Dr. Rochelle Walensky

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Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery and the great minds who are shaping the health care of the future. This week mark and Margaret speak Dr. Rochelle Walensky Director of the Centers for Disease Control and Prevention. She talks about vaccine progress, confusion around new mask guidelines for vaccinated Americans, how the CDC is reorganizing to better respond to future pandemics and addressing health inequities across the country.

FactCheck.org's Managing Editor Lori Robertson joins us looking at misstatements spoken about health policy in the public domain separating the fake from the facts. We end with a bright idea that's improving health and well being in everyday lives. If you have comments, please email us at CHCRadio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program. Now stay tuned for our interview with CDC Director Dr. Rochelle Walensky here on Conversations on Health Care.

Mark Masselli: We're speaking today with Dr. Rochelle Walensky, Director of the Center for Disease Control and Prevention. She was Chief of the Division of Infectious Disease at Massachusetts General Hospital and Professor of Medicine at Harvard Medical School.

Margaret Flinter: Dr. Walensky is a past chair of the Office of AIDS Research Advisory Council at the National Institutes of Health. Previously, she served as an adviser to both the World Health Organization and the Joint United Nations Program on HIV/AIDS. Dr. Walensky, we welcome you to Conversations on Health Care today.

Dr. Walensky: Thank you so much. Thanks for having me.

Mark Masselli: Yeah, it was great. When I when I think about wearing masks, I think about safety. When I come out of my house, I put my mask on. If I go into a public setting, I'm wearing my mask. I can I guess understand why there's a little consternation in the country when all of a sudden my cheese got moved in terms of what I think mask wearing was all about for so many people. I'm wonder if you could just share with our listeners just a high overview of what the new CDC policy is. Then talk a little maybe about the science behind it. You got a lot of feedback, I'm wondering if you've heard anything that was constructive, where you thought a point well made.

Dr. Walensky: Thank you for that. Yes, things changed on Thursday and I will -- let's just acknowledge where we are 16 months later into this pandemic. All of those things that we have been telling you to do, we're now

telling you it's okay not to do, and change is hard especially since we've been so locked down for such a long period of time. Maybe what I will say is that the new guidance that we've put out is for fully vaccinated people. The guidance reads that if you are fully vaccinated, it is safe to take off your mask in essentially all settings. Certainly, there are some carve outs not during travel, not during in healthcare settings, not in correctional facilities. But for the most part in all general public settings it's safe for an individual who's fully vaccinated to take off their mask. We also want to be sure that everyone knows that if you're immunocompromised for any reason, you should consult your doctor before taking off your mask.

How do we get here? There were several big things that were really moving us, one is our case rates are really quite a bit down, they're down out just over the last two weeks by 30%. The rates we haven't seen really since last spring, over a year ago. Two is vaccine is available for everyone now. 90% of Americans live within five miles of a shot, and there is enough vaccines such that if you want it you should be able to have access to it. Those are two things that are going on outside the science.

What's happening within the science was several studies, just even over the last two to three weeks, and they were -- they kind of bucket into three different areas. One is what I call the real world effectiveness studies, the studies that said that the vaccine is working in the real world just like it did in the clinical trials. The effectiveness is somewhere between 90 to 95 to 97%. Two is that the vaccines are actually working against the variants that we have here in the United States, and there was just recent data about that. Then three is data that was not examined in the clinical trials, and the question was if you're vaccinated can you asymptomatically get infection and potentially give it to somebody else? An emerging data has really demonstrated that that doesn't happen either. At the coalescence of all of this new science and the intersection of cases coming down and vaccines being available, we really thought now is the time to release that guys.

Mark Masselli: Great.

Margaret Flinter: Well, I thought there are some very good news in that, and I appreciate that we get to sit in the studio fully vaccinated and not wearing a mask, which we did not do for the entire year of the pandemic. But yeah I want to focus maybe a little bit on the kids. I'll start by saying in January and February I had never met so many people over the age of 100 in my life as we did at our mass vaccine clinics, when we first rolled it out and they were an incredibly appreciative group of people to get the vaccine. We marched down the timeline, the 80 plus people down to the 50s and beyond, and

now we arrive at our young people. We know that children account for about 22% of new COVID cases in the United States. While many have mild illness, we certainly know there are also some very severe cases.

We're wondering what your messages to the parents of which the surveys show maybe only about 30% of parents plan to vaccinate their 12 and up children right now. We're hearing from our frontline teams that sometimes those kids are bringing in their parents saying get me vaccinated, I never want to be in quarantine again. But what's your message to parent and educators about the risk to children of COVID, the benefit of the vaccine and what they can expect in the coming months in terms of kids being able to go back to what we hope is a normal life?

Dr. Walensky: First, I think let's celebrate yet another moment last week, which is that we have the authorization and recommendation to give the Pfizer vaccine to 12 to 15 year olds. This is the first vaccine that's available to kids lower than age of 16, and now all the way down to 12.

Our data have shown that, you know people haven't necessarily wanted to be first, but they are really willing and confidence increases over time. I think that we'll see that again here. I can tell you, I have a 16 year old who was vaccinated as soon as it was available to him. I was encouraging that, and I think you're exactly right, I have received so many pictures from text of these high school stadiums filled with like really excited kids to get back and vaccinated. As you know when we've had more and more people who were vaccinated who are older, our cases are now concentrating in our younger populations.

We do know that our teens tend to act from a transmission standpoint, like our 20 year olds or older adults so that we know that they can actually transmit. What we really want us to allow them to get back to their lives, when we think about what the toll has been for them with schools with real milestones that have lost-- many have lost graduations. I have one myself who've lost a graduation. I think they are really enthusiastic about getting vaccinated.

Our clinical trial that they did in these teens demonstrated it was 100% effective and no different safety signals. We had -- certainly they may have the sore arm that we all got, and they may have a little bit of aches and feel feverish or headaches the day or so after. But for the most part, the symptoms are exactly the same as the adults. My message is let's give our kids their lives back and get them vaccinated.

Mark Masselli: My youngest graduated from high school this last weekend, and it was a wonderful event. You know I want to go back and pull the thread on your comment earlier about the clinical trials and try to

figure out those trials told us, I forget when, in November that the vaccines were safe and effective for us to start taking. Tell us a little more about those clinical trials because they're still going on, and they have some important information they were going to be able to tell us somewhere along the line.

I think they're at least saying now publicly, the vaccine is good for six months, it may be good for much longer. But science really likes to go back and look at those clinical trials. What are we learning from them? I don't ever sense not that people are hiding it, but a sense of transparency, but they will be a harbinger for what might happen in terms of things like a booster, or whether or not there is a an annual -- as many people have to get for influenza, an annual shot. When will we hear word about what's happening there?

Dr. Walensky: The clinical trials provided us information with two months of safety data which allowed us to have the authorization. What we're really now looking at is six months of data, which will allow us to have approval that Pfizer has just put forward, and so we don't expect any signals there at all. We're certainly going to follow, we'll see what they say. But I don't imagine that they would have put forward with the approval if there wasn't just good news to share.

Certainly some of the people who participated in the trial received placebo, perhaps have opted to get the vaccine in the interim. We may have lost some of our power in that situation in terms of long term two year follow-up, but we are looking at the two year follow up and those trials will go on and look at follow-up up to two years. They're continuing to do their work. I think that there isn't really news to share with regard to them, which is why you haven't heard a whole lot.

Your point is, well, taken with regard to boosters, though, so among the things that we're looking at, not just in the trial, but really in the real world studies as well is what happens to our immunity, doesn't wane over time? I want to be very clear to people, when we talk about boosters, that doesn't mean you're not protected now, the question -- and because that has caused some confusion. The question is not do we need a third today? You are -- if you get your two doses, you're protected now. What we want to see is if in a year from now you will continue to be protected. We're looking at those data not just in the trial, but in clinical studies as well.

Where we're worried most about that to start is among the population that got vaccinated first, of course, and that's our long term care facilities where people might not have had a robust immune response to start. We really want to make sure that they're going to maintain protection.

Margaret Flinter: Well, Dr. Walensky we appreciated your recent statement, and it really echoes out to so many great leaders around the country that racism is a threat to public health in this country, and it has been for a very long time. But we've zeroed in on it this year with the unmistakable reality in front of us of what we saw. The Biden administration, the American recovery plan has many provisions that are focused on addressing inequity in health care. We've really been intrigued by this rebuilding of the public health workforce and infrastructure, and in some new ways in this country of -- I noted the public health AmeriCorps, AmeriCorps being a program we've championed for many years, community health workers, also public health specialists from your perch, leading CDC. How are you going to use these resources in this kind of new and revitalized workforce to address racism as a public health issue in this country, and to really help us move much closer to health equity?

Dr. Walensky: Well, we had big news on masking last week, we had extraordinary news on investments about on our future, and that's really what I'm super excited about how are we going to take our $7 billion and strengthen the public health system that we have, a system that has lost over 50,000 jobs just in the last decade. What I think is really important as we do so is not just investing in new people, But in training people in a diversity of disciplines from genomic epidemiology to contact tracing and all across the spectrum.

One of the things that's critically important to me as we do this is to make sure our workforce looks like the people they serve, and really ensure that we have the diversity in that workforce, be it urban or rural, African-American or Hispanic, and to make sure at all areas of the workforce we're training people that look like the people that they serve, because those are actually how we make those contacts those trusted messengers. I feel very strongly as an infectious disease doc, as a person who trained during in taking care of patients with HIV and AIDS. We knew and have known all along that there have been extraordinary disparities in health. We're taking this moment in COVID where we've seen it yet again, and to call it now totally inexcusable, and to take these new investments moving forward and to make sure that we invest and make sure that people understand this is about where they work and how they traveled to work and where they play and where they pray. To make sure we have investments in those areas to ensure health everywhere.

Mark Masselli: We’re speaking today with Dr. Rochelle Walensky, Director of the Center for Disease Control and Prevention. I want to connect the dots between our conversation about boosters and the public health system, and thinking a little bit about the hubs that we all created. Here in Connecticut, our health center was asked by the governor to set up for large mass vaccination sites. This upcoming week we’ll have

delivered our 500,000 dose of the vaccine, and those hubs were really important for everyone in our in our state. But we've also developed lots of spokes that are out in the community. They're at the immigrant center. They're at the food pantry. They're really in the neighborhoods.

But I'm worried a little bit about the states now seem to be saying maybe the mass vax, the hubs their work is completed, certainly we're seeing we're on this side of the bell curve. Our own numbers show that if something goes wrong our lesson learned on this whole thing is we didn't have a distribution system in place. I think the Biden Administration got the pharmacies started to recruit pediatricians has done all that. But I'm thinking hope for the best and fear for the worst, how will we be prepared for that large distribution, God forbid we need it to stand those up again, if we're taking them down. What's your sense as you think about the infrastructure over the 50 states and the territories of how we can make sure that this never happens again that we're caught short?

Dr. Walensky: Yeah, so that's a great question. I have a few responses to that. One is we never had a vaccine distribution plan for adults, we have a vaccine distribution plan for children, but we never had one for adults. In fact, our flu vaccination rates, which are somewhere around 40 to 60% every season, probably demonstrate that right, we should be far higher than that. Now, we very well may be, we have one for children that works pretty well, so maybe now is the time to capitalize on this moment and say we're going to need a vaccination plan for adults.

One of the things I feel really strongly about, and one of the silver linings of this is we've made those inroads, we've created those hubs we've created those spokes, we've created this network of trusted people, and I really feel like we need to not just keep it for boosters, but to keep it for hypertension control, and to keep it for where 11 million childhood vaccinations behind. We need to keep it to make sure we get those children caught up on their measles vaccinations and to do all of the other stuff that we should be doing in the community. Why are we not doing diabetes training in the community at the food pantry that just delivered your company vaccine?

We've made some of these networks, we've created a system of people who are willing and wanting to engage, willing and wanting to help, reaching people where they are. We've done that now, let's solidify it and make sure that we actually can engage in that for all other areas of health.

Margaret Flinter: Well, I'm really glad you addressed all that other stuff, because that's exactly where I wanted to go next. Here you have this amazing organization, the CDC, and if we can take our eye not off of COVID, but maybe at least broaden our gaze for a moment. Opioid crisis

didn't go away while this was going on, people continue to die all over the United States from opioid addiction and overdose. Certainly, the issues that we see with obesity, the climbing rates of diabetes, continued, concerns with HIV/AIDS, we don't need to make the whole long list. But as you come into this position, I know you've been there for a little while now. What's your picture for CDC's role and its vision even beyond the COVID pandemic, which will end at some point to really address these enormous public health issues of consequence in the country, what's the game plan or the vision for CDC going forward?

Dr. Walensky: The big goal, right? Maybe I'll break it down to several, and one is the public health infrastructure of the country, and that's $7.4 billion we've talked about before. But I do think we need to invest in workforce, we need to invest in laboratory structure, and we need to invest in data modernization across this country. That doesn't necessarily feel like we're disease specific, but I do think that if we have a more established public health workforce, if we can report labs and really understand where issues are happening, if they can integrate, and we really can see them at the local level, we will be better off and better serving our communities to know where we need to target intervention. Big public health infrastructure that needs to happen with data modernization.

Two is his health equity, we've also talked about that. But layered on top of the public health infrastructure, we really take an intentional view of all the work that we're doing within equity lens. I have challenged my own organization to do this, I said, please do not document the problem anymore, you can document it, but now is the time to test interventions to see if they work. Some will and some won't and we can't be afraid to fail. Let's fail fast and learn what we have and move on to another intervention that might work, because I just -- I don't want year after year for us to just say we having more of a problem. We do need to do a lot of work in health equity.

Then, new ways, numerous issues I could list many more. Certainly we have to do something about mental health and opioids in this country. It was bad before the pandemic, it got worse during the pandemic, and we have young people old people dying of mental health disease and of opioid overdose and then of opioid, collateral damage of opioids infections and whatnot. Opioids and mental health, maternal mortality, one of the highest rates of maternal mortality around the world affects African Americans and Asia Pacific communities almost two fold more than anywhere else.

There are many, many -- and the AIDS/HIV epidemic which had such momentum and then kind of lost the momentum over the last year, so lots of different areas there. I do hope that the public health

infrastructure, the investment in equity will raise so many of these, I worry a lot about community violence, domestic violence, gun injury prevention, so lots of different areas that we're hoping -- that we're hoping to focus on when we can take a little bit of our eye off of the pandemic and even while we have our eye on the pandemic.

Mark Masselli: Well, let me just get one last question and we're doing so well, the Biden administration, your leadership on thinking about the country, but America is one of the most consequential nations in the world. We look around, we see in our TV how the pandemic is sweeping over India, causing so much tragedy and hardship. It was good to see that the President had announced that, I think, it was 60 million additional doses were going but it's a large planet with lots of needs. What's our role? We had Dr. Van Kerkhove, from WHO on last week, and she was really talking about building this partnership, this global partnership. What's the role that CDC is going to play and the advocacy and it's so difficult sometimes, because certainly our country is interested in making sure all of our citizens are vaccinated. But we play such an important role globally. How do you envision the CDC in terms of its global responsibility?

Dr. Walensky: This is critically important, I think, from both a humanitarian perspective, but also because I think it's been said, no one is safe until everyone is safe, right? I think if you look at what has plagued our country over the last 10 years, between H1N1, Zika, Ebola and COVID-19, none of them started here. We really do have a critical key role to play. Really in COVID-19 as well, our vaccines will only work if we don't have circulating virus in other places that create variants [Inaudible 00:22:06]. Much of CDC's work is really been in partnership.

We have collaborations in 60 countries. While there was Ebola happening in Guinea and DRC, we had people on the ground there because we have a long standing relationships there. When India was calling and saying we were following and seeing that they were having challenges. We have a 20 year old country office in India, and we were able to provide technical support and oxygen to get there and PPE and how do you roll out vaccines and vaccine safety data collection, and all that sort of support, so that's much of what CDC role has been is the technical support on the ground. The deployment of people into Brazil, we have two teams in Brazil, to be able to provide that on the ground support with lessons that we have learned here in the United States.

Margaret Flinter: Great. We've been speaking today with Dr. Rochelle Walensky, Director of the Centers for Disease Control and Prevention. You can learn more about this agency's vitally important work by going to cdc.gov and follow her on Twitter @CDCDirector. Dr. Walensky thank

you so much for your career long contribution to health to infectious disease, for lending your sensitivity to the needs of vulnerable populations, for leading the CDC and for joining us today on Conversations on Health Care.

Dr. Walensky: Thank you so much, and thank you for all the work you all do.

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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: Let's take a look at the COVID-19 variants and vaccination. So far COVID-19 vaccines have been effective against variants of the Coronavirus. Scientists are monitoring the situation carefully with updated or new vaccines of possibility in the future if need be. The fact that variants of the original SARS-CoV-2 virus have emerged is not surprising. Viruses mutate randomly as they replicate and make errors as the genome is copied again and again.

A variant is a distinct virus, typically with several mutations. Most mutations don't change the viruses' biology or how the body's immune system responds. But sometimes mutations can result in an advantage for the virus and its ability to replicate or transmit for instance, or in how effectively immunity from a previous infection or a vaccine is able to fight the virus. The good news is that so far the authorized vaccines in the US have been largely effective against the variants that have most concerned scientists.

The Centers for Disease Control and Prevention is using three classifications for variants. There are five variants of concern, that's the CDCs middle level four variants for which there is evidence of increased transmissibility, more severe disease, or reduced effectiveness of treatment or vaccines. There are no variants in the CDC's top classification level of variant of high consequence. While the authorized COVID-19 vaccines in the United States were designed to protect against the original SARS-CoV-2 virus, that's not the virus the vaccines ultimately have confronted, still they worked extremely well as shown in the clinical trials. Real world studies have shown they continue to work well against those variants of concern.

In Qatar, researchers used national databases on vaccinations, testing and clinical characteristics to estimate the Pfizer vaccine effectiveness against any infection of the B117 variant at 89.5%. That's the variant

that first emerged in the United Kingdom and is the most common variant in the US according to the CDC. Effectiveness against any infection of the B1351 variant, first identified in South Africa was 75%. But effectiveness against severe critical or fatal disease from any variant was an estimated 97.4%.

The Johnson & Johnson vaccines clinical trial data also gives an indication of its effectiveness against variants of concern since it included study sites in South Africa and Brazil where such variants were identified. While the vaccine's efficacy in preventing moderate to severe disease was lower in those countries than in the United States, in the trial the effectiveness against severe or critical COVID-19 was more than 80% in all three locations. That's my fat check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Louisville, Kentucky has consistently been on a top 20 List of US cities you don't want to live in if you have a lung disorder. Surrounded by the nation's leading rubber manufacturing entities and nestled in the Ohio River Valley, this is a city that has grappled with pollution. Several years ago, the city's newly hired chief of innovation made a decision to tackle the issue.

Ted Smith: I wondered if there was something we might be able to do new and different. Maybe the risk is concentrated in certain place, and if we knew where the risk was concentrated, if that were true, maybe there would be something we could do about it.

Margaret Flinter: Through his work in public health research, Ted Smith had learned of a tech enabled smart inhaler that when synced to a person's phone, acted like a GPS for whenever that person needed to use their rescue inhalers.

Ted Smith: It's essentially to put a GPS transponder on top of your inhaled medication so that when you took a puff of your medication, it would take a snapshot of what time it was and where you were. That kind of real time monitoring of asthma events, especially those rescue inhaler attacks, is really high value signal, and you're capturing it in real time.

Margaret Flinter: Smith dubbed the program Air Louisville and tracked 1100

participants over the course of a year. He said they were able to chart environmental triggers in any given area where an asthma attack occurred, and chart real time data on the conditions and the location, giving them some great public health epidemiology data.

Ted Smith: We ended up with a very high spatial resolution map of the burden of asthma in Louisville, Kentucky, and then that led us to explore where those little micro areas are that are problematic and what we might be able to do about it.

Margaret Flinter: More importantly, the smart inhalers gave users a feedback loop of information which allowed them to better manage their exposure to known asthma triggers.

Ted Smith: One part of the use of the technology is the surveillance, but another part of the technology is the feedback loop to the user who learns how poorly controlled or not their asthma is, or how adherent they are with the medication they're supposed to be taking daily. There is an immediate effect, people end up getting better control of their respiratory disease

Margaret Flinter: Reliance on emergency inhalers dropped 78% among participants, and the city was now armed with data that could help them devise pollution mitigation strategies.

Ted Smith: With the harder problem that I think the rest of the country has, which is our ambient air quality standards are still not low enough, and people are exposed to levels of pollution that we are going to have to work hard to figure out how to remove.

Margaret Flinter: A tech enabled smart inhaler that gathers meaningful data that informs public health officials how they might reduce the burden of asthma health cost while teaching asthma sufferers to better control their disease and stay healthier. Now, that's a bright idea.

[**Music**]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community

Dr. Rochelle Walensky

Health Center.