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A Conversation with CDC Director Dr. Rochelle Walensky on Meeting Our Public Health Challenges

Drew Altman: Hello. Okay, folks, grab a seat. Or, stand up because we're getting started. Well, the Warriors are right over there, and the Giants are right over there. What, I have to say is, go Celtics. You can all boo.

But the important event in San Francisco today is actually right here, this morning. So, good morning. I'm Drew Alman from KFF. We are now called KFF, by the way, if you didn't notice, please remember. And so welcome to KFF. It was actually March of 2020 when I went to Costco and stocked up for what I thought would be a couple of weeks away from the office. And we haven't had an event in our Barbara Jordan conference center in DC or here until today. So I just want to say how perfect it is to be able to restart with Dr. Walensky and the CDC and the CDC Foundation. Thank you all for being part of that. And I'll just say finally, it's been a very long time. I think you know us for our scrupulously careful and independent, policy analysis, polling, and health news coverage.

So I just need to acknowledge, right off the bat, that I am a huge Rochelle Walensky fan. I am, just except for one thing, which is that I'm from a Brookline, Mass., and Dr. Walenksy is from, Newton, although I think she was born in Peabody, which for those of you who are not from there, it is not Pea-body. It's Peabody. And I grew up with the orange and black of the Newton Tigers as our larger, a bunch larger, rivals. But she made it all up when she threw out....I can't remember, I think this last season, the first pitch at Fenway Park, which was just so really cool. This is an act that heals in Boston. So maybe not this second, but you all need to Google it. And it was a great pitch, too. You all need to see it.

Dr. Rochelle Walensky: I practiced it.

Drew Altman: I was in government twice--federal and state. I had to say no also a couple of times. And those times that my obligations prevented me from serving were on my mind as I introduce Dr. Walensky today because Dr. Walensky went for it in the middle of what truly has been a national crisis. She had a great job at the best hospital in the world. And she answered the call. I guess I should say that best hospital in the world part softly, because UCSF is right here and is also exceptional. But when you grow up in Boston, it is the best possible. You know, it hasn't been celebrated every minute of every day in that it hasn't been, absolutely a cakewalk. And that's just a testament to how challenging our world has been. Covid has been a public health crisis, but it's also been a crisis for public health. Many of you, I know, follow our Covid Vaccine Monitor, and I would say tragically, it is tragic to me, in our surveys, absolutely the strongest predictor--at a level of nothing else is close--of whether people get vaccinated or not, is just simply whether they're Republican or they're a Democrat, which is obviously a proxy for lots of other stuff that's going on in the country. There's a 30 point difference between Democrats and Republicans in the shares of each group who have gotten the Bivalent booster.

There's a 50 point difference in the shares of the two groups who say they would get an annual covid vaccine. There's a 48 point difference in trust in the CDC. There's a 61 point difference in trust in Dr. Fauci. All this is fueled by polarization, but it is also fueled by misinformation. You know, that the deaths are being exaggerated by the government and also that they're being hidden by the government, which is a neat trick if you think about it.That Ivermectin, is effective that you can get Covid by the vaccine and more of these myths that I think you're all somewhat familiar with. So, as we put it in, I thought a terrific

investigation that our KFF Health news did with the Associated Press: Public health was both underfunded and also under threat; and that's just Covid.

The CDC deals with a whole range of equally challenging health issues. And it does it all over the world. Its mandate takes it absolutely everywhere. Next year, in a big move for us, we plan to add a new program area at KFF that addresses misinformation in health and works on rebuilding trust. This is our first new program area since I established the news service, which was now way back in June of 2009. And you may also hear today about changes at CDC that Dr. Walensky's initiating. And, you know, these are changes that will not be simple, but have long been needed. Those of us who work with the agency are already starting to see the impact of these changes. And I will just say that in stark contrast to making changes at a place like KFF, they're hard because a lot is beyond the CDC director's immediate control, including the agency statutory mandate and authority.

And certainly it's funding as well. You will also hear today about the CDC Foundation and from Judy Monroe, who's a partner to all of us in the private sector who work on these issues, a really critical organization because it has degrees of freedom that an agency just doesn't have. But also it exercises independent leadership on all of these issues that we work on. So that's important, and we're looking forward to that as well. So finally, I'll just say, we're just hosts today on behalf of the Bay Area. On behalf of everyone that's in this room. The program today is the CDC's and the CDC Foundation's, along with our Senior Vice President, Jen Kates, who runs our global health and HIV program, who is herself, a star, who will moderate the program for all of us today. But we begin with remarks this morning from Newton, Massachusetts.

Dr. Rochelle Walensky: And Atlanta, Georgia. Thank you very much for that warm welcome, this warm introduction. I am really delighted to be here. Good morning. Thank you for having me today. Again, honored to be here with the Kaiser Family Foundation and the CDC Foundation, and to share the stage with colleagues, with colleagues, old and new, with dear friends and old friends, and so many friends in the audience. In a moment, I will share with you some of our updates of CDC moving forward and our agency's priorities, as well as touch on how climate change is affecting public health. But before I do, I want to address this specific audience of public health professionals, of journalists, community partners, and more. I share the following information, not merely to communicate topical facts, but because each of you possess power to affect change, you are deeply engaged.

And frankly, we are all in this effort together. So thank you for all that you have done. Thank you all for all that you will accomplish to inform national health issues and policies that shape them. Over the past three years, COVID-19 has tested our public health system, its workers who labor tirelessly to prevent the spread of disease and to save lives. While there were many moments of un- celebrated community and triumph, there were also many challenges that revealed a weakened and frail public health system. The pandemic emphasized the importance of public health, of public health workers, and a system, an infrastructure that supports both. We at CDC have reflectedon the last three formative years to apply them to lessons that we've learned to move CDC as an agency to be a more modern, responsive, and forward-leaning public health agency of the future.

CDC Moving Forward is a strategic initiative we launched in April of last year after an extensive review of the agency with internal voices and external input. CDC Moving Forward addresses long standing agency-wide challenges, which require changes across all of CDC, from structure and process to culture and operations. Since I announced this initiative, we've taken multiple steps to address past shortcomings and strengthen the agency's ability to be prepared and respond to future public health threats. At the end of last year, I also rolled out an agency-wide reorganization that eliminated reporting layers broke down silos, elevated foundational public health capabilities, and helped improve bidirectional communication and accountability. However, I want to be clear that CDC's Moving Forward

initiative will achieve much more than simply moving boxes on an org chart. That organization and reorganization needed to happen. But I am more focused now on our hard work in tackling our processes and our systems and our incentives, our internal incentives.

Our goals remain to strengthen the agency and shift our culture so that we can share our scientific data and findings faster, so that we can translate that science into practical, easy to understand policy. So that we can prioritize our public health communications. So that we can promote our results-based partnerships. And so that we can develop a workforce that is ready to respond to emergencies. And in many of these areas, we have already identified solutions and implemented change. Scientific review times are down 50% without sacrificing quality. And we are not done. We've prioritized releasing data and new scientific information quickly with multiple technical reports and data releases, including during the Mpox response and the latest update technical report on Avian Flu. Our CDC website is undergoing an overhaul of over 200,000 web pages. To streamline the website, to more effectively and efficiently share user focused, data-driven content.

We've implemented strategies to ensure our entire workforce is ready to respond to future threats, including requiring emergency response training and standing up a roster of staff that are ready to quickly to deploy into emergency roles, both within the agency and all around the country. There is so much we are doing. In fact, over the last several months, we've identified 161 priority actions in all and an agency that is now deeply committed and engaged in those activities to improve our accountability, our communication, our collaboration, and our timeliness and partnerships. These are, and many of the other priorities are underway and will lead to an agency that is stronger and better positioned to deliver public health and its mission and to address future public health threats. And while we continue to make strides towards an agency prepared for any future public health threat, we also need you all to know that to fulfill our potential, we also need congressional action and support.

Budget flexibility and new authorities would allow us to work faster and be more nimble. It would allow us to fulfill the mission you expect of us, to be an exceptional science-based agency and an exceptional public health response-based agency. To do this, the authorities that CDC need range from public health and regulatory to human resources and operational, and in most cases, will take congressional backing. When faced with seasonal and emerging disease threats, we need to be able to call up comprehensive standardized data from across the country quickly, something that we currently do not have the authority to do. During the Mpox response, we were responding with blind spots in our data on how and where disease was spreading. Limited by our patchwork system of data use agreements with states and jurisdictions. When faced with critical decisions about Mposx vaccinations, I can tell you where I was as we were making these decisions, we had to go state by state to set up data use agreements to ensure we could get information on who was sick and who was getting vaccinated. Even as a nationwide vaccine strategy unfolded starting in June of 2022, it was not until September that we had established data use agreements with each state to get the information on who was getting vaccinated. When our staff are called upon to respond in emergencies, we don't have some of the flexibilities and resources that other federal response agencies have. When our staff are called to an Ebola treatment unit across the globe, we cannot offer danger pay when they're clearly on the front lines and in harm's way. Remarkably, and this is just a testimony to the people I get the honor of working with, they go anyway, speaking about how they feel undervalued.

We are limited in our ability to quickly hire surge staff to support work on new disease threats and the huge strain and demand these threats put on an already frail and understaffed public health system. We appreciate the support and help we get from partners like the CDC Foundation. We are so grateful for it. And as I've traveled the country, I've heard time and time again how invaluable the support of the CDC Foundation has been during these times. But we also recognize that not being able to quickly pivot and respond to the most pressing health threats cannot go on. We've learned a lot about recent public

health emergencies, and I hope we can come together across the government industry and communities to strengthen our nation's health and preparedness for future threats. So I want to close by pivoting and discussing another more chronic but critical issue, climate change and how it affects public health.

Many do not consider the immediate threat that climate change has on health, and that has the potential to be one of the greatest health threats of the 21st century. The impact of climate poses unique risks to people's health and wellbeing. And again, stories I have heard across the country, the obvious, such as increased risk of respiratory and cardiovascular disease from air pollution or weather-related injuries and deaths. And the less obvious, such as imminent threats to food security, mosquito and waterborne diseases expanding geographically and dramatically across the country. And mental health and stress related disorders. Although everyone is at some risk concerning the health implications of climate change, not everyone faces these risks equally. Communities who are most affected are those that are under-resourced, marginalized, overburdened, and generally, frankly, those who are not the ones most implicated in creating the harm. This means that communities of color, as well as tribal and rural communities, are expected to bear the brunt.

Addressing the broad scope of health implications from climate change and reaching communities at the greatest risk is critical and will require a multidisciplinary approach. This rapidly progressing threat requires an integrated cross-sectional approach at CDC and across our entire society. CDC is creating action, uh, taking action by creating tools that all communities can use to combat the adverse effects associated with climate change. CDC plays a leading role as a fed federal agency on the health implications of climate change, with a focus on the preparedness and resilience to protect communities. And we're committed to addressing climate change by continuing to bolster public health capacity to elevate the voices of trusted messengers, to support long-term solutions in effective communities, to partner with community organizations, faith-based groups, every level of government and across sectors. And to educate the future public health leaders in a science which merits a much more expanded workforce.

However, this is not CDC something CDC can do alone. Public-private partnerships are critical as we are addressing climate changes, current and future threats. Everyone has a role to play in preparing for and combating the negative health implications of climate change and promoting equitable preparation for all communities. So as you can see, we have our work cut out for us. It's reassuring to know that the CDC Foundation and the Kaiser Family Foundation share similar values and responsibilities when it comes to realizing the work that we have ahead together. As dedicated public health workers, we must continue to work collaboratively, creatively, and consistently. And through our combined commitment, we can achieve a better public health reality--one defined by efficiency, readiness and equity. So thank you again for your time today. I really look forward to our continuing conversations and about improving CDC today so that we can transform public health for tomorrow. Thank you so much.

Jen Kates: Thank you. Hi, everyone. I'm Jen Kates. I'm here at KFF and I'm thrilled to be able to moderate our discussion because this is going to be a discussion or a conversation. It's going to be between Rochelle, Judy, and Jen. And then, that's what we'll refer to ourselves, and then we're going to open it up to some Q and A from, from all of you. I was thinking as you were talking and as Drew was talking, you know, one of the new realities that we all find ourselves in prior to Covid, I think the average person living in America, had no idea of how what the CDC was or the CDC's role in their life. Because when there's not a crisis, public health is in the background and, you know, things are come humming along and you don't see all these processes and then there's a crisis. And so the reality, everyone got a sort of front row seat to see what CDC does. And just, I was thinking about your last 24 hours you were on the Hill testifying about many of these issues and why CDC needs the budget that you were asking for you

last night, recommended an updated vaccine schedule for Covid 19. So anyone out there who's 65 or older immunocompromised, think about getting a booster again.

You know, so a lot's going on <laugh> and it's just, just, just, and those are just the things I read about. I'm sure there is a <laugh>, the, the many flyers you're putting out this morning. So big picture, stepping back, I have a question, and this could be because I was talking to my kid's teacher, but if you could give a report card on the nation, you know, where we are in terms of covid now, you know, look, thinking big picture, that's part one and part two on where we are as a nation in terms of being prepared for the next pandemic. Those are big questions I know, but what, how are we doing?

Dr. Rochelle Walensky: Yeah so I mean, certainly I think compared to where we were three years ago, two years ago, a year ago, we are in a far better place when it comes to Covid 19 and that is because of the hard work of testing, vaccination, paxlovid. We have the tools now that we didn't before. Our case rates are harder to follow day by day, but our hospitalization rates are far lower than they had been. Our death rates are still in the 200 a day, and as far as I'm concerned, that remains too high. The character and quality of who is dying is different than it was earlier on. But again, that number is still too high as far as I'm concerned. So I do think we're in a better place. Obviously the public health emergency is scheduled to come down on May 11th and I think we need to be in a posture of preparedness, because we don't know, you know, what is to come.

But we are in a far better place. And partially because so many people have had some form of vaccination, infection or some combination that leads to relatively good protection against covid 19. In terms of the preparedness, we've made huge strides over the last several years and when I think of sort of our public health preparedness, I really do think of our infrastructure because we really don't know what tomorrow's threat would be. I think if all of us rewound the clock, we wouldn't necessarily have anticipated that the summer '22 threat would be Mpox. And so what that really means in my mind is that we have to have a workforce and data systems and laboratory systems that can respond to any public health threat. Just to give us cites, and these are data that are, you know, evolving, but prior to the pandemic, there was a report that estimated about 60,000 public health workforce jobs in deficit.

There have been other estimates that say that half of public health workers have left during the pandemic. That just gives you a sense of the frailty of the public health workforce that we have. The fact that CDC went into this pandemic receiving data, and this is from 64 states, territories and big cities, 3000 tribes, oh sorry, 3000 counties and 574 tribes and they all come in different ways, different times, different systems, different standardization, that is not an acceptable data system. That got much improved during covid from the public health emergency. But that's one, one infection, right? So what happens when we have to do this for Mpox or when we have to do this for, you know, name your next, you know, scary pathogen. So those are the things that we're really working on. And among the things that I testified yesterday for in the budget is to really ensure that we have a sustained long-term investment in the public health infrastructure. Supplemental monies will not alone do that.

Jen Kates: I think people are always shocked when they find out that you, CDC can't require state and local jurisdictions to send data. They just, they didn't know that.

Dr. Rochelle Walensky: My new favorite line is when you ask for data from CDC, you should always ask, does CDC get the data you're asking for?

Jen Kates: <laugh>. Before I ask you some of this, Judy, you said something about the public health emergency, which is ending on May 11th. What are from CDC's perspective, you know, what are some of the implications of that?

Dr. Rochelle Walensky: So one of the big things that we're working on is the data issues, right? So with the public health emergency and the sort of long runway that it took to get the data use agreements and sort of some changes that have happened over time in terms of how people are using PCRs versus how they're using antigen tests, there are some data that we're not gonna get and there are some data that we will continue to get. So, I do believe that from a respiratory virus standpoint, we will have a really good window on how Covid is doing, because we will have systems in place that are actually better than our current surveillance systems for influenza and RSV. And we do that pretty well every year. That said, the public has become accustomed to seeing some data from CDC that we will not be able to provide anymore. We will not get case data. Those, the viability of those case data in general is limited at this point. The frequency at which we get hospitalization data may be a little bit less. So those are the kinds of things that we are working on. But again, not necessarily within CDC's authority to change,

Jen Kates: Going to CDC Foundation because one of, and you can talk a little bit about this, but your role kind of jumped in and when the Covid emergency started and kind of working on trying to fill gaps or innovate and promote, where do you see where we've come out at this point?

Dr. Judy Monroe: Yeah, well, I think it's, first of all, there are silver linings and there's certainly some positives that came out of the pandemic. But I think we need to go back. If you go back to 2008 and the Great Recession, it's the numbers, Rochelle you were talking about. We were in a deficit with workforce in this country. And if you don't have workforce and leadership and the skills needed, that's like the fundamental thing that you need. So fast forward from early to 2018, now we have an opioid crisis. There was funding that went to CDC that went out to 12 states. 12 states come back to CDC and said, this is great. We're getting the funding. This is a major crisis, but you know, we can't hire and please send us people. So that was the starting point for the CDC Foundation actually getting into workforce.

We ended up hiring at that time about 90 to a hundred people that were CDC Foundation field staff. We managed everything, embedded them in these 12 states. That went really well. We built muscle during that time as an independent non-profit, we're an operating foundation, so if there are resources and the need, we'll build it. Because we don't have the restrictions of government so we can move with this speed and flexibility. That went really well. Fast forward, it was three years ago, I think this month actually, that, the health departments were all of a sudden now in crisis. And they've got this fast moving novel coronavirus, I dunno if they the name, maybe it'd been named Covid by that time and they couldn't hire staff. And, and that's the other thing. So public health authority lies at the state level, which you've mentioned people don't understand that.

But the other thing that folks don't understand are, and across the country it's so uneven, but hiring authorities cap on FTEs, even in an emergency can't hire don't have the FTE, they can't get the skillset, they can't pay the salaries, that would attract the right talent that you need, so all of these things. So we've then stepped in and I do want to make sure folks understand that during covid with this hiring service that the health firms needed, we hired nationally. So we, CDC Foundation received some attention for all the hiring we did. We ended up hiring over 4,000 people. They were our CDC foundation field staff. That was a stretch from an organization. We built a lot of muscle embedded across. We literally had our staff in every state across the nation.

But there were other like public health institutes that were doing the same thing on behalf of their state. Like Michigan actually has an institute that was, required that was created by their legislature to do the same thing. Or there were some newer institutes that were doing regional hiring to be able to make sure health firms had had their staff. So to me, we're at the juncture now that we've got to modernize not just our data systems, we gotta modernize how we hire and, and get through all these bureaucratic

challenges that we have with hiring folks into government positions. And the crazy part is, that there was just a report out, 55% of graduates of schools of public health would like to work in government because of the mission. They're very mission driven. They want to drive. It's like 17% of those that actually get jobs. And they cite the challenges of just having job descriptions getting through the process. They end up going elsewhere. So we've got a lot to do.

Jen Kates: So this might not be answerable. This is a data question, so we will need data on this. And I don't think we have it yet. But given the workforce challenges that you boths have talked about, we know people have left the field. We know how crushed the public health system became. We also know there were innovations and there were some silver linings. Do you think at this point the public health infrastructure, local state, et cetera, across the country, is worse off than three years ago? Or is it better? Are we now, where are we? Do we have to make up for lots of lost ground? Or do we, are we a little bit ahead, but we still have a long way to go?

Dr. Rochelle Walensky: You know, I think we're fragile. We are really, because we have made huge investments. When I think about the data systems that we have invested in, just to give you a sense, prior to the pandemic, we had 187 healthcare facilities that could electronically report data to us. 187 in the country. We're now 23,000, massive improvements, and that's 25%. So we have, but to let go to have that supplemental funding where we've made so much progress and then have that diminish so that's really where I say we're really in a fragile state. There have been so many, I mean, when you think about the people who were invested in the pandemic to help, those are all people who have bought into the public health mission and they are now saying, I was in community-based organization after community and federal FQHC after another and they can't sustain the funding. So these are people who were, you know, brought onto the mission, but they can't continue know work they're doing because the founding is not there. And so we have this like prepped, primed, ready to go workforce that is slowly trickling away from us, because we don't have the resources to continue to invest in it.

Jen Kates: It's certainly something we hear from state and local health officials all the time that they are really facing that cliff and it's presenting a challenge. So that was my first set of questions around the, the external report card. I wanna go to some of what you talked about on a little bit of the CDC's internal report card. You taking on this huge effort to change an institution that has been hard to change. Where are, how do you feel that, I mean, some of it as you mentioned, or alot of it is out of your control, and then there's the things that are in control. What is, where are, where is the report card on that? How are we doing?

Dr. Rochelle Walensky: So we did this review starting in April, started talking to people and did a whole comprehensive review. That report came out in August, the reorg by the end of the year. But the reorg I said is really part of it. Like the fact that some of our core capabilities within CDC were lying down numerous layers of bureaucracy, made it really hard to really see what was going on. So that was, I call it necessary but not sufficient. he sort of work that we're doing in CDC moving forward, I'm really energized. We we're probably too early in the semester for midterm

Jen Kates: <laugh>

Dr. Rochelle Walensky: But I would say that like, what I can see now is the successes that we've been already able to deliver. That we were the first in the world to report on [inaudible] performance. When other countries were so far ahead of us in being able to do that in covid 19. We put it online and then we put the published report out. It merits peer review, but we knew the answer before the peer review

was happening, right? The fact that we had four Mpox technical reports, the technical report I said on avian flu, people are understanding the import in an era of preprints to get science out faster. And we're starting to see our ability to do that. And people are energized. Because we're getting good feedback on that. Communications, we just had a whole discussion about how do we preempt what we anticipate might be mis- and disinformation if an event were to happen.

And can we think about, we think we know in a week that this is going to get released. What is the pre-bunking that we can do? How do we set the stage to say and so we're doing a lot of that work and we're actually seeing the successes of that. So I think that as the agency is starting to see that as part of CDC moving forward, we're getting, we, we don't wanna be in the news about CDC itself. We wanna be in the news about the public health threats that are out there. And more and more over the last several months that's what we've seen.

Jen Kates: Right, Judy? I wanted to speaking of some of the internal things are changing, one is data modernization. And I know that you've done a lot in that area from CDC Foundation's perspective. Can you share how that, what you're doing to try to promote that? To get the, what, 23,000 now or sharing, but that's only a 25% of the..

Dr. Judy Monroe: So I do wanna, I'm gonna give you a grade. My observation is your attracting really good students. If we're going with the school coming into CDC and data is one of those, uh, there's some really topnotch folks that have answered the call to come to CDC to work on data modernization. When we think about data, you know, simply we just need data in public health that moves faster than the disease, right? A lot of people have said that that's what we need. Being here in the Bay Area, I have to tell you, there's a whole lot of really interesting innovation while the high tech, so imagine, you know, the fax machine, uh, we, we were saying data to CDC through fax machines for some of those, those data sources. And now you're doing data entry, right? Instead data analysis. And you can't

Take data for action if, if you're backlogged on all this, right? So the data modernization is very exciting. One of the roles of the CDC Foundation has been playing, and it played out at the end of February, we were in DC we convened, um, industry days bringing together CDC, the office of the national coordinator at HHS, and industry partners and set the stage for them to come together to create a vision going forward together. But yeah, when I think about the vision, again, being here in the Bay Area, imagine all the data out there if you had an app that you could check and shade to see what the infectious disease risk is in your community, what if you had an app that you're working on, programs like trying to decrease diabetes, and you've got real time data in your community, are you making inroads or not?

Right? That happens. And we, y'all don't use the old rotary phone to call a taxi anymore. And look what happens when you call rideshare. I mean, not only do you get the ride, but you've got visualization, you've got an app, you see where the car is, you know, the name of the driver, you know, the license plate. And then they've added all the security. I don't know if y'all have been stuck in an Uber lately, I got stuck and we'd sat and, you know, just stopped traffic next thing I know I'm getting, are you okay? And then I didn't, you know, I didn't hit it. I didn't know what it was initially I didn't hit an alert. Two minutes later, the driver, are you okay? Oh yeah, who's the perpetrator? If there's a risk, right? That's the power of today's technology that needs to be harvested for public health so that we can move as faster than the pathogens and disease. And that's really the aim of this. It's to unlock that potential for public health.

Jen Kates: You didn't even mention that you can also get your food delivered that way and a covid test. <laugh>

Dr. Judy Monroe: No, exactly.

Jen Kates: Yeah, I think we have time for a couple more of our questions before we get to you, so type tee them up in your minds. Um, we'll come to the audience soon. I wanted to step back a little bit about something Drew alluded to and his remarks around vaccination, not just vaccination for covid, but you know, we're concerned, and we've seen this in our polling, and I know you are concerned that vaccination as a measure has taken a hit and it's going to be really challenging to promote vaccination for routine vaccinations in this country and that connects to this issue of trust in public health and trust in data. So I'm curious both of your thoughts on that. And a related piece that's, cause I forgot to mention another thing you were working on this week, announcing a new covid vaccine program for uninsured adults. So I'll leave it to both of you to take those on. But starting with just this issue of routine vaccination and kind of the threat to how people see that in our lives.

Dr. Judy Monroe: Do you want me to jump in quick on that part? Yeah, I'm really passionate about this topic and you may have seen UNICEF, I think just yesterday, put out a report worldwide, the distrust in childhood vaccinations. This is tragic. We have got, and we've gotta approach this very differently. My mother had polio and so I grew up, you know, hearing those stories, right? In practicing medicine, Haemophilus influenzae b, I remember four plus sick kids coming in every night in the ER, that vaccine hit

Boom it went way, right? But the parents today haven't seen that. And then we've obviously communications are very different. So, we are going to have to have the best and brightest lines around this issue of being able to build. And I do think our community-based organizations and the partnership between public health and community-based organizations is super important too, for those on the ground friends and family that are, that can be trusted and trust is the issue, It's not the technology.

We've got better technology than ever. it's trust.

Dr. Rochelle Walensky: So I have a lot of thoughts. First let me say yesterday, so we had this vaccination for the uninsured for Covid. There are 13 ACIP CDC recommended vaccines for adults and there is no coverage for the uninsured for any of them. So this would cover covid for the short term, but not necessarily for the long term and we need a bigger solution. You can't get a shingles vaccine. You can't get a pneumococcal vaccine. All those things that we recommend are not covered if you're uninsured. In this country we have a Vaccines for Children program that does cover the uninsured. We've had it since 1994. It saved trillions of dollars in over a million lives. We need a parallel program. It was in the fiscal year 2'3 budget. I just advocated for it again yesterday in the '24 budget.

But that would solve that problem, so that is something that we are really advocating for. In terms of the kids this is going to be a huge challenge. We had am MMWR that came out a couple months ago that showed in the last year we lost 1% of kindergartners who were fully vaccinated or who had all routine vaccines coming into kindergarten. The year prior we lost 1%. That's a quarter million kids entering kindergarten who are not vaccinated for routine vaccines and we think we've actually lost some kindergartners too, that they are doing more homeschooling, o that would actually likely mean less kids. As we've talked to states, one of the real challenges is as we're trying to push other policies, well, don't push that one because they're threatening our vaccines, our incoming childhood vaccines into kindergarten.

So not only are we actually seeing the manifestations of it in the data and a case of polio in this country and a measles outbreak in Ohio, there is some product of our own success, right? When I talked to my parents about what happened when polio vaccine was first, they were scared, right? That's what

happened and we haven't seen that fear. People have not had all of these infectious threats touch them to recognize that fear. And I think that's one of the challenges. It is because we're so successful. But that is one of the challenges.