AMERICAN PUBLIC HEALTH ASSOCIATION

and

THE NATIONAL ACADEMY OF MEDICINE

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RESPONDING TO COVID-19: A SCIENCE-BASED APPROACH

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WEBINAR #17: A NEW YEAR OF COVID-
THE STATE OF THE PANDEMIC &
U.S. STRATEGY IN 2021

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WEDNESDAY
FEBRUARY 24, 2021

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The webinar convened at 5:00 p.m. Eastern Standard Time, Georges Benjamin, Moderator, presiding.

PRESENT

GEORGES BENJAMIN, Executive Director, APHA, Moderator
ROCHELLE WALENSKY, Director, Centers for Disease Control and Prevention
MARCELLA NUNEZ-SMITH, Chair, COVID-19 Equity Task Force
ANDY SLAVITT, White House Senior Advisor on COVID-19 Response

ALSO PRESENT

LAURA DESTEFANO, Director of Communications, National Academy of Medicine

VICTOR J. DZAU, President, National Academy of Medicine

P-R-O-C-E-E-D-I-N-G-S

5:01 p.m.

MS. DESTEFANO: -- credits for CHES, CME, CNE, and CCH. None of the speakers have any relevant financial relationships to disclose.

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If you experience technical difficulties during the webinar, please enter your questions in the Q&A. Please pay attention to the chat box for announcements about how to troubleshoot.

This webinar will be recorded and the recording and transcript will be available on covid19conversations.org. More information on the series and recordings of past webinars are also available at that link.

Now I'd like to introduce Victor Dzau, President of the National Academy of Medicine, to provide some opening remarks.

DR. DZAU: Thank you, Laura. Good afternoon and good evening. This is Victor Dzau, the President of the National Academy of Medicine, and I, too, want to welcome you to the 17th webinar in the COVID-19 Conversations series brought to you by the National Academy of Medicine and the American Public Health Association.

You know, we began this webinar series, hard to believe it, 11 months ago, and we want to explore the state of science on COVID-19, and inform policymakers, public health, healthcare professionals, scientists, and the public. Well, it's been extremely popular and well attended, with registrations as high as 10,000.

So, I want to begin my thanking my co-sponsor, the APHA Executive Director Georges Benjamin, and the co-chairs of our advisory group, Carlos Del Rio and Nicki Lure.

Today, we'll hear from three national leaders about the current state of the pandemic in the U.S. and the new Biden administration's strategy and efforts to curb and control the virus.

Joining us are Dr. Rochelle Walensky, Director of the Centers for Disease Control and Prevention, Dr. Marcella Nunez-Smith, Chair of the COVID-19 Equity Task Force, and Dr. Andy Slavitt, the White House Senior Advisor on COVID-19 response.

I think you're going to enjoy hearing them. They're just great leaders, great physician scientists, and I want to welcome and thank them for finding the time in their very busy schedules to speak to us.

So, without further ado, let me turn things over to the moderator for today's webinar, Dr. Georges Benjamin. Georges, over to you.

DR. BENJAMIN: Victor, thank you very, very much. It's now my pleasure to introduce Dr.

Rochelle Walensky, the Director of the Centers for Disease Control and Prevention. Prior to her tenure at CDC, Dr. Walensky was the Chief for the Division of Infectious Diseases at Massachusetts General Hospital and a professor of medicine at the Harvard University.

Now, Dr. Walensky can only be with us until about 5:30, so she's going to deliver her remarks and then we're going to have a brief Q&A period before turning to our additional panelists. Dr. Walensky, thank you very much for being here.

DR. WALENSKY: Thank you so much, Dr. Benjamin. I'm honored to be with you today to talk about the COVID-19 pandemic, the public health challenge of our lifetime, and how science will lead this nation out of this crisis.

I want to thank the American Public Health Association and the National Academy of Medicine for hosting this webinar today and for creating this space for this important dialogue.

I would like to use the framework of CDC's 2021 COVID-19 pandemic response strategy to provide an update on our work to help end this

pandemic.

As you'll recognize, this is not a wholly new strategy. Our experiences this past year have reminded us to be nimble as the science evolves.

As we learn more about this virus, we must be humble and open to pivot after new discoveries are made, and it's against this backdrop that we continue to refine our public health strategy as we move into the second year of this pandemic response.

CDC's strategy does not exist in a vacuum. All aspects are closely integrated with the administration's National All-of-Government Strategy. While only in this position for a month, I can tell you I'm truly delighted to convey the amount of interagency collaboration I have seen as we nurture our nation back to health.

This slide provides a quick overview of the national strategy. Within this strategy, CDC plays an important leading role in reducing COVID-19 cases, hospitalizations and deaths, and scaling up COVID-19 vaccinations across this nation,

but for the remainder of my talk today, I will focus specifically on the nine strategic objectives of the CDC's response strategy which are outlined here.

Our initial strategic objective is to ensure the integration of our pandemic response activities into the broader federal government response.

First and foremost, our mission is to slow the spread and mitigate the impact of COVID-19 in the United States, and to do this, we are working to synchronize public health prevention actions across all key stakeholders.

Health equity is our second strategic objective. It is woven into the fabric of our strategic objectives and it's absolutely central to all of our activities.

The COVID-19 pandemic has disproportionately impacted the most vulnerable members of our society. It's also laid bare longstanding health inequities that contribute to a broad array of health impacts, including COVID-19 morbidity and mortality.

It's critical that we systemically work

to reduce the disproportionate burden this pandemic has placed on racial and ethnic minority populations and on other disproportionately affected groups, and as CDC Director, I'm committed to tackling this inequity going forward.

Through the pandemic, we have gained invaluable insights into how inequities and social determinants of health contribute to COVID-19 morbidity and mortality, but we've also learned new ways to approach these challenges and to mobilize affected communities and to embrace and learn from their actions.

We must leverage these new insights and lessons learned not only to bring an end to the COVID pandemic, but to make real progress in reducing longstanding health inequities and the myriad of health challenges they exacerbate, ultimately achieving optimal health for all.

Our third objective relates to key improvements in data and surveillance. Successful public health efforts, including the response to the COVID-19 pandemic, are grounded in accurate, complete, and timely information.

And during the COVID-19 pandemic, CDC is receiving and analyzing massive amounts of data, of disparate data, to track the pandemic and to forecast where it is going.

Never has this nation had a reportable disease in such volume so fast. The data challenges we face with COVID-19 are unlike any we have faced in modern history.

The vast array of big data coming from so many jurisdictions at such a large and fast quantity have overwhelmed our antiquated public health data infrastructure and spurred new innovations and investments to bridge us into a new era of public health data modernization as we leverage these advancements to share data and in place with our federal, state, territorial, tribal, and local partners to help inform the real-time decision making.

For example, CDC's COVID data tracker is a critical new resource that pulls data from multiple sources into one transparent and easy to access portal to guide decision making, including vaccine distribution and administration, as well

as identifying high-burdened communities that need additional support. This system and most of the data streams feeding into it did not exist when the pandemic began just one year ago.

While there have certainly been frustrations and setbacks with regard to data and surveillance, and opportunities to improve remain, we have made great progress as a public health community.

Protecting the health of all Americans requires us to recognize that a health threat anywhere is a health threat everywhere. The COVID-19 pandemic has been a stark reminder of how interconnected we are as a global community.

We know this virus knows no geographic borders, and addressing this reality is more pressing than ever before given the rapid proliferation of COVID-19 variants that stand to reverse the progress that has been made to control this pandemic.

That's why global reach is our third strategic objective. CDC continues to issue science-based international and domestic travel recommendations to deter travel related to viral

transmission.

Internationally, individuals are now required to provide proof of a negative COVID-19 test before traveling to the U.S. and wear a mask in transit. Once here, individuals should get tested again every three to five days after their trip and self-quarantine for seven days after travel even if they receive a negative test.

Domestically, measures are now in place to require mask wearing on planes, buses, trains, and other forms of public transportation, and in U.S. transportation hubs.

CDC is supporting country and regional offices and partners, working with our allies across the world to prevent and mitigate global spread, and to better understand and track emerging COVID-19 variants, and studying how these variants may impact vaccine and therapeutics.

Conducting epidemiologic and data studies have been a foundational public health role for the agency since its inception. Since the beginning of the pandemic, CDC lab scientists and field epidemiologists have been tracking the

dynamics of COVID-19's spread and control to inform our national response.

To further these efforts, we're now expanding the number and types of diagnostic and rapid tests for the virus available in communities to assist with both diagnostic testing, as well as screening testing to help communities reduce the spread of COVID-19.

CDC is also providing information to help communities target rapid testing in different settings such as schools and workplaces, and we're closely studying the course of SARS-CoV-2 infections and immune responses to natural infections and to COVID-19 vaccines.

Of particular concern to our laboratory and epidemiologic work are the rising numbers and rapid spread of new, more transmissible COVID-19 variants in the United States and around the globe.

As of February 23, at least 44 states have confirmed cases of COVID-19 variants, with over 1,700 confirmed cases of the B117 variant in 44 states, over 40 cases of the B1351 variant in ten states, and five cases of the P1 variant in

four states.

CDC's scientists estimate that the B117 variant will be the predominant form of the virus in the United States by mid to late March.

In response to the grave threat posed by these variants, CDC is greatly expanding our genomic sequencing capacities in collaboration with state public health and private sector lab partners.

Since November, state health departments and other public health agencies have been regularly sending samples to CDC for sequencing and further analysis in a new system called the National SARS-CoV-2 Strain Surveillance or NS3.

We've contracted with large national and commercial reference labs and academic partners to increase our sequence capacity. In addition, we're leading a coalition of 200 cross-sector organizations to set standards and share information about SARS-CoV-2 sequence-based surveillance.

Last week, the administration announced a $200 million investment to more rapidly expand our sequencing capacity to reach the goal of 25,000 samples sequenced per week.

The insights gained from these new efforts will be critical in helping us to understand the diversity of variants circulating, how they are spreading, and provide key data to inform the impact variants will have on vaccine and therapeutic efficacy.

One of CDC's most important jobs during this pandemic is offering specific guidance to communities based on the best available science. The guidance extends from health system infection prevention and control guidance to workplace safety, safe school openings, and day-to-day steps individuals can take to protect themselves and others.

Our guidance is geared to emphasize support for community interventions among vulnerable populations.

A cornerstone of CDC guidance is the concept of layered prevention, recognizing that all prevention strategies provide some level of protection, but when implemented together or layered, they provide the greatest level of protection, especially when one layer is

inadvertently breached.

Beyond providing guidance to help individuals and communities, CDC support is critical to facilitate the pandemic response of our state, tribal, local, and territorial partners.

This support includes deployments of key CDC personnel directly to state health departments and communities, epidemiologic investigations, assistance with contact tracing efforts and modeling to forecast local pandemic developments.

To date, CDC has deployed 442 teams comprised of more than 2,100 deployers to state, tribal, local, and territorial health departments since the beginning of this pandemic, a remarkable number that's truly a reflection of CDC's commitment to partner across the nation.

CDC has also provided billions of dollars in funding to support COVID-19 response activities in jurisdictions.

Consistent and credible messaging telling everyone what we know, what we don't know, and what we're doing to learn more is now more

important than ever, and we need our public health partners to amplify accurate and accessible messages.

This is critical in the midst of increasing mis- and disinformation that is working against our critical public health messages.

We need to help people understand what actions they can take to protect themselves and each other such as wearing a well-fitting mask, social distancing, avoiding crowds and travel, and practicing good hand hygiene.

Equally important are our efforts to instill vaccine confidence and combat vaccine hesitancy. CDC has been working on multiple fronts to strengthen public health messaging and support communities in their efforts to reach high-risk populations.

We have created messaging toolkits, social media and other digital graphics, and public health education campaigns, as well as teamed up with numerous external partners to further amplify public health messages.

In addition, CDC has provided funding

and support to minority serving community-based organizations to develop and disseminate tailored messages on COVID-19 public health actions and to instill vaccine confidence among high-burdened and high-risk populations.

This week, CDC convened a first of its kind three-day virtual national forum to bring together over 13,000 participants from 6,000 organizations from all 50 states and across territories and tribal nations to share best practices and the latest science on how to scale up vaccinations in communities across the country.

We are making progress with mask use up and hesitancy waning, but we have still so much more to do. Coordinated, science-based messages tailored to different audiences that address underlying drivers of behavior are essential to further advance these vaccine efforts.

One of our most pressing areas of work currently is getting vaccines into communities as quickly and safely as possible. Approximately 45 million people in the United States have now received one or more doses of the COVID-19 vaccine and 20

million have received two doses.

Encouragingly, we continue to open up new venues for vaccination through strong interagency collaborations. Three weeks ago, CDC launched the Federal Retail Pharmacy Program for COVID-19 vaccination.

This program, which is partnered with CDC and 21 national pharmacy partners and independent pharmacy networks, is intended to bring vaccinations to communities in an equally accessible manner. Once fully implemented, the program will expand to provide vaccinations in more than 40,000 community pharmacies in the United States.

And two weeks ago, CDC, in partnership with the Health Resources and Services Administration, launched the Community Health Center COVID-19 Vaccination Program.

This program will help ensure that our nation's underserved communities and those disproportionately affected by COVID-19 are able to get vaccinated at health centers across this nation.

In addition, I'm particularly proud of

our partnership with FEMA to stand up community vaccination centers and mobile vaccination units that are targeting vulnerable populations and hard to reach populations.

Collectively, these new initiatives represent key components of the administration's national vaccine strategy, and I'm honored that CDC is able to play such a central role in all of these efforts.

But I want to be clear that their success would not be possible without the collaboration of our federal partners and the close collaboration of our state and local counterparts.

In addition, CDC is providing technical assistance to 64 jurisdictions and five federal entities to support the successful distribution and safety monitoring of COVID-19 vaccines.

Most importantly, we have implemented the most extensive safety monitoring program in U.S. history for these vaccines. We're using existing systems, including the Vaccine Adverse Event Reporting System or VAERS, the Vaccine Safety Datalink, and the Clinical Immunization Safety

Assessment Project to monitor our safety signals.

We also launched V-safe, a new active safety monitoring system. V-safe is a smart phone-based app that sends personal check-in prompts after vaccination to rapidly assess the adverse events individuals may be experiencing.

This new resource is a key piece of our vaccine safety monitoring program, and to date, over six million people have registered and provided information through V-safe.

In fact, because of these efforts, last week, the CDC was able to publish new important information on the safety of the current COVID-19 vaccines in MMWR, including data from over 1.6 million people reporting data to V-safe.

Our findings showed that while mild side effects such as injection site pain, fatigue, and headache were common, serious adverse events such as anaphylaxis were rare and in line with the rates we've seen in other commonly used vaccines.

So, I began this talk with an emphasis on science and how science underpins all of our strategic objectives in our COVID-19 pandemic

response strategy.

I would like to close with a focus on six priority areas of CDC's COVID-19 science agenda, understanding COVID-19 disease detection, burden, and impact, studying the transmission of SARS-CoV-2 and the natural history of SARS-CoV-2 infection, identifying effective strategies for protection in healthcare and non-healthcare work settings, studying prevention, mitigation, and intervention strategies, and advancing social, behavioral, and communication science.

I'm committed to sharing our findings with the scientific community and the public in order to have open and honest communication about how we can make progress combating this COVID-19 pandemic together.

Before I take questions, I would like to reiterate the importance of collaboration among our public health and medical practitioners. You are our trusted community leaders and your voice carries great influence with your patients and with your communities.

Please do help me carry these critical

messages on effective strategies to help stop this pandemic. We are all in this together. We must all work together to turn the tide. Thank you, and I look forward to your questions.

DR. BENJAMIN: Thank you very much, Rochelle, Dr. Walensky. Can you talk a little bit about the concept of global vaccine equity as a part of the CDC's strategy?

DR. WALENSKY: Yeah, you know, I think what we are all recognizing, and I touched on this a little bit, is that we're all in this together.

If there is circulating virus, replicating virus, active virus, that is an opportunity for variants to emerge. That is an opportunity to potentially undermine all of our efforts.

So, even if you were not necessarily leaning towards wanting to be part of the global health effort, we need to because all of the efforts that we are moving forward here in this nation could be potentially undermined in a heartbeat of these variants emerging.

So, I think we have numerous reasons to embrace the global health effort here. One is because this is the right thing to do and the second is because I think we have to to make sure that we have virus control, not just in this country, but around the world.

We have committed $4 billion, this was announced, to the global effort, and we're working across the administration to ensure that those resources get deployed in the most efficient and equitable way.

DR. BENJAMIN: Thank you. Another question from the audience is about NIOSH and COVID guidelines for workplaces. I know NIOSH had some early guidance. Are you folks planning to put out any additional guidance from NIOSH, and if so, when?

DR. WALENSKY: You know, I can't exactly give you the timeline, but what I can say is NIOSH is actively working on other guidance for other settings.

DR. BENJAMIN: Thank you. Obviously at the end of this, we're going to have to think about how we rebuild the public health infrastructure.

What are your thoughts about the need to do that and how will CDC engage in that process?

DR. WALENSKY: I have a lot of thoughts on that. There are a couple of things I want to just convey. One is we've had a massive mobilization of people dedicated to public health this past year.

We've had an influx of people who are serving as community workers, vaccinators, contact tracers, and I think one of the things that we really risk is that when the pandemic is behind us, that they all disperse again and are not participating in public health moving forward.

I have been really active. I've been on the phone with a lot of congressmen, a lot of senators talking about the importance of the fact that these infectious threats, public health threats are here to stay. We can no longer rely on staccato funding from one threat to another to build this public health infrastructure.

The reason, among the reasons that we are where we are right now is because our public health infrastructure was frail. It was not robust

enough to handle this, both in terms of resources and in terms of people, and I mean that in several ways, not just the people, that's true, our data infrastructure, our laboratory infrastructure, and then our dedication to health equity.

So, I think we need more longitudinal funding so that we can have a more robust workforce, public health workforce, and then we really need to ensure that those who have been doing such great work in the public health workforce over the past year are really doubled down and committed to want to stay in it.

DR. BENJAMIN: Thank you. And our final question is how are CDC's plans to address the mental health burden of this crisis, and in particular, engaging with SAMHSA?

DR. WALENSKY: Yeah, that's a great question. I've been briefed on that in the last couple of days importantly. We're doing a lot of work, both in examining the data, where are we with mental health? Where are we with suicide? Where are we with overdoses?

And, so we have the survey -- we have

the data, we have survey statistics, and then we are engaging in those communities where these are the biggest issues so that we can provide toolkits.

We can provide technical support. We have collaborations with AAP to make sure that we are getting to reach, for example, pediatricians, who can then reach out to parents as children are home.

There are a lot of ongoing efforts on the mental health side for adults and for children, looking both at the data and the science, as well as engaging to make sure that we can actually make a difference.

DR. BENJAMIN: Well, Dr. Walensky, listen, thank you very, very much. I appreciate your time today. This was very informative, and we look forward to all of us working very effectively with you over the next several years.

DR. WALENSKY: I also look forward to that partnership. Thank you so much for having me.

DR. BENJAMIN: Thank you. So, it's my

pleasure now to introduce our next two panelists, Dr. Marcella Nunez-Smith, who is the Chair of the White House COVID-19 Health Equity Task Force. She is the founding director of the Equity Research and Innovation Center at the Yale University, and Mr. Andy Slavitt.

Andy is a Senior Advisor to the White House COVID-19 Response Team. His previous government experiences include serving as the Acting Administrator for the Centers for Medicare & Medicaid Services.

So, I'm going to start with Dr. Nunez and I'll turn it over to you.

DR. NUNEZ-SMITH: Well, thank you so much, Dr. Benjamin. It's just a great pleasure to be here this evening, and, you know, with Dr. Walensky, as well as with Mr. Slavitt, and to engage in this COVID conversation, and I'm just going to take a few minutes and reflect at the top.

I mean, it really is hard to believe that it's 400 days since the first case of COVID-19 in the United States and we are still so very much in the throes of what is the greatest public health

crisis in several generations.

I don't know about for you, but for me, this can be so surreal at times thinking about all we've lost since those very first days. You know, we've lost our old routines, the opportunity to work, socialize, just move about our communities in the ways that we just have become so accustomed to and had taken for granted.

And, you know, just today we are, you know, projected to have crossed yet another grim milestone, I mean, just an incredibly heartbreaking threshold, likely now having lost over 500,000, half a million family members, our friends, our neighbors, and our coworkers to COVID-19.

You know, I think the numbers can be so overwhelming and even hard to understand. I just can't help but think of the loss of love really, of joy, and frankly, of unrealized potential. Every single life that we lose is one too many, and the fact remains that some communities, you know, are continuing to grieve and to suffer more than others.

So, I know I'm with my public health family here today. You are already familiar, too

familiar with the inequities that we're all working against. It just does bear mentioning though just to remind us of the size of the task in front of us. The boulder is big and the hill is steep.

To compare to white, non-Hispanic persons, an American Indian/Alaska Native is nearly twice as likely to be diagnosed with COVID-19, and a Black American is nearly three times as likely to be hospitalized with COVID-19, and folks in the Latino community are over two times as likely to die from COVID-19.

And even when we think about other factors, our rural residents appear to be more vulnerable to serious infection or death from COVID-19.

So, in this pandemic that has been terribly difficult really on all of us, you know, we cannot miss the opportunity. We have to meet the moment and speak up and speak out against the disproportionate toll that it's exacting on some communities. You know, we can't miss this chance to step up and each one of us find our own role in correcting these inequities.

And so as you heard at the top, I have the honor of serving in a couple of roles in the Biden/Harris administration. You know, I serve as the Senior Advisor to the COVID-19 Response and I also chair the administration's COVID-19 Health Equity Task Force.

You know, I would summarize my charge simply in both of these roles. Really it's to spend every minute every day championing, just championing for our national commitment to COVID-19 equity.

Now, there are certainly some factors, I think, that make this work unique right now in this moment in our country's history. We have a President in Joe Biden who is genuinely passionate about ensuring an equitable response to the COVID-19 pandemic, and Vice President Harris couldn't be more committed to the mission of ending this pandemic, you know, really in part by tackling head-on the inequities experienced by communities that have been the hardest hit, and at these highest levels of government, we have the charge to really press for equity.

So, the Biden/Harris COVID-19 equity

agenda was outlined in the national strategy that was released on the very first day of the administration. We identified seven foundational efforts to protect those most at risk and advance equity in the COVID-19 response.

And so, of course, we established the COVID-19 Health Equity Task Force. This task force is comprised of members really representing a broad range of very diverse backgrounds and expertise, representing different racial/ethnic groups and many other constituencies.

You know, in the coming months, the task force is charged with issuing a range of recommendations to help inform COVID-19 response and also a recovery, and that work launches in earnest later this week. Our first task force meeting is coming up this Friday.

So, I'm very excited about the work of this group and look forward to sharing their recommendations, you know, with all of you when that report is finalized.

But with my moments with you today, I'm going to talk about the work with the White House

and what else the administration is already doing to advance equity.

You know, I think everywhere I go, I talk about this. You know, we're working really hard to increase data collection and reporting for our high-risk groups.

So, whether we're talking about testing or cases, you know, hospitalizations or deaths, or quite frankly, even access to therapeutics and vaccines, we must, we just must optimize the data we have from every state, every locality to give us the information we need to target resources and pivot when necessary.

So, certainly we always try to model by example. Not only the federal agencies expand their data infrastructure to increase collection. You know, we are going to keep engaging with the states and locals to help make sure they can give us the information we need.

You know, we're going to make sure that everyone in every community has equitable access to the critical resources necessary to combat this pandemic.

So, that includes things like their personal protective equipment, so making sure people have masks and what they need to be safe at work and as they move about in the community, you know, testing, support for quarantine and isolation, therapies, and of course, the vaccine, so let me just turn to that with these remaining comments.

You know, we're working not only with states and locals to support their efforts in vaccine distribution, but we've also designed a series of federally run efforts, and at their core, they are designed to promote equity and getting to our hardest to reach communities.

So, for example, our community vaccination centers, so some of them are mass vaccination sites, but others will be smaller and will be located in neighborhoods, and community centers, and school gyms.

You know, the sites where these community vaccination centers are located is selected based in part on measures of social vulnerability and really the likelihood of reducing inequity.

You know, the retail pharmacy program,

the community health center partnership program, both of those programs extend vaccine availability to trusted entities in communities, similarly with sites selected based on measures of social and economic disadvantage.

And we have supported or created nearly 400 mobile vaccination sites. You know, those are designed specifically to get into the hardest to reach communities.

So, you know, in our COVID-19 equity efforts, we'll also work to expand access to high quality healthcare, to expand the public health workforce, to strengthen the social service safety net, and always, always, always make sure that we're supporting the communities most at risk for COVID-19.

And to keep our finger reacting on the pulse of the needs, we're making ongoing engagement just a center point of the plan. You know, so, in fact, we've anchored all of our processes around this one single concept, which is listening to communities.

We want to understand the reasons that different communities might be expressing different

levels of confidence in safety and efficacy when it comes to the authorized vaccines, you know, or different levels of trust in the entities responsible for the vaccination processes in the first place.

So, just this week, I've been hosting a series of listening sessions to hear directly from communities that have been the hardest hit. This will inform our work.

This engagement, it's not a one-time deal. You know, we're going to stay close and remain engaged with these communities. We're going to be transparent and we're going to be held accountable throughout this entire vaccine rollout.

So, certainly, you know, don't get me wrong. We're not under any delusion that this work will be easy, but the difficulty of pressing on for equity in this moment is the precise reason that it is so critical.

You know, in a way maybe that we haven't faced before, the success of our nation right now hinges on our ability to respond equitably and to redress, quite frankly, the inequities forged in the earliest days of our country.

But, you know, this isn't just work or an endeavor of government alone, or healthcare alone, or even public health. You know, this is work that affects all of us. You know, we're 330 million people tied together in a single destiny, and so with that reality, you know, I'm grateful to have each one of you in this fight.

I'm hopeful we can -- you know, we will get this done. So, I will stop. Thank you again for having me this evening. I look forward to partnering on all of the work to come.

DR. BENJAMIN: Thank you, Dr. Nunez-Smith. So, we'd like to now hear from Mr. Andy Slavitt. Andy?

MR. SLAVITT: Thank you. I think someone has to unblock my video, perhaps. There we go. All right. Hopefully that's working.

So, I want to join my colleagues, Dr. Nunez-Smith and Dr. Walensky in thanking you at the American Public Health Association and at the National Academy, for having us here.

I think it's patently unfair that you asked me to follow those two speakers. So, next

time I've got to get my request in early. Because, really, what's to say beyond, I think, the important messages around public health, around health equity, about what we mean to one another, what we owe to one another, that Dr. Nunez-Smith and Dr. Walensky expressed.

So, maybe what I'll do, is just wrap up a few comments around those thoughts. And give you just a feel for what it -- what we are doing day in and day out. And what it feels like and what we're up to in trying to lead and coordinate this entire effort here in the White House.

The second day after President Biden's inauguration, he released a 200 page, seven point plan that is, spells out all the things we think we need to do in significant detail.

That plan, as all of you, I think, know, is about 10 percent of the job. It's necessary, but not sufficient. I can't imagine marching forward without one. But, now we've got a chance to live it.

The first part of that plan, and I think essential, has been to establish trust with the

American public. And one of the first things we've done, is we released all of the data that had been going to governors, and governor reports, and all of the information that the public needs to be healthy publically.

And we've continued to do that with all sources of information. We began briefings Monday, Wednesday, and Friday, where Drs. Fauci, Nunez-Smith, Walensky, and myself, sometimes Jeff Zients, try to talk directly to the public, take questions, and provide real information and specifics on our progress.

Just facts, very few opinions. Answers like, yes and no, and we don't know. So that the public can have the information it needs in the most straightforward way possible.

The second part of the plan is vaccinations. And you've heard Dr. Nunez-Smith just speak about this.

I would say, I think about this as more, better, faster. More vaccines, better distributed to the people who need them, and as quickly as we possibly can.

And that means more vaccination sites, we need more vaccinators. We have 1200 federal vaccinators out there.

We have over 100 community vaccination sites. And all the other sites that we've spoken of.

And we've now, in the five weeks since we've been here, we've doubled the production and delivery of vaccines into communities. And we intend to do that again.

So, we will continue to do this. And we're giving all of the providers as much visibility as possible into vaccine doses, and how much they can expect.

Third is the support of public health. And this means the President's 100 day mask challenge. It also means the support and development of the scientific processes, which sometimes means, how do we get out of science's way so we can make sure the therapeutics, diagnostics, vaccines, can be developed rapidly response to an evolving enemy.

You saw the FDA released guidelines on

Monday on how scientists can continue to keep up, and indeed keep ahead of the virus.

The fourth area is moving to open schools and open businesses. And getting those conditions right.

The CDC released, I think, a very critical piece of work. Which essentially gave the conditions to school districts on how they can open safely.

And essentially an important element of this, was that there are conditions. If you de-densify your classroom. If you have universal, well-fitting masks.

Where school districts even in zones that are hot -- hotter spots, can open. But, it's not just schools. It's also workplaces that need to be safe.

And we'll be making announcements with many of the country's largest employers and many small businesses, around steps that we are asking businesses to take, and businesses are taking, to make sure that the workplace also becomes safe.

Fifth is scaling manufacturing. When

we arrived, there was not as much inventory sitting in a stockpile as we had come to think.

And one of the first things that happened, was President Biden directed us to purchase vaccines for every adult in this country, sufficient for every adult in this country.

That's been done. Not even accounting for the potential of the Johnson & Johnson vaccine.

The sixth point on here is equity. And equity is essential to all of the other points that we've made.

And I think when we're on our game, and we're doing our jobs well, 100 percent of the decisions that are important, will include the voice of equity in the room, until people are trained to make that a part of every conversation.

And I think thanks to the leadership of Dr. Marcella Nunez-Smith, but also as she said, the culture that starts at the top with the President and the Vice President, that is something we are quickly embedding throughout not just government, but throughout all our conversations in the country

And I have to say, I'm so pleased with

the reaction that we get. Dr. Marcella Nunez-Smith and I were just commenting earlier today, what a world of difference it is in people's acceptance of the messages around things like racism and healthcare and what a role it plays, and how you don't get the push back and resistance that you once did.

The seventh part of the plan is rejoining the global community. Rejoining the WHO, and funding vaccinations for the rest of the world.

We are not just taking Dr. Walensky's account of why we need to make sure that we are on top of the threat everywhere, but we are also an administration that believes that we have obligations as a country, as a wealthy nation, to the world, even beyond our self-interest.

And that is something that the President has made very, very clear. That we have an obligation to the world. And we need to meet that obligation, even as we meet the obligation to our own people. Let me just finish with a couple of reflections of what I've seen since I've been here.

One is that you may have heard the

President say, we need to set science -- we need to let science lead. And, for me, the great pleasure, the great pleasure is in unleashing these great agencies, the CDC, the FDA, the NIH, and some of the nonscientific agencies, FEMA, et cetera.

Our career civil servants in the U.S. government, I believe, are among the best experts in the world. And letting them free to do their jobs, asking them in effect, what have we missed? What would you have liked to get done that you haven't gotten done, is a great pleasure and a great opportunity and where a lot of the solutions lie.

And, you know, as we were taught by President Obama, that we have to let science speak for itself when it's inconvenient -- and especially when it's inconvenient.

And President Biden, with all of the focus that he's had, and all the work he's done in the arena of cancer care, has just -- has then held that just quite naturally.

The second thing is, a sense of urgency. I think starting from President Biden onto the rest of us, I don't think he expects his team to

have a goodnight's sleep until Americans can sleep easy again.

And so, we do not declare victory. We do not pat ourselves on the back at signs of progress. We do not think this will be done until this is felt by the public. And we've got the energy and the focus to do that.

Third is, that this is indeed an orchestra. The solutions have to come from everywhere. State government, federal government, county government, the care provider community, the scientific community, Congress in passing the American Rescue Plan.

Everybody has a role to play. And indeed, it is much harder to ask people to do nothing, than to do something. Asking people -- not calling on people to contribute their gifts is a more challenging way to get through this pandemic. And so we are doing that, and we are going to do that.

Finally, I would say that I find that there is opportunity in the crisis. Never before have any of us had the opportunity in our lives, I would say, to wake up every day with the opportunity

to save so many lives, to improve so many lives.

And while none of us relish having acute needs in front of us, I know that many, many of you, if not all of you, are purpose built for this moment. You've trained for it, you've got the resilience for it, you've got the knowledge for it, you've got the leadership for it, and the country's counting on it.

And, in that regard, I consider myself incredibly lucky to be among you, and someone who has an opportunity to serve and have an impact during this time. So, I'm grateful. I'm grateful to all of you for all that I know that you do for the country, for your communities, for our families.

DR. BENJAMIN: Thank you very, very much. So, why don't we just go into a Q and A for the two of you.

So, what have been some of the lessons from COVID on data modernization and surveillance? You know, kind of, what kind of improvements should we make, particularly around getting data by race and ethnicity?

DR. NUNEZ-SMITH: Yeah, thanks. I

mean, this is nothing short of an obsession for me, is thinking through how we improve our data.

You know, right now we have race-ethnicity data on about half of all vaccinations that have already been administered in the country.

Now, two takeaway points from that. One is that despite the fact that we have incomplete data of varying quality, still there is an early pattern out there. And so we see, you know, in particular, Black and Brown communities are getting vaccinated. And this is in that early, early part into the data that we have, that getting vaccinated at lower bands of representation in the general population.

But, still, it begs that question. You know, we have almost complete data on some other variables, things like age, or recorded, you know, gender. And so, we still have a ways to go with race and ethnicity. Even Dr. Walensky spoke to this as well, that some of the data infrastructure, we need to modernize some of that.

But also for the federally administered program, so just by way of quick reminder, you know,

thinking about the community health center program, the community vaccination center program, the retail pharmacy program, and then the mobile clinics that are often associated with those community vaccination centers.

We are modeling by example in terms of collecting data on race and ethnicity consistently. As well as, you know, other promising practices. Engaging with community-based organizations, faith leaders, thinking about ways to optimize registration and participation. So, you know, hands down we have to do better.

But the early story of the pandemic was that we didn't have great race ethnicity data; I'm optimistic, because we got better as we went along, in terms of data on places, hospitalizations, and death. And I think we can and will do better in terms of race ethnicity data on vaccinations.

DR. BENJAMIN: Okay. Andy, we know that we have a new vaccine coming online over the next several months. Can you talk more about what the value of those additional vaccines are in our quest to achieve herd immunity?

MR. SLAVITT: Yeah. Thank you, Dr. Benjamin. So, I'm going to give you somewhat of an answer. But I was going to begin by saying, that the most important of those answers are going to come first from the FDA, and the experts on the FDA. And then, of course, from ACIP.

And that as soon as those come out, our scientists, Dr. Nunez-Smith, Dr. Fauci, Dr. Walensky, will help the public interpret and understand what the data is saying to the extent that it's not already clear.

And I don't consider that my role. And I just think it's important for me to say that whatever that is, and whatever variety that has to it, we will -- we will drive our approach based upon that.

Now, of course, we are preparing for every possible scenario in a couple of respects. First of all, distribution, making sure that it's fair -- that the vaccines are fair and equitably distributed.

We all want more vaccines. We think a vaccine that, as the data that we've looked at says, has after 30 days no deaths and no

hospitalizations, and it's safe, is a great vaccine.

But, again, we're going to wait to hear what the experts say about that. But, that's something we're all very, very excited about, certainly. And I know the rest of the country is as well. We're going to make sure that all the vaccines are available, and produced in large quantities. That's going to be, you know, that's going to certainly be critical.

As it relates to herd immunity, I think, I'm going to stop short of saying that we have a perfect understanding of cause and effect, at least at this point between vaccinations and herd immunity.

What I would say, is that I have found throughout this crisis, it has been very tempting to look at what's happening, and try to backwards explain it by what's happening.

And oftentimes, I've been reminded that how much bias is in that judgement that I made. So, I think what we don't know about the future is how good a job we will do in overcoming vaccine hesitancy.

What we don't know is a perfect view

of how the vaccines will handle the variants. And we are preparing for all those scenarios.

So, all of us -- all of us want this to be over as quickly as possible, and to move on with normal life.

I think our job in the White House is probably not to crystal ball, but to execute as quickly as humanly possible. And attempt to over-deliver on whatever commitments we've made.

So, I know that's not a -- this is not a satisfying answer of giving you a date. But I also don't want to offer false precision.

And I might ask Dr. Nunez-Smith, as one of our clinical leaders, if she has anything you would add or amend to that?

DR. NUNEZ-SMITH: I totally second everything that you said. Nothing to add, perfect.

DR. BENJAMIN: Thank you. You know, we know that Asian Americans are often left out of the equity conversation, but experience really poor outcomes. Any thoughts about that?

DR. NUNEZ-SMITH: Yeah. I mean, I would -- the disaggregation of data is so important.

So, you know, we have -- and I'm grateful for this question as well, because it really lifts up our need.

You know, I often say that we have to, every time in the data that we collect, the data we don't collect, we're making choices. Right? And we have to make visible these realities. And we can do that through data.

I mean, I think that there are various stories of many communities who are effected. I mean, it was late in the pandemic before we started seeing data emerge, for example, on Native Americans and indigenous people. It's still -- and it's more to do in terms of understanding everything happening in our prisons, our jails.

So, absolutely, we have to -- we're inviting everyone into this conversation. I think that's so important.

I just want to lift up something that I said earlier, that we are committed in the administration to hearing from the communities that are affected by COVID-19, to listen, to learn, to respond. And so, you know, everyone is -- it's

an open line of communication. We want to be transparent in this work. We want to be held accountable in this work.

So, it's very much on our radar, these disparities, that Asians are affected differently. This was part of the roundtable conversation earlier today, actually. And so the plans are very much aware of the disproportionate impact in many of those communities as well.

DR. BENJAMIN: How about people with disabilities?

DR. NUNEZ-SMITH: Yes. I mean, similarly, and I think this is a great opportunity to talk about, you know, intersectionality, which everyone in -- you know, I think many people are trying to understand.

You know, part of the reality, when we think about disproportionate impact, where we think about the social structure of drivers, you know, how differential access to resource and opportunity is manifesting now in the pandemic.

But we have to lean into the reality. And for people with disabilities we have a similar

challenge, where often our data systems are not keeping up and helping us track, and helping to respond. But we know that there is differential impact, we know there is need, and these are all the groups.

You know, Andy referenced, as did I, the national strategy that the President released the first day, and these are all groups that are included in there and explicitly named in goal six that we have to, have to, have to address in the response and the recovery.

DR. BENJAMIN: Thank you. How's the Administration thinking about how this ends? Obviously, there are several possible futures. You know, from the endemic disease to re -- a seasonal disease to this being a false reduction in our, you know, getting another fourth surge.

So, how's the Administration preparing and thinking about that, and trying to get ahead of where the outbreak is? Because you know, we've been chasing it since the beginning.

MR. SLAVITT: Do you want to start Dr. Nunez-Smith? Or would you like me to?

DR. NUNEZ-SMITH: Yeah. I mean, I think it's what everybody wants to know. Like how do we get to our new normal? Like, when will we know? I think there -- you have to resist that urge to say, we are going to try to crystal ball.

What we know now is that we have the benefits of great scientific discovery and breakthrough in the authorized vaccines. And quite frankly, in the therapeutics that are underutilized.

We have tools in the tool box. We know that basic public health, things that work, masking, socially distancing, all of that.

So, I think that we, you know, I think it is early to say exactly where we will end up, and will we end up with an endemic sort of COVID-19.

What we do know is that our immediate issue is to try to reduce pressure on the virus to mutate in ways that are critically significant. And the best way that we can do this is to be efficient and equitable in our vaccination work.

MR. SLAVITT: One of the things that I would add to that, is that I think we could all be critical of ourselves as a country over the last

year for kind of approaching everything in sequence instead of in parallel. Not doing a great job seeing around the corner.

So, we have a -- we have a ventilator crisis. We have a -- then we have another crisis. Then we have another crisis. Then we have another crisis. And, you know, you begin to wonder, could we not have seen some of these things coming?

I mean, there is after all, a pretty predictable pattern with this infection. It's mysterious, in many respects, but -- but not hard to foresee some of these things.

The thing that though you get humbled by, is how often you get thrown curve balls. And how often what you think is going to happen, doesn't happen because of any one of a number of factors, which you all are quite expert at, including just bad luck.

When does a super-spreader event happen? And what time and in what way? How did the virus mutate in ways that we didn't know? And I think you heard Dr. Walensky talk about the fact that we have to really beef up our surveillance if we're

going to get ahead.

So, I think step one is we have to be, we have to have much better real time ability to see what's happening, and where it's happening in -- to react to it.

Second is, we have to do scenario planning. We have to actually have the people in, the scientific community in the government. People who are willing to challenge. To say, what are the possible scenarios? Dr. Benjamin, you named a few of them.

But, for being prepared for scenarios, particularly the unpleasant scenarios, we could all, you know -- I think we spent a lot of time in wishful thinking over the last year. We could all wish for this to be the last wave. But we wouldn't be doing our jobs if we weren't actively focused on containment measures for the variants.

If we weren't actively focused on how might therapeutics help to minimize the effects of the variants. How might we make sure that if we do have another wave, it feels different?

I'll give you an example. If we have

another wave in say March or April, by that point in time, knock on wood, we could all knock on wood, we may have the large predominance of the long term care community vaccinated.

We may have a large percentage of people over 75 and even over 65 vaccinated. Will we have everybody we want too vaccinated? Absolutely not.

Will we have every front line worker we want vaccinated? Absolutely not, if this happens at this time. But you can imagine another wave where we have a large spread of cases, because we know cases spread among people under 50. But imagine that where the people in nursing homes, long term care facilities, assisted living, and in many other highly at risk communities, aren't being hospitalized at nearly the level.

That would be a way that you could imagine with our current set of resources, our current focus. We could successfully plan for a potential near-term scenario.

So, all of this is to say, the question you're asking is a good one. And as Dr. Nunez-Smith said, well, we won't predict the future internally.

We do feel like we have to prepare for each of those scenarios, and not try -- and also not try to answer the unknowable questions.

DR. BENJAMIN: Well, I've got a couple of closing questions here. One, you know, when I was out kind of doing the work you're doing, being out in the public a lot, I would always get questions.

And I was always getting asked, how can people get questions to me after I leave? So, that must be something you get asked all the time.

Any answers to that question?

MR. SLAVITT: Yes. I mean, you know, look, I think, I would suggest that certainly through -- if there's a way through this forum to collect questions that you want to put out, Dr. Benjamin, or Dr. Dzau.

And then get them to us collectively. You know, we can -- you can funnel them to us. You know, normally, I think, both Dr. Nunez-Smith and I would both say, just send them to our email boxes.

And in fact, when I was at CMS, I read every beneficiary email personally, because that

-- because that was an important part of my job.

I would worry that I would -- I would not be responsive enough if they all came individually, you know, through that. I think my inbox looks as bad as probably many of yours do. And I know Dr. Nunez-Smith's does as well.

So, if you want to offer a way to get questions through the APHA, or through the National Academy, and then get them to us, we will absolutely jump on them.

DR. BENJAMIN: Yeah. We do try to collect these, and try to put together the -- lump them together and try to get some of the answers, as best we can, out to folks.

I think finally, the question is, you know, the social determinants of health have been such a big component of exposure and the disparities in this terrible pandemic.

What do we need to do to, to kind of reach beyond just the classic medical care stuff to try to address this in the future?

DR. NUNEZ-SMITH: Yeah, thank you for that. I think that's a -- you know, to -- yes,

that is our question.

In the social structural, you know, drivers that I think people are very much aware of now, you know, all the things you said. You know, why do we see these differences in terms of which groups are affected?

We don't think, as before, there's something biological or genetic. Right, this is about social risk and social exposure. Whether it's living in multi-generational homes, being over-represented in the jobs that we deem essential. Right? I mean, the list that the audience, I'm sure, can articulate well. So, it has to be at the core.

You know, when we see now the realities around rising rates in nutrition and food insecurity, in terms of housing instability. And so, you know, I would say that definitely the President's plan recognizes all of this right now.

The American Rescue Plan speaks to, in the fiscal priorities, the need to address each and every one of these. This is certainly work that is being taken up across the Administration.

And also in the task force.

So, I think that the, you know, what is implied in the question, if stated, is correct. To have a full conversation about health equity, healthcare equity, is you know, healthcare is about 20 percent of what drives the differences that we see. So, it's going to be fundamental that the policy work speaks directly to these drivers.

Yes, Andy?

MR. SLAVITT: You know, I just want to add, add one thing. Which could be both an easy and a hard thing to do. Because I would have, if I could have articulated as well, I would have said the exact same thing that Dr. Nunez-Smith said. So, I'm just going to give you something to add to this.

Which is, next time you have a colleague that talks to you about a noncompliant patient, maybe it's a great opportunity to stop and think and remind them that the social determinants of health are not some conceptual, theoretical, population-based thing. But there are things that are affecting everybody's life.

And people who tell me that they believe about, how deeply and how much the social determinants of health are a factor, and talk about noncompliant patients, people who don't take their medicine, people who -- who over-eat because they may have mental health issues, or because of whatever other factors, social, societal, whatever, we don't always connect those dots.

And so, at the individual person level, at the individual level of people's consciousness, we all fall in these traps. And I'm sure I have as well.

But, just reminding people at those moments, that those are the moments where a different type of intervention. Well, maybe they couldn't afford the prescription.

Well, maybe they couldn't get to you for a follow up visit. Or maybe they were scared. Well, maybe life got in the way. But, intervening in those moments. And this is obviously beyond simply COVID-19. I find that we've got to be much more willing to do that.

So, I'll just throw that in as a sort

of frosting on the very good cake that Dr. Nunez off -- Dr. Nunez-Smith offered.

DR. BENJAMIN: Well, thank you very, very much. So, this concludes today's webinar. And our next webinar will take place on Wednesday, March 17 at 5:00 p.m. Eastern Standard Time. It will be on the subject of coronavirus variants.

Now, everyone who's registered for today's webinar will receive an invitation for the next webinar.

And just again, to remind you, that we do offer continuing education credits for this -- for this webinar. The webinar has been recorded. And the recording, a transcript, and slide presentations will be available on the covid19conversations.org website.

And I want to thank again our panelists, and to the National Academy of Medicine for cosponsoring this webinar series with the American Public Health Association.

And, of course, I want to thank you, our listeners, for joining us today. Best wishes, be safe, and take care.

(Whereupon, the above-entitled matter went off the record at 6:10 p.m.)