

The Thomas Willis Lambeth Distinguished Lecture

*Emerging from
the Covid Crisis:
Where Do We Go
from Here?*

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Former Secretary, North Carolina Department of Health and Human Services

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It's an honor to be giving the lecture today. I am shocked that anyone wants to hear anything else about COVID. I know we've all been over COVID for so long at this point, but I do appreciate this opportunity to look back and take stock of what has happened, what we've learned and what we can do as we try to move forward from this. We will and must move forward.

This was actually a very, very hard talk to put together. While it was two years of work, which felt like 10, there are so many things in the twists and turns of what the last two years have brought that I want to share. I can't do it in 45 minutes. I'm sure there are things I will leave out. There are more lessons I want to tell you about and there are a number of ways in which we need to move forward. I'm certainly going to focus on the ones that are closest to my area of expertise in public health and public policy, but there are so many others concerning the fundamental scientific investments we need to make, and beyond, that I hope we will have continued conversations about.

But I'm excited to jump in, and so this talk will really be in three parts. First, a look back, then a bit of what does that mean and what did we learn from it? And then, what do we do going forward? And the reason I want to make sure that we do take the moment to look back is that we know it's been said many times, that those who fail to learn from history are doomed to repeat it.

Those who are looking at the illustration below may recognize on one side something familiar to us now: the COVID virus. But on the other side, on the left, is the flu virus. Many of you will remember that the 1918 flu pandemic crippled the world back then. During the past two years we saw some of the same things that



happened in 1918 happen again. So we have to make sure that we are learning from this experience, so that we don't go through it again.

To start off, it's really important in thinking about any crisis response, to ask, what was our preparation going into it? You have to think about it the same way you think about a hurricane: It's no one's fault, hurricanes happen. How prepared are you going into that response? And I think North Carolina had a lot of strengths, but COVID threw at us some very, very unique challenges that we were not ready for. But I do think we had some strengths: we had some existing data systems, some flu and communicable disease surveillance systems built over a number of years with a lot of hard work.

One of the really prescient things was actually having a consolidated state-level health and human services agency. This is something that predated me, and it doesn't actually exist in many states across the country. Often, you'll see the components of health and human services broken up into many agencies that each report directly to a governor. But in North Carolina, bringing together health and human services under one umbrella allowed us to have a lot more collaboration, coordination, and frankly, better execution in our crisis response, because they were all under one department and we were able to leverage resources from all parts of the department in the response effort.

Luckily or not, we also have been a state that's seen crises. Hurricanes are something that we unfortunately have gotten used to responding to, and the partnership with emergency management, both at the state and local level, had been pretty extensive. There were relationships already present between my department and emergency management that were incredibly important to accelerate our response effort. I also want to praise the relationships among our major hospital systems. I'm going to come back and talk about this more, but I think it really was a differentiator for North Carolina. Not that we just had great health systems, but that they worked together. These are business competitors that needed to work together, and I saw that every day in North Carolina, and I will say that that cooperation did not exist in every state.

I also think it was really helpful that we were focused on some whole-person health efforts before we went into a crisis. We had a foundation to work from. But COVID threw some unique challenges at us. This was a new and changing virus. We had very little information at first, and I think it was the first time that a lot of us were seeing science play out in real time. And that was hard to watch, because we didn't know all the answers at the beginning. A very smart communications expert said to me that in any crisis communication, you want first to get all the information you can, and then decide what to talk about. That was not possible in this crisis. We didn't have all the information, and frankly, we're still learning information two years later.

I will say that this was the first time I saw profound resource scarcity up close and across the board, in every community and at every income level: from the non-existent and then limited number of tests that we had, to the limited number of vaccines at the start of the rollout, and then the limited treatment options. Sadly, certain communities and people experience resource limitations and scarcity all the time, but COVID took resource scarcity to an extreme level across the board that showed all of the cracks and warts of our system.

The lack of data was profound. And unfortunately, it still exists to this day. We're going to talk a lot about data, because I think it's one of the most important tools in being able to move forward.

And unfortunately, we went into this crisis with a lack of cohesion and trust. I think what a lot of folks are starting to understand about crisis response is that trust is really, really hard to build during a crisis. And you need to have that trust and cohesion going into the crisis. We definitely saw that countries which had more cohesive and trusting societies had much better responses. Even if they had less resources, less data, less everything, social cohesion and trust really mattered.

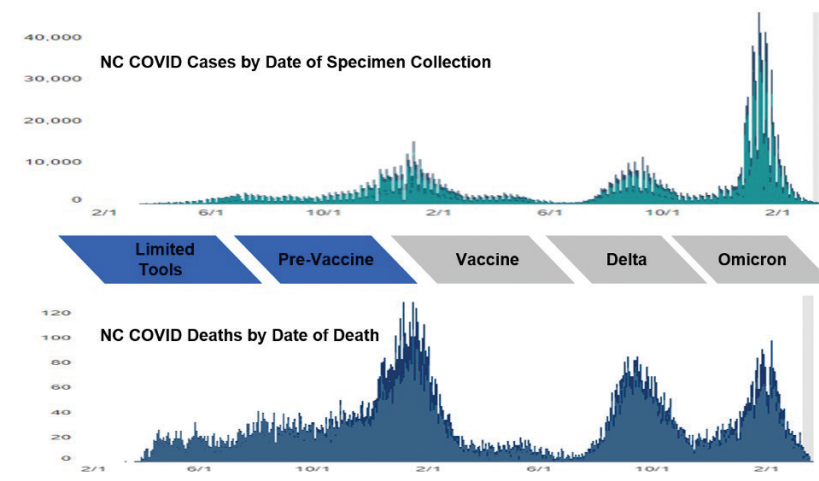
We also had underinvested in public health, and that was particularly true here in North Carolina. In 2014, there was a study done to provide an apples-to-apples comparison of public health investments among U.S. states. And in that study, North Carolina ranked 47th out of 50 in per capita public health investment. So we in North Carolina weren't leading the pack in investing in our public health system.

And that showed in some of our challenges as we tried to build up our response effort, particularly at the beginning.

And lastly, we went into the crisis with a less healthy population than in many states. We have an older population here in North Carolina than in many states, as a retirement destination. We have more chronic diseases, and we haven't taken certain steps to expand access to care, such as expanding Medicaid, which I've been very outspoken that we needed to do before COVID, and we absolutely need to do going forward. So, this was the scene that was set for COVID.

So next, I've tried to capture in one picture the course of COVID over these past two years. The top shows the number of cases of COVID over the last two years. The bottom is the number of COVID deaths. Obviously, these are different scales. The top number of cases per day goes all the way up to 40,000. Deaths in a day goes to 120. But you can also see three large peaks over this period. The first peak was what I'd call the original strain of the COVID virus. It was the winter wave from 2020 to 2021. It was before we had vaccines that were available. Then the next peak was the Delta wave, and then the last was Omicron.

As you put together the cases and the deaths, what you can see here is that the vaccines definitely did protect us as we went forward, but nonetheless, given the



large number of cases due to the increased contagiousness of Omicron in this third wave, we unfortunately did still see a lot of folks succumb to this virus that is constantly changing.

What I want to remember, as we think about lessons learned, is what did it feel like two years ago? I was thinking about that in particular on St. Patrick's Day, because that was the day in 2020 when we issued a stay-at-home order. Back then, if you look at the chart, we didn't yet have a lot of cases, but we also had such limited tools, and such limited understanding of this virus. In those times we were frantically scouring the earth for protective equipment for our hospitals. We literally could not give our nurses N95s to protect themselves at the hospital. We didn't have any tests, so we didn't know who had what. It was a frightening time. And when we had such limited information and needed to think urgently about protecting health while we figured it out, we had to use more drastic measures, such as stay-at-home, to try to slow the spread of the virus and keep from overwhelming our hospitals and health providers.

Luckily, we learned quickly over time how to respond. We learned more about what this virus was, who it affected and in what ways, and how we could protect people from getting it. And we got better at knowing the settings and scenarios that would cause more spread of the virus. So we were able to start recommending more selectively: this is safer to do, wear a mask, wait six feet apart, and wash your hands. And we started a campaign around these "three Ws." And we were actually able to open most activities back up by the end of May 2020. Our focus was on trying to protect folks, and not overwhelm our health system, until we got the vaccine.

And what an achievement of the scientific community, getting us a vaccine in less than a year! Many of you may know that the earliest we got a vaccine prior to that was after a four-year cycle. But for COVID, not only were we able to have a vaccine approved, but it also was mass produced within a year. It's incredible. And I don't think that we fully recognize the incredible achievement and collaboration that this represented – some of which came from this university and others in North Carolina – that allowed us to get from early January of 2020 to a vaccine in many, many arms, within a year. We did some hard work to maintain our hospital capacity during that year, and to make sure that we were not overwhelming it both with

COVID deaths and with deaths from other conditions that could ensue from lack of hospital capacity. But we struggled to control spread throughout that year until we really had vaccines.

Once vaccines were more abundant in the spring of 2021, we thought we were doing well, and we were really proud going into June of 2021. And then the virus changed. And this is a big lesson we'll talk about learning: to make sure we have the humility in our work to recognize that we're not going to have all the answers at all moments and that things can change. And that was what happened with the Delta virus, prompting a need to do more.

Obviously, we also still needed to get vaccines for children under the age of 18. So there was still a lot of work to do. There are so many additional details that I wish I had time to share, but I really want to move on to talk about moving forward.

So to sum up the past two years, how do I think North Carolina fared overall in our COVID response?

First and foremost, I'm really proud that we never overwhelmed our health system capacity anywhere in the state. And that is not something that most states can say. I don't think we ever saw the colossal implosion of the health system like what New York saw right at the beginning, but in many many states we absolutely saw pockets of health systems just be completely overwhelmed and need to call for help. We never had that here in North Carolina. Multiple times, we were sending ventilators to South Carolina. Fortunately, we never needed to ask for that kind of help from other states and we were always able to stay on the helping end as opposed to needing to call in help. I think that's pretty remarkable in and of itself.

Overall, if you look at our numbers, I'd say we were a little bit better than average. At the end of 2021, we ranked 31st for cases and 36th for deaths. This is the ranking on which you want to be closer to 50. So at 31, we did better than average, and at 36, still pretty good. What that tells me is that we had viral spread here, but that we actually were better at being a bit more targeted in protecting those who are most likely to be ill. And that was part of our strategy. We had the lowest death rate in the Southeast, something I'm very proud of. And as we focused our efforts on those who were at highest risk, we were top in the nation for vaccinating those over 65. In North Carolina, 95% of those over 65 are fully vaccinated, meaning that 95% had

gotten at least two doses of Pfizer or Moderna, or one of Johnson & Johnson. That's a really incredible achievement. So we did a good job of getting our highest risk folks vaccinated.

The other thing that I'm incredibly proud of is that we did all of our response work thinking about equity, and we were among the lowest in the nation for any equity gaps. What that means, for instance, is that if you look at the vaccination rates for our Hispanic community, after a lot of partnership and a lot of work, we actually were vaccinating our Hispanic community at a higher rate than the white community. And for our black community, our vaccination rates were about equal to our white community, and even higher in certain age groups. That is something we did not see across the country, and again, I think it was unique to North Carolina's response effort and our prioritization of equity.

At the same time that we are always thinking about our stats related to public health, we had to contain the impact of this virus on the economy and on people's livelihoods. I certainly saw that every day in the governor's leadership, holding in the balance both public health and economic health. One indicator of our success in that was that we also had the lowest job loss in the nation during the COVID crisis. I think we did a good job of trying to find that middle ground.

The other things that I'm incredibly proud of are some really, really important partnerships that I'll come back to. Some data systems that we built were invaluable, as was the transparency that we were able to provide with online "dashboards;" and the data and the dashboards also allowed us to really target our efforts in important ways.

We were lauded, which I'm very proud of, for our equity and our race and ethnicity data. We often focus on grading our COVID response by asking did folks get tests? Did folks get vaccines? But we know that there was so much of a devastating impact of COVID beyond just access to medical care. We know that folks' lives were turned upside down and we at a department, because we were health and human services professionals, were able to put together some really incredible programs not just to help people get access to tests, but to make sure that they could survive and thrive even though we were in a crisis.

We put together, for example, a COVID support services program that helped folks who needed to isolate at home. And if they worked at a job where they wouldn't get paid if they don't show up, we were able to do things like wage replacement, help paying for rent, food delivery, and transportation. It has been recognized as a model as we go forward in crisis response in the future. I think that's something we actually learned well in our hurricane response and put it to work here for COVID.

So, while most people saw my time at press conferences sharing the latest updates and answering questions, most of my time was spent marshaling incredible, incredible people across this state that I'm so, so proud of. Whether it was community health workers who were from our Latino community, who really reached out to make sure that we were building trust around vaccinations, or our doctors in our emergency rooms who were absolutely on the front lines every day, or our military here in North Carolina, or the many, many nurses doing work: these are the folks that I was thinking about every day, in addition to the many, many millions of North Carolinians who needed good information and wanted to understand where we were going next. So it was a hard two years, but I look back and remember the incredible work of North Carolinians across the state and what an incredible team effort this was.

So I want to get to lessons learned. What did I personally learn? It was really hard to come up with just a few examples of lessons. But let's dive in.

First, I think there's incredible power in a unifying vision and purpose. As we think about public policy, and particularly leadership by those who are making those policies, it was crucial that we had a clear way to articulate what we were trying to do and why it was important. I go back to that scientific achievement in creating vaccines: yes, the scientists made that vaccine, but it was also an achievement in manufacturing. We had never manufactured at that level, at that scale, at that pace before, in any time in history. And our unifying vision and purpose, I think, allowed us to bring all of those kinds of resources together for that kind of achievement. And I saw it every day in multiple ways. I think I've learned the most about leadership and communication through this crisis.

I will say, we could not have been more lucky to have the governor that we did. I was so grateful that he and I were partners as we moved through this crisis. He's an incredible leader who very much focused on the goals of transparency, simplicity, and humility at all points. Transparency: we did more than 150 press conferences. I don't think we could have talked more and answered more questions. I never thought I would be in front of a camera talking about graphs and saying, "Look, this line's going up and this line's going down, and we are red and green." We tried to help folks see what we were seeing; to understand when we had to make a hard decision, why we were doing it and what information we were looking at; and to explain what we were doing. We tried to do it in the best way we could by being simple and repetitive. I'm really proud of the "three Ws" campaign. I know it was working because people stopped me in Target or Costco and said, "You're the three Ws lady." And that's right. I am. I was. But it means our campaign was working. Folks knew about the three simple things that they needed to do, and I said it a million times, and that was intentional.

And most importantly, we had the humility to maintain trust. There were missteps at times from our federal partners, when they wanted to project an air of certainty but this virus did not allow us to do that. I think I always tried to give as much information as we could, but tried to put it in a context of saying, "This is what we know right now today." So when folks say, "Well, would you have done this differently or that differently?" I always respond that you can't Monday-morning-quarterback a crisis. In that moment you have only the information you have and must make hard decisions. And I feel like we really worked hard to put all of those decisions into context – why we were doing it – to maintain trust. That was really important in order to counteract a lot of misinformation that was out there. And the ways in which we tried to combat misinformation were to build credibility and trust, and then make sure we were putting out as much good information as possible.

Once again, I'll go back to the governor here, from whom I learned so much. He is the most amazing listener of any political official I've ever worked for. People often think of communication as what's said at the podium, but so much of what leading is about is listening – listening to your team, listening to the different stakeholders

– and he is the best listener I have known. I hope that I can emulate that as I go forward into my career.

Another lesson learned was the need to have centralized public-health decision-making ability and authority. And if you're going to give folks that authority, it definitely has to come with accountability, but you do need that centralized decision-making ability.

I'll give you two examples of where it went really wrong, and then one that I thought went right. The first two were both at the federal level. When we first got into this crisis, there was an absence of federal coordination, particularly concerning the supply chain. All the states, localities and hospitals were competing against each other to buy ventilators, to buy N95 masks, to buy gowns, and it really was a mess. It drove up the price. We didn't get the things that we needed at the right time. And we had stockpiles in places that were very well resourced and we had empty shelves in places that didn't know whom to call and how to call. That worked badly. It did not go well.

But when we got to vaccine efforts, as you know, the federal government made all the purchases for the entire country. There were times where multiple states said, "Can I buy more? Can I buy differently?" But no, we stayed coordinated, and let the federal government both purchase the vaccines, create the distribution formula, and get them to each of the states. Then it was our job to allocate those supplies out beyond. While that was one of the hardest things I have ever had to do as a leader – to really think through how to get those millions of vaccines in a prioritized way out to our communities – it was the right way to coordinate the federal and state roles. If we had had the every-man-for-himself kind of mentality that we had at the beginning, I think we would not have had as many folks vaccinated today. So, I really think that this centralized decision making is critical as we go forward.

Obviously, though, if you're going to centralize authority, it has to come with accountability. You have to be doing a good job if you want that. We want that authority, and we have to put the guardrails on it.

Another important lesson was the critical importance of coordinating our public health infrastructure with our traditional healthcare infrastructure: our hospitals, our

clinics, our local public health departments. If we expected public health to respond alone, we would never have made it. This had to be an all-hands-on-deck effort, but we also needed to know who was doing what. We needed role clarity – we needed to know who was responsible for what – and we built that as we went along, but I think we have a lot of lessons learned that I’ll get into about how we need to coordinate across the system a lot better. And again, I think one of the reasons North Carolina fared well was because we were able to do this well.

Data, data, data. Data’s the oxygen that powers this response. When it comes to national security, we are incredibly diligent in gathering information: data intelligence. We pride ourselves on having incredible data and insights so that we can protect this country. We have to see data insights in the public health and healthcare space as just as important for us to have those insights going forward. Public health is national security. I’m going to talk about it tactically – what does that mean going forward – but without data, we are blind in our response effort. I think we got much better over time, but we need to make sure we’re building good data. Data’s only as good as what you collect and your ability to put it together to tell you what’s going on, but this is absolutely critical for a response going forward.

And then on health equity, I was mentioning that in our response effort, we really put equity at the center. Again, the governor’s leadership really was powerful here. But you can’t just say, “I’m interested in health equity.” It takes prioritization and work every single day. You can’t put one person in charge of health equity off to the side on your team. The leader of the organization needs to own it from the top, every day, all the time. And that is hard, because there’s a lot going on in a crisis, and it’s really hard to make sure that you don’t just fall back into old patterns and skip over what efforts are needed to make sure you’re really building on equity. And again, this is where data comes in. You can’t solve problems you don’t see, and the data really help you see where certain communities are getting less access to a test or a vaccine, and where we need to deploy extra resources. It requires constant effort, and it needs to start at the top.

The last point is that whole-person care matters. If we were only focused on tests, or only focused on vaccines, we would do well, but we would miss a large component of what makes up someone’s wellness and health. We must make sure

that we are creating an infrastructure, both going into crisis and during a crisis, that thinks about whole-person care, including behavioral health, access to food, and stable housing, as well as access to medical care.

So those are my broad lessons learned. I now want to get a little tactical for our public policy students in particular about what these lessons translate into in terms of public policy. I’m not going to the needs for NIH funding and basic scientific research, but what infrastructure investments do we need going forward to ensure we can respond to a future crisis?

First and foremost, we need a data infrastructure that can power a response going forward. Some have conjectured that if we had had better data, not just here in the United States, but across the world, we could have reacted differently in a different period of time: maybe we would not have been in a two-year crisis, but something shorter. Hindsight is 20/20. But we need data systems to help fuel our response. You can’t just build pipes to say, “Oh, you just send me data over here, and that’ll work.” You need the authority to say, “You must.”

We got lucky here in North Carolina that we were able to do a lot of data sharing not because of authorities that existed, but because of relationships that we built over time. But you can’t rely exclusively on relationships in a crisis. The authorities have to be there. I realize that data is power, data means leverage for a business: particularly in the healthcare space, data is coveted to make sure that you are winning in your space. So we have to do this thoughtfully.

But we have to get to a place where data, and particularly clinical data, are shared quickly and securely. What I mean by clinical data is we need to know what’s happening in emergency rooms. If people are showing up with a collection of symptoms, we need to be able to understand that, identify it, and investigate it quickly. There’s more that we need to do, and it has to be at the level of the individual person: we need to be able to identify data in a way that John Smith over here is different from John Smith over there. We really need to think about a unique patient identifier, similar to a social security number, so that we can track people over time: again, in the service of making sure we know what is happening and can respond with appropriate public health measures.

That's data. I could talk about data for a long time: I love data, and it's really, really important.

The other part, though, is thinking about the core public health structure and authority. I think we have a lot of work to do to understand an optimal public health system, and how to structure it and fund it adequately. I thank the Institute of Medicine in North Carolina, which is doing this work, for thinking hard about what is core for public health. What are those core functions? What are the things that public health organizations take on because they just need the funding temporarily, versus what do we need them to be focused on?

And we need to resource it appropriately. What's the appropriate size of a local public health department? In North Carolina we have 85 local health departments for a state of ten and a half million people. Just to compare, California has 53 local health departments for a state that's 10 times our size. I don't know if California is right, but North Carolina having 85 local agencies for ten and a half million people probably isn't optimal to allow for infrastructure to be sustainable and well-funded over time.

I also think we have to think about the public health workforce. We went into the COVID crisis with many vacancies, and you can't fill those vacancies in a crisis. The thing that dried up for me immediately was talent. And it was really, really challenging trying to figure out how we could get talent into our state to build data systems, and to build the public health response effort. So we have to think about the workforce pipeline, training, and deployment, and this is where universities and others really need to get into planning for future needs and crises with us.

Once again, we also need to consider carefully the roles and responsibilities for our healthcare system. We have a lot of players in various parts of our healthcare system. We spend a lot of government money on laboratories, on health systems, on our primary care infrastructure. But we are not clear about what expectations we have for those entities, and what we need from them in a crisis. We need to be clear what their responsibilities are. When they get millions and millions and millions of dollars in funding from the federal government, for example, there should be certain requirements as to what they need to do in order to be ready to respond to a crisis.

Some of those requirements may include data sharing, for instance, and some might include workforce training and tabletop exercises so that a nurse who might work in an outpatient setting could rapidly be redeployed to work in an ICU if needed. But we have to be really specific about what we need and what accountability we expect for the resources that are provided.

Let me touch on a few more points about emergency response issues beyond public health, and then I'll stop and take some questions. North Carolina public policymakers know that our emergency powers and authorities were really created with hurricanes in mind, or weather events: something temporary. They absolutely were not thinking of a prolonged public health emergency. But here we are, we've learned lessons, and so I do think that we have to rethink both the decision-making structures and authorities that we need.

I mentioned that I think one of our strengths here in North Carolina was the single overall umbrella of health and human services. I saw that break down at the federal level, where there were a lot of very well-intentioned folks doing hard work but not in coordination with each other. And it was really hard to pull all those threads together. When the federal government was disorganized, it was really hard for the states to react, and if the state was disorganized, it was hard for the locals to react. So, that alignment is really important. We need to be modernizing our emergency authorities to reflect the potential duration of a public health emergency.

This need for modernization includes everything from needing flexibility around procurement, to the fact that we had very crude tools by which to enforce rules to protect public health. To enforce a public health protection rule, we really only had the authority to throw you in jail if you violated it. The two extremes of having something be just a suggestion versus making a violation involve jail time felt much too limiting when trying to protect the public's health. But we didn't have other tools to use. We need to look at some other states that had more of an array of tools, a broader menu, that allowed alternatives to making every public health emergency mandate enforceable only by a criminal penalty. I think that was too extreme, too blunt a tool for us to use.

In addition, we have to strengthen our public health institutions more generally as we think about going into the next emergency. We have to invest in health equity and whole-person care. North Carolina absolutely, 100%, must expand Medicaid. We have to at least give folks access to preventative care right now. We want folks to be as healthy as they can going into any one of these crises, and so there's tons of public policy here that I could go through, but I don't want to divorce that from recovery efforts around COVID.

There are also some real and important things other than policy that we have to do together collectively, because there's no policy lever to help our leaders be good listeners or to make data-informed decisions. How do we build and maintain critical relationships and trust in non-crisis times? As I said, relationships were critically important: I want to make sure that we are embedding relationship-building and trust-maintaining in how we prepare for the next crisis. It's not a policy necessarily, but it is definitely something that we all need to invest in.

Finally, we need a lot more rigorous research and training in leadership, healthcare particularly focused crisis leadership, communication, and behavior change. When I went looking for good research on "How should I do this? Where is the academic paper that's telling me what is the best way to communicate this or to think about behavior change," there was some information, and we sought it out and we tried to put it to work, but not nearly as much as I needed. This is another place where academia can really play a large role going forward.

So that was a little look back, a bit of lessons learned, and then some tactical things that I think we can all do right now. If you are having trouble sleeping, there is a very long paper that North Carolina's Department of Health and Human Services put together that documents a lot of what I just reviewed.

I'm so grateful to my team at the department who just went over and beyond, every single day, and did more than I could ever have hoped that they would. They did it with an exceptional service mentality, and I'm so grateful that I got to work alongside them. I've already praised the governor and his team who are also incredible, but it also included everyone from the chancellor to leaders in the General Assembly. If you only looked at Twitter you would think everyone's fighting with each other, but that was not the reality of what I experienced. When I needed to

pick up the phone and said, "I need something," ninety-nine times out of a hundred (and there were many of those calls), folks on all sides of the political spectrum jumped in to say, "How can I help?" And that was what I was really grateful for in North Carolina, and something we can maintain as we think about crisis response going forward.

With that I will stop, and I would love to take your questions. Thank you again for having me.

Dr. Mandy Cohen



Dr. Mandy Cohen is an internal medicine physician and nationally recognized public health expert with extensive public sector experience in senior leadership positions at the state and federal level. Most recently, Dr. Cohen served as Secretary of the North Carolina Department of Health and Human Services from January 2017 until December 2021. Dr. Cohen led and was the face of North Carolina's COVID response for Governor Cooper, participating in more than 150 press conferences. Her leadership and the state's COVID response have been lauded for its focus

on equity, data accountability, and transparent communication. Dr. Cohen also led the transition of North Carolina's Medicaid program to managed care, and received national recognition for its innovation and its focus on whole-person care and the non-medical drivers of health.

Beginning in March of 2022, Dr. Cohen will join Aledade, the leading primary care enablement company, as Executive Vice President and will serve as the Chief Executive Officer of Aledade Care Solutions (ACS), the company's new health services unit. Prior to her leadership in North Carolina, Dr. Cohen served as Chief Operating Officer and Chief of Staff at the U.S. Centers for Medicare and Medicaid Services, helping to implement the Affordable Care Act's health insurance exchanges and innovative new payment models.

Dr. Cohen has been elected to the National Academy of Medicine, and currently serves as an adjunct professor at UNC's Gillings School of Global Public Health. A graduate of Cornell University, she received her medical degree from Yale School of Medicine as well as a Master's in Public Health from the Harvard School of Public Health; she trained in Internal Medicine at Massachusetts General Hospital.

Thomas Willis Lambeth



The Lambeth Distinguished Lecture honors Thomas Willis Lambeth, who led the Z. Smith Reynolds Foundation as its executive director for more than two decades until his retirement in 2000. Born in Clayton, North Carolina, Lambeth graduated from the University of North Carolina in 1957 with a bachelor's degree in history, and served as Administrative Assistant to Governor Terry Sanford and to U.S. Representative Richardson Preyer before being named to lead the Foundation in 1978. Described by one journalist as "the state's do-gooder-in-

chief," Lambeth throughout his career has exemplified the qualities of personal integrity, a passionate devotion to education, democracy, and civic engagement, and wholehearted pursuit of the ideals of the public good and of progressive and innovative ways of achieving it.

During his tenure, the Reynolds Foundation awarded grants totaling more than \$260 million to address many of North Carolina's most pressing public policy issues, particularly social justice and equity, governance and civic engagement, community-building and economic development, education, and protection of the state's natural environment. Tom Lambeth also has made a strong personal impact on many key public policy issues in North Carolina and nationally, including leadership of the Public School Forum of North Carolina, Leadership North Carolina, the North Carolina Rural Center, and a task force of the national Institute of Medicine on the problems of people who lack medical insurance. He also has been a national leader in improving the management and effectiveness of family philanthropic foundations themselves.

*The Thomas
Willis Lambeth
Distinguished
Lecture in
Public Policy*

The Lambeth Distinguished Lecture was established in 2006 at the University of North Carolina at Chapel Hill by the generous gift of an anonymous donor. Presented annually, its purpose is to bring the UNC campus distinguished speakers who are practitioners or scholars of public policy, particularly those whose work touches on the fields of education, ethics, democratic institutions, and civic engagement. The Lambeth Lectureship Committee, composed of faculty, students and distinguished individuals engaged in public policy, provide overall leadership in collaboration with UNC Public Policy, College of Arts & Sciences.

