

Bonus COVID-19 Update #7:

Borne the Battle

BONUS: COVID-19 Update No. 7: Clinical Trials and Emergency Care

<https://www.blogs.va.gov/VAntage/80172/borne-battle-bonus-covid-update-7-clinical-trials-emergency-department-procedures/>

(Text Transcript Follows)

[00:00:00] Music

[00:00:00] OPENING MONOLOGUE:

Tanner Iskra (TI): Hey there it's a Wednesday, October 21st, 2020. This is Borne the Battle, brought to you by the Department of Veterans Affairs. And I am your host Tanner Iskra. I'm going to skip most of the intro, music and whatnot. If you click on this bonus episode, I'm assuming, you know what we're normally all about. But we're skipping most of this as it is a bonus on a pretty serious subject that has more than probably definitely affected your life in some form or fashion. We're talking about COVID and we're giving you some updates and some insights on how VA is responding or supporting the fight, supporting you, however you want to slice it that's what we're going to be talking about today. And, it's been a while since we've had a COVID update. I didn't know if we were going to do another one. And you can find the others in our archive and on the blogs on [blogs.va.gov](https://www.blogs.va.gov) [Link: <https://www.blogs.va.gov/VAntage/>].

But, some new information and some new subject matter experts were brought to my attention. And before I talked with them, I decided to bring those conversations to you as they happened. The first conversation is going to be surrounding VA's role in the COVID-19 vaccine trials that you're hearing about in the news. As you probably know, Operation Warp Speed is a collaborative public, private effort that involves many pharmaceutical companies and crosses many roles of government, the CDC, Health and Human Services, and yes, the Department of Veterans Affairs. We have clinical trials currently being conducted at over 50 VA medical facilities and it was bigger than I thought, as you will hear in the interview. It's pretty unprecedented. I also heard that they're looking for veterans to volunteer in the vaccine trials. So, I recently linked up with Dr. Molly Klote, an army veteran herself, who is the Director of the Office of Research Protections, Policy and Education, to hear from her what these trials were all about and how veterans were to be protected. Because me, I have no idea what's

involved in a clinical trial and that's what I wanted to talk about. So here it is, take a listen.

Music [00:02:19]

[00:02:27] Interview with Dr. Klote:

(TI): Now you're the director of office and research protections policy and education. Doctor, that's a lot of words. It's a lot of government speak, what does all that mean?

Dr. Molly Klote (MK): It is a lot of government speak. And it really boils down to, we are the office that oversees human subjects protections in all of the research that the Department of Veterans Affairs conducts. So we set the policy, we run the central IRB, which is an Institutional Review Board, which does the ethical review of some of our big multi-site studies across VHA, the Veterans Health Administration, and then we're responsible to do the education of people in the protection of human subjects. And it's a great mission to have. Because we really serve not only the veterans who were protecting in the research, but we get to interact with the researchers, we get to see all the different research that's going on across the VHA. So wonderful mission.

(TI): Very good. So and you're a veteran yourself? Correct. You went to ROTC at JMU. Former Colonel?

(MK): I did yeah. I served 30 years. I retired in 2018. From the army.

(TI): Gotcha. Do you know retired Lieutenant General, Raymond Mason?

(MK): I don't.

(TI): He's currently running the army Emergency Relief Fund former guest he also went to JMU. Actually he said he helped stood up the ROTC program at JMU. And so you'd be in the JMU ROTC alumni, thought maybe there was a connection there?

(MK): No, I will look forward to hooking up with hikm at some sort of alumni association meeting and finding out more about his efforts, okay.

(TI): Yeah, no, he's in archives here borne the battle. So if you get a chance, go ahead and check it out. Okay, first of all, how did you find your way from the army to this position here within VA?

(MK): Actually, it was a really natural transition for me. So I started off as a researcher, you know, as a doctor, doing clinical research at Walter Reed, during my residency fellowship and my early staff years and found that the research regulatory process was very complicated, and had the opportunity to move over to the research department at Walter Reed where they had a similar function in terms of managing human subjects protection and research policies. But on a, you know, a smaller scale, of course, than what I'm doing now but, in going over to the Walter Reed department of research, I really got a sense of that, you know, we needed some leadership in this area. And I joined that department, I help them streamline function ultimately oversaw the similar process for the 8th Army Medical Centers. And then the Surgeon General of the Army asked me to come up to her office and oversee all of Army Human Research Protections. So when I retired from the army, VA had this position open. And for me, it was getting back to, you know, biomedical, clinical research, but on the largest scale that there is in our country as the as the largest integrated healthcare system in the country, with more facilities doing research than any other group. It for me was that next step in my career.

(TI): What does it mean for you to be working in this role within VA?

(MK): I'll have to say Tanner, that it is a great privilege, really, to be on a team that looks at all of the potential roadblocks that there could be to getting research trial up and running, or establishing a policy that we can implement across the whole VA. But it's great to have a team that can go through, evaluate these roadblocks and figure out, you know, ethical and regulatory compliant ways to solve those problems so that our researchers can bring these, you know, treatments and bring these research projects to our veterans so

that our veterans have the same access to cutting edge treatments that they could get if they went to Johns Hopkins or the Mayo Clinic or, even at times to the NIH.

(TI): Yeah. Very good. That's, why we're here talking today. You mentioned clinical trials, you know, your office reached out and said, Tanner, do you want to talk to those in VA that are assisting with COVID-19 vaccine trials, we need to get veterans to know, so they can participate. And I said, of course, that's, that's pretty exciting. And that's pretty cutting it cutting edge stuff that you guys are working on. It's not only relevant to veterans, but really to the entire world. So yeah.

(MK): For those of us in the research world, this is one of the most exciting times as tragic as this pandemic has been. And you know, our hearts go out to everyone, you know, who has lost someone as a result of this pandemic. But it challenges us, too, and motivates us to work really hard to bring these clinical trials to try to find a way to either find a vaccine or something therapeutic for the people who are affected by this. And ultimately, the vaccines, of course, then would prevent you from getting it or at least decreasing your symptoms.

(TI): Yeah.

(MK): If you did contract it after you got vaccinated

(TI): Not make it as deadly, you know. I understand you're trying to say Doc, you know, COVID-19 is terrible. And it's, you know, just like Ebola, just like swine flu, whatever you call it a deadly disease. But it gives researchers and clinicians and people that are that are working on vaccines it gives you a chance to help the world. Now, there are a huge batch of vaccines now that are coming up and clinical trials, right, or are they going on right now? And there are 17 VA's across the country. Right.

(MK): Well, just the Janssen trial is that is being stood up at 17 of our VA medical centers.

(TI): Okay.

(MK): But we've got more than 50 medical centers who are participating in clinical trials for COVID-19.

(TI): Okay, wow. So you got, you mentioned Janssen, who's running the trials? Are they VA developed? Or are they new ones out of the private sector that we've been hearing about that's out there on the news?

(MK): Right, that we're part of the Operation Warp Speed. Maybe you've heard about it, you know that

(TI): I think so. If you live in the Beltway?

(MK): Right, right. So Health and Human Services and NIH you know, and partner together they've created Operation Warp Speed. So the trials that we're working on, some of them are under the umbrella of operation warp speed, and some of them are trials that we have developed in house within VA for other therapeutics that, you know, we identified, you know, as potentially beneficial, particularly to our veterans.

(TI): Gotcha. So, public private partnership. You got Janssen, what other what other ones are out there right now that VA is assisting

(MK): Right there's the Moderna Vaccine trial, which is part of Operation warp speed, the AstraZeneca trial. There's the Pfizer vaccine trial that's going on at Cleveland. That's outside of operation warp speed. But another trial that we did join. There's two therapeutics trials that are starting under an umbrella of something called the accelerating COVID-19 therapeutic interventions and vaccines, it's called the ACTIVE initiative. And we are participating in ACTIVE two and ACTIVE three right now. One is an inpatient therapeutics or treatment project, and the other is an outpatient treatment project for people affected with COVID.

(TI): Therapeutics, you know, that words getting tossed around a lot. That's Is that pretty much just, hey, it's not a vaccine, but it will help you get through the disease.

(MK): Right. So a therapeutic is, and we can look at the word and it's therapy, right? So a vaccine is something you want to give to someone before they get, you know, infected.

(TI): Yep.

(MK): A therapeutic or a therapy is something you give to somebody after they've been affected by it.

(TI): Very good, outstanding. Okay. So have you ever seen, like this many trials for the same type of, you know, for COVID-19, for one type of virus at one time?

(MK): I have not. I mean, this has been a massive, you know, reengineering of everybody's priorities across government. And in my 31 years in government, I have never seen the cooperation across government like we've seen. Now. You know, I was not even in medical school yet when all of the HIV work was going on. So it's possible, but that this same sort of effort, you know, was going on then. But, you know, since I've been involved in research, I've not seen something like this.

(TI): Yeah, it just sounds like it's all one huge, coordinated effort. I mean, Okay, like I said across government, multiple, you know, multiple trials at one time. It just seems like a huge, massive undertaking that I've never heard of about before, either. Now, these trials, they're at VA medical centers that 50, like you said, because veterans are taking part in the trials, correct? Or they or do they want veterans take part in the trials? Do they need veterans assigned up? Is it all three?

(MK): Oh, gosh, yes.

(TI): And the answer's yes,

(MK): The answer is yes. A big sighing yes. We would like well, you know, all Americans, of course, to participate, but veterans in particular, you know, they're great at volunteering, to start with, they've already given so much to their country, asking them to do something, again, is another "Ask by the Country". And so we

would like you know, all Americans to continue, you know, to consider participating. But especially our older veteran, demographically, they have been affected by this virus. And so we would love to have our older veterans participate. And then the most critical groups that we need to have participate are our African American or Hispanic, you know, all of our nonwhite populations. And it's important for two reasons. First of all, they've been the most affected are the minority populations. But secondly, when you have people from, you know, the African American and Hispanic communities participate in a vaccine trial, when the vaccine gets an approval, if it gets the approval from the FDA, it's more likely to be accepted by those communities. And that's really the goal of these trials. It's not just to invent a vaccine. The goal is to then get communities to accept that vaccine and take that vaccine so that we can protect those communities against the virus.

(TI): Have you guys considered Native American as a demographic? Because I remember when it first got really hot, the Navajo, the articles that came out of the Navajo Nation about what they went through, during the height of it and of the deadliness of this virus, the per capita wise they got hit extremely hard.

(MK): Absolutely. And our VA's actually cared for many of them at our VA medical centers. You know, we have a fourth mission in VA to, you know, to care for citizens who are non-veterans, when there's, you know, an overflow or a need for that, and, and we did help the Native American population. And absolutely. And we have just recently formed a subcommittee of our national research Advisory Council to focus on diversity and inclusion, not just for these trials, although that's what we're focused on now. But going forward, you know, it's really a national need.

(TI): Because you want to make sure it works in all demographics, you want to make sure it works in all physiological, you know, sectors of the human of the human experience, right?

(MK): Well, that's right, we're learning that, you know, genetics and, and all kinds of factors play into our immune systems. And so and that's what a vaccine works on, it works on your, you know, your

immune system. And so we want to give these vaccines the broadest exposure that we can during these phase three, safety and trials to see if they actually work and protect against the virus. So that we can make sure that they do work in all the different population.

(TI): Gotcha, tracking. I understand it, and I get it. But to me, it's kind of scary to take part in a vaccine trial, especially with COVID-19. You know, I have a spouse that's high risk to the virus. You talk about protections, what precautions are taken with someone that takes part in a vaccine trial?

(MK): Right. So what is really important to know is that when you're in a vaccine trial, we're not giving you any type of an infectious agent, you know, we're not going to make you contagious, right, we are giving you a vaccine, that's going to build up your immunity against it. But, you're not going to become contagious by participating. And just because you participate in the vaccine trial, we also don't want you to stop, you know, social distancing, or wearing your mask or washing your hands or not touching your face, or all those sorts of things, we want you to continue taking all of those same precautions, if you participate in the trial.

(TI): Okay. So it's not, hey, take a vaccine, you're taking a little bit of the virus or hey, it's not, so you're gonna, you know, get a little bit sick to see if it fixes it, or hey, it's not take the vaccine and then go to a concert, or anything. We're gonna host a vaccine concert, you know, to see if any of this works. We're gonna have some controls in there. Yeah, I

(MK): Absolutely not.

(TI): I have no idea how it works.

(MK): And we, and I completely understand that that is, and there are people who have talked about what are called challenge trials, right. Where you give someone a vaccine, and then you challenge them with the agent. It's what we do with malaria.

(TI): Okay.

(MK): But we have a cure for a certain strain of malaria that we do challenge trials for. Right now, we would not consider it ethical to do a challenge trial against this virus, because we don't have a, you know, a full on absolute cure yet. So we wouldn't do that today.

(TI): Or a therapeutic that you know, for sure. It's like, Hey, this is it.

(MK): That's right. That's right.

(TI): Tracking, Okay, great, good. How long are the trials? How long is it? How long if you say like, hey, okay, I'm in, let's do it. How long is that trial going to be?

(MK): So each of them vary in length, depending on, you know, what has been approved by these ethical review bodies for how long they think people should be followed, but on average, they're about two years. And to start, you know, it would be come in, get all the screening done, and then get your vaccine. Now, some of the trials, it's a two shot regimen, right? You have to like some of your other childhood immunizations, you have to get two or three of them for it to be fully effective. And then for other of the vaccine trials, it's just one vaccine. So it's one shot, you know, and then you're finished. But what we want to do is track you closely. And that I think, is part of that safety that you were talking about earlier, where people who come into clinical trials have a lot of oversight. And there are a lot of stopping rules that are built into these trials to make sure that they are safe, right so we're at phase three in the trial, and how you put a trial together. So there is a phase one. That's just the Few people have phase two, which gets you up to about 100 people. And then a phase three trial now, which is like 30,000 people. And what we are looking for are signals of, are there going to be problems when you introduce this vaccine into a larger community? But, there's a whole groups of people that are watching this on a daily basis, who have the ability to stop, if something's not quite right.

(TI): Yeah. Very good. So there's continuously monitoring during the trial, during the time of the trial. So okay. Quick question, you said

two years is the average, is that going to be the average for a vaccine for COVID? I know, there's been different opinions of like, when a vaccine would become available. And now if the trials last two years, is it going to be, hey, it's good. But then we're still gonna, this is what we're calling the vaccine, but we're still gonna do monitoring afterwards, for a year or two?

(MK): Right. So, there's a couple of things to unpack there. So first of all, we do have a couple of vaccines that are on the cusp of getting reviewed by the FDA. So they've finished their phase three trials already.

(TI): Wow.

(MK): These are new ones, right? So you have to imagine we're trying to vaccinate the world, right?

(TI): Yeah.

(MK): One vaccine, one company is not going to be able to do that for everybody. And one particular vaccine might not be the most effective in every population. But we don't know that yet. And so we want to continue doing these trials. We want to continue learning, you know, from these, and we want to continue to monitor what potential health effects there might be. And so just because, you know, one vaccine might get what's called an emergency use authorization from the FDA, it could begin to start vaccinating people because it got through phase three, it doesn't mean we want to stop all these other trials.

(TI): Yeah, you know could mutate, could do a lot, the virus could self can move. So you got to continue monitoring and trialing and I hear all that. Now, is there is there payment? Are they asking for volunteers?

(MK): Well, we asked you, of course, all research in the United States today, you are required to volunteer, I mean, you volunteer, you're not required to volunteer, but you volunteer. The requirements of the ethical Review Boards is that people volunteer. There is no one that can be directed. There's

misconceptions out there that the military can be ordered into these kind of trials, and they can't be all of this has to be voluntary.

(TI): Okay.

(MK): But the companies do give monetary compensation for your time and effort and things like that. Each, you know, the amount of which varies depending on you know, how many times you have to come in and be seen and, and all sorts of different factors.

(TI): It differs on different covenants to tracking. Okay. So, say a veteran is hearing us and they're like, Alright, cool, I'm in, let's do it. How do they take part in these trials? How do they sign up?

(MK): So the easiest way right now, we just launched a COVID-19 research registry at VA. And it's [research.va.gov](https://research.va.gov/COVID-19.cfm). And it's [research.va.gov](https://research.va.gov/COVID-19.cfm). [Link: research.va.gov/COVID-19.cfm]

(TI): Okay, we're gonna leave that in there. But I'll also ask you that you email it to me. And I'll make sure ends up in the blog of this episode on blogs.va.gov. So if somebody wants to go and click on that website, they can go to blogs.va.gov [Link: <https://www.blogs.va.gov/VAntage/>] find the blog on this episode, and just click on that thing in there and knock it out. Very cool. Doctor Klote, we've had a very short conversation, but I think we've covered a lot of ground. Is there anything I might have missed? Or didn't ask that you think it's important to share with anybody that's listening to this?

(MK): I think the biggest thing that, you know, we keep talking about is not only for the vaccine trials, but for everyone's just general health. And we had a meeting this week with the US Surgeon General, Vice Admiral Adams who reminded us that everyone getting the flu shot this year is going to be critically important, because symptoms of the flu can seem like symptoms of COVID. And if, you know, get your flu shot, you know, you're going to be less likely to develop those types of symptoms less likely to be going into hospitals where, you know, you might get exposed to,

you know, all kinds of different things. So, I would just put in a plug for everybody this year to get your flu shot. And when there is a vaccine available, you know, consider it for yourself, consider it for your family, consider it to try to get life back to normal, I would just ask people to, you know, to just think about participating and getting a vaccine we know each year that only about 35 to 40% of Americans get the flu vaccine every year. And really want to stress that if there is a year in the past that you haven't gotten your flu shot, this is the year to get your flu shot. So I'll leave it with that.

Music [00:26:00]

[00:26:02] Second Monologue:

(TI): For me, that conversation was fascinating because again, I know nothing of that world. I want to thank Dr. Klote and her team for reaching out to *Borne the Battle* and talking with me. And like the good doctor said for more information on these trials, you can go to www.research.va.gov/COVID-19.cfm [Link]. Alright our second interview is with Dr. Chad Kessler, who is our Director of Emergency Medicine and Urgent Care here at VA. He's also a professor of medicine over at Duke University. I said over like it's near me. But, it's out in Raleigh, North Carolina. You know, we read off a lot on the press releases, throughout *Borne the Battle* concerning COVID procedures at hospitals. And I know that he was one of the gentlemen in the room. So, I wanted to know if any has changed or will change concerning these procedures based on the viruses' activity. I also wanted to talk about the unique communication method he employed internally here at VA, which was an internal podcast, that got doctors to quickly share techniques and methods to treat the virus. Here's our talk, take a listen.

[00:27:20] Music

[00:27:28] Interview with Dr. Kessler:

(TI): Welcome to *Borne the Battle* and thank you for taking the time to come in to talk to us about Emergency urgent care and how the VA has responded in the current world we live in.

Dr. Chad Kessler Yeah, thank you for having me. It's a pleasure.

(CK):

(TI): So, Chad, you oversee 141 emergency departments and urgent care centers. You must have been in some of the discussions when COVID was hot, and when VA conducted some of its fourth mission down in New Orleans and some other places. Did we do some of that in New York as well?

(CK): We did. We did a lot of the fourth mission work in New York. That was actually where a lot of this started and where we learned a lot and we're able to share some of those practices. But New York, New Orleans, the first ones that were really got hammered by this disease.

(TI): Yeah. Did emergency care have a role in some of that?

(CK): We had a huge role because sort of front door and what you would expect is that the EDs emergency departments, urgent care centers would just get inundated and blasted. But what we found was not that. I mean initially, yes people are scared came in. But what happened actually, is that we got some great information out. And our ED volumes over the past months, not now, now it's picking back up, but when it first started January, February, March actually dropped and dropped significantly.

(TI): ED meaning? Emergency department.

(CK): Emergency department.

(TI): Very good, very good.

(CK): Yeah, we the in the lay term person I think is more ER, but in the in the biz, if you will, ED or emergency department is the language they like that a lot better than ERs, but interchangeable. So yeah, the volumes went way down not only in VA, but sort of across the nation. As a couple things. One there is that fear, no one wanted to go out and then contract this disease if they didn't have it already. And B, I think we did an excellent job of certain reaching out to people and saying, hey, let's do this over the phone. Let's

use virtual care. The appointments in virtual care VA, video connect, any kind of zoom calls, anything like that skyrocket. So we were able to do a lot more virtual care.

(TI): Yeah, exploded.

(CK): Absolutely.

(TI): Yeah. Very good. Yeah, I remember when we first opened up for COVID patients there was that press release that read that I read off about a contacting your local VA Medical Center about you know the certain procedures that are available within your own VA Medical Center. Concerning emergency and urgent care, what are the procedures now for both COVID and non COVID patients? Has any of it changed?

(CK): Absolutely. So when, and let me take you back a little bit, I got to answer a little of that. But the reality is emergency medicine did a lot more. Because when people would come in, no matter how they came in, they usually try to limit it to one or two entrances. And often that was the emergency department. But that's where we want to be able to have the tent set up, we did a lot of outdoor tent screens across the nation, San Diego and some other places. New Orleans did this too. And so, what happened is, even before people got into the hospital, we're able to create these outer rims, if you will, to separate the hot and cold zone or COVID and non COVID, potentially. So, when we called it was ILI again, another in the biz term, Influenza Like Illness. People come into the emergency department, they don't come in waving their hand, say, Hey, I'm Tanner and I have you know, COVID or I have appendicitis. It's more like I'm coughing, and I have a fever, or I have belly pain. And then it's our job as emergency physicians to go figure out what you have. And so, in these tents, we did great screening. And oftentimes the nurses are amazing, amazing triage, emergency medicine nurses, as smart as nurses in the whole building, would be able to look at them and do their triage screen and separate them into Okay, this is potentially ILI, that influenza like illness. They're sick, maybe they have COVID, maybe they have flu, just some type of cold respiratory illness. Or they have something else like, hey, I have back pain, and it's been bothering

me, and it's really bad, and I can't walk now. Well, that's sort of this different zone. And so, we separate people, so when get in to the emergency department, even before then they would get admitted or go upstairs, we'd have a little sense about who they are, who they were, and what type of protection the staff and the patients would need. So, then you ask sort of how did that change? Well, before, during the heat of this, everything was COVID, I remember getting a call from my friends in New Orleans, and they passed on our EDIIS board, our EDI Information System boards, a tracking board. So, it's a glorified version of a whiteboard that you see tracks, the patients when they came in, and what room they are, like you see in any type of emergency department.

(TI): Okay

(CK): And on the board, every one of them was the color designated for COVID. So, it was no longer this person is COVID, and this person, is not. It was this is a heart failure COVID. This is a pneumonia COVID. This is a UTI COVID, everything was that. So, when patients come in, they would be appropriately protected. And then we in our staff, whether it's the MSA is the triage nurses, the physicians full on protection for PPE, they have a gown they have a face shield mask, some use the respirators, which are the N95 masks, so have really good protection. Now that's changed. And honestly, it really depends on where you are. So, there's certainly some hot zones, some high prevalence, where people still are going to treat everyone like it's potentially COVID, or that ILI and where they appropriate mask and gown. But in many places, you're not. And after we do that screening, and we're pretty confident that it's not related to a respiratory illness, the physician might wear a mask and a face shield. And the patient would be as opposed to say, a full N95 respirator.

(TI): Just in case, just to protect the patient as well.

(CK): That's our first and foremost, protect the patient, protect the staff. And I think it's an important note that our face coverings that we use the mask that we now wear out in public, people need to recognize that that doesn't necessarily protect them. I mean, it does a little to a point. But really what you're doing when you're

wearing that face covering your surgical mask is protecting others. If you cough, you sneeze, if you know, to just talking, it prevents a lot. There's a lot of great videos you can see out there about those germs spreading out. And so that's all we want everyone, of course, so we can be protected as well.

(TI): Very good, very good. Is it safe to say that all the PPE in the very beginning, all those red designations of COVID was because of how hot it was at the time, and then as it gradually became cooler in some areas? That was the reason behind. Now we're changing some of these procedures.

(CK): Yeah, absolutely. And I think a lot of it had to do with prevalence too. It's very hard to set one standard for absolutely everything. When you have a prevalence of 20% in x community. And in the mountains in Montana, there was zero. And so, for us to say that every patient that comes in and a clinical prevalence in that community is zero to use this type of PPE wouldn't have been smart or responsible. Because again with a limited supply, you have to be smart about this are also very quickly we would run out and then not have enough for anyone and this isn't VA. This is around the nation.

(TI): Yeah

(CK): If everyone out there for every type of encounter of everything would put on a full gallon mass respirator, you know, that's a challenge. So, you need to be smart about what we can and should use at different areas different times.

(TI): Do we have procedural plans in case we have to ramp up COVID and emergency response care again? Or do we have plans on how to open up if COVID becomes more treatable, or less deadly, or vaccine becomes available? Are we flexible in that area right now in terms of PPE in terms of other procedures?

(CK): We are, we learned a lot through that January, you know, April, May time. And what we used, we learned and share that from New York and New Orleans to Chicago and Detroit to the west coast. Seattle was one of the first case first death. And then it

never hit, they did such a good job with socially distancing, and appropriate PPE and good community standards that really, Seattle was largely spared. Again, you can't say that all everybody was hit to some point, but not nearly like what we saw in New York in New Orleans.

(TI): Yeah.

(CK): And so, what we did is we learned the VA, one of our superpowers is the fact that we do have 141 EDs in urgent cares and hundred 50 plus sites, and we can cross level. And if somebody is not using their 12, ventilators and a site in VISN 10 in our network, 10, say in the upper Midwest, that we can share some of those with another site that is. Maybe they need to come into Chicago or Detroit, or on the east coast. And we can easily transport those supplies, ventilators. And we did that. I remember sitting on calls with our undersecretary and team, and they would talk about this cross leverage and no one was in a hurt at all. Whether it came with swabs, or testing material or protective personal equipment, you name it. I thought that was a real superpower of VA. And now again, we've learned we've leveled things have settled out. But of course, now things are coming back. As we reopen parts of the economy, as more and more people come in for appointments and whatnot. We're seeing more cases.

(TI): And we're reentering into the flu season. So, it's kind of a season that kind of breeds. Is that fair?

(CK): Absolutely. Yeah, we're really concerned about that Tanner it's a great plan. I'm so glad you bring that up. We did a whole couple episodes on COVID in 20, about flu. And first of all, we really encourage everyone who can and should to go get a flu shot, especially the season. And it's community immunity. It's not just for you and veterans are so amazing about protecting their brothers and sisters and their families about that. So, I know I have seen a lot of patients I'm still in the clinic and the EDs, and I don't usually get Doc it causes some pain or had a bad reaction. Well, if you're not allergic, and it's something that you can do, it's definitely something we should do this year. Really cool Tanner if we look at the flu season. And what's neat is that we can do this in

different areas of the world. And so, we see what the flu season looks like, even before it hits North America. So in South America, different countries, flu season is sort of already going. And we are seeing the lowest, if not no flu season in some of these southern hemisphere countries that we have ever seen. Why? Why is that? Is it just a lighter then? No, it's because people are doing smart things to protect themselves, like wearing masks like socially distancing. And again, you can't live life like this forever is 100-year pandemic. But the flu rates we're seeing in the southern hemisphere are just so incredibly low to like nothing, it doesn't even look like we're having the flu season. We are hoping here in North America and the VA that that trend follows, that we will also have a very light flu season.

(TI): Very interesting, very interesting. I've heard rumors about the flu shot and how they make the flu shot. And this kind of getting off COVID for a sec. But is the flu, is that kind of developed through what you see in the southern hemisphere. And then you kind of

(CK): They try to, yeah, it's a seasonal vaccine. So, it is based on the strain flu, A flu B, whatever is going around that year, it's not the same year to year. It changes in some years; we honestly don't get it perfect at first. Sometimes there's a second strain that comes out. We've targeted a vaccine against influenza A strain, whatever. And turns out that later on the flu season, December, January, you see that modify and change, mutate. And so, we have to work at it again. And sometimes the flu shots aren't as effective as we'd like them to be maybe fifty percent. So, people say, but wait, I got a flu shot. How can I get the flu? Well, that's possible. Many years. It's extremely protective, some years it is and not as much. And so being smart, just like we're doing now, for COVID will also protect you against the flu, the fact that you're covering your face, you're keeping a little bit of distance, you're washing your hands, I can't emphasize that enough. Wash your hands. So, all these things that we should be doing. We're probably paying a little bit more attention now in 2020 than we have in past years.

(TI): Absolutely. Absolutely. No, it's good to get some background on the flu shots because I think a lot of people have questions about how that gets developed. So, appreciate it.

(CK): Absolutely.

(TI): Okay, you mentioned COVID in 20, and you mentioned about sharing information between the VAs. And you guys did that in a unique way. You hosted a vidcast and internal vidcast called COVID in 20. And it was, like I said, it was a very unique way for doctors and medical staff to communicate COVID procedures, treatment and therapeutics to each other. In doing that, what have you learned about COVID, and about the VA staff working in that environment every day?

(CK): Yeah, and then just so I don't know, I can't tell you how exciting it has been. We started off very small, homegrown, we wanted to share the lessons, like I said, from New Orleans in New York with the rest of the country because there was clearly waves going on.

(TI): Yeah.

(CK): And so, when I got calls from Julie Slick in New Orleans, saying, Chad, I haven't taken off my you know, gown and PPE, this entire 12 hour shift. I intubated seven people. And this is crazy. And we can't do business as normal. I said, I got we got to learn from this quickly, how you're doing prone ventilation, different intubation strategy techniques, how you're screening? Why does everyone need to develop this 150 times. So we took what we learned from New York and New Orleans, put it up on the air, grab some people after their shift, this was a low tech, let me tell you put on the Adobe Connect flashed the open, and there you go. And we had 600, 800, a 1000 people tune in. And again, this wasn't so much a veteran facing as a staff facing to educate our front lines. It was from the front lines for the front lines.

(TI): Yeah.

(CK): And we got amazing feedback. And in this time, people were really down. I mean, we had people not checking emails, forget about trying to get messaging out that way, or education not doing that you're going on shift, come home and sleep in and do it again. And so, what we found is that we needed to find a unique way to get

this information out to the field, to the front lines really quickly, we weren't waiting for New England Journal of Medicine articles to come out for these folks to read.

(TI): Yeah.

(CK): And so, we put them on, we recorded it. And as I was saying, again, kind of some dark times. And what we did is we just, we added a bit of humanity, it wasn't enough to just you know, go and say, Hey, this is what you do for prone ventilation. Here's the PowerPoint, like, people weren't just going to listen to that. So we put a little music on, and Josh our AO, our Marine AO we called Jarvis because he does everything, played some live music. And then we did some feel good videos, as people were starting to come together and do a Bohemian Rhapsody song from the nurses in greater LA and we put that on. And along with this content with some experts who have done it, people around the country really wanted to hear. So of course, not everyone's available at whatever time you choose, but we recorded it and people could listen via podcast, or watch the video. And you know, the first show the one film in New Orleans has like over 10,000 of our staff watching it.

(TI): Yeah

(CK): So now we get somewhere between 600, 800, and 1000, maybe 1500, if we're talking about vaccines. And then you know, it's just a big tail on the thousands that are that are listening in. And I think what we've done is created a great way to get training out to our frontline clinical staff and others, you know, we celebrated MSAs and EMS people cleaning the beds, they have to know what's going on too.

(TI): Sure.

(CK): With that addition of humanities, and some humor and some fun and slides, we do some Chai awards, I love Chai. So, we did the COVID Hero Award for innovation and just celebrated people with a toast to Chai to them for doing something cool, like creating an intubation box or doing walks to get people out in a safe manner. There was just so many things. So, we celebrated us a little bit.

(TI): Doing your best to increase the morale too, that's important. But you're also getting some training out there to the frontline staff in a very unique way, you know me as a podcaster, you know, we had the VA Podcast Network. I thought that was very unique. Very cool. You know, I know, you know, it wasn't an external podcast like we talked about, it was internal. But I hope that you do consider maybe have an external podcast for the VA Podcast Network in the future, and we should get with public affairs and figure a way to do.

(CK): Yeah, well, it'd be great to get a veteran facing one that gave them reliable and trustworthy information, because so many people now, where are you getting your media from? Or your news, and this is something you can trust when it's coming from VA.

(TI): Well, I don't think it's just a veteran facing. I think its outward facing content from the VA period, because you would only not cross over into a veteran's, you'd cross over into the medical community, you know, with your background as being a doctor in emergency care, you know. And there's a whole section of health care podcast. So, you know, I'd like to see that in the future. All right. Okay. Chad on the basis of COVID, and what you learned in COVID? Is there anything that I may have missed, or haven't asked that you think is important to share?

(CK): Yeah, gosh, there's so many things that we've learned, I think most important things we talked about, especially the flu season come about washing your hands, six-foot distance. I find that in our veteran population, people are really good, because that community immunity is so big and they're not just looking out for themselves, but veterans are looking out for all other veterans and family and friends and their community. We oftentimes get this incredible look into disease processes, epidemics, pandemics now, and I hear what's going on the communities a small emergency medicine community. So, I see and hear what's going on and academic hospital x or community hospital and things often are going crazy. And then the VA, although this is impossible not to be a crazy time, it's controlled. People know what they do. They have discipline, they know what they need to do. And I find that that's

just incredible. If we can keep that up, keep up the innovation that we're doing. And here's the big thing. There's so many 350,000 employees across VA frontlines, they have hundred and 50 plus hospitals, we have amazingly wicked smart doctors, researchers. I just had people coming on talking about convalescent plasma yesterday, how we're using people who've recovered from COVID, their blood to treat other COVID patients. How neat is that? We're in trials. Now vaccine trials, we need to get this stuff out there. So we can't have someone in Durham doing this amazing thing and someone in Boise, Idaho have no idea what they're doing and have to recreate something. We got to use this superpower that is the VA and you know, 150 plus sites covering their entire country and beyond and share all this information, these great ideas, these innovations across the network, dissemination science. If we can get it out through programs like yours, through other podcasts, that's how we're gonna sort of get through this and everything else. We are the largest integrated health care system in the United States that has something to say, bigger than Kaiser bigger than Inner Mountain bigger than any of the academics. And we have, again, the best and the brightest people, you pull them in, you share what they're doing, at least the veteran to veteran health care. If we put that wellness piece in and I think that's a big point, Tanner, we got to have that time for wellness to take care of us. Happy employees will make happy veterans that same Southwest thing you know, if they're happy, the people who are flying are happy. Well, I'll tell you what if the doctors and the nurses and the MSA is and clerks are happy, our patients are going to be happy. Our care is assumed in the VA when you walk in, you are going to get outstanding medical care from nurses from doctors. It's everything else that's going to put us over the top. It's the greeting and say Hey, Mr. Johnson, how you doing today instead of Johnson 4715. You know, that's not the way we greet veterans. It's that friendly smile if we can do that we're going to win.

[00:47:31] Music

[00:47:36] Closing Monologue:

I want to thank Dr. Kessler for reaching out to talk with us about his department's past, present and a future role as we fight this virus. For more information on VA's emergency medical care, you can visit va.gov/communitycare [Link] and you can navigate to both COVID-19 guidance and emergency medical care tabs.

That's it for this bonus episode of *Borne the Battle*. As always, if you liked this podcast episode, you can hit the subscribe button. We're on iTunes, Spotify, Google Podcast, iHeartRadio pretty much any podcasting app known to phone, computer tablet, or man. For more stories on veterans and veteran benefits, check out our website, [blogs.va.gov](https://www.blogs.va.gov/VAntage/) [Link: <https://www.blogs.va.gov/VAntage/>] and follow the VA on social media. Facebook Twitter, Instagram, YouTube, RallyPoint, LinkedIn. DeptVetAffairs, US Department of Veterans Affairs. No matter the social media, you can always find us with that blue checkmark. Thank you again for tuning in here to *Borne the Battle*. And we'll see you right here on our normally scheduled day, on Monday. Take care.

Music [00:48:47]

(Text Transcript Ends)