Good afternoon and thank you for joining us here at CSIS. We’re going to be hosting a fireside chat with Dr. Rochelle Walensky, the CDC director, to really focus in on CDC’s preparedness and the road ahead. I’m Julie Gerberding, and I serve as the CEO of the Foundation for the National Institutes of Health. I’m also co-chairing, with my colleague former Congresswoman Susan Brooks, the CSIS Commission on Strengthening America’s Health Security. I also served as the CDC director from 2002 to 2009, so you can imagine this topic is pretty near to my heart.

I’m delighted to be hosting Dr. Walensky here today. She’s been the CDC director since 2021, but I bet it feels a bit longer than that. Before her tenure in government, she was the chief of infectious diseases at the Massachusetts General Hospital, a professor at Harvard, and has an amazing track record of contributing not only to the events in the COVID pandemic there, but also a long history of contributions to combatting HIV/AIDS on the frontlines, as well as a few other infectious diseases that emerge from time to time. So we’re absolutely delighted to have you here. Welcome.

Thank you so much. I’m delighted to be here. And thank you to CSIS for hosting us. Thank you.

I’m also happy to be here with my colleague, Dr. Tom Inglesby. Tom is a member of our commission and has been a consistent and remarkable contributor for a long time. But he also is the director of the Johns Hopkins Center for Health Security, and he has a very astonishing track record of contribution, particularly in the science of public health preparedness and the actual translation of that science into operational planning and response. He is co-chairing, with Steve Morrison, a work group here at the Commission on the future of CDC and CDC preparedness. So welcome, Tom, and thank you very much for joining us.

Great to be here.

I think it would be fair to say that we’re at a pivotal moment in the CDC’s future. On one hand, I know – and I think anyone who’s watching closely recognizes, that the CDC has had a tremendous impact on the course of this pandemic and has done a spectacular job in many dimensions. But they’re also showing signs of strain. They face many challenges in public. The scientific rigor has been challenged, the communication, competency, and capacity has been challenged. And I think the political assaults have really intensified. So it’s been a really tough time.

When I was the CDC director, we faced some similar challenges, but what was different then – at least, from my point of view – is that the context in which these challenges were experienced and adjudicated was much different. We’re operating in an exceptionally partisan environment, but
we’re also operating in a world that is filled with external challenges, disruptions, and other major issues besides the pandemic. We have a citizenry that’s frightened, that’s sometimes confused, and really is not able to tolerate the kind of ambiguity and uncertainty that a chronic pandemic has created for them. So it’s really eroded the trust in all of the institutions. And clearly, CDC is no exception.

I think we want and believe that CDC remains the gold standard of public health expertise, not just here in the United States but I think around the world. And probably more conspicuously globally today than ever. But we also know that CDC does need to change, and that’s really kind of what we hope to address here. Dr. Walensky has come forward with some agenda for reform at the CDC. She’s already gotten started. There are things underway. We are anticipating the adoption of more modern tools, further development of the workforce, and hopefully sustained investment so that the agency can really move ahead and not have the crisis to complacency funding that we’ve experienced in the past.

So, Tom, maybe you’d like to add your two cents’ worth before we really get into the meat of our discussion, because I know you’ve been watching this from the same place I’ve been watching it – from afar, thankfully. (Laughs.)

Dr. Inglesby: Yes. Yes, indeed. And thank you, Julie. And it’s great to be with you, Rochelle. And thank you for all that you’ve been doing, I absolutely agree, this is a pivotal time for public health in America, and particularly for CDC. And it’s a time where we should be doing all that we can to strengthen public health preparedness and CDC’s work to secure its own future and for the country.

We all know how important it is to do this in a bipartisan way and that we will only make progress if we have the support of the administration and Congress, and we also know how important concrete actionable steps will be for forward progress in the time ahead.

And so we really appreciate, Rochelle, you coming to join us for this discussion, and earlier this month you announced the results of your own internal review process, and you laid out plans for the agency’s future and your reform agenda, and we have seen that these efforts are already beginning to take place.

We here at this commission and in this working group are reflecting on similar issues and eager to learn more from you today and to hear about your plans for the future. We have a lot of ground to cover this afternoon so we want to get right into it and make this a kind of an informal interaction with you and we’re really eager to do that.
We also have a small group of experts on our commission who are here with us today who we will turn to for input and questions towards – later in the conversation. So with that, let me turn back to you to get us going, Julie.

Dr. Gerberding: Thank you.

Yeah, I’m just sitting here realizing that probably a lot of people don’t really understand what CDC is and what its broad mission really includes. Our focus right now has been sort of on the urgent emergency preparedness part of the CDC’s responsibility but, actually, it has a very important and a much broader agenda. So maybe you could just start us off by the fundamentals. What is the CDC and what is its mission?

Dr. Walensky: Great. Thank you, and, again, delighted to be with all of you.

CDC is a public health agency and public health means caring for everybody. So that is what we do. We are charged to work 24/7 to protect the health and security and safety of all Americans, whether those threats come from domestic threats or from abroad. We’re an agency of about 12,000, 13,000 people and I think that those people are our biggest asset, and they really have been incredible.

As you note, CDC, you know, became, you know, part of dinner table conversation through our pandemic but the work that we do there, I think, is not really recognized as what we do beyond the pandemic.

So I can tell you that Victoria Shu rappelled out of a helicopter as an EIS officer to deliver test kits to the Diamond Princess and Alex Hoffmaster led a team on outbreak investigation of melioidosis, which I’m certain many people have not heard of, when it started to strike in numerous disparate states and it is, generally, endemic in a world away and he found the source. His team found the source.

We had 63 food-borne outbreaks in 2021 that most people didn’t hear about but that we were charged with addressing. We’ve deployed 400 people to five different countries to address Marburg hemorrhagic fever in Uganda and CDC’s polio effort in Afghanistan and Pakistan and, you know, numerous COVID outbreaks around the world.

So there’s so – and then, of course, that’s many of the infectious threats. But the noninfectious threats are a really key component of what we do as we think about COVID-19. We think about it as an infectious threat but the people who were most impacted by COVID-19 had, in fact, many noninfectious comorbidities, so as we think about mental health, environmental health, opioid crises, and then, of course, chronic conditions – chronic heart disease and obesity.
So we do have a wide vast menu of things that we are tackling. In the news you’re going to hear about COVID and monkeypox and polio. But what we do every day – our subject matter expertise does every day is what leverages our ability to do that, and, in fact, we know so much about monkeypox because we have decades of work going on within the CDC about monkeypox specifically.

Dr. Gerberding: Now, when – I see Dr. Besser here in the audience. Dr. Rich Besser led our Center for Emergency Preparedness and Response when I was at the CDC, and we went deep on preparedness in terms of planning and exercising and investing and so forth.

But I think, looking back on it, we thought of it as a health crisis, and we approached it as a health crisis. We concentrated on the medical and the public health dimensions of it. We didn’t think so much about the economic crisis, and we didn’t think so much about the social consequences and inequities that were part of what we’re experiencing right now in the context of this pandemic. What that really says to me is it’s a whole-of-government responsibility. And so I guess part of the issue is: How does CDC fit into this much broader governmental context? And how do you negotiate your unique role, and yet at the same time participate in the interagency process?

Dr. Walensky: Yeah. That, I think, has been something that I had to learn quickly and is so key, because we will say we lead with science and we do lead with science, but as we make policies, we can’t ignore the fact that these are interagency policies. So how does our school guidance intersect with the plans of Department of Education? How does our infection control and prevention guidance intersect with what Labor is doing – Department of Labor is doing? How does the eviction moratorium intersect with Housing and Urban Development? And so almost every decision that we have made in a context of a pandemic – in the – of the pandemic in our guidance, in our decision-making, has brought – and those are just, you know, several brief examples – has brought interagency collaboration, important policy intersections that we have to take into account as we’re making these guidances and recommendations.

Dr. Gerberding: Do you want to jump in, Tom?

Dr. Inglesby: Yeah. So, Rochelle, just picking up on what you said a little earlier about your deployments overseas, I’ve heard you say before that when an infectious disease crisis hits many parts of the world the first call people make is to CDC. You want to say anything more about your international work that you’re doing?
Dr. Walensky: Yeah. I think that, actually, people recognize CDC for its domestic work, but I think – I had my first opportunity to go abroad – and we’ve had a lot of work happening domestically, so I haven’t been able to go abroad as much as I would have liked. But I had my first opportunity to go abroad, and it has been – and I’ve been doing outreach to our 60 country directors. We have a presence in 60 countries. And truly, meetings don’t start in many of these countries without – and minister of health meetings don’t start unless CDC is at the table to provide that advice. When there is a minister of health who is giving advice to a government, they want CDC at their side to give that technical support. We do an incredible amount of work in the training of the public health leaders, the epidemiologists, the laboratorians, the disease detectives in these international sites. In Uganda, I got to see, you know, a staff of 160 that were called to do a leptospirosis outbreak investigation.

So I think that here in the United States it’s underappreciated how important it is, our domestic – our international footprint. And of course, we now know that no one is safe until everyone is safe, right? And so an international threat very much is one that could, from a global health security standpoint be a domestic threat.

And I am particularly proud of the incredible work that we do internationally. I try and stay in touch with our international offices to – our country offices to make sure that they know that headquarters is with them.

Dr. Inglesby: And, Rochelle, you noted a minute ago that people may not know about the international work. Are there other things about CDC, misperceptions or things that you see every day that the American public may not see, things that you’re particularly excited about, or?

Dr. Walensky: You know, I think the science of the agency is really – it’s just incredible. And there have been – when I started and I started really learning – and mind you, before I got here, I was an avid consumer of CDC. Like, I knew more than the average person about the CDC. (Laughs.) And yet, when I got to the CDC and I started really doing a tour of all the divisions and centers and the work that they were doing, it was a bit of a kid in a candy store: We do that here? Vital statistics and environmental justice and, you know, cardiovascular disease I, of course, knew about. But the deep subject-matter expertise that when there was this first case of monkeypox, I could talk to somebody who literally had spent decades of her career as a – you know, working in monkeypox. And that is true for name-the-infectious-disease.

And I will say this melioidosis case that I sort of brought up, I was the first person to say, gosh, I don’t know if they’re ever going – (laughs) – to find where this came from. And sure enough, they did. So that is the incredible work of the people every single day. And mind you, we will never know their names. I gave you their names, but they are not doing it for credit. They’re
not doing it for recognition. They’re doing it because they believe in protecting our health and safety and security.

Dr. Inglesby: So can we keep going in that direction around the work that CDC is doing for epidemic preparedness and response, pandemic preparedness and response? I mean, obviously in this pandemic many things have been happening. And when things don’t work, they may be called out. But they’re not always called out when things are working. And so can you say a little bit more about the things at CDC where you think, even as you’re looking at your reform agenda and what you’re thinking about changing, where do you think CDC’s biggest strengths are, their assets are?

Dr. Walensky: Yeah, first, I think we should just acknowledge that in the last 19 months we have delivered 600 million vaccines to Americans – that’s kind of extraordinary – with a vaccine safety and effectiveness profile that has been rigorously studied, from moms and babies and infants. So that, in and of itself, is something that I think is underappreciated, what it took to vaccinate – we can call it 75 percent of America. So that, I think, is something we should acknowledge.

In terms of the work that we’re doing and have been doing, there have been numerous things. When I started as an admirer of CDC from the outside, I could also say that these were challenges that I perceived as the outside. Our science needed to move faster. CDC had been long criticized for our science not moving fast enough. So how can we get things out faster, our clearance process out faster? That was something I addressed earlier on.

Equity clearly a challenge in the pandemic. And this was something that I know all of CDC actually believed in, but we had this moment to do more for health equity. And actually it was one of the things that worked to boost the morale most at the agency when I got there was to talk about equity, to mobilize around social determinants of health, around a core strategy for equity, around addressing diversity and inclusion within the agency and outside of it.

Data. I’m a data geek. (Laughs.) So data has always been important to me. We launched the Center for Forecasting and Outbreak Analytics, which was really important to think about innovation, data sources, how we can project, how we can forecast, how we can work with our partners. What do they need in terms of forecasting? I’m really excited about this new center.

Also in data, you know, I don't know that everybody recognized in – as an infectious-disease doc, when you report something to the CDC, it was a handwritten form that you send and say this patient has measles or this patient has tuberculosis. In COVID, it was a million a day. (Laughs.) We were getting reports to the tune of a million a day. And some of them were literally
coming in by fax machine. That’s not a data system. And so we really went from case reporting of 187 places to 15,000 health-care facilities that were now reporting data electronically. So we’ve really scaled up our data systems.

And there may be one final – because Julie mentioned communications – and that is where I started and we had a communications-director position that had been opened and vacant for four years. We posted it twice. We’ve just had that hire in the last couple of months. Kevin Griffis, I’m really excited, is now with us. But that’s been challenging; there’s no question.

Dr. Gerberding: So, you know, you’re mentioning this data systems problem. But a lot of people don’t really understand what your authorities are from the state and local level. And I think it’s really worth emphasizing that you get data by being a good partner, but you don’t really have the authority to require it.

Dr. Walensky: No. And thank you. So there are two major challenges, I would say, with data right now. One is the pipes don’t connect; like, data coming in from one state or even one county doesn’t connect to its own state, doesn’t connect to CDC. And even if it did from that singular state, it doesn’t match the pipes from a different state. So if you were – so if one jurisdiction was to send data to us, we can’t send a similar jurisdiction back to see how they’re doing comparatively. That’s problem number one.

Problem number two is, even if all the pipes connected, there’s nothing going through it. (Laughs.) And so through – and, you know, having come in in the middle of the pandemic, when we had the public-health emergency, many of those systems started coming in, because through the public-health emergency we got some of the authorities for the data to come in. But you are exactly right. We do not have the capacity to compel data to come in. We get it voluntarily. We did not get it from monkeypox. We are just now able to get vaccine data from jurisdictions through 64 legal teams working on data use agreements each time, so that we can get those data in. And they’re now just starting to flow. We can’t make real, live, nimble decisions when three months after, you know, a first case we are first starting to see data.

So it’s both of those issues. We can work on the systems issue. We need the authorities issue. And we need the partnerships, because I really do want to say – what I’m not interested is mandating data from jurisdictions. What I’m interested in is a bidirectional highway where if data are to come in, we have a responsibility to give it back in a way that’s helpful to the jurisdictions as well.

Dr. Gerberding: And I think that’s tough, because it’s – as you said, the pipes don’t match up. And just linking one institution’s – health care institution’s data to their local public health department is a huge challenge, let alone trying to construct
such a system for the entire country. But the idea of a data commons in public health is, I think, an idea whose time has come.

Dr. Walensky: Critically come, yeah. And we’re actively working on it.

Dr. Gerberding: Yeah, it’s – yeah. It’s really important. And you need Congress – congressional help, absolutely.

Dr. Walensky: Yes, we do. (Laughs.) Yes, please. (Laughs.)

Dr. Gerberding: That kind of leads us to the topic of the reform agenda. And I think many people are already familiar with the basic framework of the reform agenda. Maybe you could just highlight what you’ve already done, because I know that you didn’t wait around for, you know, time to pass. You got started right away.

Dr. Walensky: So we did a lot of work on the data side. We did a lot of work on the equity side. We’ve done a lot of work on the communications side. We’ve done a lot of work on the laboratory side too. So clearly laboratory has been a challenge. We’ve read that in the news, and so one of the first things that we did when I came in was to do sort of a deep dive and try and understand, but also to have our advisory committee of the director reconvene, we had lost our advisory committee to the director, so reconvene, and one of our first work groups is on lab.

Also, a lot of work on quality assurance in lab. Our laboratory – our Office of Laboratory Science, our director had stepped down. So we needed to have a replacement, but also – and Jim Pirkle is serving in that role, which I’m delighted about – and really do a lot of work on quality assurance. And then, importantly – and this really will get to the core public health capabilities, we need to raise our core public health capabilities. Laboratory has to be one of them. They had been sort of in layers of hierarchy within the agency, and not necessarily at the top, rising to the top. So laboratory, I think, is really important, really key. We also, from a laboratory standpoint, I will say, have developed an infectious disease laboratory taskforce. No test will leave the agency now without triplicate review. So that is something that is now in place.

So in terms of the core public health infrastructure, laboratory, data, and workforce. And what I really believe is I certainly wouldn’t have imagined in 2022, in addition to COVID, I would be dealing with a national monkeypox challenge. I don’t think any - if you could have predicted it. (Laughs.) But, you know, what I think we – it really does say is we need a nimble workforce that knows how to deal with public health challenges, whatever they may be, because we don’t know what tomorrow’s are. So if we have a workforce, a laboratory system, and a data system that is really strong and really elevated
as our core capabilities, then whatever the subject matter that is the challenge we will be prepared to tackle it.

**Dr. Gerberding:** You know, it's a lot to do at CDC and looking at it from a headquarters point of view. But I think our commission, and many of us, believe that it's a broader systems issue than just the CDC, and that our state and local health departments, which are so critical to the frontline, have the same challenges. They need data. They need competent workforce. They need resources and a whole lot of other things.

And we could say the same thing about our schools of public health, for that matter. These are generally among the poorest-funded and resourced components of most universities, and yet arguably they're the frontline of creating better health protection for everyone. But we don’t treat them like they're valuable treasures and resources. So in your reform of the CDC, how are you thinking about the responsibility and the advocacy for the rest of the system?

**Dr. Walensky:** Yeah. I think that this is really key. You know, I was really energized when, after we declared racism a serious public health threat, there were 200 other areas of public health, departments of public health that either followed suit or were dated – or motivated were working in that direction also.

I have since also heard that state departments of public health are actually looking at a review of what went well, what didn’t go so well, in the last year and a half.

But to your point about workforce, I think the de Beaumont Foundation did a review and estimated that our public health workforce is about 80,000 in deficit, which is truly extraordinary when you think of the work that we have to do.

These are folks that often left public health. We have a lot of folks who are retiring – people who’ve retired, stuck it through the pandemic, really wanted to do their best. But also folks who are realizing this has been a hard job. It’s been a divisive job. Many have been threatened, and so, people have left.

What the good news is, is that the public health schools, the applications are up. Med schools, applications are up. People are interested in leaning into this moment. I am an HIV researcher because of when I trained. That is what I wanted to do. (Laughs.)

And so, you know, I think that this is a time where we can energize people towards this field, but we do need the infrastructure. We do need the
support from Congress – from a bipartisan Congress, to say that these are valued, revered positions because you’re helping others.

Dr. Gerberding: Thank you for that.

Dr. Inglesby: So, Rochelle, in terms of the workforce, you’ve mentioned this before, talked about the very high importance of having a prepared workforce that can respond to emergencies in front of it. What does that look like at CDC?

I mean, I think maybe people don’t know how challenging it is to for people to divert from their day jobs and be deployed to overseas for an Ebola crisis, or you know, in the field in the United States. What would it take to get that workforce where it needs to be, and how do we do that?

Dr. Walensky: Yeah, that’s actually a really important point. So, 12,000 people in CDC, and what I don’t think many people know is during most of our pandemic response we had 2,500 who were deployed to our response. So, that’s like 25 percent of the agency at any given time was working in our response. That means two things.

One, that they had to agree to be deployed, and two is whatever work they were doing, it didn’t stop the, you know, foodborne outbreaks. And nothing else stopped because they were deployed in a response.

And so, what we have to do I think as an agency is make sure that – there is a role for everybody in our agency in the response. I’ve been doing – I call them unsung heroes calls, and I just call people who maybe haven’t been seen or heard as to the work they’re doing, but somebody booked all the flights for people to deploy to Operations Allies Welcome. Up all night booking flights all night long. That person was deployed, right? So, we need all levels of expertise.

And we have that at CDC, but we don’t have everybody trained in order to do that every single day, and we don’t have an incentive structure in the agency that says your celebrated because you deploy, and that’s actually a lot of the work that I think we need to do is to set up that incentive structure to be able to say, you know, extra something by deploying whatever it is factors towards it is, whatever those may be. Because right now it does feel like you’re abandoning your home – your homework if you agree to deploy. That’s a challenge.

Dr. Gerberding: You know, there is a difference between deployment and embedding, and so, deployment as there’s a crisis – let’s send some people there to help deal with the problem. The other complementary model is embedding where people are permanently detailed to serve in a public health department at a local level or a state level or an international setting, and there have been
several reports and commentaries on the CDC recently that have called for much more embedding to move the workforce closer to the front lines of public health. Is that part of the reform that you envision?

Dr. Walensky: I think it’s going to take resources and people and mechanism by which we do it, but I do completely agree – and they’re not mutually exclusive, to be clear. I do completely agree that by working in a state or a local department of public health you understand the local challenges. You understand how some decision that may come from CDC results in some big old challenge that happens locally. And that – so much of what we need to do – and I’ve said this as part of our review – is partnership.

And that means being a good partner, and listening as much as, again, the bidirectionality here. We are only as good as our effector arms, and we can only help them as much as they can provide us information as well. And, you know, the first monkeypox case was not found by somebody at CDC. It was found by somebody in a local jurisdiction, who was reported to the local department of public health. That’s how it comes in. So we really have to be amazing partners here.

Dr. Gerberding: Well, I will say I admire your candor and your courage as you take this on. And, you know, just even being able to step forward and say: Guess what? We didn’t do everything right, and we have a responsibility to fix it, takes a lot of leadership, confidence and courage. But I also know firsthand that it’s very difficult to do. And I’m sure that you are already experiencing some bumps in the road. How do you get help? Who are you going to turn to help you carry this banner forward? And how can the commission help you?

Dr. Walensky: Yeah. Well, first of all, I think – thank you for that. I will say, I have had a lot of support to do this. I think, for the time I’m in this position, my job is to better public health in the country. And I think we saw some challenges over the last year and a – two and a half years. And so my job is to get it to a better place. Some of the challenges – you know, CDC wasn’t set up for a pandemic. It wasn’t necessarily set up for some infectious threat that would touch 330 million Americans, literally. And we think, you know, about 95 percent of us have gotten COVID already. So – and of course globally, right?

So what are the things that we need to do? Having learned this lesson hard, what are the things that we need to do? I do think that – and so I’ve had a lot of individual support. The agency, I think, wants – people in the agency read the headlines too. They want to be in a good place. They want us to be in a better place. Bipartisan congressional support, there are a lot of things that I can do within the agency, and ways that I can – that this review shed a light on things that we could improve upon, or ways that we can change, incentive structures that can be set up so things are better.
There are many things that have made it so that we can’t be nimble. Data authorities are among them, as you talked about. Human resource authorities. We don’t have the capacity, we’re not permitted, to hire the way FEMA does, to draw in resources the way FEMA does. Contractual authorities. Even in a pandemic, how quickly can we move? Do we have to compete this contract? It’s going to take three months to compete this contract. What if we needed a contract in New York City to combat polio education? Do we really need to wait three months for that contract?

So, and then Paperwork Reduction Act. How can we get data faster and do studies faster, before the public health emergency is declared? So there are numerous areas that would, from a bipartisan standpoint, would really allow us to be more nimble. I will do all the work that I can from within the agency and ask for a little bit of grace and time. We’re making these changes. Some of these challenges didn’t happen overnight. The changes are not going to happen overnight either. But also to say that there are a lot of different ways, as I look at the bigger structure, outside of CDC at an interagency level, that things could be – we could be more nimble.

Dr. Gerberding: You know, Tom, I know you’ve been thinking a lot about this from the standpoint of the work group. When you look at all of these reports that have already been disseminated and, you know, you must feel like you’re getting a lot of advice. (Laughter.) You know, what are the things that you’re most interested in focusing on?

Dr. Inglesby: Well, I think it’s exciting to hear about – and maybe you could say a little bit more about this, Rochelle – your interest in changing culture and incentives, to try and align with what America’s expectations for CDC are, your expectations. So it would be great to hear a little bit more about that. And the other thing that I’ve heard you say, which I think is really important, we’ve heard lawmakers from Capitol Hill talk – some of them have said, we really need more accountability. You’ve said the same thing in your talk about reform. Maybe you could say a little bit about what you’re thinking about accountability. What does that mean, in this case? And how do you do that?

Dr. Walensky: Yeah. You know what? I think about the incentive structures. We have traditionally been an academic-like agency. We talk to academicians. We talk to public-health officials. We talk to scientists and likeminded people. And over the last two and a half years, we’ve learned we need to talk to the American people.

And so we need to be action-oriented, and our science needs to be action-oriented. So if, you know, one would be promoted for a publication or for their publication productivity, how do we promote people for their public-health action? How do we promote people not because that publication made it to the New England Journal, but because that publication led to
something implementable on the ground that changed practice, even if it was in some lesser-tier journal, because it was really important to public health?

So it’s really the – lining the incentives so that we now communicate with the American public in things that are not sort of esoteric and weedy but sort of that the American public can understand, and then also aligning our incentives towards action, towards deployment, towards embedding, towards other things that, like, lead to – and, in fact, sometimes when we implement, we have to implement differently in different places. And how do you learn that what you implement in frontier America is going to be different than what you implement in inner-city America? And you do that probably by embedding, right, or by deploying to those areas to see what’s culturally sensitive and needed.

Dr. Gerberding: Now, one of the challenges that I think is implicit in some of these local public-health efforts and the communication challenges is the fact that we’re working in a society that doesn’t have high scientific literacy, and certainly doesn’t have high health literacy. And we don’t need to recap all of the issues around social media, misinformation, disinformation. But, you know, that is a root cause of many of the challenges that you’re facing in getting uptake of the guidance and the recommendations. And then layered into that, of course, is the political divide that sometimes amplifies that.

Is that part of your communication plan?

Dr. Walensky: It is. And I think if you look at about two weeks ago, we released updated COVID-19 guidance. One of them was a school guidance. And I think if you just look at that and put it side by side from what we did in February of 2021, they look different. They intentionally look different. They’re talking to different audiences.

Much of what had initially been in many of our guidance documents was the weeds of what about this and what about this and what about this, which we kept being asked. But we can take that out and not all of those need to be in a guidance document. They can be in frequently asked questions. So you can find your question and say what if I want to visit grandma this weekend? When do I do my test? We don’t have to sort of embed that in the guidance. So we’ve been doing a lot of that.

I think, from a communications standpoint, it’s been interesting. We have the health-literacy challenge that you noted. We also have the challenge, first of all, that we’re making decisions in imperfect times, sometimes with imperfect data. Controversy is always great on the news. (Laughs.) And if we had a piece of guidance that had 12 really important areas of guidance, and one of the – there was really pretty uniform agreement on 11 of them, but
one of the 12 we didn’t have all the data and we had to land on a certain place, that’s the one that makes the news. (Laughs.)

And you can get really smart people who I very much respect on the pros and cons on that. And I could have fought on either side of those pros and cons, right, because we didn’t have enough data to inform it. But that’s the one that is – and then, of course, people say they’re confused. And that makes sense that they’d be confused. So how do you create a communications space where we can admit we didn’t have all the information? We needed to make a decision, because not making a decision is a decision in and of itself. And this is where we leaned for all these pros and cons.

Dr. Gerberding: That’s really tough. That’s really tough, yeah.

Dr. Walensky: (laughs.)

We’re going to ask our audience to have a chance to come to the microphone in just a couple of minutes. So think of your questions. And there will be one live mic here in the room.

Tom, do you want to chime back in here?

Dr. Inglesby: Yeah. So I wanted – you’d asked before, what are some of the things that really stand out as part of the challenge? And it seems from the outside, and just want to check in with you, that the budget of CDC is a very difficult thing to run.

Dr. Walensky: (laughs.)

Dr. Inglesby: There are lines that are directed from Congress that go page after page after page, and my understanding is that you cannot move money –

Dr. Walensky: Yes.

Dr. Inglesby: – from one line to the next. So when you have a large unexpected crisis, you do not have a large sum of money to be able to deploy for that crisis. Is that true still?

Dr. Walensky: That – yeah.

Dr. Inglesby: And what would it take to change that?

Dr. Walensky: (laughs.) Julie’s laughing because she knows. (Laughter.)

Dr. Inglesby: She went through this.
Dr. Walensky: Yes, it is exactly true. And in fact, it really is a challenge. So early in COVID when it became clear that we needed contact tracers, our best contact tracers are in our STI clinics. But we have a line-item budget for our STI clinics for those contact tracers and mobilizing them to do – and this is really what I’m talking about with, like, the core infrastructure.

We need an investment in the core infrastructure. We need all – not all of it but much of that budget to be in the people and the labs and the data so that those are all there with some of those line items, because I believe in those line items. It’s not that I don’t want to have every single one of those line items exist. They’re critically important. But they lock us in in a way that does not allow us to be nimble.

And so the words I use are disease-agnostic resources so that today when we have a monkeypox challenge we can borrow from COVID of yesterday if we need to and that’s really – I mean, the permission and layers that we need to do in order to get in order to be nimble for that is paralyzing in our ability to move forward.

Dr. Gerberding: I think every CDC director who’s ever looked at the CDC budget knows exactly what you’re talking about. It is completely inflexible, and you have, really, no authority to move money from one budget to another. Maybe a smidgen but nothing that can really support.

So I wrote this word down, disease-agnostic resources. (Laughter.) This will be something we want to make sure we include in our report for sure.

Dr. Walensky: Sustainable disease-agnostic resources. Have I said it before? (Laughter.)

Dr. Gerberding: We got it. We got it. Thank you.

Karl Hofmann: Thank you so much, Dr. Walensky, for being with us. I’m Karl Hofmann. I’m a member of the commission and I run a global health nonprofit called PSI. Used to be in the State Department.

Let me just say at the outset I think everyone here admires you. I’m not sure how many of us envy you because the job is really difficult for all the reasons that you’ve been talking about here.

Let me take you back to your comments about the CDC’s very impressive overseas work. You know, I – as an American, of course, I’m a beneficiary of what the CDC does domestically and now I work and have worked in my previous life and interacted with CDC overseas and found that to be very rewarding as well.
But it’s a complicated thicket, right, of players and agencies, just thinking about the U.S. government overseas in terms of global health. Can you say a word about how the CDC and USAID and the State Department and other agencies – DOD, for that matter – how you look at that as a collective, how you see your role in that – the agency’s role in that collective U.S. government response overseas?

Dr. Walensky: Yeah. It’s a great question and I’m actually glad I can answer it, having come back from our – because I really do have a much better sense. It’s one U.S. mission when we’re abroad, right. We speak with one voice. It is one U.S. mission.

So I see CDC’s role there as critically important at the table, the forefront, but much of that is technical expertise, teaching to sort of – it’s the old term, you know, teach somebody to fish rather than give them a fish, right. You want to make sure that you’re providing the technical support but also fostering towards independence.

And so that’s a lot of what we do based on our infrastructure, the teaching, and, as you say, in some countries I’ve seen it where this region of the country was doing – COVID vaccination was being done by AID. This region of the country it was being done by CDC. Sometimes in other places it’s been – you know, we’re all doing the entire country but we’re looking at different areas in which we’re doing it.

But laboratory system it’s much of the same. It’s workforce, it’s laboratory systems, setting up our emergency operations centers, our field epidemiology training programs, FETP or FELTP – the epidemiology and laboratory training programs. They’re teaching the next generations in country.

And so that, I see, is a very parallel role to what we’re doing here but, really, with one U.S. voice in country.

Dr. Gerberding: Rich?

Richard Besser: Yeah. My name is Rich Besser with the Robert Wood Johnson Foundation, formerly with CDC.

Dr. Walensky, I can’t imagine what it was like coming into CDC, running CDC in the midst of a – of a pandemic. You lifted up a little while ago the declaration you made of racism as a public health crisis and the ripple effect that had around the country with health departments. When I look at what you laid out last week, you mentioned in there a health equity office. And I’m wondering what some of your thoughts are about what needs to change at
CDC so that CDC is an agency that meets the needs of all Americans, and that not only will the next pandemic not have a disparate impact based on race but the everyday issues that people face will not have such a disparate impact by race.

Dr. Walensky: Yeah, thank you. So this is clearly something – my work in HIV is something I have been passionate about and was actually really – as I mentioned, really mobilizing at a time when morale was really pretty low when I started, to say we’re going to do something around health equity, everybody was onboard. And what happened was our different centers and divisions all came together and talked about everything that they were doing in health equity. It was one of those places where we were able to really break down silos and look at the intersection of all the important work that was being done.

So this office will really raise that. It'll be an office that reports to the director. We really do want to raise up our key, core capabilities. We talked about the lab and workforce and data, but also our policy, our communications, and equity as being a really key important one.

We've talked a lot about promoting a workforce that is as diverse as the communities that we serve. We've talked about our core infrastructure and our core capabilities. And also, one of the things that I did early on was charge the agency with proposals. Everybody put forward a proposal of how – I was – really didn't want to document the problem anymore. We know that wherever you look there's an equity problem. We knew with monkeypox vaccination – we never saw the data – (laughs) – but we knew as soon as we did there was going to be an equity problem. So we have to document the problem. But in addition to documenting the problem, let's look at how we can implement solutions.

And I charged every single center and division with putting forth proposals of how they could address equity. Folic acid in tribal nations. There were – everybody came forward and it was really mobilizing. And you know, they have a year to sort of work on those proposals. In fact, we should be starting to see some of them. And not all of them will work, but some of them will actually work in different parts of the country, right? So that’s a lot of the mobilizing work that we are doing, and I’m hoping we’ll be setting an example for other health departments.

Dr. Gerberding: You know, you’ve been talking a lot about workforce, and we haven’t really talked about the Commission Corps. Could you say a word about the Commission Corps and what you might imagine the future role of the Corps at the CDC might be?
Dr. Walensky: Yeah. I mean, the Corps has been key. It has been – (laughs) – from a deployment standpoint, much of the folks in the Corps we were saying, no, you can't take the Corps because we actually were deploying the Corps towards our own key missions through. So, you know, much of the Corps, of course, lies with the – the Corps does lie with the assistant secretary of health in the secretary's office, but I do believe one that is key and critically important.

Other areas, though, that I do want to mention: bolstering up our EIS program, bolstering looking at loan repayment, our AmeriCorps for Public Health program. So really spending – and then we, of course, have this incredible opportunity with $3.9 billion in workforce resources to the states. So I think we need to invest in our public health workforce at the Commission Corps level, but also in many of these other areas.

Dr. Gerberding: Jeff.

Jeffrey Sturchio: Thanks. I'm Jeff Sturchio. I'm a senior associate here at CSIS.

You know, for the first 40 minutes of the 45 minutes of your discussion we were talking about public health, but we didn't talk about the public at all. And I was glad to hear you talk toward the end about the hard lessons that CDC learned about public communications during the COVID pandemic. Recently, when Tony Fauci announced his retirement, we were all reminded that in the early days of the AIDS epidemic one of the breakthroughs that happened was when Tony Fauci and others – it wasn't just Tony Fauci – began listening to AIDS activists and listening to what they were saying about the design of clinical trials and how community trials could be conducted and we could get data faster and things could really change. So I wonder if – just with that in mind, could you talk a little bit about what you're thinking about how to bring the community's voice more directly into the work that CDC does? Because that's one of the ways you'll be able to really address the equity issues you were just talking about. But I'm just curious to know, you know, if there are advisory groups, if there are ways that you could build on those kinds of models to bring those voices more directly into your work.

Dr. Walensky: Yeah, that's actually a terrific question. In fact, it was in those moments where Tony – (laughs) – inspired me, or when I was very early in my career. I will tell you, just anecdotally, that I had the great privilege of being on a White House call very early in the monkeypox pandemic – or, in the monkeypox outbreak. God forbid. (Laughs.) Where one of said advocates said, could you imagine if we had been on a White House call with CDC within a week of an outbreak that was affecting our community in 1981? And I have a phone call with community folks every week for exactly the reasons, as you note.
But I think one of the things that’s really important here is ensuring that the community is part of our workforce, and it gets back to as diverse as the communities we serve. How do we know what will work in Dalton, Georgia’s vaccine centers if we don’t know what the community needs in that vaccine center? So we really do need – and we need to listen. There’s no question that we need to listen. But we need to recruit people in health in all of those areas. That’s what we’ve been doing globally. That’s what we do on the ground globally.

And then, of course, you know, I think we need to rely on community and also on our local jurisdictions to understand and recognize – one of the things that’s been interesting as we’ve put forward guidance is to be able to articulate, you know, if somebody has a challenge with our guidance, our guidance has to be applicable in Manhattan, and American Samoa, and Cherokee Nation, and Alaska. And so as we think about all of the areas that our guidance applies to, we need to understand what the communities in those areas need.

You know, as we talked about, wastewater surveillance or even our COVID-19 community levels, we needed to recognize that we couldn’t use wastewater surveillance because there is no surveillance in Alaska. So what is it that our communities need on the ground? And you’re absolutely right, we have to listen to that. Public health only works – it can’t work from above. We’re not an empire. It has to work from the bottom up.

Dr. Gerberding: Rochelle, you know, I really understand and agree with your premise that science needs to happen faster. And there are lots of – you know, good science takes time. We all understand that. But at the same time, the processing of science and the communication of science is something that often can be sped up. But I think most of us still believe that the real secret sauce of the CDC is its science, is what goes on in the labs and what goes on across the entire agency, in all of the different domains of public health. How is that science faring while we’re all focused on infectious disease and the outbreaks? Are we doing OK in those other domains?

Dr. Walensky: Yeah, I do think we are. And I want to be very clear, because I firmly believe in the peer review process. I will say, almost every paper that I’ve written I think got better because it went through the peer review process. And things that I hadn’t considered were addressed through that process. The statistics got better through the peer review process. So that is still happening. And it is still happening well. And I don’t want to discount that, because so much critical science is happening – and formative science – is happening at the CDC. They can’t be mutually exclusive.
But I do – you know, if I look back to it – I think it was, like, July 24th. That was the day that I saw the data – it was a Friday afternoon – from Barnstable County, Massachusetts, and it was very clear that people who are vaccinated were transmitting Delta. That changed. We looked at those data on Friday afternoon, we corroborated it with data that were coming out of the U.K. over the weekend. We saw another outbreak that was happening in a correctional facility. We had three different places where we were seeing this. And we needed to change the guidance before any paper was going to get out. And that’s what I mean. We need to make those data public, so that when we change our guidance people recognize this is the science around it, and we’re not going to wait for peer review.

Dr. Gerberding: That makes sense. Makes sense.

We have two people at the microphone. Can each of you ask your question, and then we’ll try to summarize? Thank you.

Asaf Bitton: Hi. Good to see you. Asaf Bitton, Ariadne Labs, Harvard School of Public Health.

You know, I think one of the surprising and positive upshots of what we’ve gone through in the pandemic is the realization that the health care system now sees itself a little bit more outside the four walls, sees itself as having perhaps a public health mandate. And so I’m wondering, is your thinking about reforms and the CDC, beyond making these necessary data interconnections, which are so critical, what are other ways that you are thinking about connecting more that bridge, that’s so critical, between formal health care and formal public health?

Dr. Gerberding: Do you want to just ask the second question? Because we want to make sure we get to both of them.

Caitlin Rivers: Caitlin Rivers, currently with Johns Hopkins, but was with the Center for Forecasting until just recently.

I wonder if you could talk a little bit about any changes you’re considering to the way outbreak response is structured at CDC. I’m thinking here specifically about the graduated response framework, where the pathogen experts often have the first pass at a response, and then as it rises in scope then more and more the agency becomes involved. Are there any changes that you foresee there?

Dr. Walensky: Yeah, thank you. So maybe I’ll – to your question, Caitlin, the – it’s good to see you again. (Laughter.) We are looking at this, because while we need some partnership between people who understand emergency response – which, in and of itself, is a specialty, right – and people who understand the
specific outbreak, or the specific pathogen. And that partnership hasn’t historically necessarily happened. So we are raising our response.

The level of response within the OD, and to – the Office of the Director – and to sort of have – and we’re working on this now, so I don’t – you know, we’re actively working on this. But we do need more training and response in being – how to be a part of a response, and different layers of the response, in vaccine effectiveness, in how one would manage or would start or would deploy to a response. So we’re actively working on that, and then thinking about the structure that we need to have as we – as we move forward. That is actively happening.

With regard to health care, I think you’re totally right. I think that one of the things I really worked hard to do when I was chief at Mass General was to say, like, our STI clinic is run by the state. Why don’t we talk to them very much? (Laughs.) And so, like, why – we need to have more fluid communication with our state labs, right? So we do need to foster these connections. I do think the pandemic has given us this opportunity. Even from a vaccine standpoint, or even a case standpoint.

If we had laboratory case reporting at CDC but we didn’t have comorbidity data that lied in the hospitals, then how could we look at how, you know, co-morbidity – how could we even examine that? If we had vaccine data that lied with the states but comorbidities, you know, or hospitalization rates that were in the hospitals, we couldn’t connect the two. So one of the things that we’re actively working on, and I’m working with ONC on this right now, is to say: Once we get our pipes connected – and we’re working really hard to get our pipes connected – are they going to connect with the Epics and the Cerners of the world so that we can make sure all of the systems connect? And there are mechanisms by which that can happen. And I do think health care is motivated to do it because, again, bidirectional highways with our partners.

Dr. Gerberding: Thank you for that.

And I’m going to let Tom round us out here.

Dr. Inglesby: Great.

Dr. Gerberding: But before I turn it over to you to close us out, I do want to thank you, for sure, for being here and for your leadership and your incredible service under some really challenging circumstances. But I also want to thank Steve Morrison, who’s really the leader of our whole commission effort and who’s so – is genius at putting these things together. But also our commissioners who are here; the members of the workgroup; my co-chair, Susan Brooks, who’s preparing for her daughter’s wedding so she has a very legitimate
reason for not being here; and our production crew, in particular Humzah Khan and Michaela Simoneau. Thank you so much for your role and for the team that’s been managing this.

So, Tom, let me let you close us out.

Dr. Inglesby: Yeah. I would just say that – yeah. Well, really appreciate, Rochelle, you doing this and kind of being here and open to this kind of forum. I think what I heard today were many of the very important changes that you’re planning to make around data and culture and accountability and workforce, and maybe some of the unsung capabilities at CDC which are strong and need to be supported. And I think you also helped us understand the kinds of things that are going to be important in the ecosystem that surrounds CDC for you to be able to make the kinds of changes that you want to make. And so I think we want to be – as this commission, as this larger community of public health, I think we want to be very supportive of what you’re planning and really engage in that process of change in the time ahead.

And I also think it’s important, just since we’re here talking about CDC, just to take a moment to thank the workforce of CDC, who –

Dr. Walensky: Absolutely.

Dr. Gerberding: I think has been at work for two-and-a-half years without a break and working weekends and nights, and often at some personal health risk. So we want to thank CDC for all it’s done since this pandemic got going and come back to thank you for leading it in a very challenging time. So thank you so much, Rochelle.

Dr. Walensky: Thank you very much. (Applause.)