This transcript has been edited for clarity

National Coalition of STD Directors

Official Transcript

STD Engage Press Briefing
December 2, 2020

David C. Harvey, NCSD

Good afternoon and thank you for joining us today. I'm David Harvey, Executive Director of the National Coalition of STD Directors, or NCSD. For anyone who's new to our organization, NCSD is a national membership organization representing health department STD directors in all 50 states, seven large cities and counties, and five US territories. We serve as the voice of our members – working with them, and for them, to support effective STD prevention in every community.

One of the ways we do this is by hosting an annual conference, called STD Engage, which is happening virtually this week., but even if we weren't having a conference…now would be exactly the time for a national discussion about STD prevention and public health. There are three big reasons for that – and they are the focus of this briefing:

First, The COVID-19 pandemic is massively disrupting STD prevention and care. With fewer people getting tested for STDs, the pandemic might also be masking new increases in the rates of STDs like gonorrhea, chlamydia, and syphilis – rates that were already at record highs before the coronavirus hit. In a moment, I'll share what we're learning from our members about the disruptions they face.

Second, STD programs have been innovating to keep STD services alive in the face of COVID-19. These innovations are working, even under tough circumstances, and they need to be widely understood and sustained as we rebuild following the pandemic.

And third, even in the face of a global pandemic, we're about to have an unprecedented opportunity to rebuild our nation's STD programs – and our public health infrastructure more broadly. This partly reflects the result of the recent presidential election. We expect a Biden administration to be far more aggressive on COVID-19, on public health, and on racial justice and equity.

Just as importantly – a new, national STD strategic plan will soon be released by the U.S. Department of Health and Human Services. NCSD has been advocating for such a plan for years. It deserves the full backing of the next administration and Congress, and we'll say more about it shortly.

Now, before introducing my fellow panelists, I'd like to very briefly set the stage. In the first weeks of the coronavirus crisis, NCSD surveyed our members to understand the impact it was having on STD testing, treatment, and prevention. We conducted a second survey in June – and we have a third survey in the field right now.

The first two surveys showed mass disruptions to STD clinical services in the U.S. – in the form of reduced services, clinical capacity, and STD outbreak control efforts.

In short: health departments have been forced to place HIV and STD services on the back burner as they support the coronavirus response. According to NCSD's June survey findings, three quarters of STD directors reported significant disruptions to their operations, and one-fifth of programs reported that their STD program operations were completely disrupted – meaning that they were unable to complete core functions.

Much of this reflects necessary decisions to redeploy STD program staff as part of the coronavirus emergency response. STD prevention programs and Disease Intervention Specialists are among our nation's core public health assets. They have a deep well of expertise – in contact tracing, in community education, in testing, and more. So it makes good sense that, as of June, more than three-quarters of the STD health department workforce reported being redeployed to COVID-19 response efforts.

STD and DIS staff have been working tirelessly to support COVID-19 efforts while keeping essential STD services in place. Many are overwhelmed and suffering burnout, and we worry about the long-term impact on our nation's public health workforce. We're also concerned about reports of shortages in STD test kits and other supplies, including such basics as swabs. In some cases, STD programs have been forced to use outdated testing approaches that are less convenient and more uncomfortable for clients.

Meanwhile, because of interruptions in testing and data collection, it's impossible to say what is really happening with STD infection rates. Just recently, the CDC reported a clear drop in reported STD cases in the spring and early summer of 2020, compared to the same period in 2019. But by mid-June, gonorrhea and syphilis cases had caught up to, and exceeded, their 2019 levels. This might have reflected a backlog of testing from the earlier weeks of the pandemic – but it might also reflect real increases in a time of disrupted STD services. At this point, we simply don't know.

Wherever the answer lies, there is clearly an urgent need to rebuild and strengthen STD programs and services, but there's also good reason to be hopeful. As I mentioned before, STD programs have made innovation a priority in recent years…and the coronavirus pandemic has pressed some of their innovations into widespread use in a matter of months.

Today I'm joined by three experts who will talk about this experience – and how the new approaches can continue into the future. Samantha Ritter is Director of Maternal, Child, and Adolescent Health at the National Association of County Health Officials. She'll talk about express visits, which have been embraced by STD clinics to facilitate patient access. Dr. Philip Chan is an Associate Professor of medicine at Brown University, and a leading researcher of HIV and STD prevention strategies. He'll talk about how the rapid growth of telehealth services can continue to extend our impact. And Chris Hall is Senior Medical Advisor at Q Care Plus, an organization that works to expand access to HIV pre-exposure prophylaxis. He also chairs the advisory council for NCSD's own Clinic Plus Initiative and will talk about the potential of STD testing with at-home, self-collection kits.

Following their remarks, I'll discuss the new STI National Strategic Plan and priorities for the upcoming Biden Administration and we'll round out the panel by hearing from Famika Edmond, Senior Public Health Educator at the Detroit Health Department. She'll discuss how STD Programs can lead the way toward health equity and justice.

And now, Samantha…over to you.

Samantha Ritter, NACCHO

Thank you, David.

STI express services refer to triage-based STI testing without a physical examination. Eligible patients vary clinic to clinic but are typically for asymptomatic patients and ones that have not been named contacts. Features of express services include patient-self collection technology and automation. There are a number of reasons to implement STI express services, but they are primarily implemented to increase the number of patients that can be seen and reduce clinic clog – individuals can be tested without needing to see a clinician; also to provide patient-centered care.

Research indicates positive findings, such as the fact that more patients can be seen, patient satisfaction is very high, and there is appropriate time to treatment which can be associated with reduced costs. Many clinics across the U.S. have already implemented express services.

However, there are several hurdles. Common hurdles include challenges with the physical space, for example, not enough bathrooms for patients to self-collect. And there is the need to bill for services, as it is likely that express services are less remunerative as doctors and advanced practitioners don't see patients. Or, express visits don't meet needs of the patient as they don't reduce turnaround time. In this instance rapid testing would be more useful.

The landscape has changed drastically with the COVID-19 pandemic. Because of the pandemic, the vast majority of clinics have reduced services, and many are prioritizing symptomatic patients, so express-eligible patients aren't even being seen. Testing supplies are also impacted – swabs are out of stock and prioritized for COVID tests, so pharyngeal testing might not be conducted, leading to a reduction in positive cases identified.

Prior to the pandemic, STI cases were at a record high, and they are likely to remain as high, just undetected and undiagnosed. As many cases have likely remained untreated, there is a risk for complications, especially those associated with untreated STIs, such as congenital syphilis, pelvic inflammatory disease, and infertility.

As express services reduce contact between patients and providers, they should be an important tool in increasing access to testing during the pandemic. Think of express services as limited contact services. Though many clinics have changed their flow to appointment-based, there are a number of clinics that schedule appointments for express services, and with shorter visit times, more patients can be seen.

COVID will permanently alter many features of STI clinics. For example, we've heard from a number of sites that were primarily walk-in that they will permanently remain appointment-based. Resources that have already been diverted from STI services might not be reinstated. But there will still be a significant need for STI testing, and even in a post-COVID world, express services present a critical opportunity to increase access to testing without increasing strain on clinics and staff, which are now stretched beyond belief.

And with that, I would like to hand it over to Dr. Philip Chan with Brown University.

Dr. Philip Chan, Brown University

Good afternoon everyone, thanks NCSD for organizing and everyone for joining!

One of the most significant and innovative technologies to emerge during the pandemic is telemedicine. Many things we use to do in-person has switched to online- including this press briefing! Telemedicine is the use of technology to provide clinical healthcare through a variety of remote methods and has really been critical during the pandemic and allowed many people to continue to receive care they otherwise would not have.

The reason is that telemedicine is a great way to improve access to health care. Think about it- you can engage with your doctor by literally just sitting on your couch! Who wouldn't want to do telemedicine? Especially in this day and age where everything is electronic.

The CDC reported that telemedicine visits increased by over 150% during the pandemic! We need to build of this success and continue to pursue telemedicine as an effective way to engage with providers and healthcare clinics.

Also, importantly another thing to remember too is that telemedicine can reduce emergency room visits. There is evidence that this is the case across numerous studies. I am working here in Rhode Island and I think similar to many states, we hit hospital capacity - In Rhode Island, we unfortunately have hit hospital capacity and have now opened up our field hospitals this week, but I think telemedicine offers ways ways to offload other parts of the medical system through key innovations like that.

Related to STDs, during the pandemic, the ability for patients to engage with providers for things like sexual health, STI visits, etc. has really been critical to maintain that linkage to care during this time. David touched on some of the points about STIs and we are not sure what is exactly going on, and we think they continue to increase as they have for the last decade, so telemedicine has really been one of those key components that has bridged the gap in the pandemic.

I agree of course that in-person clinic visits are important in many cases, but we need to supplement this with telemedicine when possible. And especially in situations related to STI screening visits, reasons why people may not necessarily need to see a provider, and things where you just want testing and counseling, and other things that seem to be pretty routine – such as clinic visits for things that are pretty routine, things like HIV pre-exposure prophylaxis, a lot of times it is just checking in and talking to your provider. So, definitely a space there for telemedicine.

And I want to highlight a key point – definitely building on where we are now and moving forward - highlight- we need insurers and the payers both public and private to commit to reimbursing telemedicine services in the future to make this a sustainable practice. I can't overemphasize how important that is to make sure things like telemedicine, and other things that we talked about. Sam talked about express STI clinics, and Dr. Hall here in a moment will talk about at-home STI testing. It is really key to think about this sustainably to make sure that the funders are on board and can fund this so that people can get reimbursed and that will incentivize a lot of people.

This was instituted during the pandemic, in a lot of states this has been through executive order and short term approaches, but we need to really solidify and make this part of what we do after the pandemic is done.

Finally, the last thing I want to touch on before I hand it over to Dr. Hall…one lesson that we have learned, perhaps unsurprisingly during the pandemic is that significant disparities exist in regard to COVID-19. David touched on this a bit, but this parallels what we see with STIs

unfortunately. What I mean by this is that African American/Black and Hispanic/Latin-x communities are affected most disproportionately. There are geographic disparities- urban settings are affected most. Lower socioeconomic status, those in congregate care settings, all affected most. Similar to COVID-19, and we are learning the lesson in real time, but for STIs, we can't address STIs or public health in general unless we commit to focusing on and addressing disparities in healthcare and the social determinants of health and that includes telemedicine.

Telemedicine may be one approach to reach people where they're at, but we need to be sensitive and careful to ensure that we are reaching communities that are affected most and provide them with the resources and means to do so.

Thank you all, and happy to answer and questions in a moment.

For now, I'll hand it off to Dr. Hall, to discuss the potential of at-home STD collection.

Dr. Chris Hall, NCSD Clinical Advisory Chair; UCSF Prevention Training Center; Q Care Plus

Great, thank you Dr. Chan…that was a thorough review of telehealth and telemedicine, and I really appreciate that. I just want to pivot off that to a discussion of at-home STD test collection or non-clinic/non-facility based STD test collection.

So, the first thing to make clear is that conducting STD testing outside of clinic walls or other health center facilities is not actually straightforward. Those tests all have to be validated, the test performance also has to be validated in alternative settings, as required by Federal regulatory agencies.

Due to the constraints of COVID-19, identifying laboratories that have completed those complex validations of home-collected specimens for STD testing is really challenging. Public health labs typically don't have the bandwidth to complete these complex validations, and so until our regulatory agencies approve self-collection of specimens for tests commonly used by our STD programs and clinics, such clinics are going to have to rely on a very few specialized commercial labs able to perform testing on self-collected specimens. Yet, you know, our hundreds of STD programs and clinics are not individually in a position to align with such labs to process specimens. This is where NCSD comes in, as we will get to in a moment when I hand it back to David Harvey.

It is important to realize that due to stigma surrounding STDs as Dr. Chan pointed out -- the same stigma that makes it challenging to talk about STDs in "polite circles" -- many of our patients are reluctant to seek services in traditional brick-and-mortar clinics, so home-collected STD testing is a way of overcoming that pervasive stigma for at least some such patients.

Also, STD test self-collection has been found to be acceptable by both patients and clinicians and such tests have been found to be highly accurate compared to clinician-collected tests, so they actually do perform well.

In the current COVID-19 era, the logistical challenges on patients to get to a clinic or a testing center, as been pointed out, is quite real. Thus, home collection of STD test kits is a solution whose time has come.

COVID-19 has forced innovation in the ways we provide care and conduct testing, and our Executive Director David Harvey is going to detail our plans to make real a solution our clinics and patients desperately need.

So with that I am going to hand it back to David, David Harvey, to further detail how we are going to move forward on making at-home test collection available at NCSD.

David Harvey

Thank you, Dr. Hall…so very quickly, responding to overwhelming need that COVID-19 has revealed for us, the National Coalition of STD Directors will be partnering with MTL labs to launch a program to make home-testing available in communities across the United States. We expect this initiative will be launched within two months.

The program will allow people to collect their own specimens at home and have them processed by overnight mail, to receive results in a matter of days.

The program was developed and will run in conjunction with state and local health departments and STD clinics throughout the United States make STD testing easier than ever before. We think this is going to make an enormous difference in patient care and will be received very well by patients.

And so, turning my attention for a moment back to the STI National Strategic Plan, which we do expect to be released by the Trump administration in the coming days.

As background, NCSD has been advocating for a national STD strategy for many years, so we are thrilled to see this happened.

In those same years – without the direction or support of a focused national plan – our members have confronted dramatic increases in common STDs, including the three federally reportable STIs - gonorrhea, syphilis, and chlamydia. They've adapted to increasing drug resistance, including the very real and looming threat of a fast-spreading antibiotic resistant gonorrhea, which our clinicians can comment on a lot better than me. And they've done this while absorbing substantial cuts to their budgets.

We need renewed national leadership – guided by a clear strategic plan – to actually meet these challenges. For helping to meet that need, I specifically do want to commend and thank Admiral Brett Giroir, the U.S. Assistant Secretary for Health, who has spearheaded the plan's development.

Earlier this year, HHS shared a first draft of the plan for public comment – and there was much to be excited about. It is a comprehensive, data driven, and well organized. It strongly discussed stigma and other social determinants of health – recognizing that we cannot make progress if we treat STD risks as separate from the rest of people's lives. In other words, we have to take this in the context of people's real lives. The plan reflected input from across the STD prevention field – including recommendations that NCSD solicited from our members.

At the same time though, there are some omissions, and we are hoping to see in the final draft a much more detailed plan that mentions specific populations including transgender men and women, which the previous draft did not mention. We're also hoping to see very explicit mention of systemic racism and racist policies and practices that have fueled the

STD epidemic in America, and we also need to see, laid out, a very detailed and specific implementation plan, which would be the next phase of this plan, which will likely be happening in the beginning of the Biden-Harris administration.

Regardless of the form of this plan, the impact will largely hinge on the choices of the Biden-Harris administration, so we call on the President-elect Biden to give this plan the full backing of the administration, to provide the necessary funding to support the implementation of this plan, choosing world-class public health experts to lead relevant federal agencies that will have lead oversight of this plan, and requiring interagency coordination and collaboration, much like we are seeing around the End HIV Initiative, which has been a major focus of this current administration.

We're really encouraged by the President-Elect Biden and VP-Elect Kamala Harris's respect for science and commitment to addressing health inequities. By throwing their weight behind this plan, they will leave a legacy of helping to move this country forward in solving and reducing STD rates.

We can, as the President-elect often likes to say, "Build Back Better." We can build back better a much more robust public health response.

This also means Congress needs to support funding for this plan, and NCSD itself has already advanced a request for approximately $280 million for STDs in the United States as well as a $500 million dollar ask specifically dedicated to STD clinics. STD clinics are not currently federally funded.

And finally, our national leaders – and the STD field itself – we need to do a better job of confronting systemic racism that fuels STD disparities. Systemic racism truly is a public health crisis, and COVID-19 is exacerbating pre-existing racial and ethnic disparities in healthcare, and too round out today's briefing with a discussion of the way forward in this area, I'd like to turn the virtual podium to you, Famika Edmond, from the Detroit Health Department.

Famika Edmond, Detroit Public Health Department

Thank you, thank you for having me this afternoon. I wanted to touch on some of the things that we are doing here at our program with the Detroit Health Department.

One thing the COVID situation has shed a light on is the disparities in our community this year and some of the things we needed to look at and start addressing. With my position, we used to do a lot of outreach, and many of our duties had to change to accommodate with this pandemic.

First of all, research has shown there are higher rates of STDs among some racial and ethnic minority groups compared to whites. It is important to understand that these higher rates are not caused by ethnicity or heritage, but by social conditions that are more likely to affect minority groups. Factors such as poverty, large gaps between rich and poor, fewer jobs, and lower education levels. That can make it difficult, as far as people staying safe, when it comes to their sexual health, and that is where my position comes into play…as far as going out in the community and educating people about the services and resources that are available…also giving them education about sexual health.

Many times, we do go out and realize many people are not aware of STDs, where to go and get tested, and the symptoms they should be looking for.

Also, looking at your community, you should be doing needs assessments in your organizations and getting feedback and involvement from the community, because I think that is huge in determining the programs you want to implement in the community. You don't want to put things in place that people are not going to come to, and you want to make sure you are meeting the needs of individuals in your community.

One of the things we did find was that condoms were an issue here and being able to access those condoms was a huge issue, so one of the things we did implement almost three years ago and has been successful here with our STD and HIV program, has been a condom distribution which is in our jurisdiction…so individuals can go on the Detroit Health Department website once a week, and they can place an order. We also do bulk orders where they go out to organizations within the community, and any type of outreach program who may go and do street outreach, they also can obtain bulk orders from us to give individuals in the community free condoms, because that is a huge issue. Many times, these condoms are either locked up or overpriced in their community and individuals are not able to access them.

Also giving education on what services are provided in the community is huge. We did implement HIV at-home testing and we are looking at doing STD testing as well. Those are things that we are trying to make more accessible for people in the community to access.

As we move forward, especially in the climate we are living in, we are going to have to make things more accommodating and doing more virtual sex education and making it available to the community is going to be a key factor in education the community.

That is all I have, thank you again for having me.

David Harvey

Thank you, Famika. – We will welcome questions in just a moment.

One of the most tragic consequences of these last few months is the further erosion of trust in public health and medicine – especially in Black communities, where the need is greatest.

We will ONLY restore that trust if we meaningfully confront systemic racism throughout our healthcare system.

At NCSD, we are committed to promoting health equity for Black Americans and other communities of color – through our policy advocacy and through the training and technical assistance that we provide our members.

We call on political leaders – and all of our public health colleagues – to join us by making anti-racism a central priority in their work and our work.

And now, we are happy to take some time and welcome questions from members of the media.

Q&A Session

Alice Ollstein, Politico

Thanks so much for doing this. I wanted to ask – I know the federal STI action plan was set to be announced a lot earlier this year and was delayed by the pandemic. I just wondered if there was any information you had on the impact there, given that some of the top people had to shift to focus on COVID this year.

David Harvey

Yeah, I will take a turn at answering that question based on what we know publicly. We do know that we are probably six to eight months behind HHS's own schedule for issuing this plan. COVID obviously delayed the final production of the plan. I think there had been an original plan to release this in the spring and that has obviously been delayed. But the Admiral has some terrific staff members who have spearheaded this effort: Harold Phillis, Carol Jimenez, Dr. Gail Bolan at CDC, who still plod away to get this done…and in the final version of this document, you will see there were upwards of 25 or more government public health scientists who had input into producing this in addition to an enormous process where community input was provided…so it was an enormous effort, it is behind schedule, but we do expect it to come out – hopefully within days.

William Wan, Washington Post

I was wondering if you could talk a little more about the timeline on when statistics will be coming out in the coming months that show the increase or decrease, can you go into a little more depth on what is the state of play of what we can say now, and what will we know and when can we say definitively where STIs are headed?

David Harvey

Well, we probably cannot say definitively now. Let me start out by answering that question and then I will let the clinicians provide some additional commentary.

So, first of all, the first thing to note is there has been a mass disruption in the surveillance system for STIs. There has also been a mass disruption in clinical care and testing, so we don't know scientifically at a national level exactly where we stand. We estimate the system is going to take a full year to recover in terms of reporting that data to the CDC.

And for those of you who are new to how the surveillance system operates, all the states and directly funded cities by CDC, and U.S. territories, report very specific data on the federally reportable STIs: chlamydia, gonorrhea, and syphilis…and then separately HIV. That data reporting mechanism, the surveillance system, has been disrupted, so we know we've seen a drop in terms of what's going to CDC now. It is going to take months for the system to recover, and so what many of us have been closely keeping an eye on is local data that is coming out. There is one study recently cited in the New York Times of a modelling study out of Atlanta that was looking at STI rates among gay men which showed an increase. There is other limited data coming out at a local level that helps us understand what's happening in individual communities across the country, but I think we are going to see this disruption in national data for some time. Of course, none of us here are representing the Centers for Disease Control and Prevention, and they are the ones to

officially comment on that…but let me turn the podium over to Dr. Chan and Dr. Hall in case you want to add anything to my comments.

Dr. Phil Chan

Great, thanks David. I guess the only thing I will add…I totally 100% agree with you – it is going to take some time to look at surveillance and understand what's happened, and this builds off a point that you mentioned about testing, right? We haven't even been able to test adequately because of disruptions in clinic hours and access to care and also supplies. Some of the same swabs we use for STI testing are also used for COVID testing and they have all been diverted to COVID testing, and so I think it is going to take us a while as we get these systems back online to understand what has happened. And I think the second component is we will need to engage the research communities to do things for example like systematic sampling approaches to understand if the prevalence and incidence of STIs has increased since the pandemic, etcetera. So that's sort of a combined public health surveillance and research effort to understand where we are at.

Dr. Hall, do you have anything to add to that?

Dr. Chris Hall

I think that's great. I think the only thing that I would add is that sometimes we've found ourselves in this field to be a victim of our own success in a way that if we put resources into testing and find cases then there is often the appearance of case going up because we are doing more testing, so there is that relationship between investing in testing and identifying cases, and we have to tease that of what actually is the case in terms of rates of actual disease on the ground. And that phenomena will apply as our clinics are coming back online after COVID and doing more testing.

One of the first things to go in COVID was screening – so that is testing people with no symptoms but who are at higher risk for infection – so that was the first thing to go. So as that comes back online, we are bound to see rates increasing, but I think we are all, as clinicians and as leaders of clinics in the field, just sort of interested in what is the reality of rates on the ground. So that is, I think a question that NCSD is really well positioned to work with federal partners, as David had suggested, to answer, and we hope to convene a process for elucidating where we are in terms of what rates really are.

William Wan, Washington Post

I had a quick follow up – could you give a sense whether the inequalities in STIs are being exacerbated by the pandemic or whether it is the existing inequalities that are persisting. Is the inequality growing worse? Or is it persisting at a bad level?

David Harvey

So I will start out, and then Famika I am going to ask you to comment, but I think it's both. And the first thing I want to remind everyone about today is that our field, the STD field, just as we've for decades have worked to support contact tracing, which is now being utilized to support COVID response, we for decades have lived with the legacy of the Tuskegee syphilis experiments. And Tuskegee has taught our field about the tragic consequences of racist approaches to research. The legacy of that research effort we live with today. It is one

of the main things that drives distrust of the public health system…so our field particularly has had to work, and it is still very much an issue today, of working to overcome that legacy.

COVID-19 has shed a further spotlight on this. There are social disparities, inequities in the rates of STIs when you look at race and gender and other factors across the country and sexual orientation and these disparities speak to the overwhelming social disparities and impact that this has on people's real lives.

Famika, would you like to add to that please?

Famika Edmond

I agree with what you had mentioned. One of the things I realized, since I used to do a lot of education when it comes to Black women's health, is that many times, we are not considered an at-risk population so a lot of times we are not going out and sending that message to that demographic. And many times, our rates are just as high as our male counterparts. So being able to provide education and awareness to everybody and not just one demographic, we have to make sure we are doing that.

Two, when we are doing our messaging, it is vital to know the audience we are targeting and making sure that message is appropriate. In a needs assessment we did, that is one of the things that came out of it. People wanted to see people like themselves coming with them to educate them and provide that messaging.

As you mentioned, with Blacks, we have had the Tuskegee project so there is a lot of mistrust in the community. And in our community in Detroit, we also had to reengage with the community after the bankruptcy and let them know that we also had the health department back, so we had to deal with these two things to make sure we were bridging those gaps so people knew we were back, and we were here for the community and wanted to make sure the community was being taken care of – and that they can trust us.

David Harvey

Yes, and Famika, what I would add as well just as a follow up is one of the legacies of Tuskegee that also has resulted in our field, the STD specific field, that employs disease intervention specialist, who have helped to lead the way on contact tracing for COVID, this is a diverse workforce. This is a workforce that is very sensitive to the local community needs and meeting people where they are and recognizing the reality of real people's lives and building trust between the public health and communities they serve.

This is a constant need, battle, work that we are doing to overcome the legacy of Tuskegee, and there are many lessons to learn here in our response of COIVD as well. So I would just point to that core public health workforce as a resource as we think hard about how to confront social disparities in our work.

Famika Edmond

Can I add one more thing?

So what we have done here at the health department, we have created a work group, a committee, so that we could start addressing those health equities that do exist in the community and that way we can start addressing it internally and externally. Because if we

don't address it internally, then whatever we are doing here is not going to project what we need to do externally in the community.

So that might be something else that local public health organizations and health departments should look at – implementing a health equity committee or work group.

Alicia Ault - Medscape

I was wondering if you could talk more about the at-home testing partnership and how that's going to work? Would that be available free of charge to people who come to the clinics or who are referred to testing? And then I am also wondering whether say community clinicians, just physicians out in the community can refer people to that at-home testing program.

David Harvey

Great questions. Dr. Christopher Hall take it away.

Dr. Chris Hall

Yes, let me just respond to that a bit. I want to tie it into the prior discussion about health equity actually. In COVID, when we pivoted to telehealth technologies and non-clinic-based testing, not everyone has had equal access to those services. You can go online today and get an STD test kit for hundreds of dollars. So if STD test kits that are online cost hundreds of dollars then those who are economically disenfranchised are not going to have access. That is why at NCSD we are setting up what might seem to some as a redundant system, but it is really not because it is going to be dedicated to making sure that folks who do STD care can direct these kits to – who we think really needs them and who might not have access to them if those price tags were to continue to be associated with them.

So that is one of our primary goals…is to address health equity in deploying these kits by the clinics. The system will be set up so that primarily programs and clinics will direct who gets the testing…and that is our primary audience at NCSD because that's our membership. Private clinicians have the ability, if they are creative, to get access to some of these technologies, but it is very time consuming and most of them are probably uninformed as how to do it. So they could work with our clinics if they knew of a patient who needed a test who couldn't come into the clinic. We think that will be possible. But our primary audience is going to be the jurisdictional programs and their associated clinics…but health equity is going to be a major focus of getting those kits to those who need them epidemiologically and also who wouldn't otherwise have access to them in terms of economic disenfranchisement.

David Harvey

And Rhode Island has a little experience, I think, with a pilot project in this area, Dr. Chan if you want to provide some comments and Samantha from the express clinic perspective too, you may have some things you want to add about his as well.

Samantha Ritter

I think that what Dr. Hall summed up was well. Express clinics so far is like a separate project that could be implemented to compliment express services. I don't think it is an either/or situation. The more access we can grant to people who need these services, the better. Whether they want to come into the clinic, great let's make it as easy as possible. If they want to do it at home, great let's make it as easy as possible. So I think it's just an example, as Dr. Chan was saying earlier, that all of these need to be looked at comprehensively.

Dr. Chan

Yes, and thanks Sam. And just to build off that – I see it as a tool in the toolkit. So one approach may not be right for one person. And frankly a single person may just want different things at different times, right? I am sort of just thinking about myself, too. So it all just sort of fits together in sort of puzzle as different tools, and they all sort of work in concert together.

David Harvey

Great, thank you everyone for joining us today, this is going to conclude our media press briefing. If you have any follow up questions, please do not hesitate to reach out.