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In January 2020, health officials across the country began preparing for what seemed to be inevitable—the spread of SARS-CoV-2, the virus that causes the coronavirus disease (COVID-19). By January 21, the United States identified the first case of the disease, and the US Department of Health and Human Services declared a national public health emergency on January 31.[1] Michigan and several other states began sending hundreds of samples to the Centers for Disease Control and Prevention, the only entity in the beginning of the crisis that was able to perform testing.[2] Crippled by inadequate testing supplies, stringent testing criteria, porous state and national borders, and a highly infectious virus with the ability to quickly spread, the circumstances in the United States during the winter of 2020 made it very likely that COVID-19 would inconspicuously proliferate across the country. Health officials had to move quickly, informing the public and elected officials about this little-known virus and the few tools available to combat it. Words such as "community mitigation," "social distancing," and "contact tracing," well-established terms in the public health profession yet completely new to others, quickly became commonplace for politicians, business leaders, health care administrators, educators, and the general public. Meanwhile, public health officials started preparing their understaffed teams and antiquated data systems to respond to the most massive public health undertaking in modern history. On March 10, Michigan identified its first 2 positive cases of COVID-19, and Michigan's Governor Gretchen Whitmer declared a state of emergency.[3] By March 23, Michigan had identified more than 1200 cases of COVID-19, and the governor issued an executive order halting in-person K-12 instruction and limiting nonessential business, health care services, and travel.[4]

Michigan was hit particularly hard early on in the pandemic, especially in the more populous southeastern area of the state. At one point, Michigan was seventh in the country with new cases and third in deaths. Over the ensuing months, the state health department worked with other governmental entities to stand up a robust testing operation, an "army" of contact tracers, critical mental health and human service support programs, and alternate care facilities for its overwhelmed hospitals. These aggressive measures and the herculean efforts of state government, local health departments, business owners, municipal leaders, and the general public resulted in Michigan's "curve" significantly declining. These efforts have been mostly lauded for saving lives, preventing spread, and allowing the economy to start to recover more quickly than other states that may not have acted as quickly or decisively.

COVID-19 has required public health officials to be skilled communicators, fearless stewards and promoters of data and science, and unwavering motivators of teams. While the COVID-19 pandemic is nowhere near over, there are some key strategies and lessons learned that can help current and future public health officials navigate the challenging role of leading through a pandemic.

1. *Public health officials must be adept communicators and exhibit professional multilingualism.*

Public health crisis communication best practice teaches us that leaders must be adept communicators. When a public health threat presents itself, the mantra of "be first, be right, be credible" is the creed of any successful leader who understands their charge during a crisis.[5] Get the most accurate information out to the public quickly, be honest, and do not overpromise. During any crisis, and particularly the COVID-19 pandemic, public health officials should be the forefront communicators to the general public, and the need for that communication to be frequent, clear, and simple is paramount. Furthermore, understanding and being able to manage media that may or may not be

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looking to paint an accurate or positive view of one's response are important parts of communicating as a public health official. Officials should expect this and find proactive ways to advance their message without becoming defensive, avoiding media engagement, or being coerced into making statements that they will later regret. Health officials should assume everything they say, or don't say, will be scrutinized closely. Michigan, like other states, has used a comprehensive communications strategy that includes a mix of targeted TV, cable, and radio ads and targeted social media campaigns.[6] We also worked closely with communities of color and trusted leaders to develop and share messages that resonate and reflect the unique needs of diverse communities. Partnering with nongovernmental entities such as hospitals, businesses, and academic partners can also help promote important public health messages with a wide-ranging audience.

Public health leaders must also be skilled at communicating with the boards, elected officials, and commissions that have the power to promulgate health policy and that often appoint health officials to their jobs. This important aspect of public health leadership is not something generally taught in public health coursework, and unfortunately most people who advance through the ranks in a health department to a leadership role have not had the experience or mentorship to prepare them for it. Most elected officials do not have a public health or scientific background—that is why they hire public health experts. The relationship one has with their elected official and their core team, and how well one understands that official's preferences, concerns, and style, can be the difference between a well-supported and executed public health strategy and a painful existence that can lead to job resentment and burnout.

To be clear, the abuse, personal attacks, and threats experienced during the COVID-19 pandemic by public health officials are unwarranted and undeserved. Dozens of health officials have resigned, retired, or been fired in the course of fighting this pandemic to the detriment of the public's health.[7] Reports of health officials being bullied and publicly rebuked by their elected officials and the public have become all too familiar during this pandemic, which is an unfortunate deterrent to future leaders considering these roles.

Despite these challenges, like any job, understanding what one's boss needs, and how to communicate with them and gain their confidence is the responsibility of any leader. Public health is no different, and navigating this critical aspect of leadership while maintaining professional integrity is critical. Imbalances here have likely contributed to the exodus of many public health officials during the COVID-19 pandemic, who admirably have chosen respect and credibility over abuse and disrespect.

The ability to speak the language of public health as well as translate it into simple and actionable language for policy makers should be part of any public health professional's toolbox. This professional multilingualism—being able to explain concepts such as "social determinants of health," "percent positivity," and "case rates" in a way that nonscientists can understand, promoting clarity and sound public health policy—is a skill that must be honed. Anticipating questions, avoiding jargon, being succinct, and understanding potential public reaction to policy proposals are paramount to supporting elected officials in navigating the COVID-19 crisis effectively. It is also important to remember that a public health official's main role is to present, interpret, and advise policy makers on the best available data and evidence-based public health approaches. While public health officials should not be oblivious to the possibility that the most effective public health interventions during COVID-19 may have significant short- and long-term economic consequences, health officials must remember that they were not hired to give economic advice. Furthermore, public health and economic prosperity are intertwined, not oppositional. All efforts must be made to avoid acquiescing to real or perceived pressures to dilute public health recommendations, whether those pressures come from the general public or elected officials. If public health leaders are not stewards of sound truth and facts, then the public's health will inevitably suffer; we are the only people in government whose job is solely dedicated to protecting the health of a population. The wisest elected officials are open to hearing the truth about public health threats and implications of proposed policies. Open communication, a respect for data and science, and a strong, positive relationship between public health leaders and elected officials have surely contributed to Michigan's initial success in slowing the spread of COVID-19.

2. *Health departments must meet public expectations for data and transparency while working to improve antiquated data systems.*

In Michigan, the disease surveillance system was first implemented in 2004. While upgrades have been made to the system in the 16 years since its inception, the system simply does not have the speed, robustness, or connectivity that people have understandably come to expect in the digital age. This is not unique to Michigan—there is no question that as a country public health infrastructure has been disinvested in for years—this includes funding and support for staffing, programs, and data infrastructure.[8] Regardless, state and local health departments must be

creative and agile at anticipating what information is necessary to understand spread of COVID-19, as well as what data the media and public will desire, all while protecting individual privacy. In Michigan, this has meant occasionally creating manual processes, intermittently having staff contact facilities to ensure information is reported accurately, and continuing to rework Web sites and process flows so that information is easy to understand and display. Trying to keep up with federal reporting changes and requirements, ensuring that manual data submitters understand the request that is being made of them, and maintaining speed of reporting remains an ongoing challenge. While electronic laboratory reporting is great for laboratories that are connected to Michigan's data system and is our main tool for receiving laboratory test results, important demographic and historical information is not necessarily included in those electronic laboratory feeds. This information becomes available with subsequent communication with the individuals who test positive (ie, case investigation) and takes additional time to ascertain. Media and important stakeholders often do not understand this multistep process and expect more automated and timely data. Furthermore, this underscores the importance of individuals, especially those who are close contacts of positive cases or symptomatic, knowing the importance of remaining in quarantine while they await their results and receive further guidance from their state or local health department.

Another data challenge health departments face is in receiving point-of-care testing results. These point-of-care tests are not connected to Michigan's electronic laboratory reporting system and present an additional hurdle to result reporting, creating potential delays, manual reporting steps, and data gaps. As the country expands use of point-of-care testing, attention to implementing data reporting systems for these tests will be important in continuing to understand disease spread and targeting the public health response. In Michigan, the pandemic has led to the availability of additional funding to update our electronic disease surveillance system, which will take several months to build. Regardless, attention to continuous quality improvement and infrastructure development remain paramount. Communicating these data infrastructure challenges with the public while striving for transparency, accuracy, and speed and robustness of reporting will be important as public health leaders continue to fight this pandemic while maintaining the public's trust.

3. *Partnerships with businesses, universities, nonprofits, and others are critical to the COVID-19 response*.

The work of public health is not simply about the work of the public health department. There are capable epidemiologists, business leaders, health systems, and others who can provide invaluable input and assist with a public health response. Public health is truly about relationships and aligning the strengths, skill sets, and resources of an entire community. In this sense, the concept of "chief health strategist," where governmental public health leaders are key conveners and leaders of public health strategy development, but not the sole implementers, allows for talents and resources to be effectively pooled together.[9] During a pandemic response, this can mean less disease spread and lives saved. Furthermore, engagement of these sectors by public health leaders can serve several purposes: cultivating buy-in when unpopular policy decisions are made, fill staffing or skill set gaps in a health department, and creating a broad set of ambassadors of important public health messages in the community. Public health leaders who attempt to create these "tables" of shared vision and alignment may run into challenges where stakeholders feel the desire to compete for credit, visibility, or ownership. Competition and vying for fame cost lives that our communities rely on us to save. The best leaders are able to harness and inspire collaboration, identify and elevate shared goals, and give each stakeholder an opportunity to highlight and receive credit for their particular contributions.

Michigan was able to engage key partnerships early on that led to a strong and coordinated response. Partnerships were formed with academic institutions to model disease spread, as well as to develop a public data dashboard and symptom tracking Web application used for surveillance. State government also partnered with the Michigan Economic Recovery Council, a multisector council made up of business leaders, university presidents, health system leaders, and public health officials, who provided guidance on business mitigation protocols and partnered on messaging campaigns around preventing the spread of COVID-19 and the importance of flu vaccination. Health systems provided leadership as Michigan worked to stand up alternate care facilities as well. These ongoing partnerships remain critical during this pandemic response.

4. *Emphasis must be placed on understanding and addressing health inequities exacerbated by COVID-19*.

The tragedy of the COVID-19 pandemic, like many other health conditions, is that those who are most marginalized from society and lacking resources are those who are also most severely impacted. To understand America's history is to understand that racism,

and intentionally created policies such as redlining have systematically impoverished Black, Indigenous, and people of color communities. Generations have been denied access to adequate resources, education, and wealth, with a subsequently profound impact on health outcomes. It is no surprise that these health disparities have borne out during the COVID-19 pandemic. Michigan was one of the first states to release COVID-19 case and death data by race and ethnicity, understanding that without understanding the issue, one cannot address it. By June 2020, we identified that 32% of COVID-19 cases, and 40% of deaths, were in African Americans, a population that makes up only 15% of the state's population. The very policies that were put in place to protect people during the pandemic likely exacerbated the challenges that these communities face. Racial and ethnic minorities are more likely to work in a low-income job that was deemed "essential" during the pandemic surge, meaning they still had to leave their homes to work and risk exposure to the virus. Lack of access to a car means those with less means may have had to use public transportation or rideshares, also increasing exposure risk. Isolation protocols call for using a "separate area" of a home, something simply unfeasible for many people who lack adequate housing or live in multigenerational or shared homes. Higher rates of chronic medical conditions such as diabetes, heart disease, and high blood pressure made minority populations at a higher risk of severe consequences and death after contracting the disease.

While data are important, simply calling out the disparity is not sufficient—action is necessary. Michigan has followed up with concrete actions to address them. This includes targeting testing resources based on social vulnerability index across the state; expanding drive-through, community-based, and free testing sites; implementing protections for workers who may need to isolate or quarantine during the pandemic; partnering to distribute more than 6 million free masks to those in need; distributing "quarantine boxes" of healthy food to the most vulnerable; and targeting multimedia messaging campaigns in communities of color. In the spirit of creating longer-term attitude and policy change, Michigan's governor implemented a new requirement for all health care providers to undergo implicit bias training, and the state health department implemented a new assessment tool to guide policy and program development with a health equity lens. The department also elevated the role of its diversity efforts by creating a new office focused on diversity and making it part of the senior leadership team. Michigan was also one of the first states to create a task force focused on disparities in COVID-19, bringing together leaders across government, academia, health care, nonprofits, and the community to better understand and tackle these disparities. The task force has been integrated into the state's public health response by advising on policy decisions, public messaging, and the need for services and programs.

Early analysis of Michigan data shows that these collective efforts may have contributed to a significant decrease in the disparity for African Americans in Michigan. From August 2020 to October 2020 (the date the manuscript was submitted), the rate of deaths and cases per million people for African American residents was the same or lower than that for White residents.[10] Because of the surge of cases and deaths in the first few months of Michigan's response, and the fact that the racial disparity was initially so large, the cumulative case and death rate differences between Blacks and Whites in Michigan have not substantially decreased. Work is still needed to address the disparities among Latinx and other communities of color in Michigan. More research is also needed to understand why this disparity exists and what interventions are necessary to decrease the long- and short-term physical, mental, and economic consequences of COVID-19 in communities of color.

The untimely intersection of COVID-19 and increasingly public displays of police brutality across the United States means public health leaders must simultaneously reflect on their own values and understanding of systemic racism, while leading exhausted and overworked teams who may be dealing with their own lived experiences of racism or figuring out how to personally and professionally address it. Public health leaders should be focused on listening to the experiences and suggestions of their teams and provide vocal, anti-racist leadership. Public health leaders must understand the intersection of race, health, and COVID-19 if they are to lead their departments and communities through this crisis effectively.

The past year has been incredibly challenging, as public health leaders have needed to lead through an unimaginable public health crisis that our systems were not built to adequately respond to. Masterful communication and leadership skills, continuous data quality and infrastructure improvement, and a laser focus on health inequities will help public health leaders navigate the next phases of this pandemic effectively.

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