John Arenas Interview

Former COVID-19 Testing Strategy Coordinator for Illinois Department of Public Health (IDPH)

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SPEAKERS
John Arenas, Rebeca Escamilla

Rebeca Escamilla 00:01
Okay, there, we got it. So my name is Rebeca Escamilla. I am a graduate student representing the University of Illinois Archives. I will let the interviewee introduce themselves. Could you please state your name, your previous professional title and the department you work for?

John Arenas 00:18
Yeah, my name is John Arenas. I was the COVID-19 Testing Strategy Coordinator for the Illinois Department of Public Health.

Rebeca Escamilla 00:28
Today's date is Friday 24th Friday the 24th 2023. We're here at the University of Illinois Archives meeting over Zoom. We will be discussing how the Illinois Department of Public Health managed and coordinated testing projects and sites alongside SHIELD Illinois. This interview will be used for inclusion in the University of Illinois COVID-19 Documentation Project and just for some notes for future researchers who might be listening in -- when we discuss SHIELD, we mean SHIELD Illinois, unless other city chose to different differentiate from SHIELD T3 or SHIELD UIUC and also for acronyms, Illinois Department of Public Health may be referred to referred to as IDPH. Just to keep that in mind, and we can I will start the questions. So for the first question, can you tell us more about your previous role as COVID-19 testing strategy coordinator for the Illinois Department of Public Health, and what did you do in this role? What were your goals, just sort of that?

John Arenas 01:41
Yeah. So when COVID-19 hit I was working in Governor Pritzker 's office with his Health Human Services Team and got exposed to a lot of the decision making early on around COVID-19. I spent a lot of time in constituent services with all the people that were really frustrated with the state or just needed help from the state in those early months. And then when the fellow--I was in a one-year fellowship, so when the fellowship came to an end in August 2020, I was trying to figure out where I could continue to serve and there was an opportunity to serve on this brand new COVID-19 testing team. Prior you know, really Illinois stood up major COVID testing sites in April in May of 2020 under the National Guard, and by June of 2020, they wanted to transition those services to be run by the Public Health Department was my understanding. I wasn't there yet. But that I was hired within you know, probably six weeks after that transition on a small team of mostly folks who were kind of doing the job in addition to their former responsibilities. I was one of the first people that was brought on where that was kind of my only

responsibility. And so my work I was pretty young, early in my career and didn't have a ton of skills but jumped in to support a couple different projects from the beginning. So the first thing I looked at was trying to understand, really the kind of--you call it supply chain, but really kind of getting the test from the very beginning of the process to the end of the process, making sure that we understood all the costs that we had within that and trying to help figure out how to minimize those costs for the department. And another major part of my role was reconciling data that the vendors that we had at the time, private vendors, to understand had we delivered results to everyone we were supposed to and also later became checking that against the invoices or the billing that we got from those vendors to understand make sure we were paying them the right amount. In addition to that I worked with vendors directly as a kind of project manager/coordinator and began to take on more and more of a role doing data analysis of the data that was coming back to the program and helping our then new chief of testing hired a couple months after me, Charles Williams, helping him make decisions about the strategy for the program. So it started off kind of small, but because it was a small team it grew and grew and I took on additional responsibilities my almost two years with the team which I'm happy to share more about, but that was how it started.

Rebeca Escamilla 04:22
Great. Thanks. So you touched upon this but do you generally remember when you first heard about COVID-19?

John Arenas 04:31
I think we were in a meeting. I mean, I'd seen it on the news, but the first time it like came up for me in the work context, we were in a strategic planning meeting trying to figure out how to kind of streamline Health and Human Services broadly across the portfolio with a bunch of kind of director, secretary level folks across the state government and my boss Deputy Governor Sol Flores and I think either Justin DeWitt or Director Ezike at IDPH basically got an email or a phone call and they said "hey, we got to step out. It's this COVID-19 thing. You know, it's becoming more of a thing," and this was probably January, early February [2020]. But pretty quickly it became apparent--I got the opportunity to join some calls for kind of planning after hours, and it became quickly apparent this was a major crisis and that action need to be taken. So that's how I remember it.

Rebeca Escamilla 05:32
And so for us, for example, some context here at UIUC, we had to go into lockdown around March. For you personally, in your work experience, did you also have to go into lockdown or start doing remote work? And what was that like?

John Arenas 05:49
Yeah, I think almost everyone in the governor's office went to remote work besides the core team for those first few weeks after the decision was made. I distinctly remember that Friday, packing up all my stuff and realizing "I don't think we're coming back." But yeah, I mean, remote work for me initially, you know, being a kind of junior person in the office, it slowed down the pace of work for sure. Not being able to be in the room and as involved. But it quickly picked up when they asked me to help with the constituent services that we were overwhelmed. We were getting hundreds and hundreds of calls per day and I think there was like a team of two or three that were used to taking those calls. So we ended

up having more than a dozen people doing that. So I got to hear directly from a lot of folks, primarily folks who had lost their jobs or lost their income and weren't able to get unemployment benefits because of the system backlog and an overwhelming number of demand

Rebeca Escamilla 06:52
And then a clarifying question, when you say constituent services, what does that entail?

John Arenas 06:59
Yeah, so basically folks that call the governor's office and have some kind of problem that they want the state governments help solving. So it's often you know, just referring people to the right place, but because the only reference we can really make is try the number again, or try the website again, you know, etcetera, maybe a little bit of troubleshooting from what we learned on the fly, honestly, it was basically like emotional support and just trying to talk to people about what steps they could take, helping people find food banks in their neighborhood, helping people just find any other kind of supportive services. I heard from many people, like "I don't have food in my fridge, I don't know what to do. I don't have an income right now." And there were also a lot of people who are really, really frustrated with the lockdown and that policy decision and also had lots of questions about well, why is Walmart open but my local grocer's not open etcetera, and feeling like the policies weren't fair. So we heard them out. And then we actually gave that feedback back up to the governor and his team directly to say, "Hey, I think maybe like does this make sense to make a minor adjustment there?" And that that really ended up being a theme for me throughout my time with IDPH is getting feedback from folks experiencing policy and how can we make a change that makes epidemiological public health sense without compromising what we're trying to do?

Rebeca Escamilla 08:16
And then would you say that there was a huge increase in these types of calls that your office was getting?

John Arenas 08:29
Yeah, like 10, 20, maybe 30 fold increase. I think we would get probably somewhere in the order of like two to three dozen calls a day, something like that. [During COVID] I was personally taking like almost 100 calls in a day. It was crazy.

Rebeca Escamilla 08:53
And you also mentioned that getting feedback from sort of the public people, for lack of a better word, how would you describe this sort of feedback? So who would filter these concerns and be like, okay, this is something that should go to the Governor or this is something that we can just dismiss?

John Arenas 09:18
Yeah, well we try not to dismiss anything. We tried to basically bucket concerns into different issue areas and then make a note of how many people had called in a certain issue. So if there was--it was really helpful when there was like a kind of niche thing that a bunch of are calling about, like, "why can't I go fishing out on my lake?" or something and you know, that's the kind of thing where you look at it, look at the evidence and say, maybe people should be allowed to go fishing on the lake during COVID.

Maybe that's fine. But then there were other things where was like, just negative, you know, whatever. We just marked down "negative on lockdown," and we'd report that back up. So yeah,

Rebeca Escamilla 09:53
so was this also kind of a data collection thing going on? Just keeping track of this information?

John Arenas 10:01
Yeah, we were trying to make it into a data collection exercise, but honestly, like the system wasn't built for that around that it's more about directly connecting people to services. So just opinion tracking, I mean, we we made an effort to do that, but it's also a pretty unrepresentative sample of the population. So, you know, again, we push the data up to leadership, I don't know what they do.

Rebeca Escamilla 10:19
Okay, okay. Sounds good. Then we kind of discussed about remote work, but how was remote work for you? Did you have to take technology home or was that just using your computer?

John Arenas 10:37
Yeah, so once I started with IDPH, I would log into virtual private network, a VPN, which gave me remote access to the system and I can I would do my work through that rather than on my personal--so I was on my personal device, but I was in the VPN rather than using my personal device for work.

Rebeca Escamilla 10:56
Okay. Thanks. Also, would you say that your [inaudible] in previous--because you did mention working for, I believe Sol Flores? [JA: Yeah] So how would you say that these previous professional roles influenced your decisions as a testing coordinator?

John Arenas 11:20
Yeah, so I mean, my experience particularly working with Latino community in Illinois and Chicago, really motivated me to make sure that if we were trying to provide services at an equitable basis to that population, which at times was a challenge. I mean, you know, I think we did not provide the right level of services to that population as a team. If you look at the disperate kind of disproportionate burden of disease on the Latino community early on in the pandemic, certainly there wasn't enough testing in those communities. Really happy that the vaccine was released and people you know, largely, after time and talking to trusted community leaders, took advantage of that. But in the early days, I felt a lot of personal burden to make sure that we were putting our services in those communities, but it was a challenge because we had already existing site lease agreements when I came into the program for certain areas, and we were already committed to financial spending in those areas so that wasn't as flexible. And then with our mobile testing, that was always a challenge. It was a program that I had a pretty direct role in, doing the data analysis for was really hard to get consistent volume and when you don't have volume, but you're spending money in a fixed costs to get people out in the field to provide service and there's not enough people taking advantage of that, it's not cost effective and leadership, eventually wanted to discontinue that program. And for good reasons, it was too expensive, but yeah, I guess I really wanted to provide those services to that community and definitely the African American community as well. You know, basically any underrepresented minority community, but that can be a

challenge for many reasons, some of which I'm not sure I fully understand even today, but it wasn't always easy to deploy resources to those areas.

Rebeca Escamilla 13:16
Thank you. And I feel that this is something that we can also talk later on in some of the questions. But I guess I also wanted to go on into the testing questions. So one of my first questions was in regards to the relationship between IDPH and SHIELD, Illinois. You mentioned that you might not have been there at the beginning, but from your perspective, how was this relationship established?

John Arenas 13:50
Yeah, so you know, SHIELD had to as I'm sure you all are looking at right, there was the basically getting the EU [Emergency Use] authorization really took a long time, or relatively long time. So we were hoping from that from the early days, I was on with folks from SHIELD and it was kind of just hey, any update on the EUA any update on the EUA is kind of like no, no, no. And so probably the first like four or five months went by, and SHIELD was kind of like, oh, yeah, that would be really great if that works out, but didn't really hear too much about it. And meanwhile, we were, you know, like I said, using this traditional model for us of large community-based sites and mobile sites, but the problem was that the IDPH had to sign agreements early on. Yeah, emergency agreements, basically, to get testing set up as quickly as possible when the National Guard pulled out. And you know, as you could expect, on an emergency basis, those costs and the fixed costs were higher than you would want in terms of how much we were spending. And so we ended up trying to figure out how to really kind of dial back on some of those really expensive programs and look to cut costs and still deliver great service. And what eventually came up by January--I don't know exactly when the EUA, when SHIELD got its EUA and was really ready to go--by early 2021, as we were kind of struggling with that very problem that we don't have enough volume to make these costs make sense. You know, what can we do? That's when I first remember talks about an IGA--an intergovernmental agreement--with SHIELD. I think something was already on the books, a kind of initial agreement to serve universities, but we ended up doing a second agreement to expand on that. And to basically have SHIELD support some community-based testing, but primarily our K-12 testing. It was around that same time, February, March 2021, when I worked with my team and helped us write an application for a grant called the ELC Reopening Schools Grant. I think that's Expanding Laboratory Capacity, ELC, it was part of federal legislation that had been recently passed and we applied for that grant. We got it as you know, one of the 50 states 50 states plus territories eligible and we received it was a $300 million grant from the CDC just to provide K-12 testing in addition to the money we already had gotten from other existing relief efforts. So then it became a question of how do we want to spend this money on K-12 schools and the leadership signed an agreement with a SHIELD to provide a large part of that service.

Rebeca Escamilla 16:36
So I guess just to be clear, kind of the timeline of it all. So first, testing was part of the military and then the responsibilities shifted to the government. And then from the government, it went to SHIELD Illinois?

John Arenas 16:56

So I would say testing was always the responsibility of the Public Health Department, but we contracted with SHIELD as--you could call it a vendor, but it was really a partnership because they were also another government institution--to provide those services. So I would say throughout it would be IDPH's responsibility to provide that testing. But SHIELD became the organization, tool, instrument, and partner to get that done because IDPH does not have the capacity, doesn't have the staff, ability to hire, ability to do a service like that.

Rebeca Escamilla 17:29
Okay. Thank you. And then also, I guess just another clarifying question. When SHIELD Illinois, did they on their own start to test on communities, or was it something that they were explicitly told? No, you have to wait first for the emergency authorization from the FDA, I believe and then go through that process, or was it something that they started on on their own?

John Arenas 18:04
They didn't start with us at all until after they got the EUA. I I don't know what things might look like kind of internally with the university. But yeah, I don't know the answer to that one.

Rebeca Escamilla 18:14
Oh, Okay. Then, for the next question, you kind of did talk about the fact that IDPH partnered with SHIELD Illinois, but I believe there was also another testing company, Midwest Coordination Center. [JA: Yeah.] Did IDPH also partner with that and what were the differences between for example, the services that SHIELD Illinois offered versus the Midwest or MCC?

John Arenas 18:51
Yeah, that's a great question. Um, they kind of come in later in the story for me so if you wouldn't mind I would love to kind of take you through what happened next before we get to that. So, we apply for this grant, we get it, we decide to SHIELD is going to help us provide K-12 testing. And that's kind of where my role really shifted from kind of helping with a lot of different things and figuring out how we can improve strategy to really being responsible for the K-12 testing program at IDPH so I worked closely with SHIELD to really develop kind of what our marketing kind of you know, you can call it public health education strategy was going to be with school district leaders, and we spent a lot of time letting them know what this service was and why it would be valuable, because we wanted to--our goal from the CDC was to test as basically as many students as possible that for any family that wanted to participate, and I really looked at it as we want to provide access to as many kids and districts as possible. Family doesn't want to participate, that's their decision, but how can we help them if they want to participate, but you have to get a get to get the school district to agree to be even be there. So we did a lot of talk that summer 2021 with school districts. We also started to think about program design and how we would do it. Now, SHIELD did a lot of the work on figuring out how the operations were going to play out, but my job was working directly with those leaders, talking with IDPH, and figuring out how can we actually make this maybe tweak, tweak some ways that operations work to make this easier for schools and so we made adjustments over the course of that early period to get as many--basically make it as easy for schools as possible. The other challenge was we had so many schools signing up at the last minute. We had said, you know, we offered it beginning of May, beginning in June. Offered it in July, but Governor Pritzker made a change to testing requirements for teachers in

August, which dramatically, dramatically increased demand for this service because of course, we were offering all of these resources for free to school districts. So they then a lot of school districts wanted it, I think maybe more than definitely more than 50 I think SHIELD has the data. I think more than 100 signed up there in the last like three weeks before school started, which was a major operational challenge for SHIELD and IDPH to meet that demand. We were trying to make sure that we weren't going to be oversubscribed. have too many folks trying to sign up at the same time, too many more tests than we can run in a given week for the lab capacity. And that's really when Midwest Coordination Center first came to the table. They were a separate federal program which in my in my opinion, you know, the fact of the Feds set it up so that they had kind of a separate federal program that wasn't really naturally communicating with the state level program that we were running, seemed kind of inefficient, silly even. But we made those connections organically and began talking with them. You know, how can we partner and so the first step was, alright, if we have too many people signed up for this, we want to make sure we can provide services, so we began to offer the Midwest Coordination Center to schools as an additional option that would help kind of spread out the lab capacity if we did have a lot of people trying to do it. And their program model was a little different: so SHIELD is really was designed for thinking about high throughput, getting a lot of students through the process at once, which is really good for big schools, but also needed schools with a lot of organization, a lot of staff capacity to help do that. And SHIELD had to deploy a lot of people to get that done as well and you know all about that or you will soon, I guess. But Midwest Coordination Center kind of operated more as a do-it-yourself model where the school district would collect the tests themselves and ship them to the Midwest Coordination Center lab network, to be tested still provided for free under the federal government. But that was kind of a challenge for schools. They kind of said, well, why are we doing this uncompensated labor? We can't afford you that our staff are busy. So that was an option for schools where they need just a couple people tested every once in a while, and I think that made a lot more sense, but we wanted to figure out how do we take these federal resources that are being deployed and make our program even more efficient? And so we were able to do was--if you can get access to the agreements, that's going to be the the most solid thing because I'm you don't have access to this anymore. I'm going from memory but basically what we did was we made SHIELD Illinois a reference lab in the Midwest Coordination Center network that they can run tests through the Midwest Coordination Center. We also set it up so that SHIELD could deploy teams to help get that done for schools slash we could reimburse the school for their labor, which was always something that had been part of the SHIELD model, which was really key to helping make sure schools could could pull it off staff wise. Once we did that, we were able to even reduce the cost of the test further down from those early highs we had. We had a new IGA with SHIELD which brought it down tremendously because they weren't a for-profit company, they were university offering it at cost or even, you know, at a loss I think. So we then were able to take, basically had the Midwest Coordination Center pay for part of the cost of all the tests that it is running, which was really great because we haven't looked at testing

Rebeca Escamilla 24:28
So I guess I have another follow up question. Um, I guess it's going back to what we previously talked about when you discuss the agreements between SHIELD and IDPH, was there just one overall general agreement that they signed? Or were there different components to it? Because I do remember that, for example, superintendents in school districts had to sign to allow SHIELD to come in to do testing at school so I was a little confused about that. So what would be the point of signing an

agreement with IDPH if the lower level school districts still had to individually sign up their schools with SHIELD?

John Arenas 25:26
Yeah, so IDPH was really... that agreement was about how SHIELD was going to be funded to provide these services to schools, but each school district is its own legal entity with its own interests and kind of risks and so their attorneys needed to look at the situation look at the agreement and make a decision with the superintendent to get permission to be in the school. So SHIELD needed to to get an agreement with each individual district for that and IDPH, you know, we're we're a separate entity, even than the Illinois State School Board of Education, and definitely then the local district level so we couldn't make that decision on behalf of a school district. It was up to the district.

Rebeca Escamilla 26:11
Thank you. And then aside from SHIELD and MCC, did IDPH partner with any other organizations or have any other major partnerships?

John Arenas 26:25
Yeah. So we will from the beginning, we had to partner with a lot of private vendors because we didn't have, we didn't have anyone else. You know, SHIELD wasn't ready to go. And so, in 2020, we signed agreements with three laboratories, a specimen collection vendor, to actually go out in the field and make those collections. We had to get an agreement with an electronic records, medical records vendor. We had to sign agreements at times with basically couriers for our specimens. And we had to sign an agreement with an organization to be a call center and answer calls that folks had and return results to them. So all in all, I mean, it was a lot to manage. From my perspective, IDPH was just a small team and we-- that's part of why we transitioned as well. Rather than have seven different vendors that you're paying separately, and that kind of increases your costs, increases how much time we're spending, SHIELD was able to do all of those services as one entity rather than send it out through seven different vendors that all need to you know, need to have a profit margin.

Rebeca Escamilla 27:47
Thank you. Um, so now that we're still in this vein of partnerships, did IDPH or I guess more of a clarifying question, what was the relationship between IDPH and the governor's office or was there even a relationship between both?

John Arenas 28:04
Yeah, so the person who is primarily responsible for reporting to the governor would have been Director Ngozi Ezike and her chief of staff Justin DeWitt. But at times, when testing was the focus of presentations to the governor and needed a decision, Charles Williams, the chief of testing, would often then go speak directly to the governor's office to share about our program and he was my direct boss. So really, you know, at times, a pretty quick line of communication. Obviously, the governor is very busy, has many different priorities even just within the sphere of COVID, but we weren't able to get decisions through his team--we needed his permission for any major decision that we were making.

Rebeca Escamilla 28:53

And then, I guess I'm also kind of curious, in the terms of how the governor's office was willing to accept feedback because we've heard from some epidemiologists, for example, that there were times that they were frustrated that they felt that they weren't being listened to. Do you feel that IDPH was being heard?

John Arenas 29:19
Well, like I said, you know, the governor had a lot that was going on a lot that his team, his team had a lot going on. And so there were times when, you know, I think the challenge really was that we were trying to operate at a really fast pace with a lot of private organizations, and sometimes we would have to wait you know, two, three, four, five, sometimes six weeks for a decision from the governor's office. And that slowed us down and our decision-making ability, made us less agile and made us less able to respond to demand that we were experiencing from the market or from the public, particularly when we're looking to make policy changes around what was required for testing that we were recommending, operationally or you know, alongside some colleagues epidemiologically, like this we think will make more sense and still accomplish our goals. We would have to wait a while to hear back and that was also primarily a challenge for our school districts. I'm thinking particularly about both the summers that I was there, you know, you're waiting. The school district is trying to make a plan for the fall. They're going to figure out what they're going to do, what's the operations plan, and we would make a proposal in say May or June on what we wanted the policy to be, if it takes four to six weeks from that point to be put into action, well, now you're looking at late July, it's very close to start to school, it's hard for school districts to make a change. And then I also mentioned that really last-minute change to how testing works. We'll get through different testing requirements in mid-August, and again, that was a huge operational shift that was a challenge for districts I know. So, again, the governor's office had so much going on, a lot of competing priorities, but I think the timeline for decisions definitely made our work more challenging.

Rebeca Escamilla 31:04
And then, I guess also continuing on with the partnership questions. What was the relationship between IDPH and kind of the K-12 schools, or that Illinois State Board of Education? Did you have to individually contact each and every single school district or how did that logistically work?

John Arenas 31:32
Great question. That was a large part of my work. So I did partner with folks at the State Board of Education to understand more about the districts, to get a better understanding about any questions I had about the structure of the education system in Illinois. But really, it was IDPH's primary responsibility to do a lot of this outreach work, at least from my perspective, maybe you know, there probably was other stuff going on, at through ISBE. They did send out some information I know but again, they had multiple priorities and this was really my sole priority so I was really, really focused on it. We did webinars and did large scale email blasts from SHIELD and from IDPH to let folks know about this, but we did a lot of one-on-one meetings. And so I spent a lot of time sometimes one-on-one sometimes with a group of districts and our local health departments were really helpful. Also the regional offices of education, which were protected to through ISBE basically regional leaders that could help educate their school districts about this program. So I did spend a lot of time answering direct questions from school district leaders to provide a public health perspective as I understood it

from my work as well ans we had weekly--more than weekly, I meant more than weekly with epidemiologists at the Department of Public Health to better understanding how we can strengthen our programs and make them line up with the best guidance. So yes, spent a lot of time talking directly with districts, you know, I probably talked to, over my time there, I would say 60 to 80, maybe closer to 100 different districts. But that's you know, that's a fraction. SHIELD talked to many more and we ended up signing I think like 220-something at our peak. So, not not necessarily everyone but really I talked to folks that had tough questions about public health, about what is the public health goal here? Why are we doing this? Maybe SHIELD wasn't the best fit to answer. They were primarily you know, operations, etc.

Rebeca Escamilla 33:34
Okay, thank you. I kind of wanted to move on to more of the community testing sites. So I guess one of my first questions was, what parameters did IDPH have when choosing a community to set up a testing site? Or did it even had to choose a community? So kind of how was that initial process?

John Arenas 34:01
Yeah, so it shifted over time. In the very beginning. The goal was to have high high throughput sites where you can test at times we did more than a 1000 to 1500 tests in a day at a site. And so the goal was a large area that you can get a lot of cars through like a big parking lot, somewhere where ideally you can provide some kind of shelter to staff and it's in a central location, you know, for folks to be able to reach. We had a pretty strict policy from our leadership that we were not going to do any community testing sites in the city of Chicago, because Chicago had received separate federal grant money directly from the CDC that was theirs to distribute and provide a program for so our leadership felt that our money was best spent outside of Chicago given that. So we did several testing sites in Cook County, and then a couple across the collar counties [DuPage, Kane, Lake, McHenry and Will counties] and then throughout the state as well. But that was the original vision. And then from there, like I said, we did mobile testing, where we would partner with community-based organizations and schedule with them. And that really relied on them being willing partners and that's, again, a theme that came up is you have to have a willing partner on the ground with a kind of model like that. And organizations, especially during COVID, didn't always have that capacity. And so often, the limiting factor was less so "was IDPH willing to go" but honestly a lot more, "Is an organization able to host us." Now that said, with the program design, we did require things from them. We needed a space. We needed Wi Fi access, you know, someone was gonna have to clean up the site, someone would have to be there to open it up. We needed their partnership to help market it. And in the beginning, especially, IDPH wasn't able to offer the site any kind of compensation for that work. And that was a challenge to getting sites that were heavily invested in helping make sure that this was a successful community site. In terms of our strategy, you know, early on, one of the things I did was trying to do a racial equity analysis of where our mobile testing was going. And look at that. And what I found was that we really were under serving black and Latino communities, and so made the push internally to drive more resources to those areas. And so that's what we did. But again, the limiting factor was do we have partner organizations in these communities that have the bandwidth to help us out and I think the challenge is, when you're talking about going to an underserved community to provide resources, if you as a state can't provide all the resources necessary and you're relying on under resourced organizations already doing a lot of other things that's putting a burden on them that really doesn't make programmatic sense.

And so we tried to make program innovations to fix that. And that's really what I think about SHIELD is really what they helped us solve being able to reimburse local organizations for their partnership with us at $8 a test for when they were helping us out. That still unfortunately, it wasn't enough to make a difference for some organizations, for many organizations. Some organizations did request "Can you pay rent for the space?" "Can you pay help us pay for our Wi Fi for that?" "Can you help us with the cleaning fee?" etc. And our leadership was not interested in spending on those kinds of things. So I think a lesson learned for me as a public health practitioner, and hope-to-be kind of public policy adviser, you really have to think through how to use your funds creatively to make sure that you're providing a proper service and a proper partnership with a community-based organization, but really offering the $8 a test made a big impact and we were able to partner with a lot of local health departments all across the state to work with us directly. Where they had a space, they were able to-- either they collected the tests or they sent a SHIELD team to collect those tests. And so as much as we wanted to target certain communities, we were kind of limited to serving communities that had enough resources to host us.

Rebeca Escamilla 38:10
Thank you. So I guess you already did talk about this, some of the challenges when setting up, but were there particular large concerns are barriers that IDPH faced when trying to set up a community testing location?

John Arenas 38:33
Um, yeah, I mean, I think it really was about the capacity of the host organization and kind of the real estate component. I mean, do you have a space where you can do this? IDPH was not interested, nor did it have the legal capacity. I mean, they had so much going on to try and sign a bunch of individual agreements with like, retail holders throughout the state. I mean, that wouldn't have been a good model. That's how we kind of started off with the ten original sites and that didn't really make sense and it was very expensive. So it really became relying on community-based organizations. Another challenge, of course, was the weather especially in the winter. Having staff out in zero degrees to collect tests was a challenge. Those people are heroes. I mean, the fact that they were out there doing that work is incredible to me. It's never something I did you know, I that's just, I can't really even you know, imagine it but I guess that was a challenge as well, trying to make sure we can keep the staff safe. And so part of what I worked on was a plan to try and not only to winterize our sites to keep the staff safe from the elements, but then also keep the staff safe from each other and from the patients COVID-wise. You can do a lot to keep it sheltered but then at what point are you risking airborne spread in an indoor area. And so that was a challenge that we had to work through. And that was also a concern we had from community-based organizations, oh, you want a bunch of sick people to come to our organization and come through our hallways? We don't want that and like, that's fair, but you can't really offer testing and then be like, Oh, you can only come get tested if you're asymptomatic That also doesn't--that's not really the public health goal, right? So, I'd say those were challenges to setting up community testing in some areas, you know, kind of like the schools. I will say there was there were areas that didn't really want IDPH to offer testing in that area, or there wasn't I'd say excitement about it, at the very least, which makes it more challenging when you don't have broad community support for an initiative

Rebeca Escamilla 40:46
I guess also, kind of following along with the challenges of IDPH, did IDPH itself face any backlash over some of the decisions it was making? For example, we also spoke with the contracts office at SHIELD, and they mentioned that sometimes if a superintendent just personally didn't believe in COVID, they just wouldn't sign up their whole district. So I was kind of interested in what were the some of the backlash challenges that IDPH faced?

John Arenas 41:27
Certainly, I think what you've seen throughout the country, in communities everywhere, right? People distrust the government, distrust public health and a lot of that's pretty warranted, right? I mean, as Americans, you know, we have a healthy distrust of our government. But as someone who's in government and you know, wants to do the right thing and want to provide services to people, you can educate them, you can talk, have a conversation, understand their concerns, try and empathize. And that's what a lot of our conversations with the school districts looked like and a lot of them then made the decision to move forward after kind of being heard out and having their concerns understood. At the end of the day, some people never took a meeting with us because of how they fell or some people felt like this isn't worth it, or some people dropped out and that's okay. That's their decision. Public health's role is to educate people. I think where people felt the most frustrated is if they felt at all like they didn't have a choice or like in some way that they were being forced to make a decision. People definitely, there was backlash to that. On the other hand, I would say one of the conversations we tried to have with school districts along the lines of, for example, you know, there's quarantine policy, and I'd like to touch on that actually, before we wrap up, but kind of quarantine policy for school districts. If you have a kid on your team that gets sick with COVID and they've been exposed to everyone else, they shouldn't be back playing a sports event the next week and so it would be up to the local health department to make a decision, you know, are they going to say you can't do that really in the school district? And I guess that's where you have a bit more of a values conversation, but I did come in clear with my values in these conversations and say to folks, "look, I don't think that playing the basketball game is worth people getting potentially sick." And so there was some of like, yeah, you do have to make hard choices sometimes. And in some cases, local health department would have to step in and say on our legal authorities to say that you can't have this event or that this person needs to stay home. Rarely do they ever actually have to use that authority in a court kind of sense, but they would have to have that conversation with folks. I think that's where it gets a little tougher. But ultimately, you know, it's not right for people to be sick and exposing people to a deadly disease.

Rebeca Escamilla 43:46
I guess a follow up question would be IDPH, when they were making their guidelines and policies, were they keeping this in mind? Or did they have to change any policies to follow kind of what the public was saying?

John Arenas 44:03
Yeah, so that was like a large part of my role was trying how do we balance the concern the operational concerns that schools have right? Everyone can't just be like, like out sick at the same time, you have to have some kind of-- It can't just be, that doesn't work practically. You have to figure out how can we kind of minimize risk, but keep stuff going. There's obviously a lot of concern about masking. Masking is

a pretty low impact intervention compared to some other things you can do, especially like quarantine or even testing, which is expensive and time consuming. So that seemed like, keep masking in place, that that isn't the best thing to change. But quarantine is really where I personally kind of had trouble. I really felt like how can we reduce the burden of quarantine for schools we want to keep kids in school. I mean, that's that's the point when we need to keep teachers at their job. How do we do that and keep everyone safe at the same time, reasonably safe, right? There's no such thing as perfect safety. There's always some level of risk, especially when we're going to school in a pandemic. And so, I had heard of this program out of Utah, from one of our epidemiologists, where they were doing some version of testing students so that once they were exposed rather than have to stay home for seven to 10 days, which really frustrated community members and I had those conversations with community members directly at times, what if we, you know, offered them COVID testing as an alternative to quarantine? And I think that was one of the best innovations that we came up with over the course of the program and eventually got permission from the governor to move forward with that and got basically an offering that to school districts and was very, very popular. It was hard to implement correctly and find out how to exactly do it, especially because we only got permission pretty late in the game, I think pretty close to school starting. Schools, you know, I'm sure there was not 100% compliance. I'm sure some kids came back, maybe not with getting all the tests that we recommended, but again, it was a risk reduction strategy while trying to keep schools open. And ultimately, many many schools adopted it. And we this Test the State program, as we call it, involve them getting tested originally four times I think we cut it down to two times after exposure. And it became a national model alongside a couple other states, the CDC wrote what's called an MMWR I think it's like a Morbidity and Mortality Weekly Report on our program, and also, I think a program in California doing similar work, and they adopted it as official guidelines in December 2021, which I saw as a major accomplishment for me personally, I thought that was really something I was I was proud of.

Rebeca Escamilla 46:54
That's pretty interesting. I thought that that had been an idea from the CDC and then kind of trickled down but it's interesting to hear that it was kind of the opposite.

John Arenas 47:04
Yeah. They like actively didn't approve of it in that fall, and we had to kind of work with local health departments and say, we know what the CDC says, but we really think this is going to be more safe and we think it's gonna be easier for your students and your districts and kind of had to figure it out. Not everyone was on the same page with us and that's okay. It's their prerogative as the local to make a decision, but we just offered that as an option for districts and a lot of folks took us up on it.

Rebeca Escamilla 47:30
So, sorry if I missed it, but would this be the Test the State program? Yes? Ok. And then we already spoke about that so we can skip that. It's just a state program question. And then, I guess, kind of touching back to what we had previously discussed about the finances for IDPH and getting the resources covered. So did it get most of them? Was it paying for its resources through the grant? Because I believe there was also that the state was probably paying for some things but I'm not completely sure.

John Arenas 48:07
Yeah, to my understanding, the grant came into state accounts, so it became state money. So it was technically state money flowing through the federal government but to my knowledge, I don't believe the state, you know, they hired internally and had to spend state money for my position, for other positions that helped run the program. But as far as the actual costs of implementing the program, I'm not aware of the state using state money at all. If so, it'd be a fraction of a percent of the total cost of the program. You know, we wanted to keep costs low, but particularly in the K-12 program as we began to innovate and lower costs and because of our partnership with SHIELD, total funding was never a problem. And that's something I tried to communicate to leadership with varying degrees of success. But again, with a $300 million grant, that was an incredible amount of money that Congress set aside really only for this purpose. If you look at the legal documents for this grant, it could only be used for K-12 testing. And so I think our first agreement with SHIELD was for the education for the financial side, it was only like $100 million plus $125 million. So again, we could run down that whole contracts and spend a little more than a third of what we've been allocated through the federal government. And so what we actually ended up doing was we were one of the most successful programs in the country, we went back to the CDC, like other states, and said "Hey, look, this program is ending in 2022. But we have a lot of money left, and we have a lot of schools signed up, can we do this again for another year?" And they said yes, so that's why SHIELD's still going today and is going to wrap up this summer is because the the Feds extended the grant for an additional year. Originally, they wanted to suspend all that money much faster and it's like, no, that's not that's not wise or possible.

Rebeca Escamilla 50:13
Thank you. So I also have another question about so for example, for IDPH and the hiring for the testing sites. Did it have to hire any new staff or was it volunteers or did it had to shuffle around some staff to move them into new roles?

John Arenas 50:15
A little bit, so on the administrative side, things like Program Management, they shifted some folks around but eventually became me and really, two other folks: James Went and Zachary Bacon who I don't know if you're going to interview but I recommend you do. I think you're gonna meet Charles so you can get their contact info from him. Zack did all antigen testing so Binaxnow deploying that and James worked on wastewater testing, which is I think, really cool, you know, SHIELD only was more peripherally involved with those initiatives. But if you're documenting COVID In general, definitely think it's worth talking about. So that was the team for a little while for a stretch us and Charles, we had a couple of different folks roll on and roll off that we're supporting the work. But we were probably there the most consistently over the course of the two years I was there. We had some folks that helped support from the mobile testing programs, some folks who helped program manage as well. Kind of co-program managed with me for a time but as far as anyone actually in the field, working on sites, IDPH did not do any of that hiring. That was our external vendors and then later SHIELD who hired their own people to carry out that work. And then I have a follow up question. Did IDPH experience any turnover from staff? Because that was something that we consistently heard from different departments, just people quitting during the pandemic. Yeah, for my team, my team was so small, it's a small sample, but we did experience, like I said, when I first started, everyone already had existing roles that they were just kind of helping out with COVID on, so they all switch back to those roles. We're talking about four

or five people that were on the team when I started. Then we hired some folks who did end up--both of the people that I have in mind started with our team and then transitioned to other roles within IDPH. And I think that's because, you know, these were folks that were more mid-career and having more responsibilities and so, the problem with public health funding during an emergency is when it's time limited. That's not really [inaudible] for people that have a lot of responsibilities. And so I think they were concerned, especially with, you know, COVID was changing all the time, like, how long is this really going to last? How long were they going to be doing this? And so they made the decision to do something different at the department. I think it was just more consistent and probably better compensated for them in terms of one note is that we were most of us hired to work on a program or contract employees under personal services contracts. That has to do with like the state of Illinois hiring issues, which you might want to--you can probably talk to an academic at the university who would know better than me, but like, basically because of the history of corruption in the state, it's really limited how many people you can hire to work, which is a pretty big problem when you're in a public health emergency. So none of us got benefits, for example, as like one problem, so I knew that for some--for me, I was under 26, still on my parent's insurance so luckily that wasn't a huge obstacle, but for someone that's, you know, a mother, for example, you want health insurance from your employer, right. So that's part of why they made that decision.

Rebeca Escamilla 53:49
Yeah, thank you. It's always interesting just to hear the opposite perspective of people who choose to leave. Um, so I guess just turning on to a new topic. You did mention the labs, but I just, for a clarifying question, did IDPH use specific labs or were most of the labs handled through SHIELD?

John Arenas 54:16
Yeah, no. So we had three lab vendors that we worked with. They were Tempest Labs, Reditus Labs, and Simple Labs that were our major vendors at the beginning of the pandemic.

Rebeca Escamilla 54:32
And were you--did you have any relationship with these labs? How was it? How was the movement of, of materials flowing through, for example?

John Arenas 54:46
Yeah, so that was a large part of my role and others' role as well, working directly with these labs and coordinating that, and so we had a separate vendor for specimen collection called HR Support, they actually collected the specimen on site and then they would deliver the specimen to the laboratories for processing and then resulting in the case of Reditus they actually helped do specimen collection as well, so there wasn't always a need for HR Support in that and they would just take it directly to their own laboratory. But that's kind of how things flowed.

Rebeca Escamilla 55:21
Thank you. [JA: Sure.] And then some of these are more of a personal questions from some of the slight research that we did beforehand. So for example, you did mention beforehand the ELC Grants. So can you tell us more about the involvement of IDPH and these specific grants, so for example, the

ELC Reopening Schools and the ELC Enhancing Detection grants? [JA: Yeah.] Is that the same grant that was funding the testing or...?

John Arenas 56:07
That's a good question. So the way to think about it is the ELC Reopening Schools are like, had to fund all K-12 testing, and the ELC Enhanced Detection funded all community testing. And so we had basically separate sections in our agreement with SHIELD outlining what was going to community what was going through reopening schools K-12. And then on the IDPH side, we had to make sure that we were paying the proper amount out of each fund, according to the grant uses, and yeah, I mean, you know, applying for that was fairly straightforward. I mean, we got basically a Word document from the CDC, that we had to fill out, answer questions about our program and what we intended to do and send that back to them. There may have been other elements that I wasn't exposed to, but I was pretty heavily involved on that project. And they got back to us, I think within like a month and a half. And we'd won the grant. But again, this was kind of it's not really a competitive grant. It was designed to be won by each of the individuals states.

Rebeca Escamilla 57:08
Thank you. And then I guess just more of a personal and then also a career question. So how did your day-to-day look like? Were you always in communication with vendors and then the networks, the lab networks or with SHIELD? Did you at any point had to interact with the public aside from the community partnerships that was going on?

John Arenas 57:39
Yeah, so a lot of my work was a mix of stakeholder engagement, so talking with our vendors, talking to SHIELD, that pretty directly led into like program management decisions to try and figure out how to make things more efficient. I would do data analysis on the testing that we had done to figure out where we wanted to target and where we were being successful, which also lead pretty directly into financial projections. So understanding if we're doing this level of volume, at this price, how much money are we going to have? Making sure that I was reviewing invoices, making sure that that line ended up where we would have projected to spend and then yeah, I did end up talking to the public a fair amount. You know, if someone had an issue, you know, maybe not the public, per se, sometimes it was public, but it was often like a local health department leader who had a problem and would call me and say, Hey, can the state help us figure out how to respond to this outbreak. So that was the kind of folks I would talk to, but I would talk to--I know I talked to parents on more than one occasion, who were dealing with an issue with their with their child and were just confused and wanted to talk to somebody at Public Health. And then also, part of it, a small role and I really took on less and less of this and kind of ask someone else to do it, but we had a public inbox that we would respond to. A lot of that was people trying to sell us stuff, to be honest. Hey, can we do your COVID testing for you? Et cetera, but basically, sometimes it was someone that's like, Hey, I'm really confused. And sometimes I would talk to people that got tested with IDPH and something went wrong. And so I talked to them help, you know, walk them through what we can do about it, apologize, etc.

Rebeca Escamilla 59:12

Thank you. And then just kind of some wind down questions for the interview. They're also more guided towards getting your personal experience as well. So for the pandemic, it's been, we had waves and different guidelines and different phases and throughout the pandemic. What do you think about IDPH's response to the COVID-19 pandemic in essence?

John Arenas 59:47
I mean, I really believed in the work they were doing, and believe we kept a lot of people safe. I think, you know, in the next pandemic, I think I would say, the more we can offer--it's a state level organization, it's hard to manage the state--but the more we can offer a community some flexibility to what's going to work for them, offering people a choice in how they choose to participate, I think that emphasizing that messaging is really important. So those are definitely lessons learned. People are free to make their own choices in most cases and so how do you kind of educate them and provide optimal options without doing anything that looks like or feels like coercion because that's not helpful or good public health in almost all cases. Yeah, and I think honestly, the biggest challenge is we just didn't have enough staff support internally at IDPH. There just weren't enough people working on this project to make it as successful or have as much oversight as I would think that a typically funded project in the hundreds of millions should have, and that's primarily I can't say, I don't know, I'm not--I don't know if that was a prioritization decision, or if that was just the limitations of internal funding or kind of like I said, you know, legal restrictions on how much hiring could even happen. But that was that was a weakness for us and I would I would do that differently, if at all possible.

Rebeca Escamilla 1:01:23
And I guess on a personal level, what were some of the challenges that you experienced? For example, we've had interviews where epidemiologists tell us that if they could do it, they would have chosen to spend more time with their family. Just more of that human aspect in a way.

John Arenas 1:01:31
Well, I really did try prioritize, you know, I don't have kids or a partner like that. So, a different level responsibility, but I did try to prioritize spending time traveling home, spend time with my parents, my grandmother and my sister and my you know, my loved ones in Chicago as well, but honestly experienced a lot of anxiety over the whole thing. My role as a very young person, like I said, not properly staffed, not really given--I had great support from my boss, but like more broadly, in the department, like not really. And so I think I felt a lot of pressure to perform in the job and couldn't always perform because of everything that I had going on, personally, that we all had going on. And that yeah, it was tough for me. I think I had to work on that personally and figure out how to navigate that issue. But that certainly was a big challenge. I think, on some level, one of the difficulties of public health or any profession where you're working directly with folks in high stakes situations is how do you--I don't know the answer to this, but how do you develop some kind of separation or distance from the work that keeps you kind of like motivated without becoming numb or disinvested? I think it's something to work on. Some people work on that their whole lives, but that's definitely, it was a challenge during COVID because you're also dealing with so much other stress, right? We all did.

Rebeca Escamilla 1:02:48

Thank you. So how did this experience in your previous role as testing coordinator, how did that influence your professional goals, or did it influence professional goals?

John Arenas 1:03:42
Absolutely. So I really enjoyed being able to, you know, manage this project, get feedback from the community, improve the program and make a real difference for people. Strengthened my skills in data analysis and kind of financial management. And it really made me feel confident about kind of taking the next step in the public health world. But I realized that I needed a break from the grind of working and had an opportunity to apply for school so I did made a decision to pursue a Master's of Public Health. And so now I'm in Boston doing that and really loving it really, really loving it. I'm not sure I want to do infectious disease anymore. Maybe if I have to, but really interested in working on, for example, like the Medicaid program and looking at how can we use Medicaid to improve people's, not just obviously access to health care, but improve what we call social determinants of health or provide their health-related social needs, so that their overall health improves and actually can cost the system less money if you take better care of people's health in the long run? So that's the kind of thing I'm interested in right now. I think I'm gonna do you know, do some healthcare consulting, kind of project management, very similar style work on the private sector side this summer, so really trying to strengthen my skills there but absolutely. Yeah, it's pretty foundational for me.

Rebeca Escamilla 1:05:12
And then, this is more of a reflection question, but if you could have done anything different, is there something that you would have done differently?

John Arenas 1:05:23
I might have asked for more money earlier from the department because I was providing a lot of value to the program, but for a while I was still being compensated like a pretty junior staff member. And I think I would have pushed harder on trying to get testing in the Latino community, particularly in those early days. I still don't know like, what necessarily the right solution was to provide access. But that's something that I regret, and I wish I had been more effective at pursuing

Rebeca Escamilla 1:06:01
Then, this is also more of a personal question reflection on your career, do you think that in your field that we will ever return to a pre pandemic--I guess it's not a return to normalcy, the normal state, but how do you see the future of your profession after COVID-19?

John Arenas 1:06:29
Oh, yeah, I think we have a lot of work to do to regain public trust. As you've probably heard, I think there needs to be shifts in the kind of posture that public health takes with the public. Because it can't, it will not work in the future to try and be like, "I'm going to tell you what to do." And it really has to try and find some way to motivate people to make the right choices on their own and find strategies that acknowledged people simply will not and still try and provide the best care you can for the rest of the community. And then we're gonna have to be prepared to think particularly about vulnerable populations, where there wasn't really a plan in place, for example, thinking about well, I'd say children, for one, right, that's obviously who I worked with, but folks with disabilities, folks experiencing

homelessness folks with kids under school age, even. We didn't really have good policy for those people even at the end of my time there. How are you--and in particular, parents of young children, if your kid is exposed in daycare and now they can't come to daycare for like a week? That's really hard, especially if you're a single parent working a lot, how are you going to navigate that? And so there has to be a better solution. I don't know what it is today, but I think there has to be more flexibility that acknowledges that different people have different abilities to protect themselves from infectious disease. And we see that in the [inaudible], right? If someone like myself who got to work from home for the whole pandemic, that was always pretty safe, versus someone that has to go in and is financially required to go into their place of work and put themselves at risk. That's not the same. Public health needed to have more flexibility and messaging around tha, it kind of was like a shaming thing, if you expose, whatever. So those are some of my thoughts.

Rebeca Escamilla 1:08:27
It's good to hear. I mean, this is why we're doing the oral history interviews, just trying to get these different perspectives for posterity. And yeah, that was my last question. But also do you have anything you want to bring up or do you have any concerns or a last thought?

John Arenas 1:08:51
No, I think that was a good good place to end for sure. Thank you for your kind of work. What's gonna end up happening with the project, like, does it go in an archive and researchers look at it or will be publicized or like what what kind of kind of happens next?

Rebeca Escamilla 1:09:08
So what's going to happen after for example, once we end this interview, we'll send you the interview agreement form to sign and then we'll also send you the transcript so you can look over the transcript and just give us your approval or if there are any changes that you want to be made to the transcript or the audio before publishing it and this will be available in our digital library repository. So that means that the public will be able to access this interview.