

THE ECONOMIC CLUB

O F W A S H I N G T O N, D. C.

Virtual Signature Event

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ANNOUNCER: Please welcome David Rubenstein, president of The Economic Club of Washington, D.C.

DAVID M. RUBENSTEIN: Thank you very much. I want to welcome everybody to our second virtual signature event of our new fiscal year. Today we have a very interesting program, a lot of it dealing with the health-care crisis that we're facing. And so why don't we start right now with Dr. Mark McClellan.

Mark, thank you very much for coming and for doing this on short notice. Let me try to do justice to your biography. And as I said to you and others, it would take 25 minutes to go through all of it. But I will just briefly summarize it. You're a graduate – you're a native of Texas, graduate of University of Texas. You have a medical degree from a joint – from Harvard Medical School. You have Ph.D. in economics from MIT. You have a master's degree from the Kennedy School. You've served in the Treasury Department, a member of the Council of Economic Advisors. You've worked on the White House staff. And you've been FDA commissioner. And you also over saw for a number of years as well the Medicare and Medicaid services part of our government. And you are now teaching at Duke, among other things – consulting and so forth.

So, thank you very much, Mark, for agreeing to join us.

MARK MCCLELLAN, M.D.: Well, great to be here in such distinguished company with The Economic Club.

MR. RUBENSTEIN: Well, thank you. And so, let's start right at the beginning. When will I be able to get my vaccine?

DR. MCCLELLAN: [Laughs.] Well, that's a complicated answer. But the early vaccines, David, could be available as soon as this fall, probably for high priority patients. I'm talking fall, like November, December. The clinical – the large clinical trial, the phase three trial for one of the vaccines by Moderna is getting underway in the United States right now. There are other advanced clinical trials going on elsewhere in the world, and more vaccines coming after that. Probably three starting clinical – large-scale big clinical trials this month, a couple more later in the fall.

The thing I would emphasize is that none of these vaccines are likely to be perfect, and there are things that can still go wrong along the way. And even when they do become available, there are still going to be issues around distribution, around prioritizing people who need it most. So, this is going to be a process. And you'll be hearing more in the weeks ahead about how the vaccines might be distributed, how they're actually doing in the further clinical testing. So, we've still got a way to go before you're getting your shots.

MR. RUBENSTEIN: I think 70-year-old private equity professionals will not be considered high priority people, but –

DR. MCCLELLAN: [Laughs.] Well, over 65 – I know you're still young – but over 65 is an elevated risk group, which is probably going to be in the earlier segment to be vaccinated,

especially if we're still having lots of outbreaks of COVID, which seems, you know, unfortunately likely at this point.

MR. RUBENSTEIN: So normally phase three drug trials at the FDA before you can have a drug available to the public takes about 30,000 people in a phase three. How can you really do 30,000 people so quickly on these vaccines? Will it – is the FDA telescoping this, such that we may not get vaccines that are really as safe as normal? Or is that not a problem?

DR. MCCLELLAN: Well, FDA has tried to make a lot of things that typically happen in sequence in vaccine development go forward in parallel. So, first, very clear guidance about what was needed to get a vaccine into clinical testing in people. Now guidance on how to do these large-scale trials, as you said, with 30,000 people. The more people that enroll the better. You know, unfortunately for the United States we're actually a good place to do clinical trials for vaccines, because there's so many communities that have high rates of cases. And so those clinical trials are ongoing – are starting now with recruitment in the south, and the west, and especially in areas with lots of cases present.

And also going on in parallel is manufacturing of the vaccine. That normally happens next, so that when the studies do conclude that a vaccine is safe and effective enough – and I don't think FDA has done anything to cut its standards at this point – then it will be available quickly. So that's why this years-long process is required. A lot of money up front, because the health and economic consequences of the virus. So, billions of dollars in co-investment by the government and growing at risk with the manufacturing capacity and setting up these large-scale clinical trials. But we've still got some work to do before we know if the vaccines work, and to distribute them successfully, to get people to agree that they actually want to be vaccinated at a large enough scale that we can contain and eliminate the pandemic.

MR. RUBENSTEIN: Well, let me ask you about this. You mentioned a lot of money's been put into this. The U.S. government's put billions and billions in these companies. I'm a capitalist, obviously, but is it fair for companies to get billions from the U.S. government and then not have these vaccines be either free or very, very cheap? Why should the companies decide the pricing?

DR. MCCLELLAN: Well, David, I think that Americans can expect the vaccines to be either free or cheap. That's less of the issue than how much are we really paying for them, how much are the manufacturers going to get per dose, for example? Especially with all of this upfront help. A number of the manufacturers have said that they're aiming for pricing that's at a not-for-profit level. Not clear what that means.

Some of these early contracts suggested, like for the AstraZeneca vaccine with Oxford University that the pricing might be in the \$3 or \$4 range. Some of the more recent contracts suggest maybe \$20. Moderna has not yet said what their pricing strategy is going to be. So that's going to be a live issue too. I would expect the numbers to come out much lower than, you know, sort of a usual price outside of a public health emergency context. But we're still talking about billions of dollars in payments.

MR. RUBENSTEIN: Now, vaccines always, like all medications, have some side effects. What are likely to be the side effects of this vaccine? And will you get one shot and that's all you need for your life, or you have to get one every month, or once a year? How's it work?

DR. MCCLELLAN: Well, there's six major platforms of vaccines that are getting into this advanced development now. And it varies across the vaccines. So far, the main side effects that we've seen in the early clinical testing in people have been the usual things that you'd expect with vaccines – fever, soreness of the site, aches, things like that. And some of those are occurring at high enough rates that people may have some concerns about taking the vaccine. So, we'll have to see how the larger scale clinical testing goes. That's why it's so important.

There is also large-scale testing for at least months afterwards. These trials are going to take months to get an idea about whether there are any, at least, immediate side effects associated with the vaccine in the months after they're being taken. There's going to be a lot of work done after the vaccines are made available to follow up on any long-term consequences. So, we've still got some important unanswered questions.

For some of these vaccines we've actually used in other diseases before, like the J&J one, the Oxford one. So, we've got a pretty good track record in general of how safe they are and what the side effects are. So that's reassuring. Some of them are newer. The mRNA vaccines, like the Moderna vaccine, the Pfizer vaccine, haven't been used before. And so there may be more questions there. And for most of these vaccines, it looks like it's going to be two doses, especially the ones that come first. Some of the vaccines, maybe the Oxford one with AstraZeneca and the J&J one, are aiming for one dose. So, all those are considerations.

The other thing to emphasize is that vaccines, to work effectively, doesn't mean they always work perfectly. So, think about the flu vax. In a typical year it might prevent, you know, 60-70 percent of cases, might reduce the severity of cases, but not 100 percent. And that's what people should be expecting with these vaccines too.

MR. RUBENSTEIN: So, what about testing? Even as today, here we are in just about August and – many, many months after this virus struck this country and the world – and people in the United States still can't seem to get testing. How can somebody get a test quickly, and get quick results? How do you do that?

DR. MCCLELLAN: Well, you're not doing it – [laughs] – we're not doing it right now in the United States reliably. We, David, desperately need a real national strategy around testing. So, we've got guidance on it from CDC and the government on many people who should get tested. That's people who have symptoms, those who are close contacts of people who are known to be infected. And they should be tested with tests that are really accurate. The so-called laboratory test that labs like Quest and LabCorp are doing, that are based on PCR technology and get accurate results like, you know, 99 percent of the time.

The part of the problem is that we're not doing fewer of those tests – we're doing more than ever, you know, 5-6 million a week now. The problem is that we're also doing a lot of testing, understandably, in other types of groups as well. So, people who are trying to go back to work, high-risk settings like nursing home residents and workers. You know, that's 4 million

tests if we're testing everybody who worked in or was in a nursing home, or kind of advanced assisted living facility in the United States. The NBA and sports leagues are trying to get back. Businesses are trying to get back. Hospitals that are reopening are testing all of their patients. And the supply is just not keeping up with demand.

So, a testing strategy here would recognize that these different types of needs merit different kinds of tests. There are more so-called screening tests that could be used at large scale, pooled testing, tests using antigens, tests using other point of care technologies that are not perfect, they're not as reliable as the lab test that you really need for people where you're really worried about infection. But if part of the goal is just to detect an outbreak early in a workplace, well, that's where fast testing and frequent testing in a lot of people could really pay off and take the load off the lab testing that we're seeing now. So that's what I mean by getting a national strategy in place. Hopefully, Congress is going to take action on this in the next week or two.

MR. RUBENSTEIN: We have – about 150,000 Americans have died so far, more than in any war we've ever fought except World War II and the Civil War. Extraordinary number of people. Are we having that many people die because we're doing more testing? Are they dying because we're doing so many tests out there? Is that why they're dying? Can you hear me? They're not dying because we're doing so much testing, is that right?

DR. MCCLELLAN: [Laughs.] No, that's definitely not why they're dying. They're dying because – yeah, that is not why. They're dying because we haven't controlled the pandemic, David. Hopefully more testing, especially in high-risk settings where we're seeing a lot of these outbreaks, communities with low-income individuals who are living close together, workers who are in essential worker settings, these individuals – people in nursing homes make up a disproportionate share of the deaths. And we've got to do a better job of containment in those high-risk populations through steps like more aggressive testing.

MR. RUBENSTEIN: What about therapeutics? Where does that stand?

DR. MCCLELLAN: We're making progress. One treatment that's been shown to be effective, remdesivir, an antiviral, is out there. The bad news is that, just like everything else with the pandemic, executing at scale is turning out to be a challenge. So, Gilead, the manufacturer, has made available 500,000 doses now through September. Just about all of that supply going to the U.S. Unfortunately, that's not as many cases as we have of hospitalized patients who could actually benefit from remdesivir. So, there are a number of other treatments in development, including convalescent plasma, plasma from people who have recovered. Hopefully, that will turn out to work. There are clinical trials going on there too.

We've got a lot of survivors of COVID-19 who could be donors. And there's some very promising neutralizing antibody therapies that are entering clinical testing now too. Those are based on monoclonal antibody techniques. It's advanced biologic manufacturing. My worry there is same thing as we're seeing with remdesivir, is being able to manufacture enough of those treatments at scale.

And then finally, we're learning more about how to treat the most severely ill patients. A great study done in England by a trial called the Recovery Trial, which enrolled many patients

from many, many hospitals in England. Would love to see something like that happen here. Found that steroids could help in very severely ill patients. Not something you necessarily expect. And there is other testing going on around drugs that can affect blood clotting, drugs that can affect immune reaction. We're learning more about how to treat hospitalized patients. And hopefully that's going to get better. That would really take the edge off of this. It's just a reminder, though, that we need to be careful about not overwhelming our hospitals if we want to prevent the deaths.

MR. RUBENSTEIN: Now, early on when people got this in the first couple months and they went into a hospital and they went onto a ventilator, I think 65 percent of the people never got off those ventilators.

DR. MCCLELLAN: That's right. They died.

MR. RUBENSTEIN: Is that the case now?

DR. MCCLELLAN: Yeah. Death rates were extremely high. And those have come down. It's partly because some of the patients who are coming down with COVID-19 are now more broad spectrum of the community, younger individuals, individuals in minority communities. The age distribution has come down some. That's probably contributed to the improvement in survival. But we're also getting better at treating those patients. A few of them are – we've learned how to keep more of those patients off the ventilators through other types of breathing support. We've developed better ventilator techniques. The hospitals aren't quite as stressed. We've got more capacity than we did earlier this year.

But, David, we're still running into challenges because we have some many cases in some many parts of the country, even with hospitals that have staffed up and gotten the surge capacity, we're still running short on personnel. And we've really got to do more to get the rate of cases down in this country.

MR. RUBENSTEIN: Now, one of my daughters came down with COVID-19.

DR. MCCLELLAN: Oh, I'm sorry to hear that.

MR. RUBENSTEIN: My son-in-law came down with COVID-19. My six-month old grandson came down with it, and my two-year-old granddaughter came down with it. And now my six-month-old grandson has antibodies. Is he the youngest person in the United States with antibodies? I don't know. But what does it mean when you have antibodies? Does that mean they're protected for life, or maybe for a short period of time? And what do you think the long-term consequences of getting COVID-19 when you're a little kid might be?

DR. MCCLELLAN: Well, we don't know the answer to that. And you know, unfortunately it does look like for some people there are long-term complications, long complications, some concerns about maybe neurologic too. Now, fortunately those seem like happening at a low rate, and this is still early on. You know, it's hard to sort out causality. But there does need – there do need to be very good longer-term studies of the complications that are happening in all – in so many patients that have been affected by COVID.

With respect to immunity, we're not seeing very many cases of people being infected and then re-infected again soon. I wouldn't put too much stock in the studies that show that, you know, your antibody levels go up then they go back down. That's just the way antibody responses work. It doesn't mean your body's forgotten about this infection and won't be able to fight it off the next time. But whether we need booster shots for COVID every year, or every five years, or whether one infection is enough, that's still – I think that's still not determined.

MR. RUBENSTEIN: So, what's going on in your home state of Texas now, can you explain what happened in Texas? They seemed to be OK, now all of a sudden there's a gigantic wave there, and Louisiana, and Florida. What happened?

DR. MCCLELLAN: Well, they're not OK. The state and other states have reopened under approaches that didn't really follow recommendations that other public health experts have made, our group worked on, Ash Jha's group worked on, about getting the case rate down and getting enough testing and contact tracing in place to really contain outbreaks. And so, we've seen a lot of reopening, and under conditions that have led to bigger spreads.

I think some good news in Texas is that there has been a shift, David. I think our culture is starting to change a bit around the basic steps that are really important for everybody to take to help reduce the spread of COVID. And that's masks. It's keeping a distance. It's not gathering in large groups, meaning like under 10. So, more people are doing that. And that, along with the state – and other states like Texas – pulling back on just how much of the economy is reopened has helped. But Texas is kind of stabilizing at a very high level of cases. Nationally we've had over, you know, 60,000 cases a day every – recorded every day this week. And that's only a small fraction of the true cases that are – that are probably out there.

So, we've got to do – we've got to do a better job. You know, we've talked about testing more, and a real national testing strategy. Talked about other steps that could be taken to slow down the spread and get more of this culture change. You know, I think it's going to be – it really would take, like, seven, eight, nine months of many more Americans – you know, 80-90 percent of us – following those basic guidelines, just like we do with not smoking indoors, you know, wearing a seatbelt, things like that. That's going to be an important part of getting there too.

And there's still – I just want to go back to – this is a very disparate infection in terms of its impact. So, Texas overall cases are stabilizing. But down in Rio Grande Valley, which is a low-income area, high Latinx population, still seeing hospitals that are closer at capacity, still seeing very high rates of new cases and deaths. And it's just a reminder that if we don't step it up around high-risk – around containment in high-risk populations, essential workers, other settings where outbreaks can occur, including schools and universities, we're going to have a very tough fall.

MR. RUBENSTEIN: So, if I want to avoid getting this disease, should I be taking hydroxychloroquine?

DR. MCCLELLAN: Ah, no. [Laughs.] I wouldn't recommend that. The randomized studies, the good studies, have not shown any benefit, and potentially some harm. And, you know, if there's another message in this, it's that for all of these treatments that we're developing we need to do as much as possible to test them using randomized studies, so we can really figure out if it's the treatment that works or not. The U.S. government is increasing that kind of clinical trial work through the active program and Operation Warp Speed.

I, along with a number of other former FDA commissioners, have been calling for really trying to ramp out the way that we do studies, to make it easier for people in hospitals, people in community settings to participate in a simple study using electronic data, where there is randomization, where we really don't know whether a treatment works. There are so many people getting treated in this country, David. And a lot of the treatments we're using we just don't have good evidence on. We could do better.

MR. RUBENSTEIN: So if the next president of the United States, if it's President Trump reelected or President Biden, if he becomes president, if they sat you down and said: OK, I want to start afresh January 20th, give me a strategy. What would you recommend that the new president do?

DR. MCCLELLAN: David, we've already talked about a testing strategy. We've already talked about the steps that people can take. So, mask mandates. They do work. I think something like that nationally. A clearer strategy around when and how states should reopen, when they need to pull back, and how. We know a lot more about how to do that now. And then we've taken a lot of steps to make vaccines available as quickly as possible through things like the parallel approach to development and advanced manufacturing.

I haven't seen nearly as much progress in that area, though, on some of these other therapeutics. I'm worried about shortages of monoclonal antibodies in the fall, which could be helpful for if the vaccines don't work that great, or if they're elderly people who don't mount a good immune response. Having a large supply of that would help a lot. So additional manufacturing capacity for other therapeutics, and for diagnostics. We need to have a – again, a lot more effective and coordinated testing strategy than we're implementing now.

MR. RUBENSTEIN: Now, you used to run the Medicare and Medicaid part of our government, which is complicated. Is the COVID crisis, because of the health-care costs increasing and so forth, is that straining Medicare and Medicaid? And what are we going to do about the enormous costs of Medicare and Medicaid? How are we going to put that under control at some point, if ever?

DR. MCCLELLAN: It's a huge long-term problem, David, especially with the fiscal position that we're headed into thanks to the pandemic. But actually, the pandemic's probably been the best thing certainly in my lifetime for health-care cost growth. When the shutdown occurred nationally, and even now as we're opening back up, health-care spending for routine services, so-called elective services, has come way down. So, our health-care spending is lower – still lower than it has been.

That's had some good and bad consequences. You know, we've seen a big switch to telemedicine. That's something that many people thought was going to take forever, but you know when push came to shove, we've seen a big shift in the way people are getting care, much more at home. We've seen a big reduction in many procedures that health policy people, like me, thought we could do with a lot less of, a lot of imaging tests that probably aren't needed, a lot of procedures that aren't needed. On the other hand, we've also lost a lot of procedures and services like vaccinations, and early cancer screening, and so forth, that really is needed.

So I think the question going forward for our health-care system is, can we take the silver lining out of the transformation in care that's had to happen over the last four months – the good things, relying more on telehealth, not doing treatments that really don't have much value, redesigning care to really focus on what matters to people. We've been doing a lot of work, David, on new payment models that aren't based on fee for service. Fee for service has been very bad for health-care providers. Primary care providers are going out of business because their revenues are down so much.

An alternative is paying for the people they're taking care of, you know, paying more for health, as our health secretary in the state of North Carolina says. Paying at the person level to really support these and lean into these new kinds of care models. And I think a big question for our health-care system is: Can we come out of this pandemic with resilience? Can we rebuild – not going back to the health care we had before, which is really expensive, inconvenient, uncoordinated. We've seen people come together, like health professionals, and do amazing work. Not just on the frontlines in hospitals, but in reaching out to their patients, helping them get care at home, dealing with hunger, dealing with social isolation. That's the kind of health care we want. It brings out the best in our health professionals. And we just need to change our payment systems beyond the public health emergency to encourage that.

MR. RUBENSTEIN: So given – your final question – given who you are, the FDA commissioner, former head of Medicare and Medicaid, all those degrees you have – how are you making sure that you aren't getting any disease? Because it wouldn't look good if you got a disease. Do what are you doing to make sure you don't get this?

DR. MCCLELLAN: [Laughs.] No, it wouldn't. And we talked about those important basic steps. They're pretty clear. We try to follow them as much as we can. My hope too is that if people follow those guidelines it will not only help prevent the spread of COVID, it'll also help prevent a bad flu season this year. If you look at the Southern Hemisphere, because of all the COVID steps, flu cases are way down. So, there are some things that we can do to not only help with COVID and keep ourselves healthy, but really protect the whole country going forward.

MR. RUBENSTEIN: Thank you very much, Mark. And thanks for substituting and doing a great job. Appreciate it, Mark.

DR. MCCLELLAN: Great to be with you.

MR. RUBENSTEIN: OK. So now I'm going to go to Ashish Jha. Ashish Jha is the professor of global health at the Harvard T.H. Chan School of Public Health. He's also director of the Harvard Global Health Institute. He is a graduate of Columbia, Harvard Medical School, and

also the Harvard T.H. Chan School of Public Health. And you may have seen him many times recently on television. He will be, in September, the new dean of the public health – School of Public Health at Brown University.

So, Dr. Jha, thank you very much for coming today.

ASHISH K. JHA, M.D.: Thank you for having me on.

MR. RUBENSTEIN: So, if you were going to design the worst possible way to handle a pandemic, could you have designed a better – or, worse way of what we're doing? Is this the worst possible handling you've ever seen?

DR. JHA: There are features that certainly make it among the worst in the world. I'm going to say that it is possible to have done it worse, but not much worse. I think it's a reasonable argument that we have the worst performance of many major country in the world. And our performance looks like that of Brazil and Russia and maybe India. And so, we really are doing quite a bad job. I guess maybe the one silver lining of having no national strategy and letting every state figure it out for themselves is a few states are doing a good job. And so that's the one silver lining in all of this. But at the end of the day, it would be much better if we acted as a country.

MR. RUBENSTEIN: So whoever the next president is, the same question I asked Mark, if that next president said: OK, I want to start all over again January 20th, forget what happened in the past, what would you say to the next president we should do at this point?

DR. JHA: Yeah. So similar answers to Mark. Really what we need is a national strategy on testing. So, look, there are three or four elements of this, David, that if we just go right, and we have the science for this, we could make a dramatic difference. So, what are those three or four elements? We have to have quick, widely available, ubiquitous testing. I mean, just the fact that a country with our economic capacity can't test people for an infectious disease, in my mind, is an embarrassment. So, we've got to fix that. And there are lots of ways of fixing that. We've got to make sure that our hospitals and our health-care workers are well-stocked with protective equipment. We've got to have a national mask law, or if we have to do it at the state level every state needs to pass one.

We have to make some sacrifices during this pandemic. I just think we probably can't afford gyms, and bars, and a few other indoor gatherings. And we have to be able to do the kinds of things that allow our economy to open up safely. If we did these four or five things, we could get 80 percent of our lives back, not 100, and have our economy, and have very few people dying. But it feels to me like for a large chunk of the country we want 100 percent back, and we're going to end up with 30. And that's the problem, is that we – that we just have not been able to mentally wrap our brains around the fact that we're in a pandemic.

MR. RUBENSTEIN: Now what about the second wave so far? Dr. Fauci talked about it. Are we in a second wave in the south, or is that the first wave?

DR. JHA: I see it as the first wave. And in some ways people start asking, well, you know, is that even such a great analogy? The way I see it is, we have the south right now sort of neck-deep in water. We have chunks – other chunks of the country that are sort of waist-deep. And then there are some place in the country that are kind of ankle deep. The reason why a wave may still be a useful thing to think about is that in the fall and winter, certainly in large parts of the country where people end up spending more time indoors, I expect the number of cases to start rising. And we have to have a strategy that says: If weather forces us indoors and number of cases start going up, what are we going to do? That, in some ways, you could argue, will be the second wave. But we're still in the first, in many ways.

MR. RUBENSTEIN: Why is it better to be outdoors? In other words, the virus doesn't communicate from people to people outdoors as well?

DR. JHA: You know, this is one where we've really learned a lot. And the evidence now is overwhelming that most of the transmission happens indoors. It happens when large numbers of people – it can be as – you know, as few as five or 10 – gather for extended periods of time, and when they're not wearing masks. That's the perfect setup for the virus transmitting. So, you know, we've even seen data coming out of those mass protests, the Black Lives Matters protests, they have not fueled very many cases. I was worried that they would. They have not. We don't know why. It just seems like the virus is far less stable outside in warm weather and in outdoor space. It may be about the airflow. There's a lot of potential explanations. But that's where the data really is coming in.

MR. RUBENSTEIN: Now, you know, you can always look back and say people should have done something differently. Should the Chinese have done something differently than they did? And had they done so, would we be better off, or it wouldn't have made a difference?

DR. JHA: So absolutely the Chinese should have done things differently. The single biggest thing is that they should not have tried to suppress the information about the outbreak of the virus. A lot of it is still murky in our heads, exactly what happened. But my best guess is that the virus started circulating in Wuhan probably in November, maybe as early as October, but certainly for much of November, and all of December. They really suppressed it. What happened during that time is there was travel outside of Wuhan. So, people infected large parts of China. And then people left Wuhan, traveled to Europe, traveled to the U.S., and started infecting people in these other countries.

So, if the Chinese government has been open and transparent, we all could have gotten a much earlier jump. Whether it would have made a difference for the United States is harder to know, because we had such clear denial about the virus for all of January and February, that if we had known in December would we have acted more aggressively? I don't know. It's an honest I don't know. But the world would have been better off.

MR. RUBENSTEIN: As a scientist, do you have any doubt that this happened by accident from, let's say, a wet market? Or did somebody create this by humans? Could a human have done this?

DR. JHA: I have no doubt. I think all of the evidence, all of the data I have seen says to me that this is a natural jump from – is it bats, is it one of the other – some other animal? We don't know for sure. Probably bats. But I'm pretty sure, based on everything I have seen, that it was a natural jump, not a manmade one.

MR. RUBENSTEIN: So how is this really different than the 1918 so-called Spanish flu, which wasn't really Spanish. How – what are we doing better than they did then? And do you think – at that time, I think almost 870,000 Americans died, something like that. We now have 150,000. What do you think is the total we're going to get to? And, again, how to contrast this with that flu?

DR. JHA: Yeah. How many we get to is an honest hard question to answer. It depends so much on our behavior over the next six to nine months. But if you force me to guess a number, I would say sort of 250-300,000 deaths, maybe more, is what I expect. The ways in which it is different – first and foremost is we obviously know so much more about this disease. And we're going to have a vaccine reasonably soon. They did not ever develop a vaccine for the pandemic influenza.

The other part is, you know, 875,000 Americans, 30-50 million people in the world, those are massive numbers if you think about how much smaller the population was. America's population was a fraction of what it is today. So that would be the equivalent of many millions of Americans dying today. I do think we'll end up doing better, partly because we've had a bit more of a robust policy response, at least in many parts of the country. And I do think we'll be able to bring the pandemic to a close. And I agree with Mark's timing around vaccines. I expect next spring to summer most of us will have had access to a vaccine that's reasonably safe and effective.

MR. RUBENSTEIN: Now, you are currently at Harvard. And the policy at Harvard is that a lot of the education in the fall will be online class. Brown, by contrast, is bringing students back, I think they were going to have, in classroom settings. So, is the Brown policy better, or the Harvard policy better? Who do you want to upset the most, Harvard or Brown, by giving the answer to that question?

DR. JHA: Well, I've been in favor of the Brown policy, and have advocated to President Paxson that we ought to try this. And I think we have to be very clear-eyed that it is going to be hard. It is – despite best efforts, may not work. So, anyone who wants to guarantee that Brown University and other universities that are trying this will be open all the way through December, there are no guarantees here. But I believe that we have to give it a shot. And we have to give it a shot smartly. And so, there's a whole plan that goes into how you open up a school in the middle of a pandemic. And I'll tell you, plenty of public health experts have looked at me and said: You're crazy. I wouldn't even try. So, I am sympathetic to the decision that Harvard made. But my pitch to my boss coming up in a month has been: We should try it. We should be very clear-eyed. We should give it our best shot. And if it looks like it's not working, we should – we should accept defeat and move on.

MR. RUBENSTEIN: You didn't leave Harvard because you didn't like their policy and you like the Brown policy better? That wasn't the reason you left, right?

DR. JHA: No.

MR. RUBENSTEIN: OK. So, you are by training an internist. So, can I get some free medical advice?

DR. JHA: I am. Absolutely.

MR. RUBENSTEIN: All right. So, am I better off to worry that I'm going to die from an infectious disease or some – a chronic disease like cardiovascular? What's the greatest likelihood that something's going to kill me, which of those? Infectious disease, or cardiovascular, or something like that?

DR. JHA: Well, so, David, I think in the next year there is a reasonable risk of people dying of COVID. So, I think that remains a real concern. And if you look at it on a population level, it depends a lot on where you live, but there is absolutely – so, parts of Florida, for instance right now, if you are an older person, your risk of dying of COVID really begins to rival your risk of dying from cardiovascular disease. Over the long run, I do hope that COVID is something we'll be able to get our arms around by early next year, at which point your risk of dying from infectious disease does diminish substantially. And then it really is much more of –

MR. RUBENSTEIN: OK. The best way to live to be 90 is to have good genes? Exercise a lot? Eat healthy? Or pray a lot? What would you say it is?

DR. JHA: I would say the best way to live to 90, assuming that you can't do manipulation of your genes and you can't pick which – you know, who your parents were – is to be physically active, to have a broad social network of friends and family. I think that makes an enormous difference. I do think eating healthy matters, of course, but if I had to pick two things, let's say, I'd say be physically active and be socially engaged.

MR. RUBENSTEIN: Right. So, you're in charge of global health at the institute there. And you're going to be doing this at Brown. So, what do you do to stay healthy? Do you run 20 miles a day? Do you eat only vegan foods? What do you do?

DR. JHA: Yeah.

MR. RUBENSTEIN: You can't afford to be sick because of who you are, right?

DR. JHA: Yeah. This is, you know, the classic, like, are you practicing what you're preaching? I will say the last three or four months have been a challenge. In the pandemic, a lot of my routines have gotten disrupted. And I have in the last few weeks I realized I need to get them back on shape. But largely what I have done is try to be really physically active. And that is, I don't run 20 miles, but I go for long walks with my family. I have – we got a dog about a year ago, so long walks with the dog. My general feeling about exercise is that the best kind of exercise is whatever fits into your life and fits into your life comfortably that you're willing to do, on an ongoing basis. For me, it's been largely hiking, walking, getting out with the family.

MR. RUBENSTEIN: OK. And you recommend everybody take a statin?

DR. JHA: I don't know that everybody needs to take one. As people get older, there's certainly very strong benefits of people who have either risk factors or elevated cholesterol. I'm 49. I don't take one. But I wouldn't be surprised if at some point in the future I might need to take one. But I wouldn't put in the water.

MR. RUBENSTEIN: What about aspirin every day? You take one of those? Is that good for you?

DR. JHA: I don't. But you know, part of it is my own cardiovascular risk is relatively low. But certainly if I developed some more risk factors or, as I get older and my risk factor – you know, my kind of risk gets higher, then at that point aspirin does start to really make sense.

MR. RUBENSTEIN: And is alcohol good for you or bad for you?

DR. JHA: So, I'm a believer in alcohol in moderation. What is moderation is somewhat debated. There's some data that any amount of alcohol is bad. Maybe it's motivated reasoning on my part, but I try to ignore that data. And I believe that for men one to two drinks a night, four to five nights a week at the most is probably fine. Much above that, and the harms clearly start outweighing the risks – the benefits. For women, maybe a little bit less than that, just from a consumption rate.

MR. RUBENSTEIN: So, leave COVID aside for a moment. The two greatest health challenges in the United States seem to be obesity and opioid addiction. So, on obesity, why are people so fat in the United States and overweight? Is it low-fat food they're eating, or is it drinking a lot of Diet Coke? What is the reason that people are so fat, compared to 25 or 30 year ago?

DR. JHA: Yeah. That's a very good question. And I would say a couple of things we know and then a lot we don't know. There is a lot we don't understand about why there's been such a rise in obesity. There's no question that people are less physically active than they were. I think that's a combination of the kind of work people do, the way people commute, et cetera. And there's also a lot around diet that I think we're still learning about. America's diet has changed quite a bit as fast food and other kinds of foods have become cheaper and more ubiquitous. I think those have really contributed.

Again, I said, there's a lot around kind of environmental, social interactions. Some of the most interesting studies out there show that when people become obese, their social network becomes more obese. And so, there's sort of these very interesting social effects that go on that I think we have not fully untangled. But that said, it still comes down in large part to diet and physical activity.

MR. RUBENSTEIN: OK. In terms of opioids, are we making any progress there? Life expectancy in the United States is going down because of opioids, I thought.

DR. JHA: Yeah. No, we had two years in a row, maybe three, of declining life expectancy and then finally a year where it got flat. Opioids obviously were the health crisis that the nation was

focused on until COVID hit. I'm worried about what's going to come out of this COVID pandemic. It has really gotten buried what is happening with the opioid epidemic. But I think as we emerge from this, we're going to see probably a spike in cases of opioid use and misuse. There have been some policy changes that I think are going to be helpful. But I'm really worried that a year from now we're going to be talking about opioids a lot more than we have been over the past six months.

MR. RUBENSTEIN: Now, President Nixon declared war on cancer some 50-60 years ago. More than that now, I guess. Is there any evidence that we actually are making progress on cancer?

DR. JHA: There is. Cancer mortality has come down in the last year or two. But it has taken a lot of effort and a lot of time. And the gains are small when you look at cancer more broadly. But cancer isn't a single disease. And what we're learning over time is that it's not even site specific. So, we used to think of, oh, well, there's lung cancer, and breast cancer. That's true. But it's – we're really learning that it's about underlying mutations and genetics. So, I – while the overall progress on cancer has been modest, I look out to the next 10 years and I'm incredibly optimistic that we're going to make a lot of progress on cancers. Not all of them, but on many of them over the next decade, because we've really started turning the corner.

MR. RUBENSTEIN: What about cardiovascular? Are we making progress there?

DR. JHA: We've made a lot of progress. I mean, the amount of death from cardiovascular disease has declined dramatically, partly both at the population level, but also, you know, if you had a heart attack 30 years ago that was close to a death sentence. No longer. I mean, most people now survive their heart attack. And the vast majority of them go on to live kind of active, healthy lives. So, we have really made massive progress on cardiovascular disease. I think that will continue. We're moving into much more genetic editing, and those kinds of approaches to people that's really high risk. Therapies will continue to get better. So, I expect cardiovascular disease will also continue to be an area where we make a lot of progress.

MR. RUBENSTEIN: Now, you teach, obviously, students. Students seem to be using a lot of recreational drugs, or whatever you want to call it. Is marijuana unsafe, or is marijuana actually medicinally good for you?

DR. JHA: So, I don't know, is the short answer. I have – so first of all, from a policy point of view, I certainly believe in decriminalizing marijuana. I don't think we should be putting people in jail for having small amounts of marijuana. But that said, I've also not been willing to jump on the bandwagon of marijuana should be, you know, ubiquitous and easy to get, because I do think it has – clearly has some deleterious effects. You know, because of the substance that it is, we just haven't done the studies that we really need. In a small proportion of people, very small, it clearly has medicinal benefit. So, people with cancer on chemo, and people with advanced HIV, we've seen that. Unfortunately, that category has gotten broader and broader, and now we're using medicinal marijuana for all sorts of things. I want to be data driven on this, and I want to see much more data on this.

MR. RUBENSTEIN: So if you're the dean of the Global Health Institute of Harvard, and you're running that, and you go to a party and you see somebody overweight, or they're drinking too much, or they're smoking, do you go up and say: Look, you shouldn't be doing that? Or you just kind of mind your own business?

DR. JHA: Well, it just depends on if I ever want to be invited back to that party or not, is I guess the way I think about it.

MR. RUBENSTEIN: I see.

DR. JHA: But in general, I feel like people know what the right answers are. Now, when I practice – and I still practice at the VA in Boston – when I have a patient that I see, let's say, who's coming for a heart attack or has come in for a problem and they're smoking or they're overweight, I do talk to them, because that to me is a clinical moment and I have a clinical role. You know, if you're at a party and you're overweight, you know, it's not clear to me that you need me to tell you that you're overweight and you need to lose weight.

MR. RUBENSTEIN: OK. Final question, Dr. Jha. I wanted to ask you, in terms of your turning 50. You're 49. You're going to be 50. Are you worried about turning 50? And you're going to be on a downward slope? Or you think you're going to be healthier when you're 50?

DR. JHA: [Laughs.] I'm not excessively worried, or maybe I wasn't until you asked that question, David. I hadn't been thinking that much about my own decline. But I suppose it's inevitable in all of us. So, I guess I've been pretty optimistic that the 50s will treat me OK. And in the short run, I'm just really focused on getting us and all this country through COVID. But you raise an important point, and maybe I need to reflect a bit more on my future.

MR. RUBENSTEIN: All right. Thanks very much for everything you're doing in educating people, and congratulations on your new position at Brown.

DR. JHA: Thank you so much for having me on.

MR. RUBENSTEIN: Thank you.

So, we're now going to go to Gabrielle Webster. Gabrielle is a native of my hometown Baltimore. As I mentioned, she's a graduate of Western High School, an excellent high school in Baltimore. And she is now the president of the Boys and Girls Clubs of Greater Washington. So, Gabrielle, thank you very much for joining us.

GABRIELLE WEBSTER: Thanks for having me. Great to meet you.

MR. RUBENSTEIN: She is a graduate of Atlanta University and Xavier University. She has a master's from Atlanta University in physical chemistry, and also a degree in chemistry from Xavier University.

Did you think you were going to be chemist, or what happened?

MS. WEBSTER: I was a chemist for a few years. But after my career path led me to nonprofit, I realized that this was where I was supposed to be. Chemistry was a great stepping-stone, however.

MR. RUBENSTEIN: OK. So, you've been involved in the nonprofit area in a number of organizations in this area – Leukemia and Lymphoma Society, American Heart Association, and United Way. So, what is it about Boys and Girls Club of Greater Washington that attracted you to become the president of it?

MS. WEBSTER: Sure. As the daughter and granddaughter of educators, it is important and always has been for me to be able to help our children. And so, Boys and Girls Clubs of Greater Washington gives me that opportunity every day. I get work with, the majority of our kids Black and brown, many of them free and reduced lunch, that really need our support. And it's an opportunity to make an amazing impact each and every day. I always quote Frederick Douglass who says, "It's easier to build strong children than repair broken men." And that's truly what we do each and every day with our young people.

MR. RUBENSTEIN: So how many young people, and what ages, do you have in the clubs? How many people do you help a year in your clubs?

MS. WEBSTER: Sure. We support ages five through 18, and about 21,000 per year. We have kids coming a million times through our doors each and every year. Many of our kids come four or five times per week. We have now started virtual programming as we have had to pivot during the pandemic. So, we do in-person as well as virtual.

MR. RUBENSTEIN: OK. So, what is your annual budget?

MS. WEBSTER: So, we're about \$10 million right now. But of course, the more revenue that we raise the more opportunity for us to support more children. Our dollars are very much in proportion with the number of kids that we can serve.

MR. RUBENSTEIN: So, do you get money from the U.S. government, the local governments in this area? Where do you get your money from?

MS. WEBSTER: Sure. We get quite a bit of revenue from the local, state and federal government, as well as through foundations, corporations, special events, and individuals. I will say we have had a strong push on to increase the support from individuals as well as foundations. And that's been one of the major things that we've been doing the past two or three years.

MR. RUBENSTEIN: So, if somebody wants to contribute to you, what do they do? They call you up? They email you? What size donations are you looking for?

MS. WEBSTER: They can call, they can email. [Laughs.] They can reach out to me at any time or go to our website. We are easy to find, at Boys and Girls Clubs of Greater Washington. And we take all size donations. Of course, the more zeros and commas, the more kids that we can help. Right now, we are experiencing just the most challenging times because our kids are in the midst of two pandemics. We've got one that's COVID-19, four months old, but we have

another one that is centuries old. And because of that, our kids are at a disadvantage all the time. Social and racial injustices are a part of their everyday life. So, it is important for us to support these kids. So, we would really appreciate anyone and everyone really being able to support this organization.

MR. RUBENSTEIN: What is your website?

MS. WEBSTER: BGCGW.org.

MR. RUBENSTEIN: OK. And so, do you have physical facilities in the Washington area? How many do you have?

MS. WEBSTER: Sure. We have four in Washington, and 15 in the greater Washington area, suburban Maryland, as well as Northern Virginia. I will say that right now we actually have seven locations open and serving youth. And we have been open for the last four months. We closed in March when the school systems closed. But we found a way, following all of the CDC guidelines of social distancing and PPE, to be able to open safely to still support our kids and provide some sense of normalcy to them in a time where things are so very uncertain for them.

MR. RUBENSTEIN: So, the people that you serve, how many of them come from single-parent families, or have other kinds of disadvantages similar to that?

MR. RUBENSTEIN: Yeah. Well over half of our youth are from single-parent households. And many of those, usually a mom, has to work. And so how can they go out and make a living if there's no place safe for their kids to be? And frankly, we're not babysitters at Boys and Girls Clubs of Greater Washington. We provide some of the best youth development programming that you can imagine. We expose young people to many things. We provide career information, resume writing. We do much more than just sports. Everything is focused on academic success, good character and leadership, as well as healthy lifestyles.

MR. RUBENSTEIN: So, the boys are separate from the girls, or are they kind of in one club?

MS. WEBSTER: No. You know, it's been quite a few years now. We used to be just the boys clubs, but now we have girls there. And the balance is about equal – about 65 percent boys and 45 percent girls.

MR. RUBENSTEIN: And what percentage of the people that you have coming to the clubs have high-speed internet at home?

MS. WEBSTER: Not a lot of them. And that is one of the challenges that they face, and one of the reasons that when we pivoted and created our virtual platform we made certain that they could do this on their phones. That is the challenge. And whether kids go back to school or not this fall, virtual learning is going to be a challenge. If you are poor, you may not have a computer. You may not have internet. You may not have someone at home that can provide you the tutoring that you need to stay up with your coursework. And there is a great concern that these kids' learning loss will be much more significant than a month or two.

MR. RUBENSTEIN: So, you're trained in chemistry. I assume you could be working at a large chemical company and making a lot more money. So why are you doing this?

MS. WEBSTER: It is my passion. When I came to nonprofit, I really wanted to make a difference. And when I came to Boys and Girls Clubs three years ago, I really expected to like my job, but I didn't expect to fall in love with these young people to the degree that I have. And once you meet them and see just how you affect their lives – over half of our kids say that the Boys and Girls Club saved their lives. When I talk to one of our young people who used to be so shy she wouldn't even speak, but now she's a standout at the performing arts school here in D.C., or one of our very famous alumni – he's become famous recently – is the first Black student body president at Yale University, in their many, many hundreds of years in existence.

So, we have stories of so many children that have succeeded. Ninety-eight percent of our kids graduate from high school on time, and 94 percent go to college – oftentimes the first in their family to do so. I mean, how could you not want to work here? [Laughs.]

MR. RUBENSTEIN: So, the Washington business community, do you think they've done enough to help you, or they're not as actively involved as you think they should be?

MS. WEBSTER: Well, I would certainly love for them to be much more involved. But I think it's up to us to be able to share what we do with them, and for them to understand that we are important to their community. As we are talking about racial justice now, think about the impact that you can have on young lives. I think that forgiveness comes with accountability. And when we write in the history books, when we go through this particular cultural moment, we'll be judged by what we did, not the conversations that we had. So, I urge all of them to reach out to me, to us. Unfortunately, it's hard to do things in person. But there's a Zoom call a minute. Please give me a call and let's talk.

MR. RUBENSTEIN: OK. And today how do you relate to the greater – the Boys and Girls Club of the United States? Isn't there a parent organization, or are they just – do they give you money, or do they just tell you what to do? Or how does that work?

MS. WEBSTER: Yeah. Boys and Girls Clubs of America is our parent. We're a member organization. But Boys and Girls Clubs of Greater Washington is our own 501(c)(3). We do get some support from them. They also advocate on our behalf. But we are our own nonprofit, and are responsible for our own budget, and expenses, and all of the things that happen here in the D.C. area.

MR. RUBENSTEIN: I see. And have you had families affected by COVID having contracted it who are members?

MS. WEBSTER: We have heard of a couple of instances of some of our kids' family members having had it. But as far as I know, we've been very fortunate that none of our staff or youth have been seriously affected. But I do know one young lady's mom passed.

MR. RUBENSTEIN: OK. So, you live in the – you told me earlier – Upper Marlboro. And I asked you whether there was a lower Marlboro, and you said no. But you cover the entire Washington, Maryland, and D.C. area, is that right?

MS. WEBSTER: That’s correct.

MR. RUBENSTEIN: OK. So, what’s the final message you would like to give to the members of The Economic Club of Washington, that you would just say this is the most important thing they should know about your organization?

MS. WEBSTER: Well, I think the most important thing is that we make a tremendous impact on our youth. It is an opportunity for them to be exposed to so many things, to be able to leave our clubs and go on and create a great future, a wonderful life for themselves. And everyone in this community could provide support and help to ensure that those dreams become their realities. It’s just an amazing organization. And I think people tend to underestimate just how much we actually do. So, I ask them to reach out and learn more and support the kids of this community.

MR. RUBENSTEIN: OK. Well, Gabrielle, I want to thank you very much. As I mentioned, you’re from my hometown. I also have a daughter named Gabrielle. So, we have those connections. And we both went to big public high schools in Baltimore. So, thank you very much for what you’re doing and thank you for coming today.

MS. WEBSTER: Thank you so much for the opportunity. Take care.

MR. RUBENSTEIN: OK. So, to remind everybody, if you want to see our presentation today go to our website, EconomicClub.org. Our next signature event will be on my book, “How to Lead,” on Wednesday, September 2nd. Andrea Mitchell will interview me. I want to thank all of our sponsors and appreciate everybody’s paying attention today and tuning in. So, thank you and good day.



Mark McClellan, M.D.
**Robert J. Margolis Professor of Business,
Medicine, and Policy**
**Director of the Duke-Margolis Center for
Health Policy**
Duke University

Mark McClellan, MD, PhD, is the Robert J. Margolis Professor of Business, Medicine, and Health Policy, and founding Director of the Duke-Margolis Center for Health Policy at Duke University. With offices in Durham, NC and Washington, DC, the Duke-Margolis Center is a university-wide, interdisciplinary initiative that

is nationally and internationally recognized for its research, evaluation, implementation, and educational initiatives to improve health and health policy. The Center integrates Duke's expertise in the social, clinical, and analytical sciences with health care leader and stakeholder engagement to develop and apply policy solutions that improve health and the value of health care locally, nationally, and worldwide.

Dr. McClellan is a physician and an economist who has informed and improved a wide range of strategies and policy reforms to advance health care, including payment reform to promote better outcomes and lower costs, methods for development and use of real-world evidence, and strategies for more effective biomedical innovation. Before coming to Duke, he served as a Senior Fellow in Economic Studies at the Brookings Institution, where he was Director of the Health Care Innovation and Value Initiatives and led the Richard Merkin Initiative on Payment Reform and Clinical Leadership.

With highly distinguished record in public service and academic research, Dr. McClellan is a former administrator of the Centers for Medicare & Medicaid Services and former commissioner of the U.S. Food and Drug Administration (FDA), where he developed and implemented major reforms in health policy. These reforms include the Medicare prescription drug benefit, Medicare and Medicaid payment reforms, the FDA's Critical Path Initiative, and public-private initiatives to develop better information on the quality and cost of care. He previously served as a member of the President's Council of Economic Advisers, senior director for health care policy at the White House, and Deputy Assistant Secretary for Economic Policy at the Department of the Treasury.

Dr. McClellan is the founding chair and a current board member of the Reagan-Udall Foundation for the FDA and a member of the National Academy of Medicine (NAM), where he chairs the Leadership Council for Value and Science-Driven Health care, co-chairs the guiding committee of the Health Care Payment Learning and Action Network, and is a research associate at the National Bureau of Economic Research. He is also a Senior Advisor on the faculty of the University of Texas Dell Medical School, co-chair of the Accountable Care Learning Collaborative, and a member of the Healthtech 4 Medicaid Board of Directors. Dr. McClellan is also an independent director on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and Seer. He was previously an associate professor of economics and medicine with tenure at Stanford University, and has twice received the Kenneth Arrow Award for Outstanding Research in Health Economics.



Ashish K. Jha, M.D.
Director
Harvard Global Health Institute

Ashish Jha, M.D., MPH, is the K.T. Li Professor of Global Health at Harvard University; Director of the Harvard Global Health Institute and Senior Associate Dean for Research Translation and Global Strategy, Harvard T.H. Chan School of Public Health. He is also a practicing General Internist and also Professor of Medicine at Harvard

Medical School.

Dr. Jha received his M.D. from Harvard Medical School and then trained in Internal Medicine at the University of California in San Francisco. He completed his General Medicine fellowship at Brigham & Women's Hospital at Harvard Medical School and received his M.P.H. from Harvard T.H. Chan School of Public Health.

His research endeavors focus on improving the quality and costs of healthcare systems with a specialized focus on the impact of policies. Dr. Jha has published over two hundred various papers in prestigious journals and heads a personal blog which focuses on using statistical data research to improve health quality. Dr. Jha is a member of the Institute of Medicine at the National Academies of Sciences, Engineering, and Medicine.



Gabrielle Webster
President and CEO
Boys & Girls Clubs of Greater Washington

After a successful corporate and non-profit career, **Gabrielle Webster** joined Boys & Girls Clubs of Greater Washington (BGCGW) in May of 2017 as President & CEO. Prior to BGCGW, she served in important leadership roles, on local and national levels, at three large non-profit organizations serving the Washington Metropolitan Area, the Mid-Atlantic Region and beyond. In these roles, she raised over \$220M. She has shared her significant development and management talent with BGCGW and within her short tenure, has worked to reestablish a high level of excellence and quality in the services and programs offered to

youth in the Metropolitan Area, especially in underserved areas. Under her leadership, the number of youth served has grown from 13,000 to 21,000, annually and three new Clubs have opened.

Gabrielle has a depth of leadership experience as a nonprofit and public sector professional with a track record of growth and exceeding expectations. Prior to BGCGW, Ms. Webster served as the Chief Development Officer at the United Way of the National Capital Area. In this role, she was responsible for the development of the strategic direction, assessment, organization, and implementation of all philanthropic endeavors. Before United Way, she served as a National Vice President for the American Heart Association where she was charged with the development, implementation, and execution of a new national business to consumer campaign. Prior to that role, she was Vice-President of the Mid-Atlantic Region's Leukemia & Lymphoma Society where she managed a \$36M budget across nine states.

Before her career in the nonprofit sector, Gabrielle spent over a decade with the Eastman Kodak Company and held several leadership positions in marketing, sales, university relations, and engineering technology.

Gabrielle is a National Science Foundation Fellow, a National Biomedical Symposium Fellow and a Polaroid Scholar. She was chosen to attend the Center for Creative Leadership in 2009 as one of the top executive directors at the American Heart Association. She is a graduate of Leadership Greater Washington 2013.

She received her Bachelor of Science degree in Chemistry from Xavier University and a Master of Physical Chemistry degree from Atlanta University. She and her husband reside in Upper Marlboro, Maryland and they have one daughter.