Texas 2036 Interview: Vice Chancellor of Health Affairs Dr. David Lakey talks about the global pandemic

Many of our higher education institutions have an infrastructure in place to help the state address a global pandemic, whether it's COVID-19 or otherwise. By way of example, the University of Texas System has the clinical perspective research capabilities and lab capacity that the state is currently leveraging to address COVID.

On May 7, Texas 2036 president and CEO, Margaret Spellings talked with Dr. David Lakey, Vice Chancellor for Health Affairs and Chief Medical Officer for the University of Texas System, about public health.

Margaret Spellings: You have been preparing for this moment your entire professional career. Thank you for your service to the university and to Texas. We are thrilled that you're here. When people drive by a hospital that says University of Texas, they get that it is a part of our health infrastructure, but they often are not aware of all that higher education institutions have in public health. Why don't you talk about how we are leveraging those assets in this moment?

Dr. David Lakey: Many years ago, I had the privilege of running the state health department and came to the realization that if you really want to improve health in Texas, you need to partner with academic institutions, because state agencies can't really solve the issues alone due to the limited number of positions and clinical capacity.

Academic institutions are where a lot of the state's resources are. There is a significant clinical enterprise under the University of Texas that is being leveraged right now. First, we have cancer centers such as MD Anderson that are protecting their patients during COVID. You have universities like UT Southwestern or UTMB that are providing very high-level clinical care, including conducting clinical trials trying out new medicines. Secondly, many academic laboratories are doing both the research to figure out how we conquer this virus, as well as transitioning to some clinical laboratory services. UTMB in Galveston, UT Southwestern and MD Anderson in San Antonio are doing a substantial component of COVID-19 testing in their communities.

I think the third prong has to do with educating the physicians, the medical students, the nurses, the social workers and the mental health specialists on how you respond – building that workforce capacity who will support the state throughout this event.

Because academic institutions have state-of-the-art cutting-edge capacity, they can help tackle tough questions of what really is working, what may be hearsay and what is the standard of practice. When I work with the Texas Medical Association or the Texas Hospital Association to try to figure out how we confront this, many of the experts who are embedded in our academic institutions are pulled to guide those policy decisions in Texas.

Margaret Spellings: Talk a little bit about coordination, not just within the UT system, but across our medical systems. How much common learning or sharing of information are we seeing in this urgency?

Dr. David Lakey: One of my mottos when I was at the Department of State Health Services was, “The time to exchange your business card is not at the scene of the disaster." You have to build those personal relationships with people between institutions before the crisis hits.”

Over the last several years, the Texas Health Improvement Network includes a variety of academic institutions meeting on a regular basis with state agencies to discuss how we work together in the midst of these type of events. I have a lot of conversations with colleagues from Texas A&M, Texas Tech and Baylor College of Medicine, as we're all trying to figure out how we work forward in an event like this.

We also have a group that we've put together that's been meeting for the last two months with the Texas Medical Association every Saturday for about two hours, where UT, Texas A&M, and Texas Tech representatives meet with the commissioner of DSHS and representatives from the state agencies, Texas Hospital Association, Texas nursing and home care industry, the nursing home associations. We are having those tough conversations of how do we manage in the shortage of personal protective equipment? How do we manage to get people tested? What are the policies?

Part of the advantage of our academic institutions is that they can be that glue and that coordination to pull these different entities together and have evidence based, science based conversations, to look soberly at the data and say, "This is how we need to work together in this event."

Margaret Spellings: Here we are in this tyranny of the urgent, what are we learning now? What is the trajectory going to look like?

Dr. David Lakey: I think in these first months our biggest decision and question is when is this going to hit Texas? And how big is that first wave going to be, and is there enough capacity in the ICU to use the ventilators, etc.? Actually, we're in a pretty good position right now related to this part of the wave. And I say that because if you look at the number of deaths and each of these deaths is obviously tragic, but Texas has just little over 1% of deaths. We have about 9% of the U.S. population. And so those initial models have been helpful to figure out this first phase of this response. But history tells us that this isn't a short event. And again, there isn't an evidence-based plan you can pull off the shelf and say, “This is how it's going to play out.”

I've been in too many of these to not understand that you have to have a big dose of humility when you're confronting these type of events. And so what does history tell us about novel viruses and how rapidly do they disperse? So history tells us there's really

three scenarios, and those scenarios are based on how the virus reacts. This virus isn't going to go away until probably about 60-70% of the population is immune, either through natural disease or through a vaccine. It also looks like it spreads more easily than flu does.

So, you're going to have to get to those levels. The three scenarios are one, a series of peaks and waves over the next year and a half.

The second scenario is we get through this wave and then come fall there's a big wave that occurs, and we need to be prepared for that. That would be a big event, but we can't plan on optimism, we need to have a sober look at what could occur.

The third scenario, which is what we're trying hopefully to get is you have this wave and then you have a " slow burn," where you have some ongoing, but manageable, amount of disease that the hospital capacity and the medical capacity are there, we're tracking down individuals, and most importantly, we're protecting our vulnerable individuals, people who are 65 and above, especially 80 and above, the people who are immunocompromised and protect them including those in nursing homes during this time period.

So I think we have to be careful right now. There is a sense of things are opening up, "Is this over? Let's go out and celebrate." I think this is going to be a long-term event.

As I've described it to some of my colleagues, I use the Churchill quote, "Now is not the end, it's not even the beginning of the end, but perhaps it's the end of the beginning."

Margaret Spellings: You mentioned you've been involved in too many of these, including Ebola. What is applicable from your experience with Ebola that we're applying now?

Dr. David Lakey: I've been in several of these, Ebola, H1N1, and a variety of these type of events. I think one of the challenges and lessons is to manage expectations – what is really going to happen. Also it's important to have trusted communicators say, "This is what the science says is going to happen." People are adults so treat them like adults and give them the best information you can in a transparent way. If you don't know something, say you don't know it, but have that conversation take place. I think one of the other lessons from Ebola is that everyone became afraid of a certain hospital. And so people that were having heart attacks, or having strokes or a baby, they didn't go to that hospital any more because they were afraid of the system.

So, we need to make sure that we manage the fear, make sure that ongoing healthcare needs are addressed. Also, we learned for the first responders that this isn't a short-term event and they needed to take care of themselves. And what I mean here is they can't go 24/7 for months at a time. They need to take care of themselves, have

some downtime, take care of their own mental health and take care of their families in the midst of this.

Then, one of my other lessons is when you're confronting a new virus and a new event, we must remember that they don't play by the rules, so you need to have contingency plans. We do a lot of planning, but none of these events go per plan. You have to have the humility and flexibility to change here and there.

An example is H1N1. We had a great plan as a nation. It was going to occur in China first and in Asia, so we would have all this information and be able to know exactly how to respond and have a vaccine ready. And it played out that I got an email on my computer, "Somebody's sick in a certain part of Texas," and all of a sudden, you're on the front lines of the response. So, you need to have that humility and flexibility and manage those expectations.

Along those lines of managing expectations, that's going to be an issue when a vaccine becomes available – how long is it going to be and how long before there's a vaccine before it's readily available to individuals in Texas?

Margaret Spellings: You all have been a tremendous partner with Texas 2036 with this eye toward long-term planning and building access, affordability, public health and population health. As you think about heading into a legislative session, what is your advice for policy makers? What should we be doing now, first?

Dr. David Lakey: I think some of my advice to the legislature is sometimes those core public health programs aren't totally understood and sometimes they become vulnerable, but they're really, really important. A variety of those programs in state agencies are needed to be able to respond to this event, such as the laboratory response network that is within the Department of State Health Services. It is there where we can identify the first early cases for an event like this. And so in a very tight budget everything becomes vulnerable and it's easy to say, “We're through this,” but you got to think long term and one of the key parts of the long-term protection of the health in Texas is having a strong health department, a strong safety net there for the people who are vulnerable.

It's easy sometimes for us not to understand the disparities that occur with a disease like this. I think COVID is shining the light on that, that there are a lot of people who are going to have a really tough time.

One of the criticisms sometimes of public health is when nothing happens, they're forgotten, but in some ways that's the success for public health. So, you've got to invest in those core things that provide for the common defense of people here in Texas in the United States.

Margaret Spellings: Another issue you've been so active in is prevention of tobacco use and vaping, which, if we address them earlier, will pay big dividends in the health of our people over time. Talk a little bit about how we can make the case for that value proposition.

Dr. David Lakey: Tobacco kills about 28,000 Texans each year. And is by far, the largest preventable cause of death in Texas. A lot of people who smoked when they were kids really don't want to anymore and they see how it's compromising their health, their ability to breathe, exercise right now. But it's hard to stop. So, I try to prevent disease, not just get better at treating disease. I think we need to do a better job at helping people keep themselves healthy and preventing their addiction to tobacco. So, we've been working with the UT system and MD Anderson for about five years now to make them tobacco free. I think that's really important because if you go to campus as an 18-year old and there are people smoking there and it's common, you're more likely to smoke and then get addicted and can't stop, especially in that stressful time period.

So our first step was to get our house in order. There were three of our 14 institutions that needed to go tobacco free and they did it. By 2017, all of our institutions were tobacco free. I believe in peer to peer learning, so we bring colleagues together and learn from each other every year. Now, our annual summit includes Texas Tech, TCU and Texas A&M. We look at cessation and how we can be better in making sure cessation services are available to our faculty, staff, and students? How do you enforce policies like this in a way that's non-confrontational, but in a way to really drive an improvement? How do we help institutions that want to put in place these nicotine policies?

Because one of the things we hear is, “Tobacco may be going down, it may not be so cool to smoke a cigarette anymore,” but a lot of people are vaping and that has its own health consequences. We need to make sure that the right policies are in place, that they're enforced in the right way, and that we learn from each other. I'm a big believer in collaboration and getting people together to try to address these issues.

Margaret Spellings: Thank you. I think this situation has taught us all that public health and sound education is really everybody's interest, that we are not disconnected from each other as we might've thought. We are tremendously grateful to you for your service to the state and for all you're doing on the front lines, and we are thankful to have you as a partner on our ongoing work at Texas 2036.