Soon, across the region, public health colleagues and healthcare workers were pressed into service to stem the spread of the outbreak. The use of face masks, sanitizer and temperature checks ensued; quarantines grounded air travel to the region, and the unfolding policy cascade — from updating the International Health Regulations to the challenges in meeting the need for diagnostics and treatments for these disease outbreaks — stretch to this very day.

Perhaps no rehearsal would have fully prepared us for this moment — a respiratory-borne pathogen, highly transmissible even before symptoms set in, with no known effective treatment. Our program, the Innovation+Design Enabling Access (IDEA) Initiative, at the Johns Hopkins Bloomberg School of Public Health only plays a small, behind-the-scenes role in responding to this pandemic. Over the past fifteen years or so, we have worked to lift antimicrobial resistance from a backwater issue to global attention. Turning in the recommendations of the Interagency Coordination Group on Antimicrobial Resistance to the UN Secretary-General last year, I cannot help but wonder if those who then balked at calling for new funding might have found the political courage and commitment to do so if they only knew that the tsunami of a global pandemic would soon make the billions of dollars to avert trillions in economic losses seem like a small down payment. I warned then that if we hoped to have a future free from the fear of untreatable infections, we could pay now — or pay much more later. No one could have foretold that less than a year later we would be facing COVID-19. But the moorings of a healthcare system prepared for the next emerging infectious disease — whether it is a viral contagion or a drug-resistant bacterial infection — overlap considerably--tackling zoonotic disease transmission, enabling effective surveillance, safeguarding patients and providers through infection prevention and control, and building robust supply chains to deliver personal protection equipment, respiratory support, diagnostics, drugs and vaccines where needed.

Early on, our team sought to distill the deluge of COVID-19 information for family, friends and colleagues, producing a resource handout; help the Hopkins-wide Alliance for a Healthier World put out a set of mini-grants to address COVID-19 and the challenges to health equity; and inform our policy community of how COVID-19 impacts our work on drug-resistant infections and has collateral health effects. For our small part, we held policy briefings on innovation and access to COVID-19 health technologies for Doctors for America and for the South Centre, an intergovernmental think tank serving 54 developing countries. Five of the ten countries leading the globe in new COVID-19 cases have been in the Americas, but unique to this region, the Pan American Health Organization has pooled procurement facilities, both for essential health commodities and for vaccines. We have volunteered to support the valiant efforts of our PAHO colleagues in devising a strategy to source COVID-19 vaccines for Latin American and Caribbean countries, many of which fall between the cracks of high-income countries buying up vaccine supplies and the COVAX Facility's Advance Market Commitment that seeks to ensure access for lower income countries. When the United States not only threatened to withdraw from the World Health Organization, but also failed to pay Member State dues to the Pan American Health Organization threatening that organization's insolvency by October 2020, we helped bring together — outside of our University roles — over thirty organizations to reverse these efforts, with some early success for PAHO.

What is so painful about COVID-19 is how it has surfaced the ugly underbelly of disparities, well characterized but too easily neglected by our society in ordinary times. Just two decades ago, we faced a stark choice over whether we would share life-prolonging treatment, priced at $10-15K per patient per year, for HIV/AIDS with the 25 million afflicted in low- and middle-income countries. The Global Fund to Fight AIDS, Tuberculosis and Malaria only became possible because the price of hope — the cost of triple antiretroviral therapy — was lowered to less than $350 per patient a year, less than a dollar a day, because of the work of civil society organizations. In the years to follow, we too often have continued to struggle, from biologics for breast cancer to life-saving treatment for hepatitis C, with access to life-saving treatments. Sadly, with COVID-19, vaccine nationalism and high prices for treatments like remdesivir—despite significant public funding — continue this struggle, but new approaches from effective pooled procurement to non-profit production may yet emerge.

Out of the darkness, I can hear a sometime too distant drumbeat for a better, more equitable future. I see a generation of future leaders more tolerant of difference,

more ready to take on intergenerational challenges of climate change and antimicrobial resistance, and we hope, more prepared to share a cure for COVID-19. At Hopkins, our community has stood strong, working tirelessly on every imaginable facet of this pandemic, from the use of convalescent sera to treat COVID-19 patients to approaches to mitigate the disproportionate impact of the disease on vulnerable populations. It has been an extraordinary, all hands on deck effort. Some have focused on safeguarding our students, workers and local communities, while other colleagues have kept the public informed, switched their labs over to COVID-19 research, or advised policymakers and governments.

Whatever challenges I may endure in these difficult times are dwarfed by the deprivations suffered by those who have lost livelihoods, cannot put food on the table or pay the monthly rent. Ironically, the self-isolation some of us can afford to undertake has allowed me time to reconnect with former trainees, many now working on the front lines of patient care. They are my inspiration that we still have everyday heroes, selfless like Dr. Carlo Urbani. They are my assurance that the battle for greater equity will go on long after our generation has passed from the scene. Their outrage over structural racism suggests a society "being woke." We have to believe in the power of new ideas, in advocating for health equity, in bringing the voice of civil society to policymakers and the public, in amplifying the voices of those unheard, in translating the power of evidence, and in preparing the next generation. In so doing, may we find our better selves, the light in this darkness, and a more equitable path out of this pandemic.

## Rachel Thornton (2010-11)

She is alive, beautiful, showing off a pretty dress and a smile. "Me! Me!", her little brother shouts, as their mother turns the camera to him. He waves at me with a smile. Their mother appears to be improving....their father's condition is more complicated. They watch him suffer in fear, praying for his recovery. The medication for his underlying conditions is expensive...and the barriers abound. Today, during our video visit, my two little patients see their mother's tears. The children themselves are enduring loss and scarcity. Their mother worries that her older child "is being robbed of childhood by the pandemic".

As a pediatrician, I assess children's development; and I deliver vaccines, anticipatory guidance, and preventative care. I get children. Yet I remain forever awestruck by the way they see adults, offering compassion and reassurance. As the older child smiles, offers a laugh, and twirls around proudly in her beautiful dress; she exudes power. The power of her spirit brings momentary comfort and peace to her mother who is burdened by illness, worry, hunger, the threat of eviction, and the heavy weight of loss from an ugly virus... "Doctora, We know so many who have died..."

When it was declared — *pandemic* — our pediatric primary care team scrambled feverishly to retool operations, communicate reliable information, create new care pathways, deliver essential healthcare services, and organize resources for patients and their families: food, formula, diapers, information, testing, testing, testing. Five months into the pandemic, local nonprofits providing food are at or nearing capacity. The pandemic electronic benefits transfer cards for children who had missed months of meals from the school nutrition program came just in time to temporarily alleviate their hunger in the face of mounting need.

When we are on the other side of this, and children are smiling joyfully again unburdened by the weight of the pandemic, I wonder who will reflect with pride that they stood up with integrity? What dreams have been lost? What potential will we lose? Who will sublimate or deflect lest they acknowledge their complicity? This pandemic is real, and it connects us all. There is no time left to negate science or our shared humanity. What more can I do?

Today, on my way home from clinic, I can take a pack of size 6 diapers and some baby wipes from the clinic and leave them at the family's doorstep with a loud knock. The children wave from the window. I drive away renewed, driven by hope, science, and empathy. Complacency is not an option.

## Sharon Kiely (1994-95)

I have been a physician for 35 years with a focus on prevention and decreasing risk. So, in January 2020, when Wuhan, China, reported an outbreak of an unusual respiratory illness and hastily built 2 hospitals with capacity for 2600 beds, I bought N-95 masks- just ten, just enough for my family. Prepare, protect prevent, cut risk. I didn't think we

would need those masks as it all felt so far away.

My husband Michael however is a critical care specialist. Manage the unmanageable, high risk, fast moving, save lives.... And he is the very best at this. We together had experienced the AIDS epidemic, in Greenwich Village, NY in the 80's. There were some parallels we drew from that experience to the pandemic especially the uncertainty and fear. Our family is a medical family and we talked about coronavirus a lot, and its spread across the world. (One) day our oldest daughter, an artist, texted me- "Is Dad in denial? Or is he delusional?" in response to his implying that COVID-19 was nothing to worry about. Everything is perspective I told her- he sees it all in his work in the ICU where miracles, innovation and skill make all the difference in survival. He is well trained, this is in fact what he trained for- to not work would be asking him not to be himself. Truthfully, selfishly, we really wanted him not to go to work.

As the Northeast started to shut down, like many families, we welcomed our adult children to come home if they wanted. Half of them took us up on it. Our daughter and son, his husband, their 2 dogs joined their Dad, our dog and me. It was a comfort and fun to be together. We had a routine, optimistic he'd stay well and we would too. We distributed the N-95 masks for the shopping, subway and trains.

Then in March, Michael called to say he was caring for patients sick with COVID-19. He had all he needed and was wearing full PPE in the ED, the ICU, everywhere. And that wasn't the scary part- he was coming home for dinner... We had all talked about this but now it was real. Our new routine, he'd come off the train, drive home into the garage, undress, leave his shoes in the garage, carry clothes to the washer- already open with detergent, close it with his elbow and hit the button, then go into the shower, new clothes and shoes by the door, remove towels and put in basket- then he could come upstairs. It was frightening to think this unseen virus was now possibly in our home.

The change was immediate- our normally affectionate family kept its distance and focused on cleaning any surface he touched. No kisses, few hugs, lots of anxiety. As the virus took hold in the northeast, our world narrowed more to making what food was available, innovating due to the lack of paper products and household cleaners, planting seeds for spring, knitting and other pursuits along with the remote work and school. In my new field of health system Wellness the work was 24x7, overwhelming, urgent and needed. It all seemed so unfathomable.

A few weeks later, a text from Michael stopped me in my tracks. He had "a chill at work, no fever, coming home- just a precaution, it is nothing" and 48 hours later he was back in the ICU where the stories were becoming more and more horrifying as patients in NY City flooded the hospitals. Then a few days later, I tried to hug him, and he told me I shouldn't. Something was wrong I thought and the next afternoon he was in bed with fever, chills, and body pain.

Now a new, new routine- quarantine- stay in bedroom, text communications as talking triggered the violent cough, food left by the bedroom door, walk away, paper plates, plastic cups and silverware, and throw everything away. Masks, gloves, laundry sanitizer. One route out of the house and back in. FaceTime meals, puzzles, Apple TV, thermometers, the pulse oximeter- the pulse ox. He would do anything we asked him to do except the pulse ox. For the next 40 days, including a hospitalization, he told us he was fine, he was sick but he was fine.

I came to peace with one hold out- the pulse ox- recognizing that he needed to believe it was nothing. That the horror he had seen in NY was not going to be his story or end, that he was strong, that he would get better that we believed he would turn the corner any minute, that he could do it, that we were proud and couldn't wait to get this behind us. Let's plan a trip, where would you like to go? And he needed to have control- agency- on this one thing that he is extraordinarily expert at- critical care. An expert in rapid response systems, simulation in medicine, medical ethics, organ transplantation... I believe my husband willed himself to health which may sound crazy. I know too none of us is prepared for what COVID is and can do but we have to fight it with everything we have.

Finally, COVID negative, 40 days and 20 pounds lighter, he returned to work within 48 hours to report to duty- to his colleagues and his patients. We know he loves us- his family- more than anything- and we love him. And that is really all that matters.

During this time, the support from my wonderful WHF Class 1994-95 has been such a gift and gave me much needed strength. Text messages, jokes, calls, ZOOM meetings - even a supply of much needed toilet paper

and paper towels were an indispensable tether to the outside world and reality. I am immensely grateful for the conversations about their families, their work and their COVID-19 experiences that helped to ground me and for the love and the laughs that made all the difference.

**Kisha Davis (2011-12)**

March 13th is my husband's birthday. It also marked the last day of public school for our children, what then was to be a two week break while this new coronavirus was to be gotten under control. Lockdown orders were to take effect two days later. In celebration, we went to dinner and a movie, not realizing this would be our last opportunity for months. The restaurant was crowded, though probably less than you would expect for a typical Friday night, our table just a few feet from another couple. I hugged an old friend. The waitress spoke to us, her voice not muffled, her smile not hidden. Those things felt so normal then and feel so risky now. What was also palpable was a coming uncertainty. An anxiety about Covid-19, would it hit here? Would our friends and family get sick or even die? As a physician, the questions from friends and family kept mounting, what should we do? Who should we listen to? Should we wear a mask? The guidance was changing and confusing.

At work we sprang into action. As a Regional Medical Director for an Accountable Care Organization, I support independent primary care practices across several states. Governors were enacting stay-at-home orders across the country, sometimes shuttering medical practices. Primary care physicians did not want to sit at home and send their patients to emergency rooms with potentially long waits and risk of COVID-19 exposure. Our organization worked aggressively to get a telehealth option for our practices and in less than two weeks we had vetted 20 companies and created a deal to provide our offices with a telehealth vendor that they could use for free. We then set about registering and training doctors and their staff, many of whom were reluctant, but realized it was the best option for their patients to keep them safe at home. We created protocols for ways to take care of patients while keeping them out of the office. We encouraged outreach to the most vulnerable. And gave guidance on the frequently changing and confusing world of small business loans and billing guidance so practices could optimize revenue in a time when they were seeing cash flow slow to a trickle. We bought them personal protective equipment (PPE) so that when they did need to see patients in person they could be protected. It was disappointing to see the lack of preparedness of many of these offices. These practices are independent and hence often don't have the support of a hospital or health care system to navigate this new world. Nor do they have the buying power to compete with larger organizations in the purchase of PPE. Many were surviving day to day and week to week without contingency plans to address an unexpected worldwide pandemic.

Helping these practices survive felt important and urgent, many of them desperate to do the right thing by their patients. There are practices that if this support had not been there surely would have closed their doors permanently. But, for me who had been away from patient care for just 8 months, it also felt disconnected from the real battle. I saw my friends with battle scars on their nose from wearing a mask all day. I saw fellow family physicians get sick with COVID-19, even be placed on a ventilator, even die. My friends in New York shared their stories of being overwhelmed with sick and dying patients. A friend kept a running tally on Facebook of the family physicians who had succumbed to COVID-19. I wanted to run to the front line to stand in the fight with them, so I renewed my registration with the Maryland Medical Reserve Corp and added my name to the volunteer list at the hospital. And then I waited to be of service. And no one called.

I certainly was still busy. Running between calls to support practices and helping my kids keep up with their virtual learning- which stretched from two weeks, to a month, to the remainder of the school year. COVID-19 grounded me. As someone who travels regularly for work, I was stuck at home. This period from March until now is the longest I have gone without getting on an airplane in over 10 years. It also reconnected me with my children and my spouse in a way that was unexpected and needed. And as I waited to be of service on the front line, I realized that I was already of service on the front lines for my family. And had helped my practices be able to be ready and present to serve their patients. Eventually volunteer opportunities would arise, but where I was needed the most, I already was.

## Jennifer MacDonald (2014-15)

*Compass*

Leading in the time of COVID-19 brings into sharp relief the import of many of the core tenets of the White House Fellows ethos: service, integrity, commitment, altruism, equity, justice, truth, contribution to humanity. In this time of change and challenge, I find renewed, profound gratitude in the wisdom, depth, and compass of this community - in knowing we hold dear those tenets and are striving ultimately in the same direction.

Following my Fellowship year, I joined VA, believing to my core that when this organization leads, the whole Nation is better for it. My role was already one I cherished: advancing the critical priorities of the health care system and shaping the future alongside a team of committed public servants; the pandemic has made serving here the honor of a lifetime. Leading in any capacity these last months has been particularly weighty, demanding, and even poignant; I know this is an experience many in our alumni community share. The innumerable witnessed moments of courage and grace, though, will stay with me all my days. I hope this for each of us.

This time has been a lesson in the power of inspired leadership at all levels, and it has underscored the opportunity and imperative to work together to advance an equitable, person-centered future where health is cultivated in communities across the country. We can achieve that future; we can lead our way through this. We will lead our way through this.

As we hold our loved ones close, reinvent our lives and leadership, and chart the way forward, may we remember that we are all in this together. May we set our sights on the future that is possible. And may we keep our common compass.

Onward.

## Jeff Stern (2006-07)

COVID-19 was wholly predictable, hardly a black swan. As Virginia's emergency manager since 2014, we had already faced Ebola, Zika, and other public health incidents, along with 50 other crises from Charlottesville to hurricanes. A pandemic is a daunting challenge, but not unprecedented. Bioscience not rocket science. Detect the sick, separate the sick from the well, surge the medical system, protect the vulnerable, reduce the ROI till the disease burns out, is treatable, or a vaccine is developed. Wash your hands. Wear a mask.

Concurrent to my day job leading the Virginia Department of Emergency Management, like many Fellows, I've had an enjoyable side-gig teaching -- in my case, an emergency and disaster management course for Georgetown University that brought me to Europe for the last week of February with my graduate students. While in Paris, fashion week commenced sans audiences as Asian hotel guests were already sporting the fashion trend of 2020, facemasks. At NATO headquarters in Brussels, we were the last group admitted for meetings as DoD worldwide force-protection lockdowns were initiated. In England, the London Fire Brigade's headquarters staff kindly asked us to wash our hands-on entry and Boris Johnson's government embraced herd immunity. But the streets and trains and shops and pubs were busy. Normal, with an air of anticipation, and an eye on the news of outbreaks overwhelming Northern Italy.

I was back in the U.S. on March 1, and the next day the state health commissioner and I met with Governor Northam to discuss the virus. By the Ides of March, as France was imposing a national lockdown, the Imperial College of London released their watershed study predicting 1-2 million fatalities overwhelming the medical system in America. Historians and epidemiologists can debate the accuracy and utility of the various models that drove policy-making; in Virginia, the Governor declared an emergency and we proceeded forward with a joint coordination effort across the state government, what we call a "unified command." Our command structure included the nation's first Health Equity Group to ensure we looked through the lens of inclusiveness and equity in our operations. I was mindful of the lockdowns in Europe where I had tread just weeks before. For a disease that spreads exponentially, I was a vocal advocate for an early lockdown -- this was a math problem to solve. The economic shutdown would be a political problem to manage, but we couldn't manage that if we couldn't manage the disease first.

We enlisted the University of Virginia to develop a model specifically for Virginia, and I hired the RAND Corporation to assess strengths and weaknesses of each of the various disease models that our leadership and the media were fixated on like a hurricane forecast.

## *Covid-19 Reflections, continued*

Despite years of pandemic strategizing and exercising by all levels of government, the obvious fact that we would need to keep ourselves physically segregated had escaped our planning, so we adapted our normal emergency procedures to the virus environment. We were the first state to virtualize almost our entire emergency operations center, at the height of the incident we had over 1,000 people and 4,000 health department employees operating under our command structure.

My team worked around the clock to prevent hospitals and first responders from running out of PPE after the HHS Strategic National Stockpile failed and the global supply chain faltered. My agency built our own warehouse hub and spoke logistics system from scratch in two weeks, as we partnered with FedEx, Estes Express trucking, the Virginia National Guard, and Battelle to source, acquire, deliver, and recycle PPE across Virginia. We chartered air cargo flights from China and developed an allocation strategy to prioritize limited resources. Our system worked; nobody ran out of PPE in Virginia.

State government partnered with the private sector at a scale that exceeded anything prior in my career; over 1,300 private companies offered assistance, from breweries that made hand sanitizer to Virginia manufacturers that converted their production lines over to make PPE. The Fellowship network helped. Given the breakdown of the entire PPE market, Jon Spaner's team at McKinsey helped us understand the global supply chain to optimize PPE acquisition. Keith Pellegrini's team at McChrystal Group helped us synchronize our emergency operations tempo with the day-to-day state agency functions in a virtual environment. The community of mutual support was very much part of this story.

I left the Virginia Department of Emergency Management in June as Virginia slipped into Phase 1 reopening and just as the Confederacy fell for a second time along Richmond's Monument Avenue. Our challenge is daunting: disasters have always been political events; however, never has trust in our government, our leaders, or the basic information and science that underpins our decision-making been more undermined by foreign and domestic actors alike. As we face the triple crises of the public health, economy, and social cohesion, it seems many have forgotten that our great individual liberty also requires personal sacrifice for the common good. Navigating these turbulent times will require self-renewal of our institutions, leadership, and our society. The pandemic will end, the economy will recover, society will heal. Our job is to ensure we are strong in the broken places.

### Scott Berns (2000-01)

In late March 2020, just two weeks into the COVID-19 pandemic here in the US, a theatre marquee in my MA hometown displayed one of my son Sam's "Philosophies for a Happy Life" (see photo). It warmed my heart to see a quote from Sam's TEDx talk, given before a standing room only crowd of 1,000 nearly seven years ago, continue to inspire the Town of Foxborough six years after his passing during these unprecedented times. And it inspired me to focus on what we CAN do in these trying times.

As a dad, pediatrician and leader of a children's health organization, over the early months of the pandemic, two crises emerged illuminating the risk for America's most vulnerable children: first, the recognition that while COVID left most children unharmed, children with special health care needs were at risk of greater impact from the disease — children with asthma, sickle cell disease, compromised immune systems, and yes, those with progeria. My second realization was of the children and families made vulnerable by racism in America's health system — so pervasive that we now face a public health crisis. The sudden and devastating effects of COVID-19 intensify the existing disparities, putting already vulnerable populations at increased risk of disease and death. This dual impact of COVID-19 on children made vulnerable by physical or social factors is

devastating — and requires the re-doubled focus of U.S. providers and public health professionals.

Another growing, broader concern occupies me and my colleagues, a concern for all children and their families: we know so little about the long-term impact of social distancing during formative years. Zoom-schooling from home, severely limited play with school-mates and others, next-to-no interaction with adults outside the home, and reduced outdoor sports and activities — each of these and the combination of all will have serious long-term impact on children's physical and mental health.

There is much we CAN do to avert this looming childhood crisis. I'm driven to focus my effort on children at risk, whether made vulnerable by special health care needs or by the disparities across all systems. And to help lead the children's care systems in the country – developmental care, education, health care, community support systems — throughout and through this crisis by joining with parents and families with support for schooling and play, working with community organizations in their efforts to support families, and lightening the effect of the wear and tear of isolation and social-distancing for all children and families.

### Stefanie Sanford (1996-97)

*Six decades overhauled in six weeks.*

I work at the College Board, the century-old nonprofit that runs the SAT and the Advanced Placement (AP) program. Millions of students take AP exams every spring, and colleges use the scores to help decide admissions and offer course credit. The classes build toward the exams — they're a right of passage for students, and a big motivator.

So when the pandemic hit in mid-March, and school children from Anchorage to Miami were locked out of their classrooms, we had to figure out if we could deliver the AP tests to millions of students who were suddenly homebound. And we had to figure it out quickly.

The idea of "virtual AP" has been around for a long time, but it was not something our AP program had been particularly excited about. Educators are big on tradition, and the whole AP infrastructure — the exam booklets, the bubble sheets, the massive (and surprisingly lively) grading sessions at convention centers across the country — is built around these very analog rituals. It's been that way since the 1960's.

I've been to some of the sprawling exam grading sessions, held in some of the biggest convention centers all over the country. Thousands of teachers and college professors hunched over endless rows of tables, paging through heaping piles of exam books shipped in from all over the country. It looks like something out of Bartleby, but they love it. It's a bonding experience for the AP community, a chance for some of the most talented teachers in the country to get together and decide what constitutes a good grasp of calculus or the U.S. Constitution. It's ComicCon for high school curriculum nerds.

There's never been a strong push to get rid of that old-school approach. Some experiments with online grading, yes. Some AP classes delivered virtually, sure. But no online exams.

On March 10, 2020, we closed College Board offices nationwide. Our 1,800 employees switched to telework, a shift made a little easier by the fact that we already did a lot of online meetings and collaboration to accommodate the many talented people we have scattered across the map. We figured we'd be back in a few weeks. But then colleges and universities announced they weren't coming back from spring break. School districts announced they'd be remote-only for the rest of the year.

We were sitting on several million AP exam booklets, all shrink-wrapped and ready to ship to schools. There's a precise, minutely coordinated playbook for all of that in a normal year, right down to security protocols if one of those booklets arrives with the shrink-wrap broken. All of those materials and those months of careful planning were blown up in a few days.

We had to decide: could we really move the AP exams online, given all the concerns already surfacing about internet access, equity in the school environment, and so much else?

We did what any smart organization ought to do in that circumstance: we asked the students what they wanted. After surveying more than 18,000 of them, we were a little shocked at the results. Damn near everybody wanted us to make it work somehow — 91% wanted to finish out their AP coursework and take an exam. "We want a shot at college credit," we heard over and over again. "That's why we signed up for AP."

## *Covid-19 Reflections, continued*

The paper exams went back to the warehouse, and our IT team settled in for the ultimate hackathon. In about six weeks, we had to develop completely new assessments for all 38 AP courses. They had to be deliverable online, hard to cheat on, accessible on a state-of-the-art iMac or a cheap cell phone, and the whole system had to handle hundreds of thousands of students logging in simultaneously.

We scrapped multiple-choice questions. At-home tests had to be open-book and open-note, so there was no point in testing facts that were easy to look up. AP always prized analysis and critical thinking more than recall; now the whole exam would have to ride on that kind of applied knowledge. That meant free-response questions only, and they needed to be psychometrically valid, completely new for all 38 courses, and delivered in a way that ensured no two students in the same teacher's class got the same question. And we needed a completely different set of makeup questions for students who had any technical trouble with the first round of testing.

To maximize access, those questions would need to be readable on any platform or device. And answers could come from typing on a keyboard or uploading a photo of pen-and-paper work. That meant that any student with a cell phone camera could take part, covering the vast majority of AP students across the country.

Then we had to somehow persuade students that all of this would work and cajole them into following instructions that involved logging on at a specific moment across every time zone in the world. This understandably caused some grumbling from the kids on U.S. military bases who would need to wake up at 3:00am Korea time, but I think they understood why it was necessary. In the age of Facebook, Twitter and TikTok, you can't have students taking the same exam at different times.

The crazy thing is, it worked. Over two weeks in the spring, more than 2.5 million students took about 5 million exams, and 90% of the students who had taken AP courses over this past year took the online tests.

Of course, we're still getting sued. Doing something instead of nothing pretty much always gets you sued. About 1% of students had trouble uploading answers or otherwise completing the test. All of them had the chance to take an automatic, free makeup exam, but a tiny fraction lawyered up. I can't tell you that story just yet, but come back to me after the suit is settled.

There have been a lot of heartbreaking stories in the education world since the pandemic began. And from reading news coverage of the exams, you'd think this was one of them. "Disaster," "fiasco," "bungled" and "glitch-plagued" were some of the nicer words used to describe our efforts.

We're happy to take those hits on behalf of the 99% of kids who got to complete their exams. All those who received a score of 3 or above — and the performance numbers look very, very strong — will receive college credit. In a year of cancelled activities, wildly varying instruction and chaotic grading, those scores are among the few objective measures admissions officers will be able to rely on when they make admissions decisions next year.

Fortunately, these metrics — rather than the stories in the press — are the true measure of what we were able to achieve for students during this pandemic.

Doing nothing would have been safe, would have been easy. Doing a decade of work in six weeks was what we did instead.

### Stephanie Ferguson (1996-97)

*History Demands the Best We Have to Offer*

Like most of you, I began 2020 in an upbeat mood. I was looking forward to celebrating the World Health Organization's Year of the Nurse and the Midwife, and attending the WHO's World Health Assembly in May. I was also excited about celebrating with my fellow Fellows at the White House Fellows 55th anniversary in November.

Fate had other ideas.

Here we are 10 months later, reflecting on a pandemic that has fundamentally reshaped our nation and our world. It brings to mind the words of former British Prime Minister Harold Macmillan when asked what was most likely to throw governments off course. "Events, dear boy, events," he famously replied.

In 2020, "events" have conspired to throw everyone — and everything – off course. More than five million Americans have contracted COVID-19, nearly 200,000 are dead, millions have lost their jobs, and many more face economic strains. Businesses are shuttered, education is upended, and social distancing is creating a mental health crisis. Amidst these challenges, we are on the brink of the most contentious and divisive presidential election in history.

It didn't have to be this way. Through my work with the United Nations, the World Health Organization and other global organizations, I learned early there was a health emergency in Wuhan, China. I understood the ramifications immediately and, like many others, tried to raise the alarm. But I felt as if no one was listening. Realizing how hard it would be to contain the virus and knowing my nation was not ready was humbling — and frustrating — to say the least.

*Right now, it's up to us to work together to mitigate this virus and stop the spread. As our founder John Gardner so eloquently put it, "We shall not get through our troubles safely until a considerable number of Americans acknowledge that they themselves are part of the process by which society will be made whole."*

Nearly a year later, the global caseload exceeds twenty million, the numbers are rising. As many as 10% of cases affect health care workers. In the Year of the Nurse and the Midwife, the COVID-19 pandemic has exposed nurses and health care workers to death, disease and mental distress at levels not seen in decades. To make matters worse, nurses on the front lines are also enduring increasing levels of violence. They have been shunned, abused, and even physically attacked because of their close contact with coronavirus patients.

But this crisis is also shining the spotlight on nursing in ways no one could have predicted. Across the globe, nurses have stepped up to meet the challenge and save lives. Their selfless work has focused the world's attention beyond the core purpose of the Year of the Nurse and the Midwife, raising awareness of modern-day nursing, and highlighting the power and potential of nurses to address major health challenges.

In the midst of all this, the WHO released its highly anticipated, in-depth look at the condition of nurses and nursing around the world. The State of the World's Nursing 2020, produced in partnership with the International Council of Nurses and Nursing Now, provides much-needed data and evidence that underscores the critical need for better support, better investment, and better resourcing of the nursing and midwifery professions. The number one recommendation: countries must increase funding to offset nursing shortages and educate and employ nearly 6 million more nurses.

Which begs the question — where are our leaders? Who is stepping up to bolster the nursing profession? Here at home, who is offering reassurance and guidance? Who can tell us that, although things might be bad, they will eventually be okay?

The answer is that, right now, it's up to us to work together to mitigate this virus and stop the spread. As our founder John Gardner so eloquently put it, "We shall not get through our troubles safely until a considerable number of Americans acknowledge that they themselves are part of the process by which society will be made whole."

We must wake up to the fact that this is such a moment. History demands the best we have to offer. We need to support our health workers and first responders. We need to do our part to care for self, family, community, and nation. We need to prepare for flu season, develop better Covid-19 drugs and produce a vaccine that can be quickly deployed to populations worldwide.

The White House Fellow's 55th anniversary will be remembered forever as the time we could not celebrate in person. But I hope it will be remembered as a time of promise, as well. A time when Americans stepped up, got involved, and worked together to meet the challenges we face.

I am trying to do just that. And I am optimistic that we will prevail.