Rachel Levine

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Marianne O'Hare: Welcome to Conversations on Health Care. This week we welcome Dr. Rachel Levine, Assistant Secretary at HHS on the Biden Administration's efforts to address long COVID, child vaccine uptake, monkeypox and women's reproductive rights.

Dr. Rachel Levine: We want to make sure that we protect patients and providers from discrimination. We want to protect emergency access to abortion care.

Marianne O'Hare: FactCheck.org's Managing Editor Lori Robertson checks in and we end with a bright idea, improving health and wellbeing in everyday lives. Now here are your hosts Mark Masselli and Margaret Flinter.

Mark Masselli: Our guest leads an office that just reported an estimated 7 to 23 million Americans have developed Long COVID. Research has shown a Long COVID condition can last weeks or months effecting all ages, backgrounds, and demographics. Previously healthy individuals may become disabled while others heal.

Margaret Flinter: Here to discuss this issue and other timely topics is Admiral Rachel Levine, Assistant Secretary for Health in the US Department of Health and Human Services. She's connected to the researchers who are working quickly to better understand Long COVID which is a multisystemic and multifaceted disease.

Dr. Rachel Levine: Thank you very much. I'm very pleased to be here.

Mark Masselli: Yeah, we're so glad that you're back joining us in Conversations on Health Care. You were last with us in June of 2021, and at that time we talked about the health equity in mental health issues related to COVID. Now, the Biden Administration just released the National Research Action Plan on Long COVID, and it's the first US government wide national research agenda focused in on this issue. Some clinicians say that patients with Long COVID are either unvaccinated or missing their boosters. Are you seeing that in the work so far?

Mark Masselli: Well, so we are seeing that vaccination is somewhat protective for people in terms of getting Long COVID, but we need more research, and that's what the National Research Action Plan in that report emphasizes is that we have done research through the NIH and CDC and other departments, but we need more research. The plan outlines the research to come.

Margaret Flinter: Well, Admiral, there's another report out now that outlines federal services that are available to Americans to address Long COVID, and it includes resources for health care personnel who are treating patients with Long COVID, which is certainly a challenge that's emerging for health care personnel in the US. What are the unique risks for

patients with Long COVID and for their health care providers? Is it significantly different from treating what we might call the initial stage COVID patients?

Dr. Rachel Levine: Well, we still have more to learn about all of the different aspects of Long COVID. There are many different signs and symptoms to Long COVID, and that is really the point of the Research Action Plan through the NIH and the CDC and others. But you're right, we have a second report, the services and supports for longer term impacts of COVID-19. This outlines the federally funded supports and services for individuals and families experiencing those longer term impacts. It also does outlined recommendations for physicians and medical providers that are seeing those patients.

We don't know exactly what is causing Long COVID, it might not be one thing, but Long COVID is real and those patients need support and they need treatment. The treatment can't be as specific as one medication or one specific treatment, but they do need support as we do for many other patients with these type of chronic conditions.

Mark Masselli: Well, I think you're so right that we need more research, and not only with NIH, but others as you indicated are doing that. We read recently in a science magazine that others have suggested that Long COVID might actually be a post-infection syndrome and may highlight there are no auto immune markers to make “a real disease,” I wonder if you can address that perspective.

Dr. Rachel Levine: Well, again, I want to emphasize that that Long COVID is real, because we want to make it to emphasize that patients are not malingering, but we don't know exactly, as I said, what causes Long COVID. There are some research studies that indicate that it might be a chronic infection with COVID-19, and there was a recent research study from Harvard a month or so ago which suggested that. But we need much more research to know if it is a chronic infection or whether it is more of a chronic inflammatory response, as you said, a post-infectious process.

In my field of adolescent medicine in my academic medicine career, I saw many, many teenagers and young adults with post-infectious symptoms, so whether that was patients with neuro immediate hypotension and a tendency to faint associated with other behavioral aspects, whether it was patients with chronic abdominal pain after probable viral gastrointestinal infections. This is not new to us. This is not new to medicine. The one syndrome that we have seen is MECFS myalgic encephalomyelitis with chronic fatigue syndrome, and we've been studying that for years. What we're hoping for is that the research into Long COVID will also give us new perspectives on those illnesses as well.

Margaret Flinter: Well, Admiral the shared numbers of people infected and within a relatively short time in our country hopefully is bringing tremendous focus on this and we really thank you for your leadership efforts in this area. There is so much going on in our country right now. I'd like to ask you about another front, we're still assessing the impact of the Supreme Court Dobbs decision overturning a constitutional right to abortion.

President Biden has just praised Kansas voters for rejecting an abortion ban. The Justice Department's filed a lawsuit against Idaho to block a state law that would allow doctors to be criminally prosecuted for providing abortions. The President signing an executive order aimed at supporting Americans who cross state borders for abortions in terms of access to reproductive health care including abortions. Can you comment on what more needs to be done, and can we expect to see further actions in the near future?

Dr. Rachel Levine: Well, this is a critical issue for the Biden-Harris Administration and for Secretary Becerra and myself and others working at HHS. Access to health care, access to reproductive health care and reproductive rights is a core value of the administration, really across the federal government, and particularly for Secretary Becerra and HHS.

The Secretary has laid out a plan and is working to take action to help people, and as you said the President signed an executive order. We want to make sure that we protect patients and providers from discrimination. We want to protect emergency access to abortion care. We want to make sure that providers have training in these services and we want to strengthen family planning care and emergency contraception in the face of this extremely difficult and challenging Supreme Court decision.

We are working through my office of the Assistant Secretary for Health, and then other offices, our office of Civil Rights and others on these initiatives. We have launched a website ReproductiveRights.gov which is a public awareness website. We are convening health insurers and calling in them to commit to meeting their obligations to providing coverage for contraceptive services at no cost, which is required by the Affordable Care Act. There is new funding to bolster training and technical assistance for Title X planning providers and more, so many different efforts across our department and the administration on this issue.

Mark Masselli: Admiral let's just stay on that topic for a moment, the administration has issued guidance to remind health plans and insurers of the Affordable Care Act's contraceptive coverage. In light of the Dobbs decision, a group of senators has asked the Veterans Affairs Secretary to provide abortion access to veterans in states that restrict or ban the procedure. Would you be in favor of such a move?

Dr. Rachel Levine: Well, that's more of a legal issue that for the VA that I can't really count on, but we want to make sure that people have access to the reproductive services that they need and they deserve, and so we'll be working across the department and administration to achieve that.

Margaret Flinter: Admiral, yet another major public health threat. Now in everyone's consciousness, we're dealing with monkeypox and we'd like to give you a chance maybe to respond to critics some in the LGBTQ community included, who say that the Biden Administration has not done enough maybe to prepare as well as to respond based on what is happening now. Certainly, we are seeing overwhelming interest in receiving the vaccine by the targeted populations at risk at our community health centers here in Connecticut, but the supply is low. We don't know whether we'll be able to be replenished. Can you comment on this for us?

Dr. Rachel Levine: Sure. Well, the monkeypox infection issue is a critical issue for the Secretary and for HHS, and obviously for the administration. They have just hired a coordinator at the White House and a Deputy Coordinator, Dr. Daskalakis, who has been in the New York Health Department and the CDC, very experienced in terms of these infectious disease issues.

Remember that the supply that we have had in the national stockpile has been for potential smallpox infection, there's no way to have anticipated that monkeypox would have spread the way it has in the world and in the United States. We are fortunate that we have had a supply of the Genoese vaccine that we have distributed to the State Health Departments for Administration, and we are working with the manufacturer which is located overseas on purchasing more. We have received much of that vaccine and are working on distributing that, and then we've purchased more for the future.

The CDC has outlined a procedure for the distribution of the vaccine looking where the infections are now, but also looking to where they anticipate the infections will be in the future so that we can stay ahead of this. We have expanded testing, and we have expanded testing to commercial laboratories, so testing should be much more available now. There are five commercial laboratories that can do testing.

We want to work on mitigation and ways that people can help protect themselves from infection with monkeypox, which is -- it's different than COVID-19. It is spread only through close personal contact, it's not going to be spread across the room the way that COVID-19 can be as a respiratory virus. We're working on distribution of TPOXX, which is the treatment. Now, again, the treatment was designed for smallpox, not for monkeypox, but it is effective against monkeypox, and so we want to work on the distribution of these resources, which

again, the vaccine and the treatment had been stored for potential smallpox infection, but we are deploying them for the monkeypox response.

There is another vaccine that people have mentioned, the ACAM2000 vaccine that also has -- does have significant stores in the national stockpile for any potential smallpox infection, but it's a different vaccine. It's a live virus vaccine that is not totally attenuated, and it does cause a viremia an active infection in people who then are usually pretty mild, who then mount this effective immune response. But for people who are immunosuppressed it can lead to a severe active infection. It also can be spread by someone who's been immunized and could have spread to a close contact who might be immunosuppressed.

In the community most impacted, the men who have sex with men community, and the potential of HIV in that community. The ACAM2000 is not really an effective countermeasure at this time. We want to make sure that we deal with any issues of stigma associated with monkeypox, anyone can get monkeypox, it just has started and spread in the men who have sex with men community. That's where we'll be targeting our resources right now.

Mark Masselli: Well, I do want to highlight that the percentage of Americans without health insurance hit a record low 8% in the first quarter of 2022, but maintaining that low rate depends on a lot of factors, whether the Senate can extend expanded Obamacare subsidies through the Reconciliation Bill. As we talk with you, it's really unclear if Senator Sinema will cast the crucial democratic vote needed to make this happen. If the Senator were listening right now, what would you say to her?

Dr. Rachel Levine: Well, so it's not for me to, as the Assistant Secretary for Health, to give any of the senators personal advice about their vote. All I can say is that it is critically important that we continue that positive trend, and continue to work on decreasing as much as possible the uninsured rate in our country, so measures that help decrease the uninsured rate are very important for medical reasons and for public health reasons.

Mark Masselli: I'm wondering if I could do a follow up because another big issue that is the emergency order that the President had still, I think, is extended until October, which for all the 50 states and territories means that, I believe, there's no sort of redetermination going on in Medicaid, and that once the emergency order is lifted there may be an enormous number of people who lose their Medicaid coverage. Any thoughts of ways that that can be mitigated, and again there's a 90-day promised back to the states that we'll let you know before we take this action, but still millions of people in the balance here, what are your

thoughts?

Dr. Rachel Levine: Well, I know that this is a very important issue, and I know that Chiquita Brooks-LaSure the Administrator of CMS and the Secretary and others are looking at this very, very closely because it is very important.

Margaret Flinter: Well, Admiral, we've been at this for a long time, we certainly remember the pre-Affordable Care Act days and hope the positive trends that were rocked by it continue. We're also proud of the work that our community health centers in terms of providing exceptional care and sensitive care to our LGBT community and this includes gender affirming hormone therapy. You were part of a recent roundtable of families who have children who were transgender. Maybe you could share with us a little bit about what you heard about what people need, what might help more Americans understand what's at stake here. Certainly, the vitriol from the anti-trans forces is very worrisome right now, particularly when we think of our young people.

Dr. Rachel Levine: We've made so much progress under the previous Obama administration and then President Biden's administration for the LGBTQI+ community, but unfortunately we are facing a significant politically motivated backlash, where there are politicians particularly in states that are enacting laws and taking actions that are politically motivated and very challenging and potentially damaging to vulnerable LGBTQI+ youth, particularly for transgender youth, and for gender diverse youth. We're talking about actions in Texas, and actions and laws in Florida, and Alabama and in many other states.

We're going to need to respond to these challenges, because we want to empower young people, but we also want to affirm and empower young people who are transgender and help them in their care. These actions that limit their participation in sports and activities, actions, that -- and laws that actually limit their ability to access gender affirming treatment offered by pediatric specialists at our expert children's hospitals are egregious, and so we're going to respond in a number of different ways. One is in terms of advocacy. The President has spoken about this, the Vice President, the Secretary, myself, as you said, I have visited with young people throughout the country at gender affirming clinics, whether that's the Adult Children's Hospital, Children's National Medical Center in Columbus, Ohio, and DC, Children's National Medical Center, and many other places I've heard from these young people.

I've heard from these families about the challenges that they're facing, so I have gone to Texas, I have gone to Florida, and I am speaking out about this. But that advocacy is necessary, but it's not sufficient. We're also working on policy. The last number of weeks our

Office of Civil Rights has put out for public comment their rule and regulation, which states that the Affordable Care Act and Section 1557, which states that you cannot discriminate on the basis of sex, that that includes sexual and gender minorities, that includes sexual orientation, and gender identity. After the public comment that will inform everything that how we look at that issue across HHS including for HRSA and community health centers, including for CMS and for our Medicare and Medicaid, and for insurance coverage, and so we're looking forward to the promulgation of that regulation.

I know that in other department such as the Department of Education, they have made the same interpretation for Title IX, and that has gone out for public comment. We know that the administration is going to be working on the legal front, and with the Department of Justice which has already weighed in with a brief and comment on Alabama's law, which actually made providing gender affirmation treatment a felony for those pediatricians and experts at children's hospitals.

Then finally, the President has called for Congress to pass the Equality Act in terms of rights for sexual and gender minorities. We have to work on all of these fronts to protect the rights and freedoms for our LGBTQI + individuals and their families.

Mark Masselli: Well, it is so important to focus in rules, regulations and legislation. There's a lot that looks like it's in the pipeline that will have a profound impact. But I do want to just note for our audience that you're known and praised for your mental health work, so thank you. Certainly it was good news when the new 988 suicide and crisis hotline began and there's a federal mandate, and 430 million allocated to states to expand their crisis networks. But now there are reports that there are 29 states have not introduced any legislation to address the 988 hotline funding. What can the administration do and can they work around the states and maybe directly fund nonprofits to do this work. What are your thoughts?

Dr. Rachel Levine: Well, so you're correct, mental health challenges coming with the pandemic have been very serious, particularly for youth, but really across the lifespan, and that includes, of course, the disease of addiction and substance use. But we have had a lot of concerns about suicidal risk among specific communities, particularly young people. Also, we were talking about the LGBTQI + community, but other communities that have been very impacted by the COVID-19 pandemic, the African-American community, the Hispanic community, and the Latino community, the American-Indian Native Alaskan community and more.

Last month with my associate, Assistant Secretary Delphin-Rittmon of SAMHSA, HHS launched a new three digit hotline 988, it is for calling

but it is also for texting and chat. As you, I'm sure you know, teenagers don't call, they will use texting or they might use chatting. Using that three digit line, they will be connected to trained counselors as part of the existing National Suicide Prevention Lifeline network, and so we are continuing to work on all of these different aspects. There has been 432 million including 105 million in grant funding to states and territories provided by the American Rescue Plan. We're working to work with states and territories on the implementation of this plan. This is being done, again, primarily through my colleague Dr. Delphin-Rittmon of SAMHSA, and they're going to try to work with all of the states and all the territories to make sure that this critically important lifeline is implemented.

Margaret Flinter: Well, Dr. Levine, Admiral Levine, we really want to thank you for joining us for your willingness to comment on such a wide range of issues of great concern and interest to our country right now. It's especially meaningful to us as the week of August 7th is National Community Health Center week. We appreciate your understanding and appreciation of the work that community health centers do and how vital health care as a right for people in our country is. Thanks also to our audience for joining us today and you can learn more about Conversations on Health Care, and sign up for our emails at www.chcradio.com. Admiral Levine, thank you so much again for joining us.

Dr. Rachel Levine: Thank you, it was a pleasure.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: Tetanus affects the nervous system after bacteria called Clostridium tetani enter the body through an open wound. More than 80% of cases occur in mothers and their babies according to UNICEF, and the fatality rate for infants is between 80% and 100% according to the Centers for Disease Control and Prevention. A lack of access to hygienic delivery and umbilical cord care contributes to high rates of infection which are concentrated in South Asia and Sub-Saharan Africa.

Although there are safe and effective vaccines to prevent tetanus, their use has been falling as have vaccination rates generally since the COVID-19 pandemic began. Despite the danger of this disease for infants, a group with a history of spreading vaccine disinformation

called Children's Health Defense has promoted a video on social media suggesting that some tetanus vaccines are actually part of a covert plot to control population growth by rendering women of childbearing age infertile. That debunked claim has been around since the 1990s. The claim rest on the false notion that a hormone blocker that would cause infertility had been surreptitiously added to tetanus vaccines. This claim like many long standing conspiracy theories is based on a grain of truth.

In the early 1990s, researchers in India developed and tested a combination contraceptive and tetanus vaccine that was designed to prevent pregnancies temporarily. It did not have a permanent effect on fertility, but hormone blockers have never been used in tetanus vaccines available to the public. They've only been used in research. Research on a birth control vaccine was revived in 2006 although tetanus had been replaced with E. coli as the vehicle paired with the whole hormone blocker, so the most recent research didn't even use tetanus. Neither the original formulation nor the more recent one with E. coli has been produced or distributed for general use.

As for tetanus vaccination, the World Health Organization and UNICEF have undertaken several vaccination programs to address maternal and neonatal tetanus. For example, UNICEF partnered with Kiwanis International in 2010 in a vaccination effort that resulted in a more than 40% decrease in the number of newborns dying of the disease between 2010 and 2015. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at chcradio.com, we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Health care providers are forever on the lookout for that magic elixir that can cure a host of chronic ills in one step. In the case of obesity, depression, anxiety and stress, that elixir could be a number of steps as in taking a hike. A large study conducted by several institutions including the University of Michigan and Edge Hill University in the UK looked at the medicinal benefits derived from regular group hikes conducted in nature.

Dr. Sara Warber: This study had enough people following them over time that we could see that these two different types of help for our mental wellbeing, they're operating independently, that means that if we go out in

nature for a walk, we're getting an additional boost to our mental wellbeing.

Margaret Flinter: Researchers evaluated some 2000 participants in a program called Walking for Health in England, which sponsor some 3000 walks per week across the country.

Dr. Sara Warber: There was investment in these walking groups in training leaders to take people on walks, finding trails that were good for people they do, even if they had health problems.

Margaret Flinter: Dr. Sara Warber, professor of family medicine at the University of Michigan School of Medicine said this study showed a dramatic improvement in the mental wellbeing of participants.

Dr. Sara Warber: Depression was reduced, perceived stress was reduced, and they experienced more positive feelings or positive emotions. There's been really lovely research that's shown that when we have positive emotions we actually have better health in the long run.

Margaret Flinter: The participants almost universally reported reduced stress and depression after participating in group nature hikes, and the effect was cumulative over time. Dr. Warber says this is the first study that revealed the added benefits of group hikes in nature and significant mitigation of depression.

Dr. Sara Warber: Because we were really interested in if you are more stressed, would you get some better benefit from being in nature, and in fact that did pan out.

Margaret Flinter: Walk for Health, a simple guided group nature hike program, which incentivizes folks suffering from depression and anxiety to step into the fresh air with others to talk about their thoughts while taking a hike, improving their mood, reducing their depression, increasing their overall health at the same time. Now that's a bright idea.

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Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Marianne O'Hare: Conversations on Health Care is recorded in the Knowledge and Technology Center Studios in Middletown, Connecticut, and is brought to you by the Community Health Center now celebrating 50 years of providing quality care to the underserved where health care is a right not a privilege, chc1.com and chcradio.com.

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