Vaccines and boosters offer best protection from COVID winter wave with Ashish Jha, MD, MPH [Podcast]

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In March 2022, Ashish Jha, MD, MPH, joined the Biden administration as the White House COVID-19 Response coordinator. The general internist physician and academic, who is on short-term leave as dean of the Brown University School of Public Health, spoke with AMA Chief Experience Officer Todd Unger about the new COVID booster and managing COVID this fall and winter.

Speaker

- Ashish Jha, MD, MPH, coordinator, White House COVID-19 Response

Transcript

Unger: Hello and welcome to the AMA Update video and podcast, an ongoing series covering a range of health care topics affecting the lives of physicians and patients. Today, I am excited to welcome Dr. Ashish Jha, the White House Coronavirus Response coordinator in Washington, D.C., for a special episode on the new COVID booster and managing COVID this fall and winter. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Jha, it is a pleasure to have you here today.

Dr. Jha: Todd, thank you so much for having me here. I'm excited to spend some time with you.

Unger: Well, you've been the White House COVID response coordinator now for about six months. Before we get into this, I'm just curious, what have you learned in your time spent in the position so far? What's been most gratifying? And what's surprised you?

Dr. Jha: Yeah, it has really been the opportunity and privilege of a lifetime to do this. One of the things that I have certainly learned is the ability to have impact at scale. I mean, sitting here at the White
House, when I first came in, one of the things I realized for instance, was that Paxlovid, about a treatment that works extremely well for COVID, we had plenty of it. It was not widely available. And physicians really weren't using it that much because the message had not gotten out that we now had plenty and people could use it.

And we were able to, within weeks, get it out to 40,000 sites across the country. We saw utilization increase almost tenfold over a two and half month period. And you realize that when there are important things to be done, first of all, you're responsible for making sure those things happen. But you really can move things at scale.

There is a bit of a mental model that you can develop when you're on the outside that, if you're at the White House, just wish for something to happen that just naturally happens. You realize pretty quickly that any decision you make, there's incredible complexity that goes into it because there are people, there are stakeholders inside government who have very strong feelings and have very specific views on decisions that are made.

There are stakeholders outside of government, people who care deeply about what decision you make. And if you want decisions to be sustainable, if you want decisions to have long-term impact, you've got to bring people along. You've got to bring them on board. But when you do, the decision is much more impactful. It's much more sustainable, has much more momentum.

So the speed with which you can move sometimes is very, very quick. Other times, it takes time to build that coalition to bring people along. But I think in the long run, that's the only way to go. And in a democracy where we want to build decisions based on as much consensus and agreement as possible, it can be a little bit extra time and a little painstaking. But it is really important.

**Unger:** I'm curious in terms of preparation for a role like this, building that kind of consensus at scale, is that something you had to learn at light speed?

**Dr. Jha:** Having worked in universities all my life and having worked in clinical settings, you realize—I've had to do that at small scale before. Again, clinically, you decide to change the way you practice something in a hospital. You've got to bring all the physicians along. But this is a different level of complexity. And I did have to learn a lot of it and still learning. But I've had a great team. And I've had lots of people advising and helping me do it better. And I'm sure over time, I'll get better yet.

**Unger:** Speaking of getting the word out, let's talk now about the bivalent booster campaign. I know this is a big priority for you and the White House. Let's just start by talking about the case for why we're doing this. What's the data that we've got to back a decision like this?

**Dr. Jha:** Yeah, so when I think about this pandemic, here we are, two and half years in. We built the first original prototype vaccines in February, March of 2020. Over the next two, two and half years,
we've seen this virus evolve enormously, Alpha, Delta, Omicron, all the different versions of Omicron. And yet, our vaccines remain stable. And it was amazing that vaccines still were doing a pretty good job at preventing serious illness.

But over time, we saw vaccine effectiveness against infection and transmission slowly get chipped away by viral evolution. And what that meant in my mind very clearly, and certainly the minds of the scientists at NIH and FDA, was we needed to make an update. And when Omicron hit, that decision was made by companies, that we needed to make an update. They built a bivalent vaccine.

And so when it comes to this decision—first of all, it clinically makes all the sense in the world. You want a vaccine that targets the virus out there, not the virus that was around two and half years ago. But the evidence behind it is actually quite strong. And as a clinician, I always remind people that you don't make a decision based on one clinical trial or one observational study. You bring the totality of the evidence.

So you ask yourself, what's the mechanism here? What's the biological and physiological data? What is the clinical experience? And the way I see this, we have two and half years of experience with the mRNA vaccines, incredibly safe. We have six months of data with the BA.1 bivalent that was developed by both Moderna and Pfizer that was both incredibly safe and showed very clearly that bivalent vaccines work better than the original at protecting people against infection and transmission.

And it made all the sense in the world in early July when FDA said to the companies, go out and build a BA.5 bivalent vaccine because that's the virus that's going to be out there. And that's the one we want to target. I thought it was a very smart decision by the FDA scientists, widely agreed on by NIH scientists and CDC and everybody else and experts from the outside.

And I think the evidence for this is so clear to me that I got one more or less as soon as it came out. I got my elderly parents vaccinated. The rest of my family is all getting vaccinated. There's no question to me this is the right move to do.

**Unger:** And I've done the same. So I'm following your lead there. I mean, when you think about the development of the initial vaccine, nothing short of miraculous in terms of time frame. Now fast forward to where we are right now and the speed with which we've responded to these new variants. I mean, talk a little bit about, how does that happen?

**Dr. Jha:** Yeah, so in terms of building these new vaccines, you mean? I mean, that was the promise of the mRNA platform. If you think about the mRNA platform that allowed us to build these vaccines so quickly, one of the promises of the mRNA platform was that we will be able to make updates very fast. And it was impressive because again the, BA.1 bivalent was built in January. We did about five to six months of clinical trials, showed that they were both incredibly effective and very, very safe.
But the problem is, at that point, you don’t want to get a BA.1 vaccine out there because BA.1 one is long gone. The virus has evolved beyond that. And the promise of the mRNA platform was, you could see where the virus was going and build a vaccine against that.

And that’s what the U.S. government did, actually, the first country in the world to say, we’re going to build a BA.5 bivalent. And we did. And again, all the credit here goes to the FDA for their bold leadership on this. And all the evidence so far suggests that these vaccines are really working great.

**Unger:** How do you feel like the rollout is going? And where do you think improvement can happen?

**Dr. Jha:** Yeah, so about 10 million people got that bivalent shot in September. Is that good? Is that bad? I think it’s actually pretty good, given that we were just getting started after Labor Day. What we’ve seen in the past with the flu shot is most people tend to get the flu shot in late September into October. That’s when the weather’s starting to get colder. People are starting to think about the winter.

So we thought of this as a pretty strong start. But we’re going to build on that during the month of October, get the word out about the importance of this as a clinician. I’m not practicing right now in this current role. But I was as of nine months ago, before I stepped into this role.

When I think about patients out there, older patients, think about what is the single most important thing they need to stay protected and safe this fall and winter. It’s a COVID vaccine and a flu vaccine. And so making sure that word gets out to clinicians, making sure that doctors communicate that to their patients, that combination, I think, will be really, really important in continuing to get more and more people vaccinated.

**Unger:** Now you’ve also said that you hope people are going to begin to change their thinking around the updated vaccine. Instead of counting the number of boosters they have, that they can start to think of what you were referring to there as it’s an annual shot like a flu vaccine. And you talked about this rapid virus in evolution and that it’s different than RSV or influenza, a lot of other viruses. What do you think will help people embrace the idea of an annual shot, particularly when the virus does continue to surprise us in so many ways?

**Dr. Jha:** Yeah, it’s an interesting question. And people have said, well, how confident are you that we’re ... it’s only going to be an annual vaccine? So here’s how I think about it. Take the average risk person, a 40-year-old person. If they got their booster last fall, they would not have been eligible for another shot until now. So for the average risk person—we’re not talking about the 80-year-old like my elderly parents in their 80s. We’re not talking about that. But for the average risk person, it’s already been an annual shot.

They wouldn’t have been eligible since last fall. So the scientists in the U.S. government, the FDA folks in FDA, CDC, NIH, when they looked at the data and we were talking about planning for the fall
vaccine rollout, there was broad consensus that we had already gotten to a point where, for a majority of people, this was an annual vaccine. If you were a 40-year-old and you got a booster shot last November, you were still protected against serious illness until now.

And actually, here’s one other really important part of this. People said, well, what if you get some crazy new variant? And I remind people, between last November and now, we did get a crazy new variant. It was called Omicron. And despite that, for an average 40-year-old who had gotten a booster, that there was no reason for them to necessarily go out and get another shot. Now if you’re 80, if you’re immunocompromised, all bets are off. It’s a different situation.

So I would not be surprised, for instance, my—as I said, my elderly parents got their shot. I would not be surprised if next March or April, they might need another one. We'll look at the data. And if they do, they'll get it. But I think the evidence right now is very clear that for a majority of people this is a once-a-year shot. And we weren’t making news by saying that. We were acknowledging reality that had already happened.

**Unger:** Now, one of the things that we've seen is in terms of a challenge over the past few years is definitely in the realm of communication. And it's just so interesting talking to you because it's very clear you have your own kind of communication style. You have an ability to speak more plainly and help people understand what are sometimes pretty complex ideas. Sometimes I think I've read a quote, get your Omicron-specific COVID booster by Halloween. You don't want to be that person who gives it to your grandma, just kind of putting it in terms of things that people understand. Talk a little bit about what we've learned about the importance of messaging. And what's your approach and philosophy that can really move the needle here?

**Dr. Jha:** Yeah, I will tell you how I try to communicate in public settings. I go back to being a doc. I go back to being a clinician and think about that exam room. Or I'm a hospitalist so I think about that hospital room where I'm next to the bed of the patient and talking about a complex diagnosis or complicated therapies. I will sometimes mention clinical studies and data. But I will not get into all the complexities.

When I don't know something, I will share with them that I don't know it. But I will tell them what I think we ought to do. I will explain my logic and thinking. This is training that we all, as doctors, have had for years, how to communicate complex scientific issues to patients respectfully, understanding that they are smart people. We don't talk down to them. But we don't also snow them with complex technical information that will get them confused.

That's what we, as doctors, do. And that's the mode I get into. And when I try to explain, for instance, bivalent vaccines, we can talk about the complexities of these things. But I remind people, it's the same way I give advice in the hospital. And it's the same way I try to talk about this stuff in public
health, which is, talk openly, honestly, acknowledge what you don't know. But also share your judgment about what people should do, what you would do if you were in their situation.

**Unger:** What do you think the biggest challenge has been communication-wise. If I'm lobbing my thought in, there are a lot of communicators. Do you find that to be a particular challenge?

**Dr. Jha:** No, I think diversity of voices is generally really good. I think one of the challenges certainly has been that there's a lot of misinformation that has spread around this virus. I think that has been a real challenge for us. There are unfortunately, I think, physicians who don't understand the complexities, who think that simplicity means you don't have to understand the details.

Like, look, it's one thing to talk to a patient about a complex disease. But if you don't understand that disease, you can get it wrong. The simple conversation can end up being wrong. So there's no substitute for that depth of experience and understanding. Unfortunately, we have seen, while, again, a proliferation of voices in general is a good thing. It is also meant that there's a lot of voices out there that can often mislead people, confuse people. We saw this around boosters last year, where there was all this cacophony of, do you really need a booster?

Turned out, older people who were not boosted, died at enormously high rates during the second wave. It turns out that if people do not get this shot, if you're older and higher risk, you're at substantially higher risk of getting not only infected but hospitalized and dying this fall. So I wish that, for all of us, we can disagree on the margins, we can disagree where the science is unclear. But where the data is clear and the science is clear, really helpful to communicate that directly to the American people.

**Unger:** Well put. Right now it feels a little bit like time of transition. On one hand, you've got a lot of people who have moved past the pandemic. They're back at work. The kids are back at school. Masking requirements have been lifted.

And on the other hand, we're still seeing more than 400 deaths a day. We've got news coming out of the U.K. saying things might be picking up there. How should we be thinking about the moment that we're in right now? And how do physicians help people understand exactly where we are with this disease?

**Dr. Jha:** Two great question. So let's take each of them. First of all, on the question of, how do we understand this moment, incredibly complicated moment. But I would say that both of those facts that you laid out that seem contradictory are true. On one hand, we're in a much, much better place. I mean, we're in way better place than we were two years ago, than we were a year ago. And that's a good thing, and by the way, not coincidental, not random. It has happened because we've gotten a lot of people vaccinated. It got built up that population immunity has made a huge difference. We have therapeutics available now.

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All of that has taken down the temperature of what the impact of this virus is. It is no longer causing people to—should not be causing people to miss work or miss school. We're in a much, much better place. That said, this virus is not done. COVID is not over. We still have 400 deaths a day. Well, people say, well, is that a lot? And I remind people, that's right now at a lull.

At 400 deaths a day, you annualize that. That's 130,000 to 150,000 deaths a year. That's a new disease causing 130,000 to 150,000 deaths a year. That's an enormous toll on our population. So we have got to drive that down. There's still lots of work to do. And I look at what's happening in the U.K., look at what's happening in Europe and think, yeah, we're going to see this. We're likely to see a new substantial increase in infections here in the United States in the later fall and winter because we've seen it each of the last two years.

But good news is, we can do something about how big a wave, how many people will end up in the hospital. People get vaccinated. People get treated. It's going to be a much less consequential situation. If we don't, then obviously, we're going to be in for a more complicated moment.

Unger: Now, addressing the issue around long COVID, it's been a focus of the administration. There's some news coming out this week about the focus there. It's affecting millions of Americans. It's pretty serious, lots of questions there. What strategies do you see for addressing what is sure to be a huge public health challenge for years to come at this point?

Dr. Jha: Yeah, let's talk a little bit about long COVID and how I think about it, how the administration thinks about it. First, again, as a clinician, Todd, you understand that we all see, there are lots of people who have post-viral symptoms and syndrome that can last weeks. But most of those, thankfully, get better. But we know from other viruses that, for some people, symptoms can persist.

But let me be very clear. COVID really does seem to be different. And it does really appear that we have a proportion of people, thankfully a small minority but a proportion of people who end up having significant symptoms that are debilitating, that can last weeks, months, or potentially even years. So what do we do about that?

Well, two things. First, the thing that we know that reduces the likelihood of long COVID best is vaccination. This is incontrovertible at this point. The evidence is overwhelmingly clear that if you're up-to-date on your vaccines and you have a breakthrough infection, your likelihood of having long COVID is much lower. And if you get long COVID, it's much more likely to be mild. That part is pretty clear.

That said, still, as you said, millions of people out there who have long COVID, what do we do? In the administration, we've made a major investment in something called the recover trial, we're building cohorts and really trying to understand, what is the mechanism? Long COVID is not one condition. For some people, it's immunologic dysfunction. For other people, it may be tissue damage from that
original infection that's causing persistent symptoms. For some people, it may be a persistent viral reservoir that needs longer term treatment.

We've really got to sort all of that out. And then, and here is where resources really become important, and as you know, it's been a struggle to get resources from Congress around this. But with additional resources, really important to run more clinical trials, try out new therapies.

And just one last point on all of this. For people who really are struggling out there, and the administration has put out a report on this in August, really important, we're going to make sure that if you are eligible for disability, you get disability. that if you need treatment and care that you get that. The health system is responsive. So we've still got to really take care of people who are suffering.

**Unger:** Speaking of Congress, another big challenge has been the lack of funding for ongoing COVID response, especially as we look to just continued evolution. That seems to be a real challenge. What changes can patients expect to see as far as access to testing, vaccines and therapeutics in the coming months?

**Dr. Jha:** Yeah, this has been possibly one of the biggest challenges of this role is that we have a disease that's out there still killing hundreds of Americans every day. And congressional action has really disappeared. They've stopped funding the response. We've had to make some really hard choices. We did not have money for these new bivalent vaccines.

And it was very clear that every other major country in the world was building these things. We said it was absolutely essential. So we pulled money out of a national stockpile for PPE. It's really important that we build that national stockpile. We will not have the kind of stockpile we need because we pulled resources out of that. We pulled resources out of building a stockpile of testing.

So if we get a major surge this fall and winter, we are not going to have the number of tests in a stockpile that we thought was really, really important. We did all of that to make sure we had enough vaccines and therapeutics for this fall and winter. Those are tough choices. But here's what it means for patients right now.

For this fall and winter, vaccines are widely available and remain free. For this fall and winter, treatments are widely available and remain free. And testing, still, people can go get tests using their insurance card, Medicare, Medicaid, private insurance. You can go to a CVS or a Walgreens and get up to a test for free, per month, per person. That still remains.

As we get into 2023, there are not going to be other buckets of money we can pull money out of. And we really are going to have to transition this all to a commercial market where vaccines, treatments, testing, all of that comes through your insurance. Our job is try to make sure that happens in as least disruptive of a way as possible.
And again, on a personal level, I feel very, very strongly. We have to make sure there are no financial barriers to people being able to access those things as we get into 2023. So still free now. But that's going to get harder over time.

**Unger:** Well, last question. You're known as an eternal optimist. And you can tell, just by your style. And frankly, some of us, many of us need that right now. You've also said you're hopeful outlook comes from being less prediction-oriented and instead, focusing on the possibilities.

In other words, as you look forward, how do we emerge from this pandemic better? And where do you see the greatest possibilities in the months and years ahead? And how can physicians out there help make those possibilities a reality?

**Dr. Jha:** Yeah, so let me answer that in two parts, one thinking about the short-term, one thinking about the long run. And I'll tell you what gives me optimism, what gives me optimism is actually thinking about the health care workforce of America, and particularly, physicians and other health care providers. In the beginning of the pandemic, the physician was at the front line because we have any tools to protect people.

So we were taking care of people in the ICU, heroic work, taking care of people in the emergency room, hospitals, saving lives. And the work of doctors in America saved tens of thousands, if not hundreds of thousands of lives. Then the pandemic shift to a more public health response, mass vax clinics, more traditional public health.

It is now shifting back into the doctor's office, less in the ICU and more in the primary care office because we are now at a point where, if we want to protect people, we've got to get them vaccinated. That comes from one-on-one conversations with physicians. If we want to make sure that elderly people are not dying at high rates, it means making sure everybody is getting treated. I believe very clearly that people over 65, there should be no one who does not get treated for COVID at this point.

That's going to come from a physician or an nurse practitioner or a PA or other providers, but mostly from physicians. So physicians have this incredibly important role in the short to medium run in getting our population protected and making sure people get through the fall and winter. In the long run, Todd, we have got and we are making investments in things that are going to make our society safer. So hundreds of thousands of people dying every year from respiratory viruses like COVID, RSV, influenza, should not be a new normal.

We can reduce that by improving indoor air quality across buildings across America. That's an area that's really important for us to invest. We've got to continue building new therapeutics, not just for COVID but for influenza and RSV, better vaccines, longer, more protective vaccines. There is really important work to do so we emerge from this pandemic much, much stronger than we are now.
But in the short to medium run and I say this to my fellow clinicians out there, there is no one who’s going to have bigger impact on the lives of your patients in the next six months than what you do in helping people build up their immunity through vaccines and making sure that when people have breakthrough infections, they get treated.

**Unger:** Well, thank you so much Dr. Jha for being here today and being such a trusted voice throughout the pandemic. That’s it for today’s episode. We’ll be back soon with another AMA Update. You can find all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us today. And please take care.

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