Dr. Michael Osterholm

Marianne O'Hare: Welcome to Conversations on Health Care. This week we're joined by Dr. Michael Osterholm, Director of the Center for Disease Research and Policy at the University of Minnesota whose pandemic predictions have come through since the beginning of the crisis.

Dr. Michael Osterholm: We could have another variant in three or four months from now that could emerge, that could easily evade the immunoprotection of what we have right now in our population or not.

Marianne O'Hare: Now, here are your hosts Mark Masselli and Margaret Flinter with Michael Osterholm on Conversations on Health Care.

Mark Masselli: In December our next guest was one of the first to describe the predicted impact of the Omicron variant a viral blizzard. He said then that we could see millions of American infected with this variant. The blizzard has indeed arrived and so have more questions and worries.

Margaret Flinter: Dr. Michael Osterholm is the Director of the Center for Infectious Disease Research and Policy at the University of Minnesota which is tracking and analyzing this rapidly evolving pandemic.

Mark Masselli: Well, it's good to see you again Dr. Osterholm, welcome.

Dr. Michael Osterholm: Thank you. It's good to be with you, I appreciate the opportunity.

Mark Masselli: Tell us what the latest data on Omicron is and what your take on it?

Dr. Michael Osterholm: Well, as I described earlier and you noted that I thought this would be a viral blizzard. I really refer to that in two different perspectives, one is just the type of transmission we would see. If you look at the course of the COVID pandemic over the last two years, we've had these regional surges that have come up and down. Some lasting longer, some more short time periods, but never did we see an entire country or did we see an entire of the world impacted.

In fact if you look at the WHO numbers for global cases, it would kind of cycle between about 2.5 million cases a week to 5 million cases a week and then back down to 2.5. This one's very different, everybody is in the soup at the same time. Doesn't matter if you're in the northern or southern hemispheres, it doesn't matter whether you're in a rural or urban area of the country. The only thing that's really different like true snow blizzard is that it hit some areas first and then

hit other areas later, and unbarring from the blizzard is somewhat slower in some areas than others. That's exactly what's happening right now.

In the United States, all 50 states are -- and the district of Columbia are in the soup, however, those states first impacted, particularly the northeast are now beginning to see the peak number of cases occur and the number start to drop. The challenge we're going to have is if we follow what has happened in South Africa and use that as somewhat of a benchmark. If you look at what's happening with Omicron there the numbers went up very quickly. We all are aware of that peak, and then it started to come down quickly. Then people kind of forgot about, well it's over, well it's not.

Right now the tail of cases in South Africa is still, from an incident standpoint, 25 times higher than it was before Omicron hit. We're not quite certain of it is once the big peak occurs and starts to come down, what will that tail look like? I think that's going to be relevant to everyone in the United States.

Margaret Flinter: Well, Dr. Osterholm you paint a great almost visual picture of the whole map lighting up simultaneously. In fact I was looking at one of the maps online today, and that's what it looks like. One of the consequences of that is we can't really help other regions very much as we did maybe in that first wave in terms of moving resources around, in particular healthcare resources.

I know this is something you're very concerned about with healthcare workers, particularly acute care just being overwhelmed and stretched so thin. What are you seeing and what are you concerned about in terms of standards of care and access slipping, is that happening? What can we do as the whole country lives through this phase?

Dr. Michael Osterholm: Well, as you just laid out very nicely Margaret, the challenge we have is that in fact the whole country is in the soup at the same time. There aren't ways that we can take and move assets or resources from one region to another. In fact, even when we take national guard unit individuals from our communities and put them into the hospitals and long term care facilities, not that they have great medical skills, but were taking a lot of other critical jobs in their community. We are seeing right now no accessibility to move people from one region of the country to another for healthcare.

Basically what was already a very tenuous situation in

maintaining adequate staffing we're now hanging on by the skin of our teeth. We've seen in the number of areas 20% to 25% absenteeism because of infected healthcare workers. Remember these are incredible vaccines, they're remarkable, but they are not perfect. One of the things that's happening is that people who have been fully vaccinated with their booster are still getting infected. It's a mild illness. They're not been hospitalized but they can't work, and so that's been a challenge that we're seeing.

If you follow the news media you can see story after story after story about regions imploring people please try not to get infected because right now we're being overrun in our ERs, in our hospital beds. In addition, we have to be mindful of what the impact is with supply chains. If you look at the number of big box pharmacies just in this past weekend that we closed because they had no one to work in there. We've had pharmacy shutdown completely. We've had those out-of-state open say it is taking three to five days to fill prescriptions, oxygen bottles etc. There's been a real hit on the healthcare system from multiple levels, not just personnel. But by far personnel themselves are the key issue.

Let me just close with one number I think that really helps put that in perspective. We have celebrated the fact that the DOD has put forward a thousand healthcare workers, a trained doctors, nurses and technicians to go into our communities, that's great. But, right now we estimate that upwards of two million healthcare workers are off the job because of infection. That DOD number doesn't do much to make up for the loss of the healthcare workers that are currently infected.

Mark Masselli: You know, I was thinking as you were talking sort of add to that laundry list of challenges or certainly what are we going to do with our schools. You've just written that it's time to acknowledge reality, and many of the schools will likely have to close because of Omicron. Obviously, the President's not that, Secretary Cardona is not there, it doesn't seem that the country is there. What's the matter with taking a wait and see approach on virtual schooling?

Dr. Michael Osterholm: Well, you know, let's just come back to what I call a common sense moment, it's just reality. The challenges is that right now this is not about not wanting kids in school. This is not about the idea that's just COVID. But when you have 35, 40% of your teaching staff, your support staff and your bus driver's out with COVID, how can you safely hold school? This is just a reality, it's not a judgment of whether we should or shouldn't

have school. Would we close schools if we were about to have a category five hurricane? You bet. Would anybody complain? No.

If there was a regular blizzard, a real blizzard, 35 inches of snow and 40 mile (inaudible 00:07:04) would anybody complain about schools being closed? No. What I've argued for over the last couple of weeks is just some common sense to say look at this surge, it's going to last only three or four more weeks likely. What we got to do is get through. If you think you're going to open your school safely with such a reduced staffing level, that's a mistake. This shouldn't be a political point where under in no condition we consider closing schools.

I've heard from many superintendents and teachers who feel like they're being punished for closing school, and the superintendent says how do I do that with 35% of my staff out? I think this is one of those examples where ideologically people made decision before they ever had the data to understand what that decision was all about.

Mark Masselli: The kids in Minnesota were walking out today, the high school kids walked out of school because of the virus.

Dr. Michael Osterholm: Yeah, some of them did. I mean, part of it was the teacher issues. I mean we've had a situation here where they've actually asked parents to come in and volunteer just to watch the kids, it's like a babysitting class. Now, you can say your school's open, you're just politically making a statement. Minneapolis schools had 38% of their teachers out infected today.

Mark Masselli: Terrible, terrible.

Margaret Flinter: Wow, amazing.

Dr. Michael Osterholm: I mean that's where I fight it hard, and that's where I push back hard against the administration and said the President's got to stop savoring and keep schools open at all cost. Nobody would say that if it was the hurricane or the real snow blizzard.

Mark Masselli: Absolutely.

Margaret Flinter: Right, right.

Dr. Michael Osterholm: This is short lived, this is not the next school, this is not the next -- get us to February and I think we're in a very different place.

Margaret Flinter: Well, obviously during this period of time with the massive

surge across the country we're concerned about all people but the most vulnerable patients in particular. One group I know you've commented on are the immunocompromised patients, and you're saying they really need to get their fourth vaccine dose. Why is that so important for this group right now?

Dr. Michael Osterholm: Well, let's be really clear because there's been some information come out on the last day suggesting fourth dose may not work. We already have a recommendation in this country based on data that already exist that supports a fourth dose for those who are immunosuppressed moderately or severely, that's about 7.2 million people in this country. That one is not even up for discussion, get that fourth dose.

The data that came out in the last day from Israel on the laboratory studies, looking at the immune response in healthy people, people who are otherwise not immunosuppressed suggested that the level of protection from that fourth dose may not be sufficient benefit to warned that it'd be used. However, the studies are still going on actually looking at clinical cases much like we did with the third dose. I think within the next month or two months we're actually going to have substantially more data on does the fourth dose really protect you in a way the three doses did. I mean we need the facts, we need the best data.

We also have to face reality. Reality is, is that if that means we have to have a fourth dose, are we going to keep giving doses every six months to so many people in the world? It's not going to happen. I think we are going to come to a point where if in fact that fourth dose does appear to be necessary or can be helpful of asking ourselves what is our model going forward? How are we going to do this if we can't even get four doses in people in the high and middle income countries, what is the chance we'll ever do anything like that in low and middle income countries? I think right now the bottom line message, if you're immunosuppressed please get that fourth dose because it surely can have a benefit.

Mark Masselli: You know, you and Dr. Manny (PH) you both served in the Biden transition team and some have really called your writing as striking critique of the administration. We're about two weeks out since the article appeared. I'm not sure if you've been invited to dinner at the White House. But tell us what the response has been and has anything changed in your own thinking?

Dr. Michael Osterholm: Yeah, it's one of those situations, Mark, where people have tried to make this as an adversarial situation. We've had a

second row seat in all of this being part of this team, not a front row where basically you have to keep your eye on the ball 26 hours a day and even sleep with one eye open. We've had the luxury of not having to do that. What we were attempting to do is actually in a very positive and collaborative way say, you know, you have to continue to deal with this firefight right now, but we have to figure out how we're going to deal with this in the future. We can't keep going from the surge to surge to surge, crisis to crisis to crisis.

What our efforts were was to help provide a framework for the administration to consider going forward. They have been very supportive of our efforts. We've shared all this information with them before we've ever published. I actually still do get invited to the meetings and the calls. None of us has gone to dinner yet. But the point being is I think we're in a very positive step forward because we have to figure this out, you know, what are we going to do?

I know no one wants to hear this, but you know as you know a year ago I was saying that I thought the darkest days of the pandemic could still be ahead of us based on the variants. Once I saw alpha and beta and gamma, I said wow this virus has that potential to continue to throw 210 mile an hour curveballs, which of course Delta and Omicron did. Well, there is still that chance we're going to have another one that could be just like Omicron or worst where it evades immune protection where either from vaccines or a natural infection. What we wanted to do is set out an approach that says, well we got to be ready for something like that. But what if, in fact, that doesn't happen again, and we start to see this become part of the seasonal milieu of respiratory transmitted disease.

Remember, Influenza on average year kills 50 to 70,000 Americans in this country, how does that fit in with COVID? Our papers were really about looking and reaching forward with the idea that we need to learn to live with COVID, and that's what we have to start figuring out how to do.

Margaret Flinter: Well, speaking of learning things from COIVD, if you spent any time in vaccine clinics or testing clinics over the last couple of years, one of the things you really got a sense of was we were making a vital service available to people regardless of cost, regardless of insurance status, regardless of citizenship status. From your approach, is there a lesson in all of that about how to address other public health or preventive care concerns? Can we use this as a lesson to make things better in health and public health going forward?

Dr. Michael Osterholm: Well, I think to me, Margaret, the number one lesson that I think has been so important in this is that it's kind of like hosing your driveway uphill. You can go up and up and up one spot or you can keep going back and forth and back and forth, that's what everyday public health is about is hosing your driveway uphill. Suddenly if you get distracted into just one small section of it, everything runs back down.

When you look it from a global standpoint and even in our own country, the kinds of negative implications that we've had because of a lack of diagnostic services, access to healthcare. Even for cancer patients, surgeries that were postponed. We have seen a degradation of overall health in the world that is really remarkable. What it really points out is we can't afford to focus on (inaudible 00:14:32) driveway. If anything what it's going to call for is major new investment just to catch up again.

I look at HIV, I look at malaria control, I look at childhood immunizations, I look at cancer screening, we are falling way behind in all of those. We're going to be paying a price for years to come. We have to rebalance the public health and medical care balance sheets right now so that we can understand we have to do COVID, it's not an option, but you can't do it only in exclusion of all these other issues. To me I think that message rings really loud and clear that if anything else COVID has proven just how important these other programs are.

Mark Masselli: Margaret talked about having approach and you're perhaps the only public health official to sort of enrolls for President George W. Bush, Donald Trump and Joe Biden. Tell us about the difference in the styles and approaches you've observed, and how this play out in the healthcare arena.

Dr. Michael Osterholm: Well, Mark, actually I've had the fortune to serve roles in the last five presidential administrations including now this one. I've always come in as just the private in the public health army. It's not an ideology issue, it's not a political issue, how can I help out. I had the good fortune, you mentioned George Bush, I served as a special advisor to Tommy Thompson the secretary of HHS for three years after 9/11 while also at the University of Minnesota.

I was a science envoy for the State Department during the Trump administration which I actually traveled around the world talking about pandemic preparedness. I think the one thing that I have to just continue to emphasize. There are some really incredibly dedicated brilliant people in our

governments that don't change their priorities just because political parties changed in the White House. Good public health is good public health, and working with these people have been remarkable. I mean, I can tell you I had a wonderful experience during the Trump administration work I did for the State Department, now helping out with this administration.

I think we so often focused on that small group of elected officials overseeing this program, and what we fail to sometimes remember is that just like with our military that these soldiers there day in and day out without regard to political party, and that's what I always remember is the commitment and the efforts that they were making to go forward.

Margaret Flinter: Well, that's a very important view to remind people about. You have been one of those people sharing your expertise in so many areas, and one of them you've referenced Influenza a while ago and I want to just go back to that for a second. January, typically a very high peak season for impact of Influenza, we've had some reports of Influenza combined with delta or Omicron to create an even more dire situation. What are you seeing around the country with this?

Dr. Michael Osterholm: Well, right now I think we're at a point of -- it surely could get worse, but it may actually be level after coming down. This is the H3 and 2 virus which unfortunately have a relatively poor match with the vaccine this year. But we haven't seen the major increase in Influenza particularly in kids which in the past years has been an indicator of just widespread community transmission. I think it's still early to tell, I wouldn't want to write this season off as having been mild or even moderate in terms of occurrence. Influenza can change in a dime.

But I think it also points out the fact that the older I get I think the more vulnerable I am to learning. One of the things you have to do with Influenza is have a real sense of humility and learn, because it control curveballs at you just like COVID's doing and it is a very significant public health challenge. I mentioned earlier 50 to 70,000 deaths a years. I'd say right now we're fortune in that we're not seeing more of it, could be an interaction with COVID and that reason why we didn't have any of it last year. But I wouldn't want to count out that we're done with the flu season for this year yet.

Mark Masselli: Since all the variants have Greek letters, it seems appropriate to think a little bit about Greek mythology as Americans are looking for its scientist to be a little likely Oracle of Delphi.

You've been so right in so many of these predictions about the virus. Where do you think will be by spring or summer or winter, and I hope you don't mind being refer to as the oracle of Omicron.

Dr. Michael Osterholm: Well, I am going to give you a very truthful answer that is correct, okay? It's somewhere between little to nothing or it's really bad, and it's somewhere in between there. I think this is where, again, Mark, the humility comes in, we don't know. All these statistical models are beyond four weeks, they're all based on pixie dust. I see these organizations out there putting these out, and you can seen in a moment by just looking back in November, December, January now, who could have predicted this in October, early November.

What I look at is I hope for the best and I have to plan for the worst. If it's less than that then we will be in much better shape. I think that people don't want to hear this, but the idea of herd immunity went out the window for me over a year ago, and it's because we don't have sustained immunity with this virus, and it's not, not unusual as well we've seen it with other coronaviruses.

Look at how many of the people right now are being re-infect with Omicron who have been vaccinated, who had boosters or previously were infected with a previous Delta variant. What it really points out is, is that we could have another variant in three or four months from now that could emerge, that could easily evade the immunoprotection of what we have right now in our population. Could be just as transmissible or not, maybe we won't see that.

I think right now the scientific community has to have that dose of humility and don't try to predict what we can't. I'll just say that right now we're not done with Omicron. We're surely not done with COVID yet. We may, as population, get done with this pandemic, but the virus isn't done with us. Knowing that that's why we have to learn how to live with it.

Our group was very involved in overseeing the writing of and bringing the experts together to come together with a plan on the influence of vaccine roadmaps on our website. This was an international effort with WHO, major foundations and it was a roadmap for how we're going to get better flu vaccines, the universal vaccine. Well, we're now embarking on a similar process for pan-coronavirus vaccines. I do believe that in the next few years we're going to see vaccine 2.0, 3.0 maybe even 4.0 that could provide us more durability, more protection against variety of variants.

I think therapies are going to huge. Imagine if we did this interview back in early 1980s and we were talking about HIV, that was a death sentence then. Look at it today where therapeutics are available, it is a manageable chronic disease. I think the therapeutic contribution to reducing the impact on our communities is going to be huge. What we need to do is get in place a global plan for rapid testing, identification of people infected and the distribution of these new therapeutics, that could be like HIV in a way even without a vaccine. We had both vaccines, better vaccines and therapeutics. I think we can definitely pull COIVD to a place in our communities where it's not scary, it's not interrupting everyday life.

Margaret Flinter: Dr. Osterholm leads the University of Minnesota Center for Infectious Disease Research and Policy which works to prevent illness and death from targeted infectious disease (inaudible 00:22:35) through research and a translation of scientific information into real world practical applications policies and solutions. Dr. Osterholm we appreciate so much you're returning to Conversations on Health Care today for this important talk, and thanks for joining us on this edition of Conversations on Health Care.

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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 healthcare 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: The U.S. Supreme Court heard oral arguments January 7th in two challenges to the Biden administrations attempts to expand the use of vaccinations. In the first case National Federation of Independent Business versus Department of Labor, Justice Sonia Sotomayor overstated the number of children with COVID-19 who are in serious condition. "We have hospitals that are almost at full capacity with people severely ill on ventilators." She said, "We have over 100,000 children in serious condition and many on ventilators."

According to the latest data from the U.S. Department of Health and Human Services, there were about 4700 children hospitalized in an inpatient pediatric facility on January 10th who had laboratory confirmed or suspected COVID-19 that includes those in observation beds HHA noted. As of early

January there has been a concerning surge in children hospitalized with COVID-19 particularly among the very young. The American Academy of Pediatrics wrote in a January 4th report that it was uncommon for children to have severe illness due to COVID-19 but more data was needed to assess the severity caused by new variants and the long term impacts of the pandemic on kids. But Sotomayor's statistic on the number of children experiencing a serious condition was way off, assuming she was talking about hospitalizations which the context of her comments suggest.

The Justice was correct that cases of children hospitalized with COVID-19 are at a record high so is the number of infections. The American Academy of Pediatrics reported that weekly data ending January 6th showed the cases among US children nearly tripling over the course of two weeks. The seven day average of hospital admissions for those up to 17 years old was 830 children on January 8th.

A particular concern is the rise in the rate of cases among children ages four and younger who were admitted to hospitals and were infected with the coronavirus. Children that young are not yet eligible for COVID-19 vaccination. The Supreme Court sided with the business group blocking a federal requirement for vaccinations or weekly testing at large employers in the US. 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, e-mail us at www.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. People living in Sub-Saharan Africa have tougher odds at overcoming diseases, and the problem is not just the lack of access to healthcare providers, access to vital lifesaving medicine is out of reach for many who are sick.

Gregory Rockson: Africa has some of the highest drug prices in the world similarly because it's a free pricing market. You can take a

single medicine and two pharmacies next to each other will sell that same drug at widely different prices.

Margaret Flinter: Gregory Rockson is the founder of mPharma a nonprofit organization that's seeking to address inequities in drug prices in Africa and the supply chain that often puts these lifesaving drugs out of reach. mPharma operates in four African countries. It decided to tackle the problem by redirecting the supply chain that forces small independent pharmacies and clinics to source their own drugs.

Gregory Rockson: We realized that if we could begin to bring together all these independent pharmacies and remove the pressure that they have to face in sourcing their own drugs, we can begin to address the issue of medicine availability and affordability.

Margaret Flinter: Rockson says they help improve the drug procurement supply chain by collecting data on actual drug sales which allows healthcare entities to avoid over or under stocking, and it reduces their vulnerability to fraud and corruption.

Gregory Rockson: Not only are we taking ownership of the supply chain, we are also providing the financing to patches the inventory. We offer them a simple value proposition, pay only when you dispense the drug to the patient. We actively help them manage their inventory.

Margaret Flinter: mPharma was a 2019 recipient of the Skoll Foundation's Entrepreneurship Award. mPharma a nonprofit entity that utilizes reliable data on drug usages, eliminates fraud and waste in the drug supply chains, makes lifesaving medications more readily available to some of the world's most vulnerable people. Now that's a bright idea.

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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.

Marianne O'Hare: 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 e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.