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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome Dr. Demetre Daskalakis, White House Deputy Coordinator for Monkeypox, and Director of the CDC's HIV AIDS Prevention Division. He talked about efforts underway to contain the monkeypox outbreak in the U.S.

Dr. Demetre Daskalakis: Whether it's a sexually transmitted disease, a sexually transmissible disease, I think at the end of the day the advice is the same.

Marianne O'Hare: Lori Robertson joins us from FactCheck.org, and we end with a bright idea, improving health and wellbeing in everyday lives. Now, here are your hosts, Mark Masselli and Margaret Flinter.

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Mark Masselli: The Biden Administration has urged all Americans to take monkeypox seriously. It's a rare infectious viral disease. The U.S. has the highest number of known cases of any country right now, and the World Health Organization has declared the recent outbreak a public health emergency.

Margaret Flinter: And joining us today is Dr. Demetre Daskalakis, the White House National Monkeypox Response Deputy Coordinator. He also serves as the Director of the Division of HIV Prevention at the Centers for Disease Control.

Mark Masselli: Well, thank you Dr. Daskalakis for joining us.

Dr. Demetre Daskalakis: Thank you so much for having me, excited to talk.

Mark Masselli: Let's start by asking you to update us on the latest situation with the spread, the vaccination, and treatment for monkeypox. We understand the U.S. now has one death likely attributed to monkeypox.

Dr. Demetre Daskalakis: So, our current case count is 18,989 cases. There is one case that's being investigated, so they're still working to get clarity. The individual had multiple medical problems, and so they're still looking to evaluate the actual role of monkeypox in that person's demise. And so of course, we send all of our condolences to the family, and continue to see what the outcome of the epidemiologic evaluation is. We continue to work really tirelessly to increase a couple of swathes of work that are important to the monkeypox outbreak. So, the first is vaccine. So we, through FDA emergency use authorization of the vaccine that was published on August 9th, were able to extend the number of doses that could be extracted from a

single vial of vaccine by changing the route of administration. So rather than subcutaneously it is an intradermal vaccine, and we're really seeing great uptake across the country, which means that what vaccine we do have, we're able to extend. It's up to five doses. In real life, it's closer to four for most people. And, also have worked really hard to increase production. And that means both offshore at the Bavarian Nordic plant in Denmark, but also just announced a [inaudible 00:02:41] facility in Michigan. It is a facility that in effect bottles the vaccine so it's actually usable. So that means that we are increasing production domestically, increasing production abroad, have more vaccine flowing, as well as extending what we've got.

Testing continues to sort of become more accessible. We're up to 80,000 tests that can be conducted in any week in the United States. That compares to 6000 at the beginning of the outbreak, so a lot of progress there. We continue to evaluate the investigational drug TPOXX or Tecovirimat. The exciting news, that is in a few days the NIH-sponsored studies will launch Tecovirimat while we continue to work on the expanded access. One of the sort of big news flashes is it used to take several hours to complete the IND paperwork for TPOXX from the perspective of access, now it's down to about 15 to 30 minutes per patient, so really exciting. Also, we have pre-positioned a lot of the drug closer to people so that everything happens much faster.

We’re lastly, continuing to do the work to provide really clear messaging. And that really means being frank, really focusing on the exposures and really working very intentionally to not generate stigma as we increase awareness of monkeypox across the country.

Margaret Flinter: Well, there's some very good news there around testing and vaccines and treatment. And we certainly have been very appreciative of being able to get the vaccine and to administer it at sites in our community health center sites around Connecticut. But, I know you've announced some plans to support large LGBTQ+ events and some equity interventions to reach communities that are at highest risk of contracting the virus. Can you tell us a little more about these plans? What are you trying to accomplish? Are you trying to make up for something perhaps that we haven't been doing? And maybe share an example of how they're going to work.

Dr. Demetre Daskalakis: Great. So I'll say that we're not really making up for anything. What we're doing is finally able to do extended work because

we're not in a scarcity model for vaccine anymore. And so I think that the very first step in the equity interventions is not one that is one of the pilots, but it's actually making sure we have enough vaccine to be able to really work hard to get it everywhere, in the arms it needs to get. So, bringing it closer to people as opposed to having people try to find a vaccine. So that's all very exciting.

We have two different equity pilots that are happening at the same time. The first equity pilot, I like to call the macro pilot, which is large events that come up on jurisdictions that focus on LGBTQIA+ individuals. And so there are several examples of events that we're looking at. So, I'll give you the short list. We've done Charlotte Pride in North Carolina, and there they almost did 600 vaccines in folks who're attending various pride events. They actually not only focused it on pride, but focused it on venues and events that focused on Black and brown people, to really try to increase the reach of equity access of the vaccine.

Labor Day weekend, there will be two other events. One is going to be in New Orleans called Southern Decadence. And they're doing just an amazing combination of events. They're actually going to venues and small events, and again, really focused on the communities who are overrepresented in the outbreak, but underrepresented in the vaccine counts. But also, they're doing what they're calling a Health Hub, which is putting in testing as well as vaccination right at the mouth of the Louis Armstrong Park, so very prominent, very central to the event. So they actually have CDC folks on the ground as well who are helping them. So it is a great example of all hands on deck strategy for these large events.

The other one is Black Pride in Atlanta, and that is very specifically designed to be an equity intervention with a lot of focus on events that are really geared to attract LGBTQAI+ people of color. Oh, and we also announced Oakland Pride festival. And so that's also coming too.

The micro version is what if you don't have an event with 50,000 people? What if you have smaller ideas or big ideas or smaller groups of people that may benefit equity? And so the second equity innovation pilot really focuses on providing a supply of vaccine to jurisdictions to really be a little bit of a lab to see what works best to get vaccine in people's arms. And so, we're going to allocate for both of those 10,000 vials. It's a pilot, and if it goes well, we'll obviously extend it. But that's really what the strategy is to try to do a real equity

intervention, which is what can we do to augment what's happening in a jurisdiction so that we can reach people in a way that they're not being reached by the sort of industrial [inaudible 00:07:41] strategies for vaccine distribution.

Mark Masselli: You know, I want to pull the thread on that sort of intervention strategy, because we've seen monkeypox cases slowing down in the United States. Vaccines and community outreach efforts are leading to declines in New York City. We see that wastewater samples in San Francisco show that the concentration of monkeypox virus has stabilized in recent weeks. Yet, we have students returning to college campuses and that poses a risk. What's happening with outreach to young people?

Dr. Demetre Daskalakis: Yeah. So, where we've had some great experience is working with colleges and universities, as well as K-12 schools. So, some examples include special sessions that have happened with university and college health services, as well as work that's happened in sort of K-12. Included in the K-12 work is a fact sheet that focuses on some of the most important questions, and that's actually gone out to many jurisdictions and to their school systems. We have created a package of guidance that is sort of the suite of guidance that when brought together, really defines like what strategies ought to be on campuses and in schools. So, for instance, university guidance really includes congregate settings guidance but also our safer sex guidance, lots of outreach and clear concise guidance that is available to all of the universities.

Also, I think we've been really clear about messaging that monkeypox is something that can affect anyone, but at the end of the day, over 90% of the cases are among gay, bisexual, other men who have sex with men, often associated with sexual transmission. So, other ways of getting monkeypox include other forms of skin to skin contact, touching objects that someone with monkeypox lesions have touched, and also rarely through close contact of respiratory secretions, though the skin to skin contact associated with sex is the most common. And I think that that should give people awareness of the disease, with also addressing some of the anxiety that there's ways that are way efficient for transmitting the virus, and ways that really aren't.

Margaret Flinter: Demetre, there was really a very moving story in The New York Times from a patient of yours, and he said that when he was diagnosed, that you really tried to console him, support him, assure him that things would work out. Tell us more about

your experience, and what you're hearing from your colleagues about the personal side of treating this virus. What are patients expressing in terms of a sense of shame or stigma, or have we moved down from that?

Dr. Demetre Daskalakis: Yeah. First I will start by saying that governmental public health and government needs to be the role model in terms of communicating in a way that is non-stigmatizing. And I will say that I think I'm pretty proud of the way that we've worked about giving information about exposures and about this virus, without creating documents and guidance that stigmatizes individuals or groups. With that said, there's definitely the experience of stigma and the pain of actually sort of experiencing this infection. And I've heard from many, you know, that it's (a) stigmatizing, (b) a lot of people experience significant pain, whether that's because of the oropharyngeal lesions, or for the genital lesions. So, it's really about not only sort of treating the virus, if folks qualify for Tecovirimat and TPOXX, but also like addressing the sort of psychological and pain issues that really are things that we can do to improve how people persevere through this infection. I think we need to be the leaders to make sure that we mitigate stigma and work in ways to actually reduce stigma by actually not propagating it through the way that we talk about this infection.

Mark Masselli: I want to get back to the answer that you gave just a moment ago about whether or not this monkeypox meets the definition of a sexually transmitted disease. Indeed, most cases, as you noted, have been linked to community of men having sex with men. Can you just clear that up, is monkeypox an STD?

Dr. Demetre Daskalakis: Yeah. So I think that the official jury is still out in terms of how to define it. But I think that it's really important to acknowledge that the most efficient mechanism of transmission we have in this outbreak is sex, and specifically occurring in sex between men. Now, that could be because of the social network. I think we're still learning about this infection. But ultimately, I think that the guidance for folks and providers as well as for people who could potentially be exposed to monkeypox, remains the same. If you're at risk, get vaccinated. And so I think we have pretty clear guidance on that. And it's not just about vaccine. Since it is sexually transmitted, there are ways to change behavior temporarily as we get the immune wall built around the population to actually reduce the possibility of acquiring monkeypox.

We have good data from surveys from the AMIS study, that gay, bisexual, other men who have sex with men have changed their behavior because of monkeypox, and they report 50% fewer one-time partnerships, 50% have reported not having multiple partners, and specifically in response to monkeypox. So I think whether it's a sexually transmitted disease, a sexually transmissible disease, I think at the end of the day, the advice is the same.

Margaret Flinter: Well Demetre, I know that you obviously are expert in HIV care and prevention, and the numbers do show that a significant number of patients with monkeypox are also HIV positive. I wonder if you could share a little bit with us about that connection, maybe share your thoughts on that.

Dr. Demetre Daskalakis: Thanks, Margaret, really a question near and dear to my heart here. So I think from the perspective of HIV, we know that there are some studies that show that individuals living with HIV could have more severe disease. Generally speaking, the stronger someone's immune system is, and the better their HIV is managed from the perspective of viral suppressions and being undetectable, the more they're going to approximate someone without HIV in terms of the way that they manifest their monkeypox disease. Regardless of T-cell count or viral suppression, it's really important that people living with HIV, who are at risk for monkeypox, get vaccinated. And so now with increasing vaccine supplies, I would say that the message is virally suppressed or not, T-cells of 500, or T-cells of 50, get vaccinated because that's going to be important in protecting you. So, I think there will be more data coming. So, I would just watch this space closely around the issue of how people living with HIV may have a different experience with monkeypox.

Mark Masselli: You know, Demetre, I want to talk to you about your work globally in terms of monkeypox. Are you having conversations with colleagues around the globe? They're certainly suffering from the lack of vaccines, certainly in Africa. You know, this is a disease, one of those rare diseases of public health significance, right, really sort of missed by CDC, by others here. We don't seem to be prepared, and I'm wondering what's your sense of what's happening globally with monkeypox, how well it's being addressed. And I think one thing we've learned from COVID is that these are global issues and that we really need to solve these problems globally, not only locally and of course locally it sounds like you are doing a great job in terms of leadership. But talk us a little bit about your conversations that are going on with colleagues around the globe and what we're learning.

Dr. Demetre Daskalakis: Yeah. So, the administration is really dedicated to making sure that we control this epidemic, this outbreak in the U.S., and also make sure that we're addressing issues around the world, not only for the U.S., because obviously if we address issues around the world, introductions become less common here, but also for the sake of the other parts of the world. And so one of, I think, a clear signal of importance is that part of the Monkeypox response team includes a global group, so with leaders from UNAIDS, as well as from the CDC. And so I think we're actively having conversations about what support can look like. And there's already been, I think, support from the perspective of vaccine that's been provided. So, this is a space to watch really carefully as we explore how we can best support monkeypox interventions outside of U.S.

Margaret Flinter: Well, Demetre, I wonder if I can build on that, just ask you a little bit about who are the people that are doing all of this work. You talked about the big events that are going on in Atlanta and in other large urban areas. You have talked about global work. We know that we need to pay attention to all of the states, right? It's not just the big states. And workforce everywhere is such an issue. Maybe just give our listeners some insights into what is the new CDC workforce Boots on the Ground of people who can go out into communities around the country and educate and reassure and also deliver vaccines, tests, whatever it is. Maybe talk a little bit about that with us.

Dr. Demetre Daskalakis: Sure. I'll start by saying, as someone who was a local health official, I used to always think of myself as a CDC and HRSA extender. So, it's like one big team. And so part of the experience, is that we're really working with our local jurisdictions to do the work on the ground. And again, public health is always a very local experience, and so really making sure that we provide vaccine and the technical resources that are needed for jurisdictions to do work. Also, I think I cannot possibly be on this call without shouting out the community health centers, and say that they're so critical in the work. And we're really excited that through HRSA there's also an allocation of vaccine that has gone to community health centers, and that I think will increase as vaccine availability increases overtime. So, that's really great news.

Definitely, from the CDC perspective, like there are responders on the ground. And so for instance, in New Orleans, there is a team that's been deployed that is really helping to sort of orchestrate with New Orleans. It's not a CDC takeover of New Orleans, but it is a hand in glove interaction between state,

city, and Federal, and the community health centers and the community-based organizations that are really, really the boots on the ground, that are out reaching the communities that we need to reach the most. So I've got to say, like having, coming from an experience with local jurisdiction, and then also having conducted a lot of outbreak responses, this is when the magic happens when you have all of the various components of government and community coming together.

And I think that these equity interventions are such a great example of that, because, you know, the community asked for us to do it, and then we figured out a way to do it from the perspective of vaccine allocation. And then the partnership got deeper and deeper to the point where it really feels like one team New Orleans, one team Atlanta, one team Oakland, and one team Charlotte. So, it's really exciting. And I can't wait to see what happens with the micro ones, the micro events because with that I think we're going to really see (a) a lot of effectiveness, but then also we're going to learn some great ideas that other folks can adopt.

Mark Masselli: You know, I really like the word ‘partnership’ here, and in public health there's always questions and criticisms. And as you know, some have said CDC has not learned from its COVID mistakes around testing as it faces monkeypox. But it sounds like maybe you can assure Americans that really the brightest minds and best strategies are in place, and it's really an opportunity for partners to come together and work collaboratively on this.

Dr. Demetre Daskalakis: Sure. I'll start by saying that having worked on a lot of outbreak responses, you know, measles in New York City I was the incident commander for COVID-19 for about eight months in New York City. The speed at which this is sort of moving, is pretty astounding. But I'll also say for instance, testing is a great example. So, within a week of the first case, conversations were already happening with commercial labs to move into commercialization, and within a month and a half it started to happen. So that is actually really fast, and really builds on the lessons of COVID, number one.

The other example is, I think, you know, the lessons that we've learned not from COVID, but HIV. And so when you look at the messaging and the strategies to sort of reach people, those are hard. There are hard learned lessons from 41 years of experience. And what I say using my HIV hat is, it only takes one moment to create stigma that can last for decades. And so I think we were so intentional, and by ‘we’ I mean the big ‘we’,

about trying to really be intentional about how not to attach an infection to an identity, but really focus on how exposures happen. So, I think there are a lot of lessons that we can pull from everything that we do in outbreak response. But I feel like when you look at this, it's really moving with a great amount of urgency. And I mean, I'm excited to be a part of it here at the White House. I was excited to be a part of it at the beginning. And I think that, you know, we're starting to reap, I think some guarded optimism, but starting to reap some of the benefits of the work that's happened.

Margaret Flinter: Well, Dr. Daskalakis Demetre, many thanks for your time in public service, and for both your passion and compassion in this work. And thank you to our audience for being here. Remember, you can learn more about Conversations on Health Care, or sign up for our email updates at www.chcradio.com. Thanks again, Demetre.

Dr. Demetre Daskalakis: Thank you so much for having me. And thank you for being the leading edge of care in the U.S. at the Community Health Centers. So we really rely on you to just make sure that we're caring for our people. So thank you.

Mark Masselli: That’s great.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist, and Managing Editor of FactCheck.org, a nonpartisan consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: President Joe Biden signed into law the Inflation Reduction Act on August 16. Part of the law deals with Medicare and prescription drugs. The law will lower at least some Medicare beneficiaries prescription costs on Part D, that's Medicare's prescription drug program, and on Part B, which covers drugs administered in a doctor's office. The law requires the Federal government to negotiate prices for some Medicare medications. It caps seniors’ out-of-pocket drug cost at $2,000 a year. It requires rebates from drug companies if their prices increase faster than inflation. It expands eligibility for prescription drug benefits in the Part D Low Income Subsidy Program. It caps monthly insulin co-pays at $35. It makes vaccines free with no out-of-pocket cost. Again, that's all for Medicare, not private health plans.

Republicans have focused on the price negotiation aspect, and the pharmaceutical industry has long fought against attempts to enact such a policy. Their argument is that the policy would reduce the number of new drugs pharmaceutical companies bring to market. The nonpartisan Congressional Budget Office estimated there would be just two fewer drugs launched over the next decade under the legislation. Seniors who spend more than $2,000 a year on prescriptions, would clearly benefit. That cap on yearly spending would launch in 2025, and it could affect more than 1.4 million beneficiaries. According to Kaiser Family Foundation estimates, right now, out-of-pocket cost of more than $7,050 for Part D drugs pushes seniors into what's called the ‘catastrophic phase’. They pay 5% of their drug costs after that threshold. The Inflation Reduction Act eliminates the 5% co-pay, benefiting more than 1.3 million seniors. The cap on insulin co-pays also could affect millions.

In 2020, 3.3 million Medicare Part D enrollees used insulin. About 400,000 Medicare beneficiaries who receive partial benefits under the Low Income Subsidy Program, could benefit from an expansion in eligibility for full benefits. Experts on health law and economics told us seniors who now can't afford to buy needed medicines, also would benefit from the bill. The benefits of price negotiation to seniors are more difficult to anticipate. The law requires the Secretary of Health and Human Services to negotiate prices for some high cost drugs that lack competition from generics or similar products and that have been on the market for 9 to 13 years. 10 Part D drugs could be negotiated in 2026.

That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country’s major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you’d like checked, email us at www.chcradio.com. We’ll have FactCheck.org’s Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Anxiety disorders are on the rise among the nation's youth, and experts in the field of child psychology feel the condition starts much earlier in childhood, and it's far more

common than previously thought, with an estimated one in five children being affected. But too often these so called internalizing disorders go undiagnosed. Unlike children with more expressive conditions, such as ADHD or Autism Spectrum Disorder, young kids struggling with anxiety or depression just seem like an introvert to the casual observer. University of Vermont Child Psychologist Ellen McGinnis says the process of diagnosis for younger children is often painstaking and can take months to confirm.

Dr. Ellen McGinnis: The whole point of it was to find an objective assessment battery for children with Internalizing Disorders, because they have similar things for children with Externalizing Disorders and for autism, but not anxiety, depression, which I think are the most overlooked disorders in that age group.

Mark Masselli: Dr. McGinnis says the traditional method of diagnosis involves creating scenarios that induce anxiety, and the results can be inexact. So she teamed up with her husband and fellow researcher, biomedical engineer Ryan McGinnis, to create a wearable sensor that can pick up on physical cues that suggest the presence of anxiety, using accelerometers and simple algorithms to compare normal stress responses.

Dr. Ellen McGinnis: So, the device is called an Inertial Measurement Unit, and it's about the size of a business card. And so we strap that to belts on each child when they do the mood induction task. And it has an accelerometer in it, and so we're able to pick up angular velocity speed, how much the child is bending forward and backward, and it actually picks up 100 samples per second, so much more than the eye can see. And so we’re able to see if kids with anxiety and depression move differently in response to a potential threatening information, and they do.

Mark Masselli: Dr. McGinnis says that it can pick up anxiety and depression disorder symptoms in a matter of minutes, instead of months. Their research paper published in the publication PLOS One, shows the device was nearly 85% accurate in making a correct diagnosis.

Dr. Ellen McGinnis: What's really great about it is that we increase the sensitivity compared to subjective parent reports and questionnaires that they fill out, so we're picking up more kids who might have gone previously undetected.

Mark Masselli: A simple, wearable tool that can assist parents and clinicians in determining if a child is suffering from anxiety disorder, leading to less guesswork and more rapid diagnosis and treatment, now that's a bright idea.

[Music]

Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

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Marianne O'Hare: Conversations on Health Care is recorded in the Knowledge and Technology Center Studios in Middletown, Connecticut, and is brought to you by the Community Health Center, now celebrating 50 years of providing quality care to the underserved where health care is a right, not a privilege. www.chc1.com and www.chcradio.com.

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