

KHN's 'What the Health?'

Episode Title: The Covid Coordinator Speaks

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Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. We hope you're having a pleasant holiday season and not swapping germs along with presents and food and drink. To that end, we have a special episode this week, an extended interview with White House covid coordinator Ashish Jha. We taped this interview on Tuesday, Dec. 20, at 10 a.m. As always, things might have changed by the time you hear this. Regular listeners will remember that we've talked to Dr. Jha before in his previous roles as a public health researcher at Harvard [T.H. Chan School of Public Health] and, more recently, as dean of the School of Public Health at Brown University. So, without further ado, here's the interview. I am pleased to welcome back to the podcast Dr. Ashish Jha, the White House Coronavirus Response Coordinator. Thank you for joining us again.

Dr. Ashish Jha: Thank you for having me back.

Rovner: So, I want to start with an existential question: Where exactly are we in the pandemic? Is it over? Is it waning? Or do we actually not know yet?

Jha: Yeah, so, here's what we know. We know there's still a lot of covid out there. And right now, here we are in December, and a lot of covid. And so the virus is obviously still with us. We're in a period of time where we're seeing increasing cases, increasing hospitalizations. You know what often follows in terms of increasing deaths. We haven't seen that yet. I worry about that. But the other thing that's very different in this moment, let's say as opposed to a couple of years ago, is we are now at a point where we know how to manage this virus. We have the tools to manage the virus. So the virus is still around, still causing disruption, and a lot of people are getting sick, but we're also at a point where we can manage this far more effectively than we could a couple of years ago.

Rovner: So hospitals are very full, very early this winter ...

Jha: Yeah.

Rovner: ... although not necessarily with patients with covid.

Jha: Yeah.

Rovner: Do we have any idea why there are so many other serious respiratory ailments in addition to covid floating around this year?

Jha: Yeah, so we are seeing a lot of RSV [respiratory syncytial virus], a lot of flu, and probably other respiratory viruses, too. We just don't measure them as systematically, but parainfluenza and a whole ... other viruses that are also circulating this time of year. I think a couple of things are going on. I mean, first of all, we see, obviously, both RSV and flu every winter. We're seeing more of it. We're seeing it earlier. We saw this, by the way, in the Southern Hemisphere, in Australia, this summer — our summer, their winter — with the flu. So not totally surprising. There's a lot of speculation about what might be causing it. In my view, the best evidence so far suggests that we've had two winters with relatively mild RSV, relatively mild flu. And what that meant is that the proportion of the population that was infected and had some level of immunity has gone way down. You know, it's a good thing, right, in terms of fewer infections the last couple of winters. However, it means there are just more susceptible people. And so we've seen RSV come

back. We've — we're seeing the worst flu season in a decade. So those things, I think, are in some ways maybe related to the fact the last two winters have been different.

Rovner: So, ironically, wearing a mask could protect people not just from covid, but from the flu and those other bugs that spread more easily in the winter air. Why is the [Biden] administration, and particularly the CDC [Centers for Disease Control and Prevention], so resistant to encourage masking? I see so many people conflating the CDC's advice that "you don't have to wear a mask" with "you shouldn't wear a mask."

Jha: Well, first of all, Julie, can I just say, with all due respect, I don't agree with the basis of that question. I don't think the CDC has been reticent. Certainly not the administration. But here's how we have thought about it, here's how I have: Whether you're talking about flu or you're talking about covid, or RSV, you want to take a multipronged approach to managing a respiratory virus. So let's just talk about covid and flu — two, obviously, really important viruses, especially for older Americans. When I think about a multipronged approach, what do I think? I think about vaccines and starting with vaccines, for reasons I can argue are probably the most important. But there are treatments, there's masking, there's hand-washing for flu, not so helpful for covid, but for flu hand-washing is really important. There's improving of indoor air quality. So there is a multipronged approach here that is really important. You know, and you've heard from the CDC director [Rochelle Walensky], I think even a couple of weeks ago, she talked about as the respiratory virus numbers go up, the importance of taking this multipronged approach, including masking. I don't know that there has been a single time I can think of where I have talked about the kind of layered approach where I have not mentioned masking. So for me, masking is one of the tools we have. I absolutely encourage people to do it. When I get on an airplane, when I am in crowded spaces where, let's say, everybody has not gotten a test, yeah, I wear a mask. And I think it's one of the tools we have for protecting people.

Rovner: Yeah, I think a lot of people I know just wear a mask because, particularly when we go into stores, because we're used to it now. So you just start, you go, you grab your purse, and you grab your mask.

Jha: Yeah.

Rovner: It's sort of second nature.

Jha: I think in crowded spaces, it's a really effective tool. What I would say is particularly important in the context of covid, but it also does help with the flu, it helps with RSV, it helps with all respiratory viruses. We should just think about it as one of the tools in the toolbox, and we should use it when we feel like it's helpful.

Rovner: But I have had people parrot back at me, saying, "The CDC says we shouldn't wear a mask." I mean, that's sort of how it's being interpreted.

Jha: Well, look, so first of all, the CDC does not say we should not wear a mask.

Rovner: I know that.

Jha: Right? And second, it just reminds me that we have to continue to get out there and explain to people it's one of the things we have and during these times where infection numbers are high, it's a pretty reasonable thing for people to be doing.

Rovner: So, the Biden administration is obviously all-in on vaccines, yet Congress just lifted the vaccine mandate for the Defense Department. Are there still persuadable people out there who haven't been vaccinated yet?

Jha: Yeah, so, there's just only a small proportion of Americans who have not gotten vaccinated at all. I mean, if you think about adults, almost 90% of adults have gotten at least one shot. I think the challenge is less sort of people who are unvaccinated, but helping people get up-to-date on vaccines. To me, when I think about vaccinations in America and the work we have to do, I tend to focus on people who are *undervaccinated*, not *unvaccinated*, but *undervaccinated*, people who are not up-to-date, and saying, "How do we help them understand the value of getting vaccinated?" so they're up-to-date. And so they're rarely people who are quote-unquote "anti-vaxxers" or people who are never going to get a vaccine. I think these are people who've gotten vaccinated who need to understand: What is the value? What's in it for them of getting that updated vaccine? And we're seeing, for instance, on the bivalent vaccine, really stunning data about the drops in hospitalizations. We've always known that people who were up-to-date on their vaccine — people who have gotten a booster, for instance — tend to have much lower hospitalization and death rates. So just again, getting out with that message and worried less about the *unvaccinated* per se, which is a small minority. It's obviously still important to try to persuade them, but really to help people who are undervaccinated to get up-to-speed.

Rovner: So, the latest vaccine monitor poll from my colleagues over at KFF shows that the resistance to the covid vaccine is rubbing off onto other childhood prevention measures, that the percent of adults that believe children should be immunized in order to attend school is actually down. And the percentage that believe parents should be allowed to decline to have their children immunized is up. How big a worry is that, that this is going to spread to vaccinations for other diseases, which we've been vaccinating for for decades?

Jha: Yeah, that's a good question. I read that poll. I saw the data, of course, and I read it in a little bit differently in the following: My read of that poll is people still believe — comparable numbers — the benefit of vaccines outweigh the risks. Where you see a small proportion of people changing their view is around mandates. And, you know, I understand that. That has been controversial over the last couple of years. And what I would say on that, first of all, is that we've got to continue reminding people the benefit of these vaccines. You're seeing what's happening in Ohio with measles. I mean, really stunning, right? In 81 cases, almost 30 children hospitalized. So I remind people — there's this mental model people have of "well, natural infection is good." Like, no! It leads to kids getting hospitalized and getting really, really sick. That is not good. Not when you have a really safe, effective vaccine as an alternative. So I think reminding people of the benefit of vaccines. And then on the decision of mandatory or not mandatory, that has always been a decision that has been made at the local level. I think about my kids, where my kids go to public school. There's a list of mandatory vaccines decided by by the town and by the state. I think it's appropriate. I strongly support it and I hope that that continues. But these are going to be conversations that are going to be happening at the local and state level.

Rovner: I feel like the more scientific information we get about covid, the more confused the public gets and the easier it becomes for people who are peddling misinformation and disinformation on purpose. How do you combat that? I mean, I feel like three years in, there's more of that than ever.

Jha: Yeah, it's a very good question. My strategy on this is a couple of things that I think are really important. One is to remind people that science is a process and not a destination. And, therefore, what scientists do is update their recommendations based on emerging and changing science. Right? And so, one of the things that misinformationists like to exploit is — and they do this to me all the time — they're like, "In July of 2020, you said this, but in December of [20]22, you're saying this. Why can't you be consistent, Dr. Jha?" I'm like, now, in July of 2020, I knew a certain set of things or I made recommendations in a world where there were no vaccines. I'm making different recommendations in a world where vaccines are

plentiful. So reminding people that, in reality, evidence changes, science is a process. It's not anti-science to change your views. In fact, it is anti-science to hold the same view as the evidence changes. I think that is a helpful framework for people to combat misinformation. The second thing is, misinformation thrives in information vacuums. And the key thing to do is to flood the zone with good information, the best information you may have. And this is where scientists get into a little bit of trouble, Julie, because, you know, I was taught growing up — in my scientific career — was that you don't really go public with stuff until you're pretty sure. That can take a while. In a fast-moving pandemic what that means is scientists are silent while trying to get sure about something, and misinformationists thrive in that. So getting out, even if you're not, you don't know all the data. Even if you don't know all the stuff but you're getting it all, uh, gathering it, telling people what you do know and flooding the zone with good information, helping people understand it's a process, I think that's important. Last point is I really think the need to get good information out, especially in a health crisis like this, is everybody's responsibility. You know, I speak to groups of physicians and many of whom are like, "You've done a great job being a spokesperson." I'm like, "It's not about me." We all have to be out there in our communities, in the grocery store, in the church pews, giving out good information on a constant basis, because that's the best way to combat misinformation.

Rovner: I still get emails all the time from people complaining that not enough attention's being paid to those with long covid. What is actually being done by the government on this? I know, I mean, these are people who are in — really, some of them — dire straits.

Jha: Yeah. Yeah. No, I'm very sympathetic to how much so many people are still suffering from long covid. Let me give you the high level of where the Biden administration is on this. In the first week that I started in this job, in early April, the president asked for a comprehensive strategy on long covid, a government-wide strategy. The secretary of HHS [Department of Health and Human Services] was tasked with it. There was a report out in August. I'm not going to get into a lot of the details of the report. Let me lay out the big picture of how I think about it. First of all, one of the first things we need to do is sort out what exactly is long covid. Long covid is not one condition, right? And we've got some really good work happening through NIH [National Institutes for Health], funded by NIH, happening at NIH. And I'll start by saying, in my mind, there are four major buckets of things that are likely underlying long covid. This comes from an NIH evaluation. So, one is persistent infection. And the reason I'm going to go through these is because it follows what we should be doing as well. So, persistent infection is one thing. Immune dysfunction is another. Third is vascular damage from the original infection. Fourth is just tissue damage. You had bad covid, you got a lung infection and it got better, but your lungs still haven't recovered. You have persistent symptoms. Right? So those are the four major mechanisms. And what we've done in the last year through the RECOVER study at NIH is worked on trying to understand the epidemiology and get all that. What you're going to see now — so, this is the reply to your friends, if I got that email, and I do get versions of that — is starting, really, in January — so in a couple of weeks — you're going to see a whole bunch of clinical trials launched to try to go after each of those mechanisms. So antivirals, immune modulators, things that can help with rehabilitation to try to deal with all four of those mechanisms. So that stuff is coming and the science on that is moving along pretty nicely. The second part that the government is doing coming out of this report in August is, you know, our health care system — this is a new condition. Our health care system doesn't know how to take care of it. And *you* know because of the years of work you've done on this, that when the health care system doesn't have a billing code, doesn't have a strategy, it fails those patients. So there's a ton of work happening at CMS [Centers for Medicare & Medicaid Services] to make sure that we can identify people with long covid. We can actually reimburse for long covid. Things that are going to make it — that are really technical — but are going to make it much easier. Last point is some folks with long covid really are pretty disabled. They have just, they're really suffering. And we've got to update our

disability and our support systems that we have in government. So that work is happening. Again, all of that is moving, I think, pretty quickly and we'll continue doing it. But that's the comprehensive strategy that HHS laid out at the request of the president. And we're plugging away on all three of those areas.

Rovner: What about there's a small subset of people who, particularly, who had covid early, who never did have a positive test, either they were unable to get tested at all or they got tested once and it was negative. And yet they are still having persistent symptoms. Is there any recourse for those people?

Jha: Yeah, it's a very good question. I mean, look, there are ways of knowing if you've been previously infected, of course, you can do certain types of antibodies. But the biggest issue in my mind is we've just got to take care of people based on whatever they have. So if they have symptoms, whether it's from long covid from, you know, we've got to be able to identify and take care of those people. I don't know, and again, I don't want to get ahead of where that comes with the standard policy stuff is, I don't know if you need to have a documented positive test. And so people, there are lots of people who are sick who never got tested, obviously it was pre-vaccines. But we absolutely have to make sure that we continue caring for and supporting those people.

Rovner: So the latest news from Capitol Hill suggests that the administration is not going to get the covid funding it's been seeking. How worried are you about covid money actually running out and people suddenly being asked to pay out-of-pocket for tests and treatments and vaccines and things that are going to be pretty expensive?

Jha: So, we've been very clear on this, right? Which is, to fight this virus, you need all the things you just mentioned. Tests, treatments, vaccines, other tools. And already we've been running a covid response that is financially much more strapped. Our ability to run really aggressive vaccine campaigns in a way that we did last year has been more limited because of lack of congressional funding. So this continues to be a challenge. In terms of the issue that you're bringing up about when people start paying out-of-pocket, our strategy has always been that we knew there would come a day when the U.S. government would get out of the business. And we wanted to make that transition as smooth as possible, to have a very clear strategy for uninsured and underinsured people, to make sure we're doing everything possible so that that is easy. That is still a commitment made harder by the fact that we don't have the funds. Because to do that really well, you need to have plenty of funding. All of this has been harder. One of the last things I'll say on this is, you know, what we have had to do is make some really tough choices. So we've pulled money out of other programs to make sure that we don't abandon the American people. Because at the end of the day, the president has been very clear to all of us that we still got to deliver for Americans whether Congress does its job or not. So Congress has made it much, much harder. But we are continuing and committed to all of those things. But boy, it would be a lot easier if Congress actually funded the response so we could do what was necessary for the American people.

Rovner: So, eventually the public health emergency is going to end.

Jha: Eventually, that is correct.

Rovner: We're not quite sure when. We are assuming it will be sometime in 2023, possibly in the first half of 2023. What's your biggest concern when it ends? I mean, an awful lot of things that have been going on are going to stop. I mean, I know that in this latest bill from Congress, they're going to extend the telehealth for a couple of years. And they're extending the postpartum Medicaid expansion voluntarily for a full year. So some of those things that the PHE [public health emergency] has created will continue, but, obviously, there's going to be a lot of things that won't.

Jha: Yeah, so, first of all, on timing, like, this is, as you know, purely a decision of the secretary of HHS [Xavier Becerra]. And he's going to make that determination largely based on looking at what the PHE, with the tools it gives us, and asking the question, "Is it necessary? Do we need it to continue to fight covid?" And if his determination is we do, then he will continue extending the PHE. The only other part I'll make on timing, and just because it's a reminder to people, is the secretary has said, and we've said, that there is an ironclad guarantee we're going to give everybody at least 60 days' notice because it doesn't serve anybody well to immediately pull it down one day when it expires. So, everybody, we're at least going to have a 60-day notice. As you mentioned, there's a whole bunch of things tied to PHE. And whenever PHE goes away, which it eventually will, and so we have a whole team of people working away to say, "Well, what are the capabilities it has given us? What do we want to make sure we don't lose?" There are some things where congressional action is really helpful. There are some things that the administration can do. So we're kind of plugging away to make sure that that ending is as smooth as possible. And that, to me, is the biggest issue because I want to make sure that we don't go back to 2019. That there is a set of things we have learned in the PHE that we continue moving forward. And then, of course, the other major concern is, I want to make sure that whenever the transition happens — it's not quite tied to the PHE, but it's related — whenever the transition happens towards a more commercial market for vaccines and therapeutics and testing, that there are not substantial cost barriers for Americans. To me, that is really, really important. It's been a really hard three years for America. The government has done so much to support and purchase these things, and it's really important that once it gets to the commercial market that we're not seeing huge copays. Or we're not seeing huge financial barriers. Because that will make this response much, much worse. The virus is not going away. We've got to have an equitable response going forward.

Rovner: So, it feels like the one thing that we have not done very much about is indoor air quality. That seems to be some pretty low-hanging fruit.

Jha: It is.

Rovner: And yet, I bought an air purifier. I know a lot of people who did it individually. But, you know, we've been talking about crowded places. I would think that doing something about indoor air would help, not just with covid, but with flu and RSV and everything else that goes around.

Jha: Absolutely. This has been a big priority of ours. And I'll tell you what we have done and what we're doing right now, and we're going to see in the upcoming months. First of all, the number of Americans who even understand the importance of this issue is still too low. So a large part of this is just getting the word out. There's a small group of aerosol scientists who've been beating the drums on this for years. And I'll be honest with you, as a public health person who's been a public health academic for 20 years almost, I had underappreciated the value of this. And it was only in the last four or five years that I started realizing how important this is. So, we've got a lot of work to do just to get the word out. And we're working on that. We held a White House summit. We brought in all the leading experts, and have really tried to always underscore the importance of indoor air quality. I will tell you, when I talk to experts on this and push them, their assessment is that if we as a country made, like, real improvements in indoor air quality, did a lot of the things that experts suggest, we could reduce the burden of respiratory illness by 30% to 50%. Some people even estimate 80%. That seems kind of high, but by gosh, 30% to 50% would be amazing, right? It would make this massive difference for all of us. So then the question is, what is ...

Rovner: You would think that employers would want that.

Jha: You would think employers would want that. So, here's what we're doing. First, in getting the word out, it's not just like we're running an advertisement, we are talking to the major employers, we're talking

to major building operators. A lot of cities have had a hard time bringing workers back because workers are, like, "I like working at home and it feels safer. Why do I want to be in an office space?" Well, if employers who want people back for whatever set of reasons, let's say they just think it's better, one of the things that I've said to them is, "Make your indoor air quality better. It will build more confidence." The other part — and then we'll talk about some specific actions — the other part is that a lot of these improvements are not super expensive. I mean, the air purifiers, the upgrade of the HVAC system, like, large buildings can do this. And what you're going to see in the upcoming weeks and months is actually major building operators take this on because of the work we've been doing in the background, voluntarily saying we want our buildings with people in it, we've got to create the space for people to feel confident. One of the challenges that's been out there has been that there have not been very clear standards. What is good indoor air? ASHRAE [the American Society of Heating, Refrigerating and Air-Conditioning Engineers] — which is an independent organization that has done this for buildings, and their recommendations are often adopted into building codes — has publicly said they are going to create these standards and we're going to see that in the spring. So I think this is an area where it took a little bit of time to get momentum. You're going to see a ton of momentum and a ton of activity — federal, state, local level, private sector, really driven a lot by the private sector — because, for all the reasons, it's really important.

Rovner: All right, last question. You've been at this awhile. You're, you're on leave from your "regular job" at Brown. How much longer are you planning to stay? And is there one thing you really want to get done before you go?

Jha: Boy, good questions. There are many things I want to get done. I'll talk about that in a second. You know, on terms of timing, I will be completely honest. I don't ... listen, honestly, I don't know. Right now I am focused on where we are as a country. My job is to help the administration, the government, get us through the latest increase in cases we're seeing, get us through the winter, into the spring. And that is my primary focus. And, you know, long-term plans, these are conversations we're going to have at some point down the road. Things I want to accomplish: You've already heard me say I want to make sure that we get real momentum going on indoor air quality. We really need to build the next generation of vaccines and treatments. Mucosal vaccines, variant-resistant vaccines. We've got to get some momentum going on that. We're seeing other countries like China and others make really big investments in these areas and there's so much good American science happening. So I want to see some real momentum on that. There's a set of things we've got to do in 2023 and, you know, when am I not useful in this role? Well, the president will tell me, as we serve at the pleasure of the president, and until then, I'm going to keep plugging away at doing all the things I need to do to help us through this period.

Rovner: Well, Ashish Jha, thank you so much for joining us. I will let you get back to work and get some rest over the holidays, if you can.

Jha: Thank you, Julie. It was great seeing you and thanks for having me back.

Rovner: Thank you. OK. That's our show for this week and for this year. We'll be off next week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks, as always, to our producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. We're at whatthehealth — all one word — @kff.org. Or you can tweet me. I'm still @jrovner. We'll be back in your feed the first week of January. Until then, Happy New Year and be healthy.