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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome Dr. Jennifer Nuzzo, inaugural Director of the Brown University School of Public Health's Pandemic Center on how to get this pandemic under control while preparing for the next one.

Dr. Jennifer Nuzzo: There's going to be more pandemic threats in the future, and we need to make sure that we're never again caught so vulnerable in the ways that we were for this one.

Marianne O'Hare: Lori Robertson joins us from FactCheck.org. 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: When experts said the end of COVID pandemic is not like a sporting match, there will not be a whistle telling us it's all over. But there is a process and data that are essential to helping us understand where we are in the situation as we head into the fall.

Margaret Flinter: Joining us to break down these details is Dr. Jennifer Nuzzo. She's leading a new effort on pandemic preparedness and response at Brown University School of Public Health. And Dr. Nuzzo and her team are working to address the urgent issues that have been exposed in this pandemic and are intrinsic to every pandemic.

Mark Masselli: Dr. Nuzzo, welcome to Conversations on Health Care.

Dr. Jennifer Nuzzo: Thanks for having me.

Mark Masselli: You know, we point out that the White House Corona Response Coordinator Dr. Ashish Jha hired you when he was dean at Brown, and his boss, President Joe Biden, said the pandemic was over, then tried to clarify his words. The U.S. is still averaging over 400 COVID deaths each day. So, where do we stand on this question? Are we still in a pandemic?

Dr. Jennifer Nuzzo: So, first of all, when I first began the thought and conversations with Ashish about coming up to Brown to work on pandemics, it was actually in between where we saw a rise in cases and then the subsequent meteoric rise of the Omicron variant. And that just tells you that even when the case numbers are low, even when perhaps there's a glimmer of hope in the future, it's worth still working on these issues and digging into them, because, you know, even if the virus were no longer part of our daily thinking, there's going to be more pandemic threats in the future. And we need to make sure that we're never again caught so vulnerable in the ways that we were for this one. It's still clearly a significant health threat. The fact that we have more than 400 Americans dying each day, thousands of Americans each week, is really quite serious, and something that we

have to continue to do work on.

Are we in the same situation as we were in 2020? Absolutely not. But that's as a result of the hard work that we've done over the past two years. And I guess one of the concerns that I have is that, you know, we're headed into a fall where we could see a rise again in terms of the cases, which happens every fall, winter. And many of the tools that we have used in order to make COVID not what it once was, are possibly going to become increasingly out of reach for people. And so really what happens in the future is up to us and to make sure that we continue to work such that people who get up-to-date on their vaccines, and we make sure that all tools are available to everyone who needs it, and there's still a lot of work to do to make that happen.

Margaret Flinter: Well Dr. Nuzzo, restaurants are full, people act like the pandemic is over, kids are in school, and yet we see these numbers of cases. When do we get to declare the end of a pandemic? What would be the measure for that?

Dr. Jennifer Nuzzo: Well, it's important for people to know that from an epidemiologic perspective, that when we use the word 'pandemic', what we really are describing is geographic spread. So, by that measure, this virus isn't going away, but what is changing is how much this virus has the potential to upend our lives. The fact that people are living differently than they were two years ago, signals progress. Whether we stop calling it the pandemic, I think is probably going to be more of a social and political decision rather than a true epidemiologic one. And I say that because the virus that caused our last pandemic, something that happened in 2009, the H1N1 flu pandemic, which I'm finding a lot of people have forgotten about, that virus is still with us and continues to sicken people every single flu season. So, these viruses are not going to go away, but with tools like vaccines and therapeutic drugs and tests, we can better manage them such that they don't pose as much of a risk to our broader community as they once did, and that the ways that we deal with them is not just simply, "Don't go out, don't see people, don't go to restaurants," etc. We just have more options for protecting ourselves than we did two years ago.

Mark Masselli: I know you said a moment ago that obviously as we come into the fall we'll see some spikes. But the Washington Post recently reported that a major fall COVID surge is unlikely. What should we be prepared for? I know there's a variant. Some suggest that it will take over where the two variants are right now.

Dr. Jennifer Nuzzo: Yeah. So, I'm not sure that I can say that a major surge is unlikely. In part, what's likely depends on what we do between now and then with respect to vaccinations. And one of the things I am most worried about is that we have a large gap in coverage of booster doses among

the people who are most at risk of severe illness. So, the fact that we have people over the age of 65, 30% of them who haven't gotten boosted, and about 60% of them who haven't gotten a second booster is a real worry. And so if we want to make sure that we have a fall and winter that's not marked by rising hospitalizations and deaths, we absolutely have to double down on making sure the people, in particular the people who are at greatest risk for illness and death, get boosted. We shouldn't only do this, but if we do nothing else, we have to make sure that those who are at greatest risk of severe illness and death get boosted.

Will we have another Omicron level surge? I don't think so. But I actually didn't expect us to have a surge that great. So, I'm a little bit humble in terms of my predictions that it won't be as bad. I do think that the amount of immunity we've amassed in our country, both through vaccinations, and the infections that have happened, do I think blunt the level of severe illness. And what I'm most focused on is making sure we keep people out of the hospital and keep people from dying. It's really hard to prevent infections, not that we shouldn't try. And there's more, much more work we need to do to make sure that doesn't happen this fall and winter.

Margaret Flinter: I was curious about a comment that I think was described to you that there's three ways to prepare society for the next pandemic, and that they hark back to the Great Baltimore Fire of 1904. Heard a lot of reference to the great flu pandemic of 1918, haven't really heard this reference back to the Great Baltimore Fire of 1904. So, explain these ideas to us.

Dr. Jennifer Nuzzo: So this really came out of -- I was actually given the privilege of being asked to give a TED Talk and they asked me what I wanted to talk about. And at the time, I was actually quite worried that COVID was starting to fade from the headlines, the cases were falling, but there was still more work we needed to do to not just address the continued hospitalizations and deaths that were still happening, but also to make sure we never have to go through an event like COVID ever again. And there's a lot of hard work building the medical and public health infrastructure and other things that we needed to do. But I was really worried that people were starting to forget.

So, I was looking for a way to try to describe to people, or make clear, that just because COVID may end, it may end in the sense that it no longer consumes our daily thoughts. Our vulnerability to infectious disease emergencies remains, and in particular, we are seeing an increase in the number of infectious disease emergencies that have been happening over time. And so just because COVID may sort of fade from the headlines, it doesn't mean that we're safe for the next 100 years. COVID sometimes is called the once-in-a-century crisis. It's

actually a wrong description for it. But I didn't want people to somehow think that once COVID is over, we've gotten 99 more years of being safe until we have to worry again.

So, I was looking for analogies, you know, what are other hazards that we encounter and prepare for that once they're over we don't just assume that we're safe once they're done. And the more I heard about the Great Baltimore Fire of 1904, and how really devastating that one event was, but also how catalytic that one event was in terms of changing how we as a country deal with urban fires such that now we don't have them nearly as frequently as we once did, and part of the reason why they're not nearly as frequent is that we rolled up our sleeves. We did a lot of hard work to make ourselves protected. And so I identified three areas in which the country committed itself to action after the Great Baltimore Fire of 1904. They were in the area of data, drills and defense. And I posed that if we committed to action in those three areas, we would be much less vulnerable to the recurring hazards of infectious diseases, and that we could deal with a future that may see more and more pandemics, but that we wouldn't be as vulnerable, or experience the same severity of impacts as we did during COVID.

Mark Masselli: Oh, I think that's a great example. You know, I think I read that you grew up near where a polio outbreak is now occurring in New York. And of course, the disease had practically been eliminated in the United States. But this gets to the heart of the vaccination education campaigns that have worked in many cases, but still seem to have resistance in some communities. And I'm wondering if social science can better help all of us in the public health try to break through with anti-vaxxers, people who are resistant to getting vaccines, with some new strategies. Just telling them the facts and urging them to get vaccinated, doesn't seem to be working.

Dr. Jennifer Nuzzo: No, it doesn't seem to be working. And I was so, so disappointed to learn about polio returning to the U.S., and particularly circulating in communities that were so close to where I grew up, in part because I always heard growing up from my mom who was actually very proud throughout her life that she had been part of the early polio vaccine trials. She always used to tell me with pride that she was a polio pioneer, did her civic duty for something that was very much feared, particularly by her generation. I think many people who grow up today, have never met somebody who has experienced polio. I did. I mean, you know, people in my mother's generation certainly were affected by it, and many people who had lifelong consequences of those infections. So it was a very much a feared thing. And so, for a generation of people to be able to participate in developing a tool that would take off the table polio’s abilities to kill, or harm people for life, was something very much a point of pride. So, it's unfortunate

that people haven't lived with that same fear, because they don't, you know, then be able to compare that to the benefits that vaccines offer.

I think we do have to figure out what are people's motivations and figure out how to better reach them. You know, many of us have been engaged over the past two years talking to people about vaccines, and I am hopeful that we can actually make more progress in convincing people of the benefits of vaccines, but we need to have more evidence-based ways of doing that. And it's going to take all of us. This is something that probably needs to be done from the ground up rather than the top down, and so the more evidence and guide that we can all use to have these conversations, I think the better. And that's really where I think social science research comes in. And if we do nothing else after this pandemic, investing in how to reach people and talk to them about risks, including how to protect themselves from it using vaccines, is I think a really important pandemic lesson.

Margaret Flinter: Dr. Nuzzo, you're obviously engaged in a lot of leadership activity in your roles in public health. But one of them is that you co-lead the Global Health Security Index, which for people not familiar with it, it aggregates publicly available data to create a picture at the national level, health security gaps from 195 countries. Maybe share with our audience a little bit more about what the intent of the Security Index is. And what do you say to some comments I think that British Medical Journal has said recently that it gives a false sense of security to some nations and maybe undue criticism to others?

Dr. Jennifer Nuzzo: Yeah. So, we started the Global Health Security Index a number of years ago. We published the first one in December 2019, so just before the pandemic. And what we really set out to do, was create basically an inventory of the capacities, and to some extent the risks countries have about future pandemic threats and other types of threats, including deliberate outbreak, something that could be intentionally caused. So, really, threat agnostic, but capacity focused.

We were doing this in part because, you know, work has been underway for many years to try to strengthen countries' abilities to respond to not just threats like COVID, but Ebola, and flu seasons, you know, all sorts of types of events. But we know that not all countries have the same capacities, and that was actually made quite clear during COVID when we saw huge differences in how much testing countries did. Then the fact that there's so much discrepancies between the amount of testings countries did, gives us a very different impression of how countries have been infected in part because we've just looked for the virus in different ways.

So, we published the first index just before the pandemic, and what we concluded was no country had everything. In fact, there were

many important gaps in all countries. You know, when we saw the pandemic unfold, and we saw countries that scored higher, like the United States really struggle to respond to COVID, that was deeply disheartening. But it also wasn't surprising, in part, because we knew that even the top scoring country like the United States had really important gaps, and really any of these gaps can be paralyzing. But, that's actually one of the things that made me start thinking about fires as an appropriate analogy, because, you know, the index basically measures the tools that countries have. And so if let's say you're trying to create an index for a fire, if one of the tools you measure is a fire alarm, and if you want to look at the risk for fire, and you look at perhaps whether there're building codes that require the installation of fire alarms, that's quite important for understanding how well a country may do in an emergency like a fire.

But we don't actually measure whether countries are going to use the capacities they have, and so what we saw unfortunately during the pandemic was many countries like the United States, chose not to use the capacities that they had, which was quite unfortunate. Because going back to that fire analogy, it's sort of like they had the fire alarms, and the alarms were going off, but they just chose to sit there and remain in their seats despite what the fire alarm is. And so we don't measure that piece, you know, whether we will evacuate the building when the fire alarms go off. And, you know, unfortunately the capacities aren't the only thing, it's how you'll actually use them that also matters.

So, my hope is that it's a wake up call for all countries, and that all countries could benefit from improving their capacities. But just having them doesn't mean they're going to be okay. It requires a commitment to using them, a commitment to continually strengthening them and exercising their use, just like we do fire drills just to make sure we know what we're doing.

Mark Masselli: You know, you're also involved with the Outbreak Observatory, which really is focused on collecting information on challenges and solutions associated with the outbreak response and share broadly with the Public Health Preparedness and Response Community Center. I'm wondering, are we learning more about how China handled or mishandled the initial COVID outbreak. And how can we expect a different response as we think about societies that aren't as transparent?

Dr. Jennifer Nuzzo: You know, I think clearly the initial response to COVID, not just in China, but in many countries, was not what it needed to be. I think, in particular, in the incidence of China, you know, the thought that there may have been more information than was shared publicly is inexcusable frankly. We all depend on each other, and we all suffer

when we don't share the information. So that is I think a clear lesson that has come out of COVID is that we need countries to first have the capacity to do tests and to gather data. That is a clear first step. But then, once they have that information, to be transparent, and to share that with others, that is also a second step.

I think there are some other lessons that we saw later in COVID, in fact, actually during the Omicron wave where there were some countries that really leaned in, in terms of collecting data, and sharing that with the world, and I'm thinking to South Africa sort of alerting the world to the discovery of the Omicron variant. And that was really heroic and extraordinarily helpful from a public health perspective. But then what happened afterwards, was actually the opposite of that, which we saw a number of countries, including the United States, implement really harmful travel bans, that struck at the kind of economic consequences for South Africa for having shared that information, but also, you know, hindered the supply, the transport of important laboratory reagents that the scientists were using in order to tell us more about the Omicron variants.

So, we still have a number of important sort of governance and policy barriers that may deter countries from being forthcoming with information that they have about situations that are happening within their borders. And, you know, we really also have to work on eliminating those barriers if we're going to expect countries to be forthcoming with what's happening.

Margaret Flinter: Well Dr. Nuzzo, even as we look forward to COVID quieting down, some have suggested that maybe we're just living in a new era of pandemics, and that they will continue and they will be more frequent. Are you in alignment with that thinking? And if it's the case, are there some fundamental ways you think that society will change to adapt to that kind of environment?

Dr. Jennifer Nuzzo: So, we live in an age of pandemic threats. We see an increasing frequency of new diseases emerging or old diseases reemerging that threaten our public health. They don't all become pandemics, but some of them can, and that just means there's probably more pandemics in our future. So, that's very much the bad news. But the good news is that I absolutely believe that there are important steps that we can take that will reduce our vulnerabilities to these threats. Again, I could go back to that fire analogy. It's not that the risk of fires went away, it's just the U.S. after the Great Baltimore Fire of 1904, undertook steps such that we are now, as a country, less vulnerable to large urban fires.

And we can do the same for pandemics. We can take steps such that we detect these events much earlier, that we can tell people how to protect themselves, give people tools in order to protect themselves

so they can continue to live, despite the presence of a new pathogen around them, and that we have a defense force. You talked about the fire department. One of the problems is that we went into this pandemic with a defense force, our public health infrastructure, that was really decimated due to continued funding cuts year after year after year. You can't fight an emergency with that. You can't just hire a bunch of people in an emergency and expect that it's going to unfold.

We have to resource and staff public health agencies for the emergency in advance. We need to make sure there's a large cadre of very trained professionals who can act in a way that protects us, oftentimes, you know, sort of even out of sight. But we very much need the protections that we can put in place like improving the quality of air in our buildings, and the availability of tests for people to test themselves at home. And this just gives people more power to continue to live despite this recurring hazard of infectious diseases, but in a way that they can do so more safely. And, you know, I think we need to work towards that vision such that we don't put our lives on hold, but we also don't succumb to these repeated viral threats in the process.

Mark Masselli: Yeah. I want to sort of pull on the thought. You just said that we need better trained health professionals, and one additional silver lining perhaps in the COVID experience is the increase of students studying public health. Maybe what's the biggest lesson they need to learn as they prepare for their careers?

Dr. Jennifer Nuzzo: Yeah. So, I think it's really heartening that many people now understand what public health is. I joked, often joke that I used to have to tell people that I was an epidemiologist, and explain to people what that was. So, it's great that we have this heightened understanding of what public health is. I think for our future public health professionals, I think there are a few lessons. One is that it's important to think about the virus, but we also have to think about the people and the systems in which the virus circulate. And we need to recognize that much of our vulnerability to viruses is in part the structure of our societies, the fact that we don't all have equal access to the tools that we can use to protect ourselves. So, we have to work to serve people and meet them where they're and, you know, fill the gaps in terms of access.

The other thing is that a lot of people, they know what public health does, but they've probably never met a public health worker in the same way, and so, in their mind, it's probably medicine. And so I really think that we have to have better integration of public health and medicine. Over these past two years, I've had conversations with lots and lots of people about COVID vaccines. And a common feature of

the conversations I've had with people who haven't yet been convinced of the benefits of these vaccines is often that they don't have a regular health care provider. So, we really, I think, need to understand how people come to health issues, and make sure that they can be served by health care providers and public health in their day-to-day lives, and not just kind of show up in people's lives in the midst of an emergency and sort of expect automatic cooperation and partnership.

Margaret Flinter: How are things in Rhode Island? We're seeing case rates for hospitalization are popping way up in Connecticut? Are you seeing the same thing in Rhode Island?

Dr. Jennifer Nuzzo: You know, actually I haven't looked at the hospitalizations. I was just looking at the cases the other day, and actually all of our data are much harder to interpret than they ever have been. Things look pretty flat. But I expect to see them go up. I just I fear though that our surveillance has really eroded in part because we've shut down so much testing, so.

Mark Masselli: That's right.

Margaret Flinter: Yeah. That's why the hospitalization rates are worrisome because they're going up.

Dr. Jennifer Nuzzo: It used to be like clockwork, you'd see the cases go up and then about two to three weeks later you would see the hospitalizations and deaths. And like, those trends have just—

Margaret Flinter: They have separated out.

Dr. Jennifer Nuzzo: They are hard to reconcile. You know, in hard to reconcile and interpret ways, it's really unfortunate.

Mark Masselli: Right.

Margaret Flinter: Well Dr. Nuzzo, thank you so much for your important work, your contribution to the public's health, and for joining us today. And thanks to our audience for joining us. You can learn more about Conversations on Health Care, and sign up for our updates at www.chcradio.com. Dr. Nuzzo, thank you again so much.

Dr. Jennifer Nuzzo: Thank you for having me, I appreciate it.

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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 U.S. politics.

Lori, what have you got for us this week?

Lori Robertson: Denmark has announced a plan for its fall COVID-19 vaccination drive. The country said it will offer the new Omicron specific booster shots to high risk individuals including everyone aged 50 and older. But those peddling misinformation in the U.S., misleadingly suggested this means the shots are unsafe for those under 50. The Danish Health Authority said that is a misinterpretation. Rather, the Danish Health Authority is focusing its fall vaccination drug on those who are most vulnerable to severe illness, hospitalization and death from COVID-19, which means those who are over age 60. But the health system is offering the boosters to everyone 50 and older as a precaution.

A spokeswoman for the Danish Health Authority told us the vaccination drive is aimed at 2.5 million people, or nearly half the country. Aiming to vaccinate that many people, shows the Health Authority is convinced the vaccines are safe. The Omicron specific booster shots also will be given to those under 50 who have underlying health conditions that put them at higher risk for severe illness, as well as those who work in health care or elder care, relatives of those who are at high risk, and pregnant women. As of mid-September, about 82% of Denmark's population was fully vaccinated, compared with about 68% in the United States.

And 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 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. When Wichita Kansas Nurse Practitioner Michael Wawrzewski learned of the harsh and often fatal conditions that expectant mothers endure in Sub-Saharan Africa, all because they live too far from a medical clinic, believing that every human being should have access to quality health care, he came up with a solution, Clinic In A Can, transforming shipping containers into fully equipped mobile clinics and operating rooms that can be shipped anywhere in the world where there is a need.

Michael Wawrzewski: When you walk in the inside, you will believe or think that you're

inside your doctor's office, or maybe you're in an emergency room or an ICU unit. They look exactly the same.

Margaret Flinter: Wawrzewski learned from his early iterations that gas-powered generators could be problematic in low resource areas, and switched all of his portable clinics to solar power, which he says was a game changer.

Michael Wawrzewski: There's no part of the world that does not have sunlight, and so solar power has become the cornerstone of how we re-engineered how we power a clinic so that now six solar panels on the top and eight batteries is enough to run a clinic for 18 hours.

Margaret Flinter: Since its founding a decade ago, Clinics In A Can have been delivered to war-torn Sudan, and more recently, to Santa Rosa, California, decimated by the wildfires that also destroyed the main Community Health Center there. Santa Rosa Community Health Center CEO Naomi Fuchs says that the portable clinic provided a lifeline for her patients, and was a godsend for her providers.

Naomi Fuchs: These are converted shipping containers that arrive fully equipped as a medical exam room. These have been an outstanding way to respond to emergencies, to set something up very quickly.

Margaret Flinter: The roughly 120 square feet shipping container clinics are designed to become a permanent fixture in low resource areas.

Michael Wawrzewski: A containerized clinic is something that's a turnkey. We equip it with the best equipment and we ship it as a completed project that once on the ground, within 20 to 30 minutes it’s ready to be used.

Margaret Flinter: Clinic In A Can, a professionally outfitted shipping container ready for deployment anywhere in the world where disaster strikes, providing quality state-of-the-art medical facilities in a low resource area, 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.

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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, www.chc1.com and www.chcradio.com.

Jennifer Nuzzo

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