COMMUNITY PERSPECTIVES ON CORONAVIRUS PREPAREDNESS AND RESPONSE

HEARING

BEFORE THE

SUBCOMMITTEE ON EMERGENCY PREPAREDNESS, RESPONSE, AND RECOVERY

OF THE

COMMITTEE ON HOMELAND SECURITY HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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COMMUNITY PERSPECTIVES ON CORONAVIRUS PREPAREDNESS AND RESPONSE

Tuesday, March 10, 2020

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON EMERGENCY PREPAREDNESS,
RESPONSE, AND RECOVERY,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:04 p.m., in room 310 Cannon House Office Building, Hon. Donald M. Payne, Jr. (Chairman of the subcommittee) presiding.

Present: Representatives Payne, Richmond, Underwood, Green, Clarke; King, Crenshaw, Guest, and Bishop.

Also present: Representative Jackson Lee.

Mr. PAYNE. The Subcommittee on Emergency Preparedness, Response, and Recovery will come to order. The subcommittee is meeting today to receive testimony on community perspectives on coronavirus preparedness and response.

Without objection, the Chair may declare the subcommittee in recess at any point.

Without objection, Members not sitting on the subcommittee will be permitted to participate in today's hearing.

I now recognize myself for an opening statement.

Good afternoon. We are here today to discuss the coronavirus, also known as COVID–19. We are at a critical point in responding to the coronavirus crisis that is facing our Nation. Americans are concerned. Hundreds of Americans are sick. Sadly, their families mourning the loss of loved ones from the coronavirus, and our hearts are with them. The Nation is seeing cases on the rise, and experts say the outbreak is getting worse.

In New Jersey we were just informed that we had our first death from coronavirus, and at least 2 dozen schools are closing for coronavirus preparation, and we have seen an increase in presumed cases. State and local governments are working tirelessly to limit the spread of the coronavirus in our communities. At the Federal level we have seen our experts at the CDC and others, other agencies, working to address this issue.

Unfortunately, we have also seen Federal officials offer mixed messages on the seriousness of the coronavirus. We are not here today to point any fingers, but we must tell the truth.

The American public needs to be able to trust the information coming from all levels of Government. It is now more important than ever for our leaders to trust science and speak with clarity and precision so that Americans can trust what they are hearing.

It is unhelpful to the outbreak response for administration staff to state as recently as last week that the virus is contained, when we know that is not true, because cases are on the rise.

Another point of confusion with the administration lies in the test kits. While the experts at the CDC and even Vice President Pence have expressed concern about potential testing shortages, the President, on the other hand, has dismissed these worries. There have been reports of the White House rejecting the advice of the CDC, and even going as far as muzzling experts. These reports are troubling.

Let's be clear. I want the Federal response to the coronavirus to be robust. No one is rooting for failure. But what I have seen is leading me to become very concerned.

With that said, the goal of today's hearing is to understand what, as Members of Congress, we can do to minimize the coronavirus outbreak for the American public. We need to hear today how Congress can support State and locals in preventing the spread of this virus.

I would like to thank the panel of witnesses today, and look forward to hearing their remarks.

[The statement of Chairman Payne follows:]

STATEMENT OF CHAIRMAN DONALD PAYNE, JR.

MARCH 10, 2020

We are at a critical point in responding to the coronavirus crisis that is facing our Nation. Americans are concerned. Hundreds of Americans are sick. Sadly, there are families mourning the loss of loved ones from the coronavirus and our hearts are with them.

The Nation is seeing cases on the rise and experts say the outbreak is getting worse. In New Jersey, at least 2 dozen schools are closing for coronavirus preparations and we have seen an increase of presumed cases. State and local governments are working tirelessly to limit the spread of the coronavirus in our communities.

At the Federal level, we have seen our experts at the CDC and other agencies working to address this issue. Unfortunately, we have also seen Federal officials offer mixed messages on the seriousness of the coronavirus.

We are not here today to point fingers, but we must tell the truth. The American public needs to be able to trust the information coming from all levels of government. It is now more important than ever for our leaders to trust science and speak with clarity and precision so that Americans can trust what they are hearing.

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Another point of confusion with the administration lies in the test kits. While the experts at CDC and even Vice President Pence have expressed concern about potential testing shortages, the President, on the hand has dismissed these worries.

There have been reports of the White House rejecting the advice of the CDC and even going so far as "muzzling" experts. These reports are troubling. Let's be clear. I want the Federal response to the coronavirus to be robust.

No one is rooting for failure, but what I have seen is leading me to be very concerned.

With that said, the goal of today's hearing is to understand what we as Members of Congress can do to minimize the coronavirus outbreak for the American public. We need to hear today how Congress can support State and locals in preventing the spread of this virus.

Mr. PAYNE. Without objection, I now recognize the Ranking Member of the subcommittee, the gentleman from New York, Mr. King, for an opening statement.

Mr. KING. Thank you, Mr. Chairman. I also want to welcome and thank all of our witnesses today for taking the time to be here. All

of us have a lot to learn on this, and I look forward to your testimony.

The novel coronavirus, or COVID–19, has already claimed thousands of lives across the globe, including over 20 here in the United States. I think, as we realize those numbers will be changing by the hour, it can be different by the end of this hearing, for all we know.

This is not the first time, though, our country has had to deal with an outbreak, and it likely won't be the last. We have been preparing for a situation such as this.

Last year the Department of Health and Human Services conducted the Crimson Contagion 2019 functional exercise, a multi-State, whole-of-government exercise to assess the Nation's ability to respond to a large-scale outbreak.

Last summer the President signed into law the Pandemic and All Hazards Preparedness Act. Since 2015, under Republican and Democratic leadership, funding for infectious disease response has increased by 70 percent—that is 70 percent in 5 years.

While the virus is here now in the United States, we didn't see the first case until mid-January. Implementing travel restrictions bought us time, and mandatory quarantine helped to initially contain the spread of the virus.

Unfortunately, through community spread, positive cases for COVID–19 have now been reported in over 30 States. The New York State Department of Health is reporting over 140 positive cases. Again, that is as of this morning. At the rate they are going, I think there is already several more, just in my county today, and a state of emergency was declared just this past weekend.

Blind panic won't help us stop the virus from spreading. Cooperation, information sharing, and strong leadership are what is critical to successfully deal with a situation of this magnitude. We must ensure that proper protocols are put in place, and the Federal Government works hand-in-hand with our State and local partners.

As recommended, the *National Blueprint for Biodefense* by the Bipartisan Commission on Biodefense—I was pleased to hear last week's panel of witnesses agree with the President's selection of the Vice President to lead the coronavirus task force. To achieve a whole-of-government, coordinated response to this outbreak, it is important that the person in charge has visibility of the entire Government and a direct line to the President. The Vice President is the right choice.

Now, while this has been a vigorous, international—already been a vigorous, international Federal, State, and local response, as the situation continues to unfold I encourage everyone to heed the advice of our medical professionals: Wash your hands, stay home when sick, and visit the Centers for Disease Control and Prevention's website for up-to-date information. I certainly commend the first responders, medical personnel, and public health officials who responded courageously for those who were sick.

Also, if I could just add, you know, there are things we can criticize. I am sure things could have been done earlier at the start. There is no problem with constructive criticism. But I think, if we just criticize for the sake of criticizing, to me that really adds nothing to it. If we can do it in a constructive way, that is fine.

I will say, in a bipartisan way, in my State of New York, under—Governor Cuomo struck the proper balance. Also the county executives in the county I represent have done that also, saying that this is real, but we shouldn't panic, and trying to provide the best health facilities possible. I know that when this does hit a certain stage, they may be overrun. But I think that is what we should be striving for.

At the Federal level—and I would disagree with the Ranking Member on this, as far as muzzling—I think it is important to get a coordinated response out.

Again, there is valid criticism that can be made, but I think we should try to keep it in focus, and try to find ways to go forward. Otherwise, you have one side attacking the other, and then it goes back, and the American people get more confused than ever.

So, I am not here to make excuses, I am not here to explain away things. But I think it is important that we try to treat this as the serious issue that it is. Again, the more briefings we get, the more serious we realize it is, and we should try to keep that focus in that way.

[The statement of Ranking Member King follows:]

STATEMENT OF RANKING MEMBER PETER T. KING

MARCH 10, 2020

The novel coronavirus or COVID–19 has already claimed thousands of lives across the globe, including over 20 here in the United States.

This is not the first time our country has had to deal with an outbreak and it likely won't be the last. Luckily, our country has been preparing for exactly this type of situation. Just last year, the Department of Health and Human Services conducted the Crimson Contagion 2019 Functional Exercise—a multi-State, whole-of-government exercise to assess the Nation's ability to respond to a large-scale outbreak. Last summer, the President signed into law the Pandemic and All-Hazards Preparedness Act. And since 2015, under Republican leadership, funding for infectious disease response increased by 70 percent.

While the virus is here now in the United States, we didn't see the first case until mid-January. Implementing travel restrictions bought us time, and mandatory quarantine helped to initially contain the spread of the virus. Unfortunately, through community spread, positive cases for COVID–19 have now been reported in over 30 States. The New York State Department of Health is reporting over 140 positive cases and a state of emergency was declared just this past weekend.

Blind panic won't help us stop this virus from spreading. Cooperation, information sharing, and strong leadership are critical to successfully dealing with a situation of this magnitude. We must ensure that proper protocols are put in place and that the Federal Government works hand-in-hand with our State and local partners.

As recommended in *A National Blueprint for Biodefense* by the Bipartisan Commission on Biodefense, I was pleased to hear last week's panel of witnesses agree with the President's selection of the Vice President to lead the coronavirus task force. To achieve a whole-of-government, coordinated response to this outbreak, it is important that the person in charge has visibility of the entire Government, and a direct line to the President. The Vice President is the right choice.

While there has already been a vigorous international, Federal, State, and local response, as this situation continues to unfold, I encourage everyone to heed the advice of our medical professionals—wash your hands, stay home when sick, and visit the Centers for Disease Control and Prevention's (CDC) website for up-to-date information.

I commend the first responders, medical personnel, and public health officials who have responded courageously to care for those who are sick. I look forward to hearing from our panel today to understand more about the COVID–19 virus and possible response and mitigation measures moving forward.

Mr. KING. So with that, Mr. Chairman, I yield back the balance of my time.

Mr. PAYNE. Thank you. Did you mean——

Mr. KING. Chairman, I was lost in the past——

Mr. PAYNE. With muzzling, did you mean the Ranking Member, or the Chair?

Mr. KING. I was lost in the past, in the glorious past, when I was Chairman and you were Ranking Member.

Mr. PAYNE. Glory days, glory days. Yes, OK.

[Laughter.]

Mr. KING. I certainly commend you, as our Chairman.

Mr. PAYNE. Thank you, sir.

Mr. KING. I see Yvette laughing over there.

Mr. PAYNE. Other Members of the subcommittee are reminded that, under the committee rules, opening statements may be submitted for the record.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

MARCH 10, 2020

As a Nation, we have faced homeland security crises from acts of terror like the September 11 terrorist attacks and catastrophic natural disasters like Hurricanes Andrew, Katrina, and Maria. Now, the outbreak of the coronavirus reminds how important emergency preparedness and response is for threats of all types.

To date, there have been hundreds of confirmed cases of COVID–19 in the United States, and unfortunately Americans have lost their lives to this virus.

Now, more than ever, we need to let sound science guide our policies. It is clear that the coronavirus is a serious public health threat to this country and it must be treated as such.

Unfortunately, President Trump has downplayed the seriousness of the virus and contradicted CDC officials' warnings about the magnitude of the threat. During President Trump's recent trip to the CDC, which was abruptly canceled and then just as abruptly rescheduled, he wore a campaign hat, compared the delay in test kits to his Ukraine scandal, and spoke against his own officials about the availability of test kits.

Americans need real leadership from all public officials at all levels. Moreover, State and local governments need assistance from the Federal Government. Test kits need to be pushed out for use in communities. Federal funding needs to be available to assist State and local agencies, as none of them are budgeted for responding to a global outbreak.

To that end, I am pleased that Congress moved quickly to get a supplemental funding package to the President's desk. I am hopeful that those resources will support coronavirus response efforts and allow us to make real headway against this threat.

I look forward to hearing from the witnesses today about how the Federal Government can improve its response and provide more support to the State and local governments and agencies on the front lines of this crucial effort. Their success will be our success over the coronavirus, so Congress and the administration must be with them every step of the way.

Mr. PAYNE. I want to welcome our panel of witnesses today.

Our first witness is Mr. Ron Klain, who is—among many other positions in public service, was the White House Ebola response coordinator during the Obama administration, and can provide lessons learned from his time battling a previous public health emergency.

We also welcome today Mr. Christopher Neuwirth, the assistant commissioner of the division of public health infrastructure, laboratories, and emergency preparedness for the New Jersey's department of health. In his role, Mr. Neuwirth provides strategic and operational leadership to coordinate New Jersey's hospital and pub-

lic health disaster resilience, laboratory services, and emergency preparedness and response.

Welcome.

Next we have Dr. Nadine Gracia, the executive vice president and chief operating officer for Trust for America's Health, a nonprofit, nonpartisan organization that promotes optimal health for every person and community that—and advocates for an evidence-based public health system that is ready to meet the challenges of the 21st Century.

Welcome, ma'am.

At this time I would recognize the gentleman from Mississippi, Mr. Guest, to introduce our fourth witness.

Mr. GUEST. Thank you, Mr. Chairman. It is an honor for me today to introduce fellow Mississippian, Dr. Thomas C. Dobbs, III. Dr. Dobbs is the State health officer at the Mississippi State department of health. Dr. Dobbs has served in this role since 2018. Dr. Dobbs has also held previous positions as the health State officer and the State epidemiologist.

He is board certified in internal medicine and infectious disease, and practiced in Mississippi before joining the department of health. Dr. Dobbs holds a doctorate of medicine and a master's in public health from the University of Alabama at Birmingham.

Dr. Dobbs, I personally want to thank you for providing your expertise on this panel today as an infectious disease physician, and for sharing about the coronavirus preparation you are leading in Mississippi. I am proud you have joined us today for this hearing, and look forward to hearing your remarks.

Thank you, Mr. Chairman. I yield back.

Mr. PAYNE. I thank the gentleman.

Without objection, the witnesses' full statements will be inserted into the record.

I now ask each witness to summarize his or her statement for 5 minutes. We are going to keep strict time today, beginning with Mr. Klain.

STATEMENT OF RON KLAIN, FORMER WHITE HOUSE EBOLA RESPONSE COORDINATOR (2014–2015)

Mr. KLAIN. Thank you, Mr. Chairman, Ranking Member King, I thank you for having me here today.

Before I begin I would like to make two preliminary points.

First, as frustrating as it may be, there is still a great deal we do not know about the coronavirus and the disease it causes. In fact, we know less about the coronavirus today than we did about Ebola in 2014. Scientists are working at breakneck speed to improve our understanding, but, as we learn more, our response to the virus will have to change.

Second, while I am a political partisan, I come here today in the same way that I approached my tenure as White House Ebola response coordinator, putting politics aside. There is no Democratic or Republican approach to fighting infectious disease, only sound and unsound measures. It doesn't mean demurring, calling out failures where they appear. I have been critical of many aspects of the administration's response to the coronavirus. Likewise, I have

praised other steps that the administration has taken. Putting politics aside is not putting—does not mean putting judgment aside.

With those 2 preliminary points made, I want to move on to how we can use the lessons we learned in the Ebola response to approach the current threat.

To be clear, the Ebola response itself was not without problems and mistakes. But ultimately, President Obama mustered an all-of-government response to the challenge, authorized the first-ever deployment of U.S. troops to combat an epidemic, and appointed me to lead a team of talented and dedicated professionals at the White House to coordinate the effort.

In the end, that epidemic was tragic: 11,000 people or more died in West Africa. But in September 2014 there was a forecast that a million lives would be lost. America's actions, as part of a global response, saved hundreds of thousands of lives.

The on-going legacy of this work is enormous. With Congress's support we implemented a National four-tier network of hospitals and medical facilities that remain prepared to this day to identify, isolate, and treat cases of dangerous infectious diseases. Nothing like that existed in 2014 before we started. And work on vaccines and therapeutics, as well.

Now the challenge we face from the coronavirus epidemic is different in many ways, but it contains some similarities. So I think it is worth thinking about the lessons that can be applied in this case.

First, in a complex, rapidly-evolving scenario like we are seeing, there is no substitute for White House coordination and leadership. At the end of my tenure as Ebola response coordinator, President Obama accepted my recommendation to create a permanent pandemic preparedness and response operation inside the National Security Council that continued through the first year of the Trump administration. But in July 2018 that unit was disbanded.

The administration's decision now to go through a series of different structures, first no task force, and then a task force led by Secretary Azar, then a task force led by Vice President Pence, then Ambassador Birx coordinating the response has produced uneven results, and certainly has contributed to the largest fiasco in the U.S. response, the failure to promptly enable wide-spread testing for the virus, which definitely is a result of some lack of coordination between CDC and FDA.

There is simply no reason, none, why the United States lags behind nations like South Korea and Singapore in protecting its people.

Second, we must ensure that science and expertise guide our actions, not fear, wishful thinking, or politics. There are reports, as Chairman Payne indicated, of senior officials in the Government rejecting the advice of professionals of the Centers for Disease Control and other aspects of sidelining or ignoring medical advice. There are many policy decisions to be made in the days and weeks ahead. Science and medical expertise must guide them, not politics.

Third, the United States has to lean forward in fighting this epidemic overseas, as that, I think, will become an increasing priority. Unlike what happened in West Africa in 2014, the nations of China or Italy, or South Korea—do not need our help in responding. But

this disease could easily spread to Africa and other countries, where we might have to step up and do the same kind of things we did in 2014.

Fourth, the administration must move quickly to implement the emergency funding bill passed by Congress last week. Congress deserves great credit for acting with unprecedented speed in funding this response. But passing a funding bill is only the first step, not the last step. Congress needs to make sure that the administration is getting that money out, and getting it out quickly and effectively. Too often bills get passed and they don't get implemented. That has to be a priority.

The White House task force should report regularly to the American people on the pace and deployment of the funding Congress provided. Where is the money? When is it getting out? What is going to be done?

Fifth, Congress has to continue to do its own work on the coronavirus. That includes hearings like this, and ultimately, work on things like the economic consequences of the virus.

Sixth, both the Executive and the Congressional branch need to work on the long-standing issues of pandemic preparedness that remain. It is not clear if this will be the big epidemic that we have seen coming, like the Spanish flu was 100 years ago. But, sooner or later, it will come. There is a raft of bipartisan proposals sitting on shelves that Congress has never acted on. Let this be a reminder of the need to act on that.

Then finally, I just want to close by saying public officials at all levels of government need to take steps against discrimination. We are already seeing discrimination against Chinese-Americans, Chinese-American-owned businesses that will spread as this virus spreads. There is—this virus affects humans, not members of any race or ethnicity. We need to step up and make sure there are no victims of that discrimination.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Klain follows:]

STATEMENT OF RONALD A. KLAIN

MARCH 10, 2020

Chairman Payne, Ranking Member King, other Members of the subcommittee: Thank you for inviting me to participate in this hearing today. I want to commend the subcommittee for moving quickly to gather information and educate the public about the coronavirus epidemic that originated in China and has now spread to countries around the world, including our own. It is a privilege to be able to present my perspective on this, and to answer your questions about the emerging U.S. response.

Before I begin my substantive presentation, I want to make two preliminary points.

First, as frustrating as it may be, it is important to understand that what we know about this epidemic and the virus that causes it remains uncertain. We know much less about coronavirus today than we did about Ebola in 2014. Scientists in the United States and around the world are working at unprecedented speed to improve our understanding about the virus and its spread; new papers are being published every day, literally. Nonetheless, there are critical questions about the virus, how quickly it spreads, how infectious it might be, how lethal it will be—and others—for which we still do not know the answers, and that—once learned—will have huge impacts on our response. Part of this is due to a lack of full transparency and cooperation by the Chinese government. But part of this is due to the fact that it takes time for science to learn key facts about a new virus. As someone who was once coordinated the policy making and implementation of a response to an epi-

demic, I know that these information gaps are vexing: Many decisions cannot wait, and have to be made on the best information available. But it is important that we understand this limitation, understand that policy choices will have to change as our fact base changes, and that we be careful not to make definitive or declarative pronouncements when the science does not justify such statements.

Simply put, at present, we do not know how serious this epidemic will become, how many people will contract the virus, how many will die, and how grave the threat is to our country. Such a lack of knowledge does not counsel a lack of action, indeed, perhaps it counsels just the opposite. But it does advise modesty in the forcefulness of our conclusions, and awareness of the need to make changes in policy choices as we gain more information.

Second, a point about partisanship and the response. I am an outspoken political partisan—that is well-known. But I come here today in the same way that I approached my tenure as White House Ebola response coordinator: Putting partisanship and politics aside. The coronavirus will not ask any person's partisan affiliation before infecting them. There is no Democratic or Republican approach to fighting infectious disease; only sound and unsound measures.

That does not mean demurring about calling out failures when they appear: I have been critical of many aspects of the Trump's administration response to the coronavirus epidemic because they reflect failures in execution and communication. Likewise, I have praised positive steps taken by the administration, such as bringing in Ambassador Birx for a leadership role, or getting strong bipartisan support for the Emergency Supplemental that recently passed Congress. Putting politics aside does not mean putting judgment aside, both good and bad.

My point about non-partisan approaches here is illustrated by what we did during the Obama administration's Ebola response. There, we relied heavily on lessons learned and expertise acquired during the Bush administration's efforts to fight AIDS and malaria in Africa. Key players in the Ebola response were veterans of both Democratic and Republican administrations. President Obama's emergency funding package passed this House with strong, bipartisan support; our implementation of it domestically involved close work with State and local officials from both parties; and the input of Members of Congress of all political and ideological camps. Saving lives, abroad and at home, turns on putting politics aside and allowing science, expertise, and sound decision making to govern our actions.

With these two preliminary points made, I want to move on to the subject of my testimony today: How the lessons we learned during the Ebola response in 2014–15 should shape how our Government—in the Executive and Legislative branches—approaches the threat now posed by the novel coronavirus.

To be clear, the Ebola response was not without its own problems and mistakes. Particularly early on, the danger to Africa and the world was underestimated; early signs of progress in containing the disease in the spring of 2014 led to a false sense of security. The fact that no Ebola outbreak prior to 2014 had ever involved more than 500 cases of the disease also led to a false confidence that a large-scale epidemic was unlikely. Early initiatives in West Africa lacked a full understanding of the complexities of implementation there and cultural and religious barriers to some aspects of the response. Confusion and a lack of preparation led to missteps when the first case of Ebola arrived in Dallas, Texas, in late September, 2014.

But ultimately, the United States got the response organized; quickly adapted and improved its approach; and made adjustments to what responders were doing in Africa and here at home. President Obama mustered an all-of-government response to the challenge, authorized the first-ever deployment of U.S. troops to combat an epidemic ("Operation United Assistance"), appointed me to lead a team of dedicated and talented professionals at the White House to coordinate this effort, implemented novel and innovative policies on travel screening and monitoring, and won Congressional approval of a $5.4 billion emergency package to fight the disease abroad and improve our preparedness at home and around the world for future such epidemic threats.

In the end, the epidemic in West Africa was tragic: An official death toll of over 11,000, with the real count likely higher. But the backdrop for this loss of life must be considered. In September 2014, experts forecast that the death toll could be over 1 million people; thus, the response succeeded in helping to reduce the projected loss of life dramatically. America's actions—as part of a global response, with Africans playing the largest part, deserving the greatest credit, and suffering the harshest losses to its health care workers—saved hundreds of thousands of lives. It was a great humanitarian achievement.

Here at home, after the initial missteps in Dallas, no one contracted Ebola on U.S. soil, and Americans evacuated for medical care in the United States were successfully treated and released, with only a lone fatality. Once implemented, our moni-

toring system successfully insured no domestic transmission of the disease, routed suspected cases to prepared medical facilities before those patients could be infectious, and enabled ample time for successful testing and response.

The on-going legacy of this response is likewise enormous. With Congress' support, we implemented a National four-tiered network of hospitals and medical facilities that remain prepared to this day to identify and isolate cases of dangerous infectious disease, and to provide treatment to those who are infected—nothing like this existed in 2014 when the Ebola epidemic began, as many earlier investments made after the anthrax attacks in 2001 had been allowed to dissipate. The capacity to test for and promptly identify diseases like Ebola grew from 3 laboratories in the United States in September 2014 to almost 100 by the end of that year. We developed rapid diagnostics that ended the risky practice of having patients wait days to learn if they were sick and/or infectious. Vaccines against Ebola were tested and developed, and as a result of that work, an effective vaccine now exists and is being used in the field. New therapeutics were developed that helped reduce the mortality rate of Ebola dramatically.

It is no wonder that this effort—without in any way minimizing the devastation in West Africa—is seen today as a huge success. Tom Friedman wrote last year that that West African Ebola response was:

"[President Obama's] most significant foreign policy achievement, for which he got little credit precisely because it worked—demonstrat[ing] that without America as quarterback, important things that save lives and advance freedom at reasonable costs often don't happen."

From mid-October 2014 to mid-February 2015, I was proud to lead the team at the White House that coordinated this response. We saw the weekly new case count in West Africa drop from about 1,000 a week to fewer than 5 a week, at which point the President announced the end of Operation United Assistance and began the withdrawal of U.S. troops serving in that mission.

This was a truly global response, with tremendous contributions by Government officials, NGO's, and volunteers from around the world, and particularly close partnership with our allies in the United Kingdom and France. With regard to the U.S. part of this global effort, special thanks should go to the men and women on the front lines. This includes our members of the 101st Airborne (who constituted the bulk of Operation United Assistance), and also, civilian responders—via USAID DART teams and CDC employees deployed to the region, and contractors who supported them. It includes the men and women of the U.S. Public Health Service who staffed the Monrovia Medical Unit in Liberia. It includes our career Ambassadors and other diplomats who served in all 3 affected countries with skill and played such a large role in the response. It includes the doctors, nurses, and other health care workers—many volunteers—who served in Ebola treatment units, hospitals, and other facilities—treating the sick under extreme conditions. It includes the scientists of the NIH and the CDC who pioneered new diagnostics, therapeutics, and vaccines. The U.S. response put over 10,000 people—soldiers and civilians, Government workers and NGO teams, contractors and volunteers—on the ground in West Africa in 2014–2015. It was a gargantuan undertaking, and a story in which all Americans should take pride.

To make that effort effective, and to match it with preparation and protection here at home, it took talented teams in Washington, in Atlanta at the CDC, and in Government agencies and private health care facilities around the country. Public servants of all ranks and all levels worked around the clock. As I mentioned before, Congress acted swiftly and on a bipartisan basis to approve most of the Obama administration's request for $6 billion in aid, less than 5 weeks after it was sent to Capitol Hill.

I would be remiss if I did not say that, of course, President Obama, too, deserves credit for this success. He weathered sharp criticism for his actions during the Ebola response, and had to ignore pressures to put aside the advice he was getting from top scientists and medical experts. He made difficult decisions about the actions we took abroad and at home. He communicated openly and directly with the American people, and chaired repeated meetings of the National Security Council as the response took shape. He used every tool at his disposal—from his bully pulpit (to destigmatize survivors by publicly hugging Ebola patient Nina Pham in the Oval Office after her discharge from the hospital), to authorizing the massive deployment to West Africa, to personally engaging numerous world leaders to activate their resources and support for the response, to pressing Congressional leaders to approve his emergency spending package, and much more: He did so much to achieve these results.

The challenge we face from the coronavirus epidemic now rapidly accelerating contains many similarities, but also, many differences from the challenge posed by the Ebola epidemic in West Africa in 2014–15. It would be a mistake to simply repeat what we did at that time, given those many differences. But likewise, it would also be a mistake to ignore the lessons that can be learned from that response, given the similarities. Hence, I am grateful for the opportunity to talk about the lessons I think are most applicable from this experience, to be applied in the current circumstance.

Among the many possible lessons that should be employed now, there are 7 in particular that I would like to call out today. I will do so briefly, but I am happy to go into more depth on any of them in response to your questions or any subsequent follow-up from the subcommittee.

First, in a complex, rapidly-evolving scenario like the one we are seeing, there is no substitute for White House coordination and leadership. While the centralization of leadership of the response in Vice President Pence and his team is an improvement over where things stood days ago, there remains confusion with the structure, and the lack of a single, full-time official inside the National Security Council at the White House overseeing our response.

At the end of my tenure as Ebola Response Coordinator, I said that there should never be another specific "Disease Czar" at the White House. Instead, I recommended to President Obama that he create a permanent "Pandemic Preparedness and Response" directorate inside the NSC, led by a Deputy National Security Adviser-level appointee with direct access to the President as needed, to oversee ongoing work to prepare for the inevitable next time, and to coordinate a response to an epidemic when it arrived.

President Obama accepted this recommendation, and set up such a unit in 2015. President Trump continued with the structure, and named Admiral Tim Ziemer—a respected long-time public servant—to fill this post. If Admiral Ziemer were still in place, I believe that America would be much better positioned to respond to the coronavirus threat today.

But unfortunately, in July 2018, when John Bolton took over as head of the NSC, he disbanded this unit, and Admiral Ziemer was reassigned to USAID. As a result, there has been no special unit at the NSC to oversee preparedness for epidemics, or the current response. In addition, the Trump administration has dismantled the Homeland Security Advisor structure that Presidents Bush and Obama used to deal with complex transnational threats, further undermining our preparedness for events like these.

The administration's sequential decisions to first say no special structure was needed to manage the response; then to create a "Task Force" to oversee the response, led by Secretary Alex Azar; then to replace Secretary Azar with Vice President Pence as the official in charge of that Task Force; and then to bring in Ambassador Birx as the coordinator of the response, part-time, reporting to VP Pence, has produced uneven results. The response is likely to be a massive undertaking of multiple agencies, State and local governments, private and public sectors, and international partners. We are still in the early days, with many tasks left undone.

But it seems that already the largest fiasco in the U.S. response—the failure to promptly enable wide-spread testing for the virus—is at least in part a product of this coordination problem, with CDC blaming FDA, other officials pointing fingers at CDC, and a delayed engagement of State and local labs and private alternatives. There is simply no reason—none—why testing in the United States should lag nations like South Korea or Singapore.

For these reasons, and many more, an effective response to a challenge like coronavirus must be led by a full-time appointee at the White House. Ideally that decision would be made by the Executive branch, but another avenue to achieve this structure would be for Congress to move ahead on the Global Health Security Act (HR 2166), introduced by Reps. Connolly and Chabot, as that bill which impose much of this apparatus by statute.

Second, the administration must ensure that science and expertise guide our actions, not fear, wishful thinking, or politics. One of the first casualties in an epidemic is rational thinking, replaced by fear, bias, and poor decision making. We saw this in 2014 with calls for needless travel bans and baseless quarantine restrictions; President Obama was right to reject these misguided calls, and to implement travel and monitoring policies based on the scientific advice he got from the Nation's leading experts.

In this case, there are troubling reports that the advice of senior officials of the Centers for Disease Control have been ignored with regard to travel advisories and public awareness. The President himself has suggested that passengers on a cruise ship with many infected persons aboard are being handled in a fashion—not gov-

erned by medical considerations—but by a desire to keep tallies of U.S. cases low. Officials who spoke publicly and truthfully of the "inevitability" of spread of the disease in the United States have been sidelined. We do not yet know whether this mindset—trying to minimize the disease, and downplay warnings—is contributing to the sluggish response of our Government. But in my experience, the tone set at the top governs how key players respond, and it seems unlikely that what we have heard from the President has been helpful.

More generally, there will be many policy decisions to be made in the days and weeks ahead. Science, medicine, and expertise should guide them. The American people are lucky to have the world's leading experts on infectious disease working in their government, led by men and women like Tony Fauci at NIH and Anne Schuchat at CDC. They have served Democratic and Republican administrations, and helped Presidents with a wide variety of political perspectives save lives and protect our Nation. This expertise should be paramount in decision making at all levels of government.

Third, the United States must "lean forward" to fight this epidemic overseas, using all of the tools and leverage that we can commit to the effort. Unlike West Africa in 2014, today in 2020, China, South Korea, Italy, Iran, and Japan—the hardest-hit countries to date—probably do not need, and/or would not accept, thousands of U.S. responders on the ground treating patients, testing new approaches, conducting research, providing infrastructure, and helping bring the disease under control. This is a huge difference.

But that should not get us off our toes, or have us sitting back and believing that our only sphere of action is the homeland. Dr. Tony Fauci of NIH has publicly urged the deployment of medical researchers and investigators to China, and key administration leaders should apply pressure to encourage the most open access possible. Nations less advanced or well-resourced than South Korea or Italy may experience significant coronavirus outbreaks and require more direct forms of U.S. assistance, akin to what we provided during the 2014 Ebola epidemic. We should send CDC experts wherever they would be helpful, and task USAID to determine where DART teams and other assistance could be usefully deployed. Likewise, we should bolster preparedness in low-income countries now—before the disease spreads further—to avoid spread in places where local containment efforts might fail. The danger of a coronavirus epidemic in Africa is enormous, and its potential consequences catastrophic. Our diplomats should be empowered and engaged around the globe, and our Government must press WHO—which has stronger leadership today under Dr. Tedros Adhanom Ghebreyesu than it had during the 2014 Ebola epidemic—to do the right thing.

This is a global challenge, and America must provide global leadership. There is no room for isolationism or withdrawal. The best way to keep Americans safe is to combat the virus overseas. We should do this not only because it is generous or humanitarian—though it would be generous and humanitarian, both great American traits—but because it will make America safer and reduce the spread of the epidemic here.

Fourth, the administration must move quickly to implement the emergency funding package passed by Congress last week, to ensure that there are no further delays in responding to the coronavirus challenge. As Congress recognized in passing this bill, fighting the coronavirus will cost money. Key Federal agencies will have costs. State and local governments will feel a pinch from monitoring contacts of those who have the virus, and tracking and monitoring individuals who have been in affected countries. Hospitals treating patients with the virus will need assistance of all sorts. Research and deployment of new therapeutics and vaccines needs Government support, and funding for private-public partnerships. The list of needs goes on.

As I will discuss in a minute, Congress acted with unprecedented speed in passing an Emergency Supplemental Funding package to help address these needs. But passage of that package is only the first step. As we learned during the Ebola response, that funding only makes a difference if the administration acts with speed in putting the funding to work: With focus and pace, and a plan for implementation that has clear metrics and accountability. At the top of my list would be testing, and preparing the health care system for an influx of cases—to increase capacity and to avoid the danger of an overwhelmed system suffering failure.

The White House Task Force led by Vice President Pence should report regularly to the American people on the pace of deployment of the Emergency Supplemental: What has been put to work and where. Not all of the money will be spent immediately, nor should it be: Our needs will develop and change in the months ahead. But quick action by Congress in passing this package must be matched by quick action in putting it to work.

Fifth, Congress must continue to do its own work in dealing with the coronavirus. The burden of action does not rest entirely with the Executive branch; Congress too must do its part.

Congress has already acted admirably in passing with impressive speed an Emergency Supplemental funding plan to power the coronavirus response. That this happened in a matter of days after the administration made such a request, at a level substantially more robust and detailed than the administration's request, all are to Congress' credit. It was also encouraging to see that action come with strong bipartisan support, as it should be.

But Congress' role does not end with acting on the emergency funding question. There are a number of other elements of the response that demand Congressional attention. Hearings like today's are important, to help ascertain how the response is going and where it needs to be improved. Congress wisely funded the Public Health Emergency Fund last year—but did so only on a limited basis. Adding to that funding, and funding a second emergency fund specific to the development of therapeutics and vaccines in public-private partnerships, should be considered. In addition, action to address the economic consequences of the outbreak will also be needed.

Moreover, as I wrote in the *Post* with Dr. Syra Madad in December—before the coronavirus hit—Congress is overdue to renew the funding for the network of "Ebola and Special Pathogens" Hospitals. This network was created during the Ebola epidemic in 2014, and funding for it expires in May 2020. Pending legislation would fund only the 10 most advanced such facilities, and would end Federal funding for the 60 other hospitals that screen, test, and provide initial treatment for these cases. Allowing this funding to expire in May would be a huge mistake.

Sixth, both the Executive branch and the Congress should take this as a wake-up call to finish the work we need to do on pandemic preparedness and readiness. Recently, America marked the 100th anniversary of the single largest mortality event in our history: The Spanish Flu epidemic of 1918–19. More Americans died from this epidemic than from World War I, World War II, the Korean War, and the Vietnam War—combined. While, on the one hand, science has made great strides since 1918, on the other hand, increased global travel, human incursion on animal habitats, and the stresses of climate change have raised the risk that we will face such a "great pandemic" once again, sooner or later.

At present, it seems very unlikely that the coronavirus poses such a threat to the United States—but we cannot know for certain. Moreover, even if this current epidemic is not "the big one" that is coming, it is a reminder that this danger lurks, and our preparedness for it is lacking. As Dr. Ashish Jha of the Harvard Global Health Institute often says, "Of all the things that can kill millions of Americans quickly and unexpectedly, an epidemic is probably the most likely . . . and the one in which we invest the least to prevent."

The Global Health Security Agenda, legislation such as H.R. 2166, Blue Ribbon Commission reports, table-top exercises, proposals from Members of this subcommittee—and my own extensive writing over the past 5 years—have set forth detailed agendas of what we need to do to prepared for this event. These bipartisan calls for action have been largely ignored. The current public focus on infectious disease generated by the coronavirus should spur us into action. The time to act on this agenda is now. If we wait until the catastrophic pandemic arrives, it will be too late.

Seventh, public officials of all parties and at all levels of government need to be on the watch for discrimination against people in our country of Chinese descent, and speak out strongly against any such fear-driven racism. The coronavirus strikes humans—not people of any particular ethnicity or race. Chinese-Americans or Chinese people in America are no more likely to get the disease, carry the disease, or transmit the disease, than any other group of people.

Yet we have already seen signs that such people are the targets of discriminatory fear—with some already being hassled, threatened with expulsion from schools and other mistreatment. As fears of the coronavirus accelerate, so too will these incidents. This kind of discrimination not only is wrong, but also makes it harder to combat the disease. If some members of the Chinese-American community feel that they are likely to face hostility, they are less likely to come forward when symptoms appear, and less likely to heed advice of public health experts.

It is incumbent on every person in authority in this Nation to speak out against such racism, and to ensure that this does not become part of our civic life during the coronavirus epidemic. Americans need to pull together to fight a disease, not pull apart to fight one another.

In closing, I want to again thank the subcommittee for holding this hearing, and for inviting me to participate. I stand ready to answer your questions about any of these points, or any other aspects of the response.

America has the tools, the talent, and the expertise to combat the coronavirus, both abroad and at home. The question now is whether our leaders, in the Executive branch and the Congress, will deploy them effectively; act promptly and wisely; rely on expertise—not bias and fear; organize and implement our response appropriately; and allow science and medicine to be our touchstone. For the sake of people around the world, and for the sake of the American people, let us work to see that it is so.

Mr. PAYNE. Thank you.

The Chair now recognizes Mr. Neuwirth to summarize his statement for 5 minutes.

STATEMENT OF CHRISTOPHER NEUWIRTH, MA, MEP, CBCP, CEM, ASSISTANT COMMISSIONER, DIVISION OF PUBLIC HEALTH INFRASTRUCTURE, LABORATORIES, AND EMERGENCY PREPAREDNESS, NEW JERSEY DEPARTMENT OF HEALTH

Mr. NEUWIRTH. Good afternoon, Chairman Payne, Ranking Member King, and Members of the subcommittee. On behalf of New Jersey Governor Phil Murphy and New Jersey Health Commissioner Judith Persichilli, thank you for inviting the New Jersey Department of Health to participate in today's hearing.

I am here before you as the assistant commissioner for the division of public health infrastructure, laboratories, and emergency preparedness. I am responsible for public health, emergency management, emergency medical services, and the public health and environmental laboratories. My goal today is to share with you New Jersey's experience for preparing for and responding to the novel coronavirus public health crisis.

More so, I will share with you experience working with our Federal partners at the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention. I am hopeful that, by sharing with you how New Jersey has responded to the novel coronavirus public health crisis, that you will be able to strengthen and enhance the coordination between critical Federal agencies and all States, including New Jersey.

Throughout January the department of health actively monitored the public health situation arising from Wuhan City, China. Our public health experts and epidemiologists readily identified a concerning novel pathogen that undoubtedly had the potential to escalate into a global pandemic.

Under the leadership of Commissioner Persichilli, on January 27, I established an internal crisis management team using National incident management system principles to coordinate preparedness and response activities from across the department.

Shortly thereafter, on February 3, Governor Murphy signed executive order 102, creating a State-wide coronavirus task force led by the commissioner of health. Since their creation, the crisis management team and coronavirus task force have provided the State of New Jersey with an incident command structure that has allowed all departments to effectively organize, coordinate, and prioritize their preparedness and response activities.

Simply stated, New Jersey continues to successfully manage the public health crisis because of our strategic organization, subject-matter expertise, and our collective institutional knowledge.

While I certainly could continue describing all of the great work New Jersey is actively doing, I must draw your attention to the two most important aspects of any Nation-wide public health response: Coordination and communication.

On Sunday, February 2, during the afternoon of Super Bowl Sunday, the New Jersey Department of Health was notified that Newark Liberty International Airport would officially be designated as the 11th funneling airport in the United States, with the first arriving flights arriving within 24 hours with more than 350 travelers on board from China.

Within moments of receiving this news, our crisis management team began working feverishly to secure housing, transportation, and wraparound services for these individuals potentially facing quarantine. Because we had established a crisis management team that was well-organized, highly-disciplined, and remarkably proactive, we were able to effectively coordinate a measured response in a moment's notice.

More importantly, as New Jersey begins facing its first cases of novel coronavirus just last week, the crisis management team and coronavirus task force continue to effectively coordinate all aspects of the State's response to ensure that communications remain organized, timely, and in the public's best interest.

Throughout the past 8 weeks, my team has been in lockstep with our friends and colleagues at the U.S. Department of Health and Human Services and at the CDC, both at headquarters and within region 2. The daily interactions and near-real time communications during fast-moving situations has allowed the State of New Jersey to effectively communicate and coordinate our activities between all stakeholders.

As novel coronavirus continues to affect New Jersey, the strong relationships we have with our Federal counterparts ensures that we can communicate candidly and resolve issues immediately as they arise. In a dynamic public health crisis such as this, maintaining tight coordination through streamlined, clear communications greatly increases the effectiveness of our collective response.

But despite our great partnership with our Federal colleagues, the State of New Jersey expends more than $1.8 million per month responding to novel coronavirus. While our CDC award of $1.75 million is greatly appreciated, it certainly will not cover the continued expenses incurred by the State or the health care and public health infrastructure, including our acute care facilities, EMS agencies, and local health departments.

Recognizing that medical supplies are facing a historic shortage, and that health care supply chain is nearly frozen for respirators, disinfectants, and other personal protective equipment, we urge you to consider additional funding to New Jersey and the distribution of items from the strategic National stockpile.

New Jersey remains committed to fighting novel coronavirus and protecting the public health and safety of all people living in and traveling through New Jersey. As the country continues to respond to this public health crisis, we ask that you remain attentive to the

evolving needs of each State, specifically New Jersey, and mobilize the information, resources, and funding needed to protect the Nation's public health and safety.

Thank you.

[The prepared statement of Mr. Neuwirth follows:]

PREPARED STATEMENT OF CHRISTOPHER NEUWIRTH

MARCH 10, 2020

COMMUNITY PERSPECTIVES ON CORONAVIRUS PREPAREDNESS AND RESPONSE

Good afternoon Chairman Payne, Ranking Member King, and Members of the subcommittee. On behalf of New Jersey Governor Phil Murphy and New Jersey Health Commissioner Judith Persichilli, thank you for inviting the New Jersey Department of Health to participate in today's hearing.

I am here before you as the assistant commissioner for the Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness. I am responsible for public health emergency management, emergency medical services, and the Public Health and Environmental Laboratories. My goal today is to share with you New Jersey's experience preparing for and responding to the novel coronavirus public health crisis. More so, I will share with you experience working with our Federal partners at the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention. I am hopeful that by sharing with you how New Jersey has responded to the novel coronavirus public health crisis, that you will be able to strengthen and enhance the coordination between critical Federal agencies and all States, including New Jersey.

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While I certainly could continue describing all the great work New Jersey is actively doing, I must draw your attention to the most important aspects of any Nation-wide public health response—coordination and communication.

On a Sunday, February 2, during the afternoon of Super Bowl Sunday—the New Jersey Department of Health was notified that Newark Liberty International Airport would be officially designated as the eleventh funneling airport in the United States, with the first flight arriving within 24 hours, with more than 350 travelers on-board from China. Within moments of receiving this news, our Crisis Management Team began working feverishly to secure housing, transportation, and wrap-around services for these individuals potentially facing quarantine upon their arrival. Because we had established a Crisis Management Team that was well-organized, highly disciplined, and remarkably proactive, we were able to effectively coordinate a measured response in a moment's notice. More importantly, as New Jersey began facing its first cases of novel coronavirus just last week, the Crisis Management Team and Coronavirus Task Force continue to effectively coordinate all aspects of the State's response and ensure that our communications remain organized, timely, and in the public's best interest.

Throughout the past 8 weeks, my team has been in lockstep with our friends and colleagues at the U.S. Department of Health and Human Services and the CDC—both at headquarters and within Region 2. The daily interactions, and near-real time communications during fast-moving situations, has allowed the State of New Jersey to effectively communicate and coordinate our activities between all our stakeholders. As novel coronavirus continues to affect New Jersey, the strong relationships we have with our Federal counterparts ensures that we can communicate candidly and resolve issues immediately as they arise; in a dynamic public health

crisis such as this, maintaining tight coordination through streamlined, clear communications greatly increases the effectiveness of our collective response.

But despite our great partnership with our Federal colleagues, the State of New Jersey expends more than $1.8 million dollars per month responding to novel coronavirus. While our CDC award of $1.75 million dollars is greatly appreciated, it certainly will not cover the continued expenses incurred by the State or the health care and public health infrastructure serving on the front lines—specifically local health departments, acute-care facilities, and EMS agencies. Recognizing that medical supplies are facing a historic shortage, and the health care supply chain is nearly frozen for respirators, disinfectants, and other personal protective equipment—we urge you to consider additional Federal funding to New Jersey and the distribution of items from the Strategic National Stockpile.

New Jersey remains committed to fighting novel coronavirus and protecting the public health and safety of all people living in, and traveling through, New Jersey. As the country continues to respond to this public health crisis, we ask that you remain attentive to the evolving needs of each State, specifically New Jersey, and mobilize the information, resources, and funding needed to protect the Nation's public health and safety.

Again, thank you for this opportunity to testify and I welcome your questions.

Mr. PAYNE. Thank you, sir. Our next witness, which—I was told by my staff that I butchered your name, so I will try to do better.

Ms. Gracia? I am sorry about that. I now recognize you to summarize your statement for 5 minutes.

STATEMENT OF J. NADINE GRACIA, MD, MSCE, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, TRUST FOR AMERICA'S HEALTH

Ms. GRACIA. Thank you, Chairman Payne, Ranking Member King, and all the Members of the subcommittee. Good afternoon. My name is Dr. Nadine Gracia, and I am the executive vice president and chief operating officer at Trust for America's Health, also known as TFAH.

TFAH is a nonprofit, nonpartisan public health organization which, among our priorities, has focused attention on the importance of a strong and effective public health emergency preparedness system. Over the past nearly 2 decades, TFAH has published an annual report, called "Ready or Not: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism."

In our most recent report we identified areas of strength in our emergency preparedness, as well as areas that need attention at the Federal and State levels. Discussion of our report findings, including our State assessments, can be found in my written testimony or on our website. I would like to highlight some of TFAH's policy recommendations to build our Nation's preparedness for our public health emergencies, and improve the National response to the novel coronavirus disease, or COVID–19.

First, we applaud Congress for rapidly approving a robust emergency Federal funding package. Federal agencies should be preparing now to quickly distribute funds to States and other partners.

Second, Congress must prioritize on-going investment in core public health and annual appropriations. The Nation's ability to respond to COVID–19 is rooted in our level of public health investment in the last decade. The Nation has been caught in a cycle of attention when an outbreak or emergency occurs, followed by complacency and disinvestment in public health preparedness, infrastructure, and work force. The Public Health Emergency Prepared-

ness Line, which supports front-line State and local public health preparedness, has been cut by over 20 percent since fiscal year 2010, adjusting for inflation, and on top of steady cuts since 2004.

In addition, we have long neglected our public health infrastructure. So many health departments are reliant on 20th-Century methods of tracking diseases such as via paper, fax, and telephone. Congress should prioritize funding for data modernization to help with emergencies, as well as on-going disease tracking.

Third, we need to ready the health care system for outbreaks. Health systems across the Nation are beginning to identify, isolate, and care for patients with COVID–19. Health care must prioritize the protection of patients and health care workers, including appropriate training on infection control practices, personal protective equipment, and surge capacity. Unfortunately, funding for the hospital preparedness program, which helps prepare the health care system to respond to and recover from emergencies, has been cut nearly in half since 2003.

Fourth, Congress should support the medical countermeasures enterprise, including BARDA and the Strategic National Stockpile, which build the pipeline of vaccines, treatment, medical equipment, and supplies for health security threats.

Fifth, we must build the pipeline of the public health work force. Although supplemental funding may help with short-term hiring, this temporary funding does not allow for recruitment and retention of workers. Emergency preparedness and response are personnel-intensive endeavors that require training, exercise, and coordination across sectors. This experience just cannot be built overnight.

Sixth, Congress and employers should consider job-protected, paid sick leave to protect workers and customers from infectious disease outbreaks. One of the recommendations we have repeatedly heard is to stay home when sick. For millions of Americans, that is not a realistic option. They risk losing a paycheck, and possibly their jobs if they stay home when sick or to care for a loved one.

In fact, only 55 percent of the work force has access to paid time off. Congress should pass a Federal law to require employers to offer paid sick days as soon as possible.

Finally, science needs to govern the Nation's COVID–19 response, led by Federal public health experts who have years of experience in responding to infectious disease outbreaks. Keeping the public and partners informed will be critical. We encourage elected officials and community leaders at all levels to make policy and communications decisions based on the best available science, understanding that the situation is evolving rapidly and messages may change.

Communities that are considering school or business closures should follow public health guidance, but also consider unintended consequences. For example, nearly 100,000 schools serve free and reduced meals to 29.7 million students each day. The U.S. Department of Agriculture should be implementing flexibility for schools to make grab-and-go meals and other options available if schools are to close.

The full extent of this outbreak, in terms of public health, health care, and economic and societal costs remains to be seen. We do

know that taking immediate steps to mitigate the effects of this outbreak will save lives and prevent harm.

Thank you for the invitation to participate today, and I look forward to your questions.

[The prepared statement of Ms. Gracia follows:]

PREPARED TESTIMONY OF J. NADINE GRACIA

MARCH 10, 2020

Good afternoon. My name is Dr. Nadine Gracia, and I am executive vice president and chief operating officer of trust for America's Health, or TFAH. Our organization is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. For many years we have focused attention on the importance of a strong and effective public health emergency preparedness system.

I previously served as the deputy assistant secretary for minority health at the U.S. Department of Health and Human Services (HHS) and chief medical officer in the Office of the Assistant Secretary for Health. I was involved in the Nation's responses to emergencies such as the 2010 earthquake in Haiti, the Flint water crisis, the Deepwater Horizon oil spill, and the Ebola and Zika outbreaks.

I am here today to discuss TFAH's policy recommendations to build our Nation's preparedness for public health emergencies and improve the National response to the novel coronavirus disease, or COVID–19.

TFAH'S READY OR NOT REPORT

Over the past nearly 2 decades, TFAH has published an annual report called "Ready or Not: Protecting the Public's Health from Diseases, Disasters and Bioterrorism." Our most recent report was published in February. In it, TFAH provides an assessment of States' level of readiness to respond to public health emergencies and recommends policy actions to ensure that everyone's health is protected during such events. The 2020 edition found unevenness in the Nation's readiness for a major emergency. While there were indications of recent improvements in some components of preparedness, our report identified areas that needed attention.

Our report is not intended to be an exhaustive review of health security data, but instead serves as a checklist of priority issues and action items for States to address.

State Assessment

In our State assessment, some key findings relevant to the response to the novel coronavirus:

We do not have a ready system in place to vaccinate the entire population:

- Less than half the population, on average, received the seasonal flu vaccine.[1] That low rate is concerning for a number of reasons—(1) the spread of flu at the same time as COVID–19 makes it harder for clinicians to recognize COVID–19; (2) if people have the seasonal flu, they may be more likely to have severe illness if also infected with COVID–19 and (3) if a mass vaccination campaign is needed in the future, it is vital that we have systems in place that can administer vaccines and a population ready to receive them.
- There are barriers to the recommendation that workers should stay home when sick. An average of 55 percent of employed workers have access to paid time off.[2] Paid time off, especially paid sick days, are critical to ensure workers can stay home when sick, caring for a sick loved one, or if measures are taken such as school and workplace closures. Without paid sick time, a worker with flu symptoms might lose income that is essential to cover basic costs like rent or food.

The public health system has been weakened by budget cuts and fewer personnel:

- More than 50,000 public health jobs have been eliminated in the Nation and public health emergency preparedness funds have been cut by a third. In the last year alone, 11 States cut their public health funding. Investing in the public health infrastructure and workforce before an outbreak or emergency hits is critical to having the systems in place ahead of time. Hiring in the middle of

[1] *https://www.cdc.gov/flu/fluvaxview/coverage-1819estimates.htm*.

[2] National Health Security Preparedness Index analysis of Annual Social and Economic Supplement of the Current Population Survey. *www.nhspi.org*.

an outbreak is important but is no substitute for the training and experience in place ahead of time.

There are obstacles to cross-State cooperation during a major outbreak:

- A third of the States lack a nurse licensure compact, which allows nurses to practice across State lines. This can be relevant when additional clinical staff are needed in an emergency.[3] This is particularly useful if some States experience a greater impact than others.

More work is needed to ensure hospitals are fully prepared for emergencies:

- Only 30 percent of hospitals achieved an A grade on patient safety measures, according to The Leapfrog Group.[4] Hospitals that excel in safety are often better positioned to handle public health emergencies and protect the safety of patients and workers. Hospital preparedness has also been hampered by a 50 percent reduction in the Federal Hospital Preparedness Program.

There was some good news as well in this year's report. We found that:

- Most States were accredited in the areas of public health,[5] emergency management[6] or both. Such accreditation helps ensure that necessary emergency prevention and response systems are in place and staffed by qualified personnel.
- Public health laboratories have long planned for the kinds of surge of testing capacity we might see during this response. However, their capacity in an outbreak with a novel virus like the novel coronavirus is dependent upon the availability of test kits and additional supplemental funding to handle the increased workload.

These data points are not intended to grade or shame any State but instead point to areas where policy makers, State agencies, the health care sector, and even individuals could take steps to improve readiness.

All-hazards preparedness and response

TFAH's report also includes a review of emergencies of the past year. We point out how States and localities have responded to many incidents in the past year, including lung injuries associated with vaping, measles outbreaks, hepatitis A outbreaks, extreme flooding throughout the central part of the country, wildfires, and other disasters. Even with reduced funding and staffing, public health personnel have taken extraordinary steps to protect the public. However, what we are seeing with COVID–19 goes beyond what States and locals can respond to without additional Federal assistance. Health departments have already begun adding staff, updating laboratory capacity, implementing isolation and quarantine policies, investigating cases, and conducting risk communications to the public and health care facilities.[7] We need to ensure our front-line public health departments have the resources they need—as quickly as possible—to mount a robust response to the virus. And we must remember that other emergencies as well as essential core public health activities are occurring at the same time as the novel coronavirus threat. This was tragically illustrated recently with the tornado in Tennessee. The same public health personnel who respond to COVID–19, were also responding to this emergency.

Report's Policy Recommendations

Finally, TFAH's report includes policy recommendations for Congress, Federal agencies, State governments, and other stakeholders. Many of our policy recommendations apply to the current outbreak. Today I will highlight a few of these and speak to our additional recommendations for the COVID–19 outbreak response.

- Congress must prioritize on-going investment in core public health as part of the annual appropriations process. The Nation's ability to respond to COVID–19 is rooted in our level of public health investment of the last decade. That is, being prepared starts well before the health emergency is upon us and is grounded in year-in and year-out investment in public health. The Nation has been caught in a cycle of attention when an outbreak or emergency occurs, fol-

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[3] Nurse Licensure Compact in National Council of State Boards of Nursing, 2019. *https://www.ncsbn.org/nurse-licensure-compact.htm*.

[4] Hospital Safety Grade State Rankings. Leapfrog Hospital Safety Grade. *https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings*.

[5] Public Health Accreditation Board. *https://phaboard.org/*.

[6] *EMAP Accredited Programs in EMAP. https://emap.org/index.php/what-is-emap/who-is-accredited*.

[7] Governmental Public Health Leaders Request Emergency Supplemental Funding for COVID–19 Preparedness and Response Efforts (press release). Association of State and Territorial Health Officials, National Association of County and City Health Officials, Association of Public Health Laboratories and Council of State and territorial Epidemiologists. *astho.org/Press-Room/Gov-Public-Health-Leaders-Request-Emergency-Supplemental-Funding-for-COVID-19/02-24-20/*.

lowed by complacency and disinvestment in public health preparedness, infrastructure and workforce. These are systems that cannot be established overnight, once an outbreak is under way. Programs like the Public Health Emergency Preparedness Cooperative Agreement, which supports front-line State and local public health preparedness, are underfunded compared to a decade ago and in terms of the increasing number of major crises public health is facing. PHEP funding has declined by over 20 percent since fiscal year 2010, adjusting for inflation,[8] on top of steady cuts since 2004.

In addition, we have long neglected our public health infrastructure, so many health departments are reliant on 20th Century methods of tracking diseases, such as paper, fax, and telephone.[9] Congress should prioritize funding for data modernization to help with emergencies as well as on-going disease tracking. Public health needs a highly skilled workforce, state-of-the-art data and information systems and the policies, plans, and resources to meet the routine and unexpected threat's to Americans' health and well-being.

- Accelerate crisis responses by funding standing emergency response funds, such as the Infectious Disease Rapid Response Reserve Fund (IDRRRF). We applaud Congress for including $300 million in the supplemental to replenish the IDRRRF. As we have seen during this crisis, having a ready reserve fund to jumpstart the public health response can be critical in the early days of an outbreak, as the Secretary of HHS has tapped $105 million to support the early response. These funds serve as a bridge between underlying preparedness dollars and supplemental funding. Congress should continue to invest in the IDRRRF in the annual appropriations process.
- Ready the health care system for outbreaks. Hospitals, health centers and other clinical facilities across the Nation are preparing to identify, isolate, and care for patients with COVID–19. They must do so without interrupting the routine and necessary clinical services for those with other health care needs. This will require training for health care workers on the identification of COVID–19 cases, on appropriate infection control practices, and treatment. Health care must prioritize the protection of patients and health care workers. The health care sector needs resources for some of these activities and to ensure it has appropriate personal protective equipment, necessary clinical supplies and equipment, and surge capacity. Unfortunately, funding for the Hospital Preparedness Program (HPP), which provides funding and technical assistance to every State to prepare the health care system to respond to and recover from a disaster, has been cut nearly in half since 2003.[10] Congress should prioritize funding for health care preparedness even after this outbreak is under control.
- Provide long-term funding for the end-to-end medical countermeasures enterprise, including the Biomedical Advanced Research & Development Authority (BARDA) and the Strategic National Stockpile (SNS). Together, these programs help build the pipeline of countermeasures for diseases that do not have a natural marketplace. We are seeing this play out today, as companies were not previously researching novel coronavirus countermeasures, so government partnership is needed to incentivize participation.
- Build the pipeline of public health workforce through training, loan repayment, and other incentives. Modern biodefense requires a well-trained workforce before emergencies take place. Although supplemental funding will hopefully help with hiring at the State and local levels, this short-term funding does not allow for long-term recruitment and retention of workers. Emergency preparedness and response are personnel-intensive endeavors that require training, exercise, and coordination across sectors. This experience cannot be built overnight.
- Provide job-protected paid sick leave to protect workers and customers from infectious disease outbreaks. One of the recommendations we have heard over and over from public health leaders is to stay home when sick. For millions of Americans, that is not a realistic option—they risk losing paychecks and possibly their jobs if they stay home when sick or to care for a loved one. Paid sick days are even less available for low-wage workers and those who are in service in-

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[8] Funding for PHEP was $714.949 million in fiscal year 2010, or $851.16 million in 2020 dollars. *https://www.cdc.gov/budget/documents/fy2011/fy-2011-cdc-congressional-justification.pdf*.

[9] Statement of Janet Hamilton, Council of State and Territorial Epidemiologists before House Labor-HHS-Education Appropriations Subcommittee, April 9, 2019. *https://cdn.ymaws.com/www.cste.org/resource/resmgr/pdfs/pdfs2/20190409_lhhs-testimony-jjh.pdf*.

[10] Funding for HPP has declined from $515 million in fiscal year 2004 to $275.5 million in fiscal year 2020. *http://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2009/2009-04-16-hppreport.pdf*.

dustries, such as food service.[11] The public health evidence is clear: For example, when employees who did not have access are granted sick leave, rates of flu infections decreased by 10 percent.[12] Employers, especially in the health care sector, should be adjusting their paid sick days policies now to help control the outbreak, and TFAH recommends Congress pass a Federal law to require most employers to offer paid sick days as soon as possible.

THE COVID–19 RESPONSE

It is clear that the Nation has transitioned from planning phase to response and mitigation of COVID–19. In addition to TFAH's on-going recommendations, we recommend some steps specific to this outbreak:

- Implement emergency funding as quickly as possible. We applaud Congress for quickly approving a robust emergency Federal funding package, with significant investments in domestic and global public health, health care preparedness and research and development of medical countermeasures. Federal agencies should be preparing now to quickly distribute funds to States and other partners, as any delay could cost more lives. We must minimize administrative delays in getting money into the hands of health agencies that need to move quickly to respond.
- Science is key to effective response and should drive policy decisions. Science needs to govern the Nation's COVID–19 response, led by Federal public health experts—including leadership at the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH)—who have years of experience in responding to infectious disease outbreaks. Policy decisions—from the Federal to the local level—should also be based on the best available science. Communities that are considering school or business closures or similar measures should consider unintended consequences and take appropriate action steps. If closings are necessary, authorities should assist families for whom such action is especially problematic, such as low-income families and individuals without paid sick leave and children who rely on school meals for adequate nutrition. Nearly 100,000 schools and institutions serve free and reduced meals to 29.7 million students each day.[13] The U.S. Department of Agriculture should be implementing flexibility for schools to make grab-and-go meals and other options available if schools are to close.[14] Home-bound individuals who need access to health care personnel, equipment, and medications may also need additional assistance.

  Keeping the public and partners informed will be critical. CDC and other Federal agencies are communicating frequently with public health departments and other sectors. We encourage elected officials and community leaders at all levels to make policy and communications decisions based on the best available science and public health guidance, understanding that the situation is evolving rapidly, and messages must change.
- Respond quickly and continue to address the spectrum of health needs in our communities. We know that people with underlying health conditions are at higher risk for severe health outcomes from COVID–19. Unfortunately, 6 in 10 adults in the United States have a chronic disease, and 4 in 10 have 2 or more.[15] So it is vital, while Congress is supporting health departments to respond to this outbreak, that we also pay attention to the on-going health threats public health is working to address—from obesity, to substance misuse and suicide, to tobacco and vaping. We need to support the on-going public health ac-

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[11] *Serving While Sick: High Risks and Low Benefits for the Nation's Restaurant Workforce, and Their Impact on the Consumer.* New York: Restaurant Opportunities Centers United, September 30, 2010. *http://rocunited.org/wp-content/uploads/2013/04/reports__serving-while-sick__full.pdf.*

[12] Pichler S and Ziebarth N. *The Pros and Cons of Sick Pay Schemes: Testing for Contagious Presenteeism and Shirking Behavior.* Cambridge, MA: National Bureau of Economic Research, Working Paper 22530, August 2016. *https://www.nber.org/papers/w22530.*

[13] National School Lunch Program. U.S. Department of Agriculture Economic Research Service. *https://www.ers.usda.gov/topics/food-nutrition-assistance/child-nutrition-programs/national-school-lunch-program/.*

[14] School Nutrition Association Letter to USDA, March 5, 2020. SNA. *https://schoolnutrition.org/uploadedFiles/News__and__Publications/SNA__News__Articles/Coronavirus-Options-Letter.pdf.*

[15] Chronic Diseases in America. CDC National Center for Chronic Disease Prevention and Health Promotion. *https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm.*

tivities that will make our communities healthier and reduce risk for COVID–19.

The full extent of the outbreak in terms of public health, health care and economic costs remains to be seen. We do know that taking immediate steps to mitigate the effects of the outbreak will save lives and prevent harm. Thank you for the invitation to participate today, and I look forward to your questions.

Mr. PAYNE. Thank you.

I now recognize Dr. Dobbs to summarize his statement for 5 minutes.

STATEMENT OF THOMAS DOBBS, MD, MPH, STATE HEALTH OFFICER, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mr. DOBBS. Chairman Payne, Ranking Member King, distinguished Members of the committee, thank you all so much for having me.

Oh, let me get a little closer. Yes, is that better? All right, great, thanks.

Hey, thank you all for having me. I really look forward to the opportunity to talk a little bit about why public health is important. Why is it different from health care? Why is it really relevant to what we are talking about right now?

When I was in medical school back in the 1990's, I thought I was going to be a medical scientist. I spent—in my initial part of my career, and much of what I was doing, I was working on HIV control and tuberculosis control, not only in the American south, but also too in Southeast Asia and in Russia.

I learned a lot, not only about medical things, but the value of public health. If you want to have an impact on what goes on in a community, you can't look simply at the individual. You have to look at the community and the environment that surrounds that person. It is this public health investment that allows us to do the work that we need to do to make sure that the public, the community, and the individual is maximally protected.

Now, switching a little bit to the coronavirus conversation, so coronavirus is a virus. Although most people will get over it without a lot of sequelae, it will be very impactful, especially for older folks. As we have seen, the mortality rate among older people infected has been really bad. We need to make sure that we tailor our responses to those that are going to be most affected.

We have tools in place now that public health has been using for years to look at different things. In Mississippi, for instance, we have these massive—well, significant flu outbreaks in nursing homes every year. We have learned very quickly that, if we implement those basic public health responses like rapid identification, immediate isolation, quarantine, restricting visitation, that we can actually severely limit the impact on our older folks.

The things that we have learned year after year from not only our sort-of micro outbreak responses, but also too from these major things like H1N1—we are talking about Ebola, Zika, chikungunya, we build up expertise, we build up capacity, we build up tools. When we talk about Ebola virus, we scrambled, right, because it was a new thing. What do you do? We are—you know, the community is really scared about what is going to happen with people in the community.

So we basically put together technology to do home monitoring, using mobile devices. But building on that foundation, we were then able to go on to use this for our folks coming over for coronavirus. These historical lessons help us work to the future.

But one of the challenges that we face is this funding up and down, where sometimes we will get specific money to address a specific issue like Zika, or like Ebola. But then, as that crisis resolves, or sort of diminishes, then we are—have to contract back to a state of acceptable, but not sufficient readiness.

When we look at what is going on in Mississippi right now, we have activated our agency emergency response functions, and we are working closely with our State emergency management agencies. Within Mississippi and other States we have a pandemic response plan that is tailored to influenza, but we know that the elements within that plan are well-suited to the response for pandemic coronavirus. Pulling together different experts within our State, especially under the—Governor Reeves passed an executive order putting a new planning committee—we are going to leverage that information that we got from responding to H1N1, making sure we are prepared for that next flu pandemic to move forward.

But we can't really make sure that we advance those efforts unless we have some steady funding, and don't go through this perpetual sort-of roller coaster cycle of funding for one thing that is limited to that, don't have the flexibility then to use it for the next thing. I really think that we could almost use less money, if given more stably over time, and be more effective if we were able to be prepared for the next thing.

Also, let's talk about innovation. I think innovation is very important, making sure that we innovate not only in technology for surveillance, because the things that we use for public health are high-tech, data-rich environments.

We are just recently in Mississippi invested in artificial intelligence, business analytics, trying to look at what is going on with outbreaks in our State. These are things that are not inexpensive, but it is not only the software, it is also the people that you have to do that. If you want to have the best people doing the most important job, we need to make sure that we build up our public health work force, and have the people there that can do what they need.

Then telehealth, I would like to really say I appreciate the creativity of expanding telehealth options as we are looking at this COVID response, because what is going to be better than making sure people can be getting care of their home, either if they are unable to get out, or if they are ill, or if they are being monitored, but also too these older folks who might need to be coming in for another non-medical reason besides a viral illness. They can stay home and be cared for, not come into the health care environment, where they are going to be exposed to these potentially dangerous things. We are proud in Mississippi to have a Telehealth Center of Excellence, where we are advancing telehealth capabilities to reach people in all sorts of areas, and the department of health has partnered with them.

I would like to thank you for the funding coming down. We will put it to good use, and make sure we do our best to cut off this epidemic. Thank you.

[The prepared statement of Mr. Dobbs follows:]

PREPARED STATEMENT OF THOMAS DOBBS

MARCH 10, 2020

Chairman Payne, Ranking Member King, and distinguished committee Members, thank you for the opportunity to appear before you today to discuss the evolving novel coronavirus (COVID–19) threat; what may well be the pandemic of our generation. I am here today to discuss the Nation's COVID–19 response from a State and local perspective as experienced through the public health system in Mississippi.

COVID–19 is a virus that causes a febrile respiratory syndrome similar to influenza. Although many have died world-wide, most cases will have mild or even no symptoms. The vast majority of people infected with COVID–19 will fully recover. Older adults and those with chronic medical conditions are far more likely to experience severe manifestations of the disease. COVID–19 is spread primarily from person-to-person via infectious respiratory droplets, much like influenza and other common respiratory viruses. Based on these transmission characteristics, measures to limit the spread of the disease will be focused on limiting contact with infectious patients and decreasing the likelihood of the public encountering the virus in public settings. To protect health care workers, strict adherence to infection control practices and the use of personal protective equipment (PPE) will be necessary. The increased utilization of protective equipment is certain to strain the supply chain, leading to resource gaps in certain areas. An increase in patients requiring hospitalization and intensive care will strain bed capacity. Staffing to care for an increased number of severe cases may be difficult, especially if health care workers are ill and must stay home for prolonged periods. There is currently no antiviral treatment or vaccine for COVID–19.

In addition to strains on the health care system, the public health system will be greatly challenged to meet the need. The public health system plays a unique role in protecting the safety and well-being of the public. When viewed through an historical lens, the majority of health and longevity gains achieved in our society are attributable not to clinical health care, but to public health activities that assure that people have clean water, safe food, healthy environments, and that they do not succumb to outbreaks of infectious diseases. This system, especially at the State and local level, serves to ensure that disease outbreaks are detected quickly and addressed promptly. These are functions that cannot be performed by the traditional health care system. Within each local jurisdiction, legal mandates charge public health authorities with monitoring and responding to disease outbreaks in a manner that is not achievable through entities such as clinics and hospitals. At the State and local level, systems and staffing are in place to ensure rapid detection of communicable disease. Trained staff ensure disease cases are located, isolated, and treated; not only for the benefit of the individual but also to the benefit of broader society by preventing additional disease from being transmitted. These actions are always in play at the State and local level, addressing diseases such as tuberculosis, syphilis, HIV, and localized outbreaks. Within the context of COVID–19, these systems have been activated in Mississippi to track down at-risk travelers, maintain isolation and quarantine, respond to outbreaks, and implement broader control measures. At a level above these localized responses, coordinated surveillance systems must be maintained and activated to support the entire endeavor and coordinate across jurisdictions. These activities are further coordinated with Federal partners such as the Centers for Disease Control and Prevention. Staffing and maintaining this complex and data-intensive infrastructure requires talent, funding, highly-specialized skill sets, and access to sophistical information technology.

When the public at large is threatened by pandemic illness, a closely coordinated response with State, local, and National emergency response systems is required. This coordination allows for a unification of mission and the capacity to bring multiple partners into the response framework, such that resource needs from all sectors can be deployed for a common purpose. The key element that makes these endeavors successful is unified command. This concept ensures that all partners are incorporated into the larger effort, and that they are accountable to a singular leadership that assures activities are coordinated and effective. In Mississippi, we are fortunate that our State public health agency is well-integrated into State and local

emergency response activities. The State department of health maintains a constant staff presence within the State emergency operations center, ready to fulfill our response function in concert with the Mississippi Emergency Management Agency (MEMA). Our local Emergency Response Coordinators maintain close connections to the county Emergency Management Agencies, ensuring that we are ready to act quickly in the event of a local crisis. Our State-wide essential services function health care coalition (MEHC) incorporates State and local government agencies with external health care organizations for the purposes of joint planning, the rapid dissemination of information, determining resource needs, and response coordination. (For MEHC members see Appendix 1.) All of these close relationships are only reinforced by our regular, joint activations for natural disasters and other events.

Mississippi sits in a state of readiness for the arrival of COVID–19, with an expectation of community transmission in the near future. As a component of our public health response, the Mississippi State Department of Health has been placing all at-risk travelers on limited quarantine. Our public health nurses have been directly monitoring every at-risk person twice daily for symptoms of COVID–19, using our established telehealth home monitoring platform that was initially designed to assist in the management of patients with tuberculosis. As of March 7, 2020, there have been no confirmed cases of COVID–19 in Mississippi. Testing for COVID–19 in Mississippi is available through the Mississippi State Department of Health and certain private labs. At the present time, we have sufficient capabilities to meet testing demand. As the lead agency for pandemic response, the Mississippi State Department of Health is working closely with the Mississippi Emergency Management Agency (MEMA) in anticipation of the arrival of COVID–19.

On March 4, 2020, Governor Tate Reeves signed an executive order forming the Mississippi Pandemic COVID–19 Steering Committee. Based on the foundation of the Mississippi Pandemic Influenza Steering Committee, this broad team of State partners will refine the existing pandemic plan to meet the specific needs of a COVID–19 pandemic. The pandemic response plan is an organizational roadmap that helps coordinate all partners, in a common mission, to meet the needs of Mississippi citizens. Such coordination is key for a pandemic event, as multiple components of society, businesses, schools, health care, critical infrastructure, and government are likely to be affected. Non-pharmaceutic interventions, activities that limit the spread of disease in the absence of vaccine or medications, will be core activities in the COVID–19 response. These include actions such as isolation, quarantine, social distancing, and school closures. These interventions, and their disruptive sequelae, require multi-agency coordination and close collaboration with external, community partners. The current pandemic influenza plan, which is updated annually, contains essential elements that are relevant not only to influenza but to any pandemic respiratory illness that is spread through similar mechanisms. This continuous planning effort, supported throughout the years with Federal funding, is absolutely essential to ensure Mississippi is prepared to execute a response in a timely manner. This existing plan includes directives for all State agencies under the existing Essential Services Functions as defined in the State's Comprehensive Emergency Management Plan. The 2019 Mississippi Pandemic Flu Response Plan, an Annex to the State's Comprehensive Emergency Management Plan, serves as the source document for our COVID–19 response. This Annex establishes a framework for the management of State-wide operations, under a unified command, with appropriately scaled and structured responses. It establishes policies and procedures by which the State can coordinate local and State planning, response and recovery efforts. This plan follows the National Incident Management System (NIMS), a tool that ensures a consistent approach for all levels of governments, while incorporating private sector and non-governmental organizations, to work together in incident response, regardless of cause, size, or complexity.

The State of Mississippi is grateful for the emergency supplemental funding being made available through HHS to combat COVID–19. With this funding, Mississippi will be able to augment testing capacity, fund State response efforts, enhance disease surveillance, implement community mitigation strategies, fill critical resource gaps such as PPE and medical supplies, improve communications, support health care delivery, support the critical social needs of the public, support fatality management and maintain critical infrastructure. Recently-enacted approaches to telehealth funding, such as permitting Medicare patients in some areas to access the service from home rather than a clinic setting, will greatly assist in community mitigation efforts by improving efficiencies, permitting ill patients to stay home, and allowing non-COVID–19 patients access to health care without coming into physical contact with a clinical environment. The emergency supplemental funding approved last week is a critical first step to assist State and local health departments in their response efforts. Recognizing that we do not yet know the extent to which this virus

will impact our health care and public health systems overall, it is important to acknowledge additional supplemental funding might be needed in the future.

Steady Federal support, through the CDC Epidemiology and Lab Capacity grant, the Public Health Emergency Preparedness cooperative agreements and the HHS ASPR Hospital Preparedness Program, are essential mechanisms for supporting action at the State and local levels. Without these programs, meaningful action at the community level would be severely hampered. The COVID–19 response is but one of many activations that I have experienced in my public health career. Threats such as the West Nile Virus, pandemic H1N1 influenza, Chikungunya, Zika, the opioid epidemic and Ebola give us historical perspective of what we are likely to face in the future; a steady stream of natural and man-made threats that will continue to undermine our Nation's health and prosperity. Although different in nature, the public health response infrastructure needed to address them is largely the same. Support for these responses is often reactive and specific to a specific disease event. Maintaining a robust and capable public health response system takes a steady investment in time and effort. The necessary skill sets, staffing, and technology are not readily scalable in the event of acute need. As you consider future investments in protecting the safety of your constituents, I would ask you to consider steady and sustained investment in our public health infrastructure. Stable support over time will permit us to remain in a state of perpetual readiness rather than diverting essential resources away from other public health issues when we must rapidly escalate a response in the event of a crisis.

APPENDIX 1.—MEMBERS OF MISSISSIPPI ESF–8 HEALTH CARE COALITION

- Agriculture & Commerce (MDAC)
- Agricultural Theft & Consumer Protection
- Animal State Board (MBAH)
- Assisted Living (ALFA, INHA, MHCA, MCAL)
- Community College State Board (MCCB)
- Coroners & Medical Examiners Association (MSCMEA)
- Dental Association
- Dental Examiners State Board (MSBDE)
- Dental Services, State Public Health
- Dialysis (Network 8)
- Education (MOE)
- Emergency Management (State, Local, Tribal, MEMA, MCDEMA)
- Emergency Medical Services (State, Local, Tribal, MEMS)
- Emergency Planning & Response (OEPR) Local and State Public Health
- Environmental Quality (MDEQ)
- Field Services, Local and State Public Health
- Funeral Directors & Morticians Association (MFDA)
- Healthcare (MHCA) Home Health
- Health Disparity, State Public Health
- Health Facilities, LTC, Licensure & Certification
- Home Health (MAHC)
- Hospice & Palliative Care Association (LMHPCO)
- Hospitals: MHA, Military, Parchman, UMMC, VA
- Human Services (MOHS)
- Institutions of Higher Learning (IHL)
- Medicaid
- Medical Licensure State Board (MSBML)
- Mental Health (MDMH)
- Mortuary Response Team (MMRT)
- National Guard (Army NG, Air NG)
- Nursing State Board (MSBN)
- Pharmacy State Board (MBP)
- Primary Health Care (MPHCA)
- Public Health (State, Local, Tribal, MPHA)
- Policy & Planning, State Public Health
- Public Safety (MOPS)
- Rehabilitation (& Vocational) (MDRS)
- Rural Health/Primary Care
- Salvation Army
- State Emergency Response Team (SERT)
- State Fire Academy
- Transportation (MOOT)
- Veterinary Medical Association

• Women, Infant & Child (WIC)

Mr. PAYNE. Thank you. I will now recognize myself for 5 minutes of questioning.

This question would be to all the panelists. Many have criticized the administration's outbreak response for being too slow to realize the severity of the threat. How would you assess the U.S. Government's response, and what aspects of the Government's response could you—could be improved upon?

Mr. Klain.

Mr. KLAIN. You know, Mr. Chairman, I would say there is two things where we are lagging quite badly.

The first is this testing issue. Again, as I said in my statement, there is no reason why other countries—South Korea—are so far ahead of us, 100,000-plus tests in South Korea, less than 5,000 in the United States. I think that is a product of some bad decisions made at the CDC, and a lack of a real effort to accelerate testing around the country.

The second thing I think is hospital preparedness. In various communities our hospitals are going to see an influx of cases, and I don't think they have been prepared for dealing with that, whether that is working with FEMA to temporarily ramp up capacity in those hospitals, or to do things like they are doing in Korea and Germany, with drive-through testing, other things. We need to be creative and flexible, but really increasing the capacity of our system to deal with the influx of cases we are going to see.

Mr. PAYNE. OK, thank you.

Mr. Neuwirth.

Mr. NEUWIRTH. So I would agree with Mr. Klain, in that the testing capabilities of each State are something that, you know, needs to be addressed. Here in New Jersey, we have only received 2 test kits to date. I am recognizing that, you know, our 9 million residents are actively dealing with SARS–CoV–2, a coronavirus. We would expect additional capacity in the State of New Jersey to effectively and efficiently test everybody that needs to be tested. To date, those 2 tests, 2 test kits, you know, are something that needs to be addressed.

The second is that, recognizing how fast-moving the situation was even back in January, it is important that information be shared in a timely manner as effectively as possible, and ensuring that decisions made at the Federal level are effectively communicated to the State to ensure that the States are in a position and maintaining a posture to implement those policy decisions made at the Federal level. The greater lead time that the States are given, the more effective and appropriate those implementations are.

Mr. PAYNE. Thank you.

Ms. Gracia.

Ms. GRACIA. Yes, I would emphasize the importance of the coordination and, really, coordination across agencies, and having senior-level coordination as we are seeing now through the White House with the coronavirus task force.

Second, the importance of continuing to rely on the science and the evidence to make decisions, whether it is policy decisions, public health guidance that is being put out by the Federal agencies,

that we continue to rely upon the expertise and the experience of the scientists, as well as the medical and public health experts.

Mr. PAYNE. So we need to believe and trust the science that is coming along. Thank you.

Dr. Dobbs.

Mr. DOBBS. Yes, thank you. You know, it has been a very complicated and rapidly-evolving situation. I understand it is very challenging.

By and large, CDC has been very responsive to our needs. I can call the leadership pretty quickly. We, in Mississippi, we are a little bit behind in the sense that we don't have much in the way of testing. But we do have adequate testing capabilities at this time.

I would say that, early on, if we were given some more flexibility in who we test, I think that would have been good. There were pretty strict guidelines at the beginning.

The other thing is, you know—and this is part of preparedness, to begin with. I think the CDC coordination with Border Patrol was a little bit difficult at the very first, when we were getting our travelers in. We had a little bit of hiccups with that. But they have been very responsive, and it is a difficult situation. I just really do appreciate the work of CDC and the assistance that they give us.

Mr. PAYNE. Thank you. In the interest of time, the Chair will recognize the gentleman from New York, the Ranking Member, Mr. King.

Mr. KING. Thank you, Mr. Chairman. Let me just, I guess, ask Mr. Neuwirth and Dr. Dobbs.

Again, you sort-of touched on this already, but what improvements could be made in coordination with the Federal Government now?

I mean allowing for whatever has gone wrong in the past, but as of today forward—or I would say the last several days going forward, how do you see the level of coordination, and what improvements can be made?

Mr. DOBBS. Yes. Well, I think the coordination even among Federal agencies would be good, because we have seen some missed communications between those levels, which then kind-of trickles down to us. That can be a little bit difficult. You know, quick communications are very important. By and large, I think that has been very good.

I think clear understanding of what funding is going to be available, and what we can use it for.

Also, I can't say how much I support the hospital preparedness program. I think that that has been cut some over the years. That is really a foundational element for these sorts of responses. We have pulled back from, I think, actually cashing up as many supplies and PPEs we had in years past, because that has—the priority on that has shifted a little bit. I think that would be very important.

Mr. PAYNE. Mr. Neuwirth.

Mr. NEUWIRTH. Specifically referencing Joint Base McGuire, Joint Base McGuire-Dix-Lakehurst, you know, this is a base used by our Federal partners as a potential housing solution for quarantined individuals. New Jersey has put forth a remarkable amount of support and resources to ensuring that this housing so-

lution remains intact and fully functional to meet the demands of the situation. You know, the base was operational for an initial 2-week period, and the State, up until the absolute deadline of Friday at 8 a.m., was unaware whether or not that—the base would remain operational for the quarantine for—as a quarantined housing solution.

So ensuring that, you know, New Jersey can appropriately support, you know, this housing solution moving forward, you know, this is one example of where understanding where the Federal Government sits, as far as continuing this operation, and how we can best support it is important to us.

Mr. PAYNE. Mr. Neuwirth, since New York and New Jersey are so close, I have a very parochial interest in this. We have probably tens of thousands of more commuters back and forth every day. How—what is the level of coordination between the States?

Also, I know Governor Cuomo has gotten approval from New York to do its own testing. Has New Jersey applied for that approval?

Mr. NEUWIRTH. So yes. So we are doing our own testing in the State. Right now, as of today, the State's public health and environmental laboratories is the one in New Jersey performing the tests in-State, ensuring a rapid turnaround time as best we can. We are in lockstep with our New York City and New York State partners.

You know, we have, you know—historically, we have had a phenomenal relationship with the city and the State, just because of our close proximity, the way we manage and deal with the risk together, how we conduct our preparedness response activities. They are often in lockstep. So it is the historical relationships that we have been able to leverage for this event that has ensured the relationship has been maintained and leveraged, so that both sides of the river are fully aware what the other side is doing, so that we are—we remain in lockstep.

Mr. KING. Thank you.

Mr. Klain, first of all, let me thank you for your efforts in Ebola. It was outstanding. I give you full credit for that.

Governor Cuomo announced something today, and I just wondered if this was ever contemplated, if the Ebola virus had not been contained the way it was. He has actually ordered the National Guard in to Westchester County and New Rochelle. It is going to be a 1-mile containment zone. Basically, it originates from a synagogue. That is—I think now there must be 50 to 100 cases, if not actually diagnosed, but certainly people being tested from that area.

Was that ever something that was contemplated by you? I know it is really—I support the Governor doing it, but I can see, if it is carried to a larger level, it is—basically, it is going to shut down almost any community center, house of worship, school. It will leave certain businesses open. But did you contemplate how that would actually be implemented?

Mr. KLAIN. Congressman, we did not. We never expected to have that many cases of Ebola in the United States. We were focused on isolating people when they came here from West Africa, and getting them promptly into treatment.

I do think, though, that this subcommittee should look at the issue raised by this, you know, kind-of quasi-quarantine of New Rochelle, and what other measures could be effective.

I also think thinking about the National Guard or FEMA to help increase hospital capacity, tent hospitals, or rapid treatment centers, I think, you know, we are going to need person power to help respond. At a time when our health care system—you know, we see doctors and nurses drop out because they are sick. They are going to get the virus, too. So I think, you know, thinking creatively about who can really help power this response is an important thing.

Mr. KING. So as far as—oh, I am sorry. My time is—I yield back. Thank you.

Thank you very much.

Mr. PAYNE. Thank you. The Chair now recognizes the gentlelady from New York, Ms. Clarke.

Ms. CLARKE. Thank you very much, Mr. Chairman. I thank our Ranking Member and our expert panelists for coming in to share your expertise with us today.

We know that America needs a fully-funded, whole-of-Government response to stay safe against the coronavirus. In my home State and city of New York, we are in the midst of an unprecedented health crisis. Leaders should not minimize or exaggerate the scale of the task before us. We can beat the coronavirus, but the administration needs to set politics aside and put scientists in the driver's seat.

Having said that, Mr. Klain, after weeks of stating that enough resources were available to fight the coronavirus, the Trump administration finally announced that it was seeking an emergency supplemental to make additional resources available. This request was made more than a month after the first recorded case of coronavirus was discovered in the United States.

How would a timelier response—or how would a timelier request, excuse me, have helped the United States respond better?

Mr. KLAIN. Congresswoman, I think that is a good question. I testified before the Foreign Affairs Subcommittee about a month ago, and said that the request should already be here, and Congress should be acting on it. I do think that more funding might have accelerated this testing situation, might be helping States more quickly.

I think it is important to know, again, Congress deserves great credit for passing this funding quickly. But the real question is how quickly does it go from Washington out to the States. The gentlemen and ladies to my left here, you know, they are going to have to actually make this work on the ground, and they can't unless the money moves from Washington to them. I think that is really where we should be focused on now, is once Congress did this incredible thing of, in 2 weeks, writing and passing a bill, is the money really getting out there to ramp up testing, to ramp up health care systems, to help the people who are going to need the help.

Ms. CLARKE. Very well. So this question is for both you and Dr. Gracia.

I think many of us in Congress were shocked and disappointed that the administration's initial proposed amount for the emergency supplemental was only $2.5 billion. Luckily, Congress passed an $8.3 billion supplemental that was significantly more robust than the administration's request.

What more can the Government do to ensure that there is enough funding to support State and local outbreak response efforts?

I would add to that, leaving an infrastructure in place so that we are not rebuilding the infrastructure time and time again as these outbreaks occur, because certainly there will be others.

Mr. KLAIN. You know, Congressman, I agree with that so strongly, and I kind-of agree with what Dr. Dobbs said earlier. The issue sometimes is the amount of money, and the other issue is the consistency of the funding.

We today are in the middle of an epidemic. That is what we are focused on, as we should be. But we are only 3 years away from the next one, and 3 years from the one after that, and 3 years from the one after that. It is these boom-and-bust cycles in funding that really undermine our preparedness.

I think—I hope that what Congress will take out of this is great job on the emergency supplemental, but what are we doing to prepare for the big threat that is out there in the future?

Ms. GRACIA. Thank you, Congresswoman. You raise a very important point and question. One is a recognition that I think you certainly have, that public health departments at the State and local level, they are truly our first line of defense as it relates to these types of outbreaks, to other natural disasters where there are public health consequences. What we have seen, however, is that there really has been a longer-term underfunding of public health, and that there have been cuts that have really impacted public health departments at the State, local, Tribal, territorial levels.

We look at, for example, the Public Health Emergency Preparedness Grant that is administered by the CDC, that that has experienced cuts over the years, 20 percent, more than 20 percent over the past decade; where the hospital preparedness program, which has been cut in half since 2003. These are important funds to really be able to support public health over time, to be able to continue to have the type of emergency preparedness response infrastructure for surveillance for the work force. It is very difficult to hire individuals for the short term, and be able to guarantee that they are going to be able to stay on board, and really build that training and capacity within the public health departments.

There also is a need for more funding as it relates to the core capabilities in public health, things like pandemic preparedness, but also communications expertise, epidemiology, and surveillance expertise, the ability to bring together coalitions. These types of areas are truly fundamental for core public health.

Ms. CLARKE. The Trump administration has repeatedly attempted to cut funding to public health. Could you describe how chronic underfunding of public health makes the United States more vulnerable to outbreaks?

Yes, I am sorry, Ms. Gracia.

Ms. GRACIA. Certainly. So I think one is to recognize that we have made, actually, important progress, in particular over the past 2 decades, as we look at public health's level of preparedness, in particular since the September 11 attacks. That—there was a recognition that public health really is part of the National health security enterprise, and that we needed to really bolster that infrastructure, which is inclusive of laboratory capacity, the work force, being able to have the surveillance systems in place, and communication systems in place, as well as looking at coalitions that can be built between public health and health care.

But as I noted earlier, what we need to do is really build on the expertise from these previous outbreaks and other types of public health threats. You know, these are the individuals who have been through these types of outbreaks and other public health emergencies in the past. Recognizing that—the need to have stability in that funding so that it is not at risk.

We have seen, for example, over the past decade, the budget to the Centers for Disease Control and Prevention has declined by 10 percent, and a large percentage of CDC's budget——

Mr. PAYNE. Please——

Ms. GRACIA [continuing]. Goes to State and local health departments.

Ms. CLARKE. Thank you, Mr. Chairman. I yield back.

Mr. PAYNE. Thank you. I recognize the gentleman from Mississippi, Mr. Guest.

Mr. GUEST. Thank you, Mr. Chairman.

Dr. Dobbs, you and I had a chance to visit earlier, before your testimony. You and I discussed about the fact that we currently in Mississippi have both the ability and the capacity to test for COVID–19 in our home State. Can you talk just a little bit about that, please?

Mr. DOBBS. Thank you, sir. Part of it may be that the timing was advantageous, but we were able to bring up the COVID testing pretty quickly. Our public health lab, within a week of getting the reagents and the guidance, was able to get the testing activated.

So far we haven't done a ton of tests. We have done about 50, but they are all negative. We have got many coming in every day. We think we have sufficient capacity to meet demand for the near future, but also foreseeing now, with private lab capacity coming on-line, like Lab Corps and others, that will help with the clinical environment.

I am looking forward to the opportunity where public health can fulfill a different role, which is mostly going to be surveillance, so we can have a better understanding of what is going on in different communities, and also maybe acute testing. You know, we can run it in about 4 hours after we get a specimen. So if there is something that needs to happen right away, we can execute that.

Mr. GUEST. Can you talk a little bit about your response that you have received so far from CDC?

Mr. DOBBS. In response to the testing, it has been good. The information that they have been giving us has been very helpful. Their guidance has been very good, especially their guidance documents for clinical scenarios.

I will say their website is kind-of cumbersome. I needed to talk to them about that. It doesn't come as fast as you would want it, honestly. I mean, we were always sitting on go for the next thing. But the quality of the work has been good, from our perspective.

Mr. GUEST. Dr. Dobbs, you have talked in your opening statement, and some of your questioning, and then in your written statement about the use of telehealth, and you say here that telehealth will greatly assist in community mitigation efforts by improving efficiencies, permitting ill patients to stay home, and allowing non-COVID–19 patients access to health care without coming into physical contact with a clinical environment.

Could you explain that very briefly again?

Mr. DOBBS. You bet. If you think about who is at risk for bad outcomes from COVID–19, it is going to be older folks, primarily, people with chronic medical conditions. These are people that are going to access the health care system quite frequently. A lot of it is going to be non-urgent, things that can be done through a telehealth platform.

So we have really been pushing hard with our partners at UMC. Actually, I was talking with some of the other big health systems today, meeting with Blue Cross, trying to help them set up systems where they will fund communications with people from their home so that you don't have to right now, you know—or at least previously, you have to go to another clinic setting around a bunch of other people. It is so much more convenient. This is not only an opportunity for us to help with COVID–19, but maybe even sort-of catapult the future of health care by thinking about what telehealth could look like.

Mr. GUEST. Is it conceivable that telehealth could be used to help screen individuals as they are coming into the country through ports of entry?

Mr. DOBBS. In a place like Mississippi, especially, where we don't have a lot of medical providers, and we have a pretty rural geography, if we could leverage telehealth for that function, or any other function that requires medical intervention, it really does expand our reach remarkably.

Mr. GUEST. Now, Dr. Dobbs, you talked about the importance of the Hospital Preparedness Program. Could you expand on that just a little bit?

Mr. DOBBS. If we think about who is the boots on the ground, who are the people who are going to respond locally when something goes awry, it is going to be those local community folks. It is going to be the local emergency management folks. It is going to be the hospitals, it is going to be the clinic. It is going to be the people who are in that area. The Hospital Preparedness Fund helps—lets us organize these health care coalitions so that we can have a reach into the communities and respond, but also to make sure that hospitals are ready, not only in supplies, but also planning, because they are going to be at the front line.

The thing that worries me more about this than anything is going to be resource utilization within our hospitals and intensive care units. Even now, if we have a bad flu year, we run out of intensive care unit beds. So having that core infrastructure to make

sure that we are ready when something above and beyond happens is going to be very important.

Mr. GUEST. So that helps you and your department with the logistics as you are trying to find placement for individuals who are ill, whether it be with coronavirus or some other illness that they would be battling.

Mr. DOBBS. Yes, absolutely.

Then also, even within the HPP program, there are some flexibilities that might help. Like for instance, we have a warehouse of PPE that we sit—that we keep. We have about 200,000 masks that we can distribute immediately if we need to. So we are ready to go. But based on some of the structure of that HPP program, we only can use 10 percent of over—of it for overhead administration, but they count rent for the warehouse as overhead, administration. So we would welcome flexibility in funding for HPP, as well.

Mr. GUEST. Dr. Dobbs, very briefly, just for the people back in Mississippi, can you talk a little bit about the emergency supplemental funding, and what that will be used—and how that will be used to fight coronavirus back home?

Mr. DOBBS. Yes. We have got a laundry list of things we want to do. We want to expand surveillance, we want to increase lab capacity. We want to expand on our informatics. We have already started doing some advanced analytics, using Biosense to figure out where cases are going to be. We want to make sure that we have resource allocated for, like, PPE or other things to support hospitals. We want to—I have already brought on 3 doctors. I don't know how I am going to pay for them. I guess this is how. Then—and nurses, boots on the ground, to get the work done, and then advancing technology and equipment and other PPE needs.

Mr. GUEST. Thank you, Dr. Dobbs.

Mr. Chairman I yield back.

Mr. PAYNE. Thank you. The Chair now recognizes the gentlewoman from Illinois, Ms. Underwood.

Ms. UNDERWOOD. Thank you, Mr. Chairman. Thank you to all of our witnesses for being here today.

It is a pleasure to see my former colleagues from the Obama administration here today as we chart a path for Congress to lead the response to the coronavirus.

Mr. Klain, what essential leadership functions must our Federal Government fill when it comes to helping the public, State, and local public health departments, employers, and our health care system navigate this public health crisis?

Mr. KLAIN. Congresswoman, I think it is a question of both competence and confidence.

So I think, on the competence side, the Government has to provide the leadership and the funding to deliver this response. This is going to be a giant project, to manage these cases, to roll out testing, as the panel has discussed, to help our health care system get prepared for the influx of cases, and to deal with all the other things, the contact tracing the State and local public health departments are going to do as we move toward containment, and all these other things.

So the Government, the Federal Government is going to have to provide expertise in the form of the CDC and people at ASPR, and

BARDA, and other agencies. It has to provide funding, it has to provide leadership. But it also has to provide confidence. I think we need to see from Washington clear direction and messaging so the American people can panic less, and can understand that there is a plan in place, and a way of attacking it, and so on and so forth.

I think both those things, you know, we just have not hit the mark on that yet. We need to do better on both those fronts.

Ms. UNDERWOOD. Thank you.

Dr. Gracia, you recently published a report evaluating States' ability to respond to public health emergencies like the coronavirus. What did you learn from publishing that report about the actions the Federal Government must be taking to support State and local public health departments, in addition to providing supplemental funding?

Ms. GRACIA. Thank you for that question, Congresswoman Underwood.

So indeed, we published this report, which, as I noted earlier, demonstrates and documents the progress we have made overall, with regards to our National health security and public health preparedness, but that there are areas for improvement, one being this issue with regards to funding for States and localities to be able to really respond in a way that meets these increasing number and frequency of public health threats.

We also recognize, too, that this is an important area that not only involves the public health sector. Often we think about these health threats as isolated to public health departments. Yet these are issues that really require a multi-sectoral approach, and one in which we engage various sectors, from the business sector to the education sector, the health care sectors, and others that are really involved and have a seat the table, as well as the community in really driving preparedness and response.

So when we think about what the Federal Government can be doing, it is really helping to support that capacity for State and local health departments, ensuring that there is that stability of funding. So that that type of coordination, that expertise, and that capacity can continue to be built in States and localities to do exactly as, for example, Dr. Dobbs has spoken about, is having the work force that is trained, having the laboratory capacity, the surveillance that is needed.

Ms. UNDERWOOD. Awesome. In your written testimony, Dr. Gracia, you also touched on how the flu vaccination is a proxy measure for our ability to vaccinate a large population once the coronavirus becomes the—coronavirus vaccine becomes available. Can you expand on that?

Ms. GRACIA. Yes. You know, the flu and what we see, for example, with seasonal flu outbreaks demonstrates a couple of points.

One, it shows how public health departments often are having to deal with multiple types of crises at the same time, and so how they can be stretched with regards to really being able to respond to the needs of the public.

But second, because with the flu vaccine it is a vaccine that is recommended for almost a majority of the population—it is recommended by the CDC for individuals who are 6 months and older—it also demonstrates what our vaccine infrastructure looks

like, in particular with regards to if we were in need of doing a mass vaccination campaign, for example, for adults. With children, children are seeing their physicians and other health care providers more frequently. With adults that may be more difficult.

So, in looking at how we are actually doing with seasonal flu, which, as a Nation, the average—National average for seasonal flu vaccination is 49 percent, whereas the actual recommendation from the Department of Health and Human Services in the Healthy People 2020 is to reach 70 percent——

Ms. UNDERWOOD. Yes.

Ms. GRACIA [continuing]. We recognize that there are shortcomings and gaps with regards to that infrastructure that entails public health departments, health care, commercial entities, as well to ensure that the population is vaccinated.

Ms. UNDERWOOD. Do you want to speak about why flu vaccination is such an important part of our response to this threat?

Ms. GRACIA. So, in particular, we are currently in the midst of, you know, the flu season, and we still have high activity across States. You know, it is important that we know that the best way in particular to prevent the flu is through flu vaccination, and that many of the preventive measures that we also talk about with regards to hygiene and hand-washing and staying home when sick, that those are similar types of preventive measures and guidance that we are providing as it relates to COVID–19 and the novel coronavirus.

So, as we think about what may be needed down the line with regards to the types of interventions, really building the capacity to respond to outbreaks such as the flu is important as we think about outbreaks such as COVID–19. We saw one of the deadliest flu seasons in the 2017 and 2018 flu season in nearly 4 decades. So that really lends to how we, as a Nation, are prepared——

Mr. PAYNE. Thank you.

Ms. GRACIA [continuing]. For these types of outbreaks.

Ms. UNDERWOOD. Well, thank you all so much for being here and for your testimony today. I yield back.

Mr. PAYNE. Thank you. The Chair recognizes the gentlemen from Texas. All right, the Longhorn State.

Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Mr. Chairman. Thank you all for being here on this important topic.

This question goes to the gentleman from New Jersey and the gentleman from Mississippi. I just want to get your take on the proper roles at the State level and the Federal level. We hear we are unprepared. We hear we are way unprepared, or we hear we are doing pretty well. It is all relative in the end, how well-prepared we are. So I want to get an idea from you at the State level.

What does preparedness look like at a reasonable and—a reasonable standard?

What is the different function of a local county public health center, versus the State level, versus the Federal level, what is the best way to interact?

Mr. NEUWIRTH. So first and foremost, preparedness looks like having the funding and resources needed at all levels of government to adequately respond to what we are seeing day to day, and

that, you know, requires our acute care facilities, our hospitals, our long-term care facilities, our health departments having whatever they need immediately to conduct their job, continue providing high-quality clinical care to those that are ill, allow the resources and staffing and information needed at the local health departments to ensure appropriate case management, contact tracing, and overall management of, you know, the pathogen in the communities as needed.

Coordination and communication at all levels of government is incredibly important to ensure that the States have a unified, coherent strategy on mobilizing all of the preparedness activities and resources that they have available to them. Without timely information from the top about important policy decisions that are being made——

Mr. CRENSHAW. Look, can we get an example? I kind-of want to dig into the preparedness, because you basically just said when everything is really perfect, that is prepared. But that is not reasonable. I asked for a reasonable standard.

You know, so, I mean, like, how much better can we be, reasonably? I mean, I want to have reasonable conversations here. Of course I could—we could quadruple your funding, and then you would be more and more prepared, and you will come back next time and ask for even more money. I know how this goes. That is all fine. Of course we want to keep getting better.

But within reason, within a reasonable construct, you know, what does prepared look like? How many masks? How many pieces of equipment are reasonable to ask for, and that we should have had ready prior? What is—what exactly are we not—is the Federal Government not communicating to you effectively?

Mr. NEUWIRTH. What has been said moments ago, that continued funding over, you know, the past several years to continue to maintain what we have built upon from previous outbreaks such as Ebola, Zika, the opioid crisis. There has been a lot of work that has been maintained, but the increases and decreases of funding year over year degrades the preparedness activities that we have put into place.

So ensuring that, again, that the resources are available to the States——

Mr. CRENSHAW. That the Federal—that is the Federal Government's job, to make sure the States have the resources. But—so at what—where is the State's role in that, and why can't you be ready to the standard that you have set yourself—set for yourself?

Mr. NEUWIRTH. We are ready to the standard we have set for ourselves. It is a matter of maintaining that level of preparedness year over year. Because in between those years, the States are managing disasters, public health, natural disasters, technological, that we use those resources and those preparedness activities to respond to.

So it requires tight coordination and support from the Federal Government to ensure that, you know, year over year, as the States prepare for and respond to various disasters, that that capability is rebuilt and, you know, exercised, and ready for the next disaster.

Mr. CRENSHAW. Sure. I am just trying to get more details, because I am trying to get examples on exactly what—where did we fall short, and then what exactly was it, and how can we do better the next time. I understand that we always need to do more coordination, and that we can talk in vague terms and say more funding and more coordination and all of that. We are really trying to get into some specifics here.

Maybe the gentleman from Mississippi could give us some insight from Mississippi.

Mr. DOBBS. Thank you for your question. I think one of the things that is important to think about from a State perspective—and I have been doing this for a long time—is that State budgets are—and county budgets, especially—are very susceptible to the business cycle. When they contract, they just—they cut indiscriminately. So the stability that we see primarily is going to be, for better or worse, there is a lot more stability from the Federal funding sources. So those—that can be kind of the bedrock of public health.

The other thing that has happened, I think almost philosophically, as we have worked to expand the insurance coverage to people, which is important, and I think people need health care, but there has been an assumption that public health and health care are the same thing. They are not at all the same. I have about half the nurses I had 4 years ago. So how do you respond to a crisis when I can't pull nurses to go to houses and check on people?

So I think this sort-of communication about health care versus public health has distracted a little bit from some of our core needs.

Then the other thing, I think relationships is so important. So sometimes some places have great relationships with the local folks and the counties and stuff. We have those relationships pre-built, it is not just a money thing, it is a slow investment so that, when things do go bad, we just call Joe and say, "Hey, we got this going on," and we know what to do together. Again, I think that gets to the stability and the steadiness of how much better it is just to have a slow and steady approach, than having a more reactive approach.

Mr. CRENSHAW. I am out of time. Thank you, Mr. Chairman.

Mr. PAYNE. Thank you. The Chair now recognizes the gentleman from Louisiana, Mr. Richmond.

Mr. RICHMOND. Thank you, Mr. Chairman. I will pick up where my colleague left off, talking about specific examples. Mr. Klain, I will ask you.

But not having enough tests is—explain to me. Was that necessary? Was that incompetence? Was it just oversight? Tell me how it is that Korea has more tests than the United States.

Mr. KLAIN. Congressman, I think this is, as I said in my statement, a singular failure of U.S. policy and execution. The President imposed travel restrictions on people coming here from China. Those travel restrictions, though uneven and not complete, slowed the pace of the disease. It bought us time. Buying time works, if you use the time productively.

We knew in December and early January we were going to need millions of tests. I have said we should test 30 million people in the United States: Seniors, people who have access to seniors, people in nursing homes. Doing surveillance, as several members have

said, not just waiting for people to raise their hands and say, "Test me." We knew we needed that in January.

The CDC pursued building its own tests that turned out to be flawed. It didn't adopt the WHO test.

We don't really know what significance there was in the messages that the President sent, that this wasn't a big deal. He said as recently as 15 days ago there are only 15 cases, and it is almost resolved. So you had a series of management failures, bureaucratic failures, execution failures that leave us so far behind other countries.

This isn't a scientific problem. If they can test 150,000 people in South Korea, America can test people, too. They don't have any wisdom that we don't have here. So that is a failure of execution in this country.

Mr. RICHMOND. Thank you.

Dr. Dobbs, let me ask you, as the lead State health official in Mississippi, I want to engage in a conversation about the collateral consequences and challenges that you face. So let's take Gulfport, Mississippi. I am a casino worker that gets paid by the hour. Biloxi and Gulfport survive a little bit on tourism. How—if I am feeling down, how do we get that person to take those days off that is necessary, or self-quarantine for 14 days, and still pay their bills at the end of the month?

Mr. DOBBS. Thank you for the question. That is an enormous challenge. We have been engaging with business communities, especially businesses that have a lot of hourly workers, and not that we have a resolution to this at all, but it is a big challenge because people who work hourly and get paid, and don't have sick leave are not going to do it.

At the State level, State government, you actually have to take a vacation day before you can take a sick day. So people are not going to want to take their vacation day. So we are looking at—as part of any emergency declaration, to actually do away with that. So with government, there are, I think, opportunities to address those inequities.

But in the business community it is a real challenge. I think we, as a country and as a State, are—really need to look at options we can do to make sure people can have paid sick leave.

Then, the other thing to think about, and this is—there is not an easy answer to this either—is when people have to go home, and are out without a job for 2 weeks, who is going to pay the power bill? You know, we are working with nonprofits, and I know there is some capabilities to do that, but it could be a big issue, and might cost a lot of money.

Mr. RICHMOND. Let me ask you a question, then. I am completely thinking out of the box, but in New Orleans we are accustomed to natural disasters, whether it is hurricanes, whether it is BP, whether it is, you know, levees. That is where FEMA steps in with either individual assistance or public assistance, and they start off with a certain amount, and then you have to go and prove your need, and all of the other things.

Is FEMA the agency that we could task with providing either individual assistance, public assistance, if needed, improve—somebody out there—if we want to be responsible with this, somebody

out there is going to have to provide some assistance. So could FEMA do that under the individual assistance program?

Mr. DOBBS. Technically speaking, I am not quite sure the best mechanism. But conceptually, it sounds like a very good fit to me. I mean, if we align this with a disaster response, it seems like it makes a lot of sense.

Mr. RICHMOND. Right.

Mr. KLAIN. Congressman, I could.

Mr. RICHMOND. Mr. Klain.

Mr. KLAIN. Five years ago I wrote a piece where I said that Congress should amend the Stafford Act to add epidemics as a disaster for the purpose of the Stafford Act. Right now FEMA could do as you suggested if you saw another hurricane in your State, or an earthquake, or a fire. But epidemics are not a natural disaster under the Stafford Act.

To go back to a question Congressman Crenshaw asked, I think that is a zero cost—I mean not ultimately zero cost, as you draw down on it, but the kind of thing that we should be doing to get prepared. Because whether it is this one or another one, some day we are going to face an epidemic that really is a FEMA-triggering disaster. The Stafford Act should catch up with that.

Mr. RICHMOND. Thank you. To—the former Chairman when I got here, Mr. King from New York, one of the last recommendations that we still have not adapted from the 9/11 Commission is to put all of the jurisdictions to responding to natural disasters and others, and putting the Stafford Act back under Homeland so that we could coordinate. I think now may be the time for us to raise that issue in a bipartisan manner to get Homeland the jurisdiction that——

Mr. KING. I agree, absolutely.

Mr. RICHMOND [continuing]. It should have.

Mr. KING. That is long overdue, and I appreciate the gentleman raising that issue again. Thank you.

Mr. RICHMOND. Thank you. I yield back.

Mr. PAYNE. Thank you. Let's see. Mr. Neuwirth and, I believe, Mr. Klain. Oh, I am sorry. I have done that once before, too.

The Chair recognizes the gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I thank the Ranking Member, as well. I thank the witnesses for appearing.

There are times when we are not as alert as we should be. I do confess that, as I listened, I was not as alert as I should have been, because I seem to believe that I heard Dr. Dobbs indicate that in Mississippi you have to take a vacation day before you can take a sick day. I am confident that I was not as alert as I should be. I should be more alert. I should hear, I should listen.

Dr. Dobbs, tell me that I did not hear you properly, that I misunderstood, please.

Mr. DOBBS. No, sir. You are absolutely correct. That is just for State government workers, though. That is not everybody——

Mr. GREEN. Well——

Mr. DOBBS [continuing]. But, I mean, it——

Mr. GREEN. But, you know, they eat the same way everybody else eats.

Mr. DOBBS. Yes.

Mr. GREEN. You was telling me that, in Mississippi, if you are sick, before you can have a sick—day of sick leave, you have to take a vacation day?

Mr. DOBBS. Yes, sir.

Mr. GREEN. Do you know of any other State in the United States where this is prevalent?

Mr. DOBBS. You know, I didn't know that that wasn't prevalent. I didn't know any better.

Mr. GREEN. So it is—well, maybe I don't know better, either. Staff, somebody, please help me. I want to know, because I—that shocks my conscience, to be very honest. It does. Sickness and vacation are totally antithetical. I mean, they are not the same. They are not in the same class of time and leave. But you have given me reason to pause and think.

Now, back to why I am here today. Much of what we hear and learn when we experience these circumstances is counter-intuitive. Wearing some sort of gear on your face, the public believes that that is beneficial. People go out and buy as much gear as they can for their faces, because they assume that it will protect them.

The staff has provided me with some intelligence that I would like to share with you, and I would like to find out what your thoughts are. It reads, "Many countries"—actually, it is "many others," but I will say countries—"Many countries have implemented travel bans, restrictions, and border closures against China and other affected nations. Notably, the World Health Organization, WHO, opposes the use of travel bans, and public health experts have expressed skepticism of the effectiveness of a travel ban."

Now, I am a layperson. I read this. I see travel bans in place. Would somebody kindly give me your thoughts on what the World Health Organization has indicated, in terms of its opposition to the use of travel bans, and the skepticism of the effectiveness?

Mr. KLAIN. I will try to start, Congressman.

Mr. GREEN. OK.

Mr. KLAIN. I think the issue is that almost—there has been numerous studies of travel bans through the year, and what they have—years. What they find is that they can delay the introduction of a disease, but not stop it. We are living through that right now. The Trump administration imposed a ban on some travel from China, and yet coronavirus is here, and spreading rapidly. It did delay, I think, the spread. But it didn't stop it.

Now, why? In part because, by the time the ban was spread, 200,000 or 300,000 people from China had come here. Now the disease also is coming from Italy. It is coming from all kinds of other countries around the world. We can't stop the spread of that. The travel bans never prevented Americans from traveling back home to our country, as it should not. But Americans can bring this disease to our country as much as non-U.S. nationals can.

Even the—Trump's travel ban with regard to China exempted crews of planes and ships. Now why? Because our health care system needs imports from China. We can't have the kind of things these other people are talking about—PPE, drugs in the health care system—unless they are coming right now in our supply chain from China. So boats from China bring those things here. Those

boats are driven by men and women who are Chinese. So that was exempted from the Trump travel restrictions.

So my point is we live in an interconnected world. Travel restrictions are always going to be incomplete, and imperfect, often too late. That doesn't mean that an effort to slow the spread of disease wasn't smart. I think it was smart in some respects. But obviously, we are living the reality that it did not keep this virus out of this country.

Mr. GREEN. Thank you, Mr. Chairman. I will yield back.

Mr. PAYNE. Thank you, sir.

I please ask for unanimous consent for Representative Jackson Lee to sit on the panel and ask questions.

The Chair will recognize the gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. I thank the Chair for his courtesies, and the Ranking Member, as well. Thank you for holding this enormously important hearing.

I am going to ask unanimous consent to submit into the record a coronavirus plan of action that I introduced about 2 months ago, ask unanimous consent.

Mr. PAYNE. Without objection.

[The information referred to follows:]

CORONAVIRUS PLAN OF ACTION FROM CONGRESSWOMAN SHEILA JACKSON LEE

- ENHANCED PRODUCTION OF N–95 MASKS
- INFORMING STATE HEALTH AGENCIES AND ALL FEDERALLY QUALIFIED HEALTH CLINICS TO TEST ALL PATIENTS PRESENTING WITH FLU-LIKE SIMPTOMS FOR THE CORONAVIRUS
- INCREASE THE SUPPLY OF FLU VACCINE AND USE PUBLIC SERVICE ANNOUNCEMENTS TO PROMOTE GETTING A FLU SHOT TO REDUCE THE NUMBER OF PERSONS WITH FLU-LIKE SYMPTOMS
- TASK FORCE MUST NAME A SINGLE CORONAVIRUS AUTHORITATIVE SOURCE FOR ALL FEDERAL INFORMATION ON THE VIRUS AND ESTABLISH CLEAR COMMUNICATION LINKS TO K–12 AND POST-SECONDARY SCHOOLS, THE MEDIA, AND THE PUBLIC
- ESTABLISH A REQUIREMENT THAT THE NATION'S AIRPORTS, TRAIN, AND MASS TRANSIT SYSTEMS BOTH SMALL AND LARGE, NEED TO HAVE RESPONSE TEAMS AS NECESSARY TO DEAL WITH AND TREAT THE TRAVELING PUBLIC
- MAKE SURE THE FEDERAL ADVISORY TASK FORCE MAKES PUBLIC REPORTS ON THE STATUS OF THE SPREAD OF THE CORONAVIRUS INCLUDING THROUGH THE DEVELOPMENT OF AN APP THAT PROVIDES UP-TO-DATE TRAVEL ADVISORIES REGARDING CERTAIN COUNTRIES AND BASIC INFORMATION ON THE VIRUS

Prepared by the Office of Congresswoman Sheila Jackson Lee

Ms. JACKSON LEE. Thank you. Let me thank all of the witnesses that are here. It is my intention to try to ask quick yes-or-no answers. I may focus—not painfully, Ron, Mr. Klain—on you, not painfully, but because you have the Federal experience, and that is where we are now. To the health nonprofits and State agencies, I want to make sure that we are being as helpful to you as we possibly can.

So we may have just the straight yes-or-no answers, but I do want to say—is that, with the leadership of the House, we passed an $8.3 billion plan—excuse me, funding that includes, through the emphasis of Members of this committee and others, funding to State and local health agencies. We hope that you will see that

money for purposes that you need to see them. So my line of questioning will be along those lines, and then I will spend some time with Ron Klain.

So, Mr. Commissioner Neuwirth, do you have test kits in your possession in the State of New Jersey?

Mr. NEUWIRTH. I have two test kits in possession in New Jersey.

Ms. JACKSON LEE. It is that entire State, or do you think your local agencies have test kits, as well?

Mr. NEUWIRTH. The State of New Jersey has 2 test kits, each with 500 tests in them. We can test a maximum of 432 individuals with 2 test kits.

Ms. JACKSON LEE. So even though they have—you said 500 apiece, or 500 total?

Mr. NEUWIRTH. Five hundred apiece, of which 432, total, between the 2.

Ms. JACKSON LEE. OK. Even with me adding and saying, oh, you have 1,000, you are saying you can test 432?

Mr. NEUWIRTH. Correct. Each individual requires more than one——

Ms. JACKSON LEE. Yes.

Mr. NEUWIRTH [continuing]. Test.

Ms. JACKSON LEE. Do you mind me saying—and this is only a news report—that your Port Authority director—recent news reports is indicating that your—the port, I guess, of New York New Jersey has—is now infected with the coronavirus. Is that something you can affirm?

Mr. NEUWIRTH. I, too, have seen that in the media.

Ms. JACKSON LEE. All right. Let me then—Mr. Dobbs is with Mississippi State. Thank you very much.

How many test kits do you have, sir?

Mr. DOBBS. We have the capacity to run about 700 tests.

Ms. JACKSON LEE. OK. So in that—can you say what—how many test kits you have? I know that you do several out of that.

Mr. DOBBS. We just got a shipment of that additional kit, and each kit will run a bunch of tests, obviously. So we have some left from the previous one, and then a new one that we just got in this week.

Ms. JACKSON LEE. OK. So you wouldn't—700 tests, does that mean on 1 individual——

Mr. DOBBS. No, that would be 2 tests for each person, yes.

Ms. JACKSON LEE. Right.

Mr. DOBBS. So about——

Ms. JACKSON LEE. So you are down to 350 persons that you could test.

Mr. DOBBS. Yes, ma'am.

Ms. JACKSON LEE. OK. I am not familiar with, I am sorry, the Trust for America's Health. Is this a——

Ms. GRACIA. Yes, Congressman, we are a nonprofit, nonpartisan public health advocacy, policy, and research organization. One of our priorities is public health, emergency preparedness. We produce an annual report called "Ready or Not" on the Nation's readiness.

Ms. JACKSON LEE. Yes. Let me just quickly ask you. There is a debate about the contagious nature of coronavirus. Would you say that it has a high level of contagiousness, if you will?

Ms. GRACIA. Well, we are seeing that it is a coronavirus that has easy transmissibility. So the way in which we are talking about taking preventive measures and precautions is similar to what we would do for other types of respiratory——

Ms. JACKSON LEE. But does it have a higher level of contagious factors?

Mr. PAYNE. Oh, yes.

Ms. GRACIA. So we are still learning a lot about the disease. I think, one, we recognize enough that, yes, there is person-to-person transmission. We are seeing community spread in certain parts of the country.

Ms. JACKSON LEE. Right.

Ms. GRACIA. So, because of that, we are taking these types of precautions——

Ms. JACKSON LEE. I think, to a high degree, maybe than some others—people are not confusing it, but comparing it to the flu. I don't pretend to be a professional, but I would venture to say that the flu does not equate in its contagious factors to now the coronavirus.

So I am going to go to—I was almost going to call you Ron, Dr. Klain, but let me move forward. My premise is that we have not been effective as a Federal Government, starting with the administration. Ebola, under the administration of President Obama and Biden, and one of the strongest—or one of the more difficult cases was in a hospital in Dallas, in the State of Texas, where medical providers, nurses, and others—someone took off for a wedding, someone else took off for vacation.

But let me ask this. We—I think we had knowledge of this in December 2019. What would have been the roadmap? Preventative equipment for our health providers? Storing up our test kits so that they could be appropriately distributed? The appropriate documentation to inform people about washing hands and otherwise? Coming out with an immediate statement, say, right after the first of the year, talking about preparedness and not panic?

Can I yield to you on the response that you have seen so far?

Mr. KLAIN. Thank you, Congresswoman. I would say there are 3 things that should have happened in January that didn't happen.

First, a real focus on getting this test capacity problem solved, either by adopting the WHO testing approach, or by some other solution. We are just way behind. As a result of being behind, we can't really have an effective containment strategy for identifying where the disease is. It is in a lot of places in this country. We don't know where it is. That is a problem. That is a failure on testing.

Second, I think getting our medical facilities preparedness for a surge of cases. Particular hospitals, particular communities, community health centers are going to see an influx of cases, and not really have the capacity to deal with that. I think that is really a problem.

The third is, I think, crisper communications about warning people that this was coming. I understand we don't want to panic peo-

ple. We don't want to be hyperbolic about it. But we have really known since January that we would see a ramp of cases that would have effects across the country. What we are going through right now is a kind-of a little bit of public panic, because it is coming on suddenly, it is unexpectedly. We haven't really prepared for that, and I think those are the 3 things that we missed by a slow response here.

Ms. JACKSON LEE. Let me just——

Mr. PAYNE. Thank you.

Ms. JACKSON LEE. Let me just thank you very much, and——

Mr. PAYNE. Yes, the——

Ms. JACKSON LEE. Ron, I will try to follow up with you. Excuse me for that, Mr. Klain. I will try and follow up with you. Thank you.

Mr. PAYNE. Thank you. The gentlelady's time——

Ms. JACKSON LEE. Thank you, Mr. Chairman.

Mr. PAYNE [continuing]. Has expired. Let's see now.

I have a unanimous consent request for the gentleman from Louisiana.

Mr. RICHMOND. I ask unanimous consent to put in the record an article by Ron Klain, "A Success Not to be Repeated."

Mr. PAYNE. Without objection.

[The information follows:]

ARTICLE SUBMITTED BY HONORABLE CEDRIC L. RICHMOND

A SUCCESS NOT TO BE REPEATED

Ronald A. Klain, External Advisor to the Skoll Global Threats Fund and Former White House Ebola Response Coordinator. September 29, 2016.

In October 2014—after the first death from Ebola on U.S. soil, the first transmission of the disease here, and in the wake of a rapidly escalating epidemic in West Africa—President Obama asked me to become the White House Ebola Response Coordinator, or Ebola czar. We got a late start, and had some shaky moments at first, but in the end, we helped save hundreds of thousands of lives in West Africa, protected the American people, and increased our health care system's readiness for a future epidemic. Now, with the AAMC's help, we can try to make sure we don't have to undertake such an effort again.

Make no mistake: The Ebola response effort delivered critical results, and the AAMC and its member institutions were major contributors to that work. We accelerated Ebola response efforts, learned from early missteps, and assembled resources to battle the disease at home and abroad. Academic medical centers like Emory University, the University of Nebraska Medical Center, and Bellevue Hospital Center were prepared and equipped to treat Ebola patients in the United States and to keep the virus contained, while many others led local preparedness efforts and continue to help advance medical research on Ebola. These facilities and the AAMC provided valuable advice in our strategy to prepare American medical facilities to screen suspected Ebola cases, and treat those with the disease safely and effectively. The association was among the earliest supporters of President Obama's emergency Ebola response funding package on Capitol Hill, which won prompt bipartisan support and was signed into law only 6 weeks after it was sent to Congress. As a result, the United States was able to provide generous help to the global response effort in West Africa, and make much needed investments in our preparations to combat infectious disease at home.

Now, our challenge is to make sure that this is a success we never need to repeat.

"A preparedness strategy that only takes us from crisis to crisis—often with unreliable funding—is not ideal, and maintaining readiness for both expected and emerging threats is a long-term and expensive endeavor."

We can't prevent the threat of other dangerous infectious diseases: Far from it. Indeed, with the increased interaction between humans and animals through habitat incursion, the impact of globalization and expanded global travel, and the consequences of climate change, the world is entering a phase of accelerated emergence

and re-emergence of dangerous infectious diseases. Middle East Respiratory Syndrome in 2012, Ebola in 2014, and now Zika in 2016—with Yellow Fever on the horizon—show how serious and frequent these sorts of epidemics are becoming.

It is precisely because such epidemics are increasing in frequency and spread that we need to change the way the U.S. Government responds to them. Yes, we had an Ebola czar, but we should not need a Zika czar, a Yellow Fever czar, or some future pandemic flu czar. And yes, we got emergency funding through Congress to fight Ebola—but the package to fight Zika has been stalled for months, and future epidemics will move faster than Congress can in assembling a response.

Medical schools and teaching hospitals are frequently on the front lines of these epidemics, and the public has come to count on these institutions to partner with the broader public health community to scale up rapidly for the highly specialized expertise in research, education, and clinical care needed to combat such challenges. A preparedness strategy that only takes us from crisis to crisis—often with unreliable funding—is not ideal, and maintaining readiness for both expected and emerging threats is a long-term and expensive endeavor.

As a result, the AAMC's help is needed to make two critical changes in how the United States responds to these threats in the future.

First, instead of appointing ad hoc czars after an epidemic breaks out, the next President should create a Pandemic Prevention and Response Directorate in the National Security Council, much like those that already exist to fight terrorism and climate change. This team would have the responsibility of developing epidemic prevention and response strategies, funding proposals, and working with private partners—before the next outbreak. The directorate would be responsible for both naturally occurring epidemics as well as potential bioterrorist threats. This permanent effort should be led by a senior White House official, a deputy assistant to the President who would report directly to the National security advisor and have access to the President. The AAMC should continue its engagement with the broader public health community and support the creation of a new, permanent White House effort to coordinate epidemic prevention and response.

This change in how the Government manages epidemics should be at the top of the list for the next President and should be in place on Inauguration Day 2017.

Second, when a tornado, earthquake, or hurricane strikes, the President does not need to wait for Congress to act to send help—the President has authority under the Stafford Act to send immediate assistance. But as we learned with Ebola, and now with Zika, the same is not true for epidemics. These natural disasters are not covered by the Stafford Act, and the President must plead with Congress to provide funding for prevention and response efforts. In the face of a public health emergency, however, the time that such wrangling consumes can put us further behind the epidemic, render our counter measures less effective, and even cost lives.

The bipartisan group—led by Sen. Brian Schatz (D–Hawaii) and Sen. Bill Cassidy (R–La.), and Rep. Rosa DeLauro (D–Conn.)—has proposed a solution: A Public Health Emergency Fund that would make immediate assistance available for epidemic response when the Secretary of Health and Human Services declares a public health emergency. When a public health threat requires an emergency response, either at home or abroad, such a fund would ensure that lack of immediate access to funds does not prevent necessary action. Backing from the AAMC for this type of emergency fund would help move this proposal closer to reality.

The AAMC played a major role in America's response to the Ebola epidemic of 2014–15, and as a result, lives were saved in Africa and a health crisis was prevented here in the United States. Now, its leadership can make a major difference in making sure we have the direction and resources in place to combat the next such challenge—before it becomes a public health crisis.

Ms. JACKSON LEE. Mr. Chairman, may I add something to the record?

This is dated March 3, 2020. "The U.S. has only a fraction of the medical supplies it needs to combat the coronavirus." This is in the *National Geographic*.

Mr. PAYNE. Thank you.

Ms. JACKSON LEE. I ask unanimous consent——

Mr. PAYNE. Without objection.

[The information follows:]

ARTICLE FROM NATIONAL GEOGRAPHIC

U.S. HAS ONLY A FRACTION OF THE MEDICAL SUPPLIES IT NEEDS TO COMBAT CORONAVIRUS

The country could require seven billion respirators and face masks over the course of the outbreak.

By Nsikan Akpan, published March 3, 2020.

Three hundred million respirators and face masks. That's what the United States needs as soon as possible to protect health workers against the coronavirus threat. But the nation's emergency stockpile has less than 15 percent of these supplies.

Last week, U.S. Health and Human Services Secretary Alex Azar testified before the Senate that the Strategic National Stockpile has just 30 million surgical masks and 12 million respirators in reserves, which came as a surprise considering that the stockpile's inventory is generally not disclosed for national security reasons. Asked by National Geographic about the discrepancy, a senior official with the Strategic National Stockpile said the department intends to purchase as many as 500 million respirators and face masks over the next 18 months.

Even such a promised surge in production may not be enough—and it may not come soon enough. A widely overlooked study conducted 5 years ago by the U.S. Centers for Disease Control and Prevention found that the United States might need as many as seven billion respirators in the long run to combat a worst-case spread of a severe respiratory outbreak such as COVID–19.

The outbreak now has entered a new, more potent phase dictated by local or community transmission. It's no longer just being imported from China. Coronavirus has started spreading locally in 13 other countries, including South Korea, Japan, Singapore, Australia, Malaysia, Vietnam, Italy, Germany, France, United Kingdom, Croatia, San Marino, Iran, the United Arab Emirates, and the United States. On Wednesday, the World Health Organization announced COVID–19's global death rate is 3.4 percent, more than 30 times that of seasonal influenza, but also stated the coronavirus doesn't spread as easily as the flu. The global tally of confirmed cases and deaths has risen to 93,000 and nearly 3,200, respectively.

In the U.S., COVID–19 cases without clear ties to China began dotting the West Coast last week. At the same time, the Nation saw an uptick in fatalities—nine so far as of Tuesday—with most occurring at a nursing home in Kirkland, Washington. Among those deaths is one patient who passed away last week at Seattle's Harborview Medical Center. Viral tests, made well after his death, revealed a COVID–19 diagnosis and that hospital staff may have been exposed.

Besides confirming the threat posed to the elderly, these deaths, the community transmission, and genetic analysis suggest the virus has been spreading unnoticed in Washington since mid-January.

"We will have community spread," New York Governor Andrew Cuomo said Monday at a news briefing about the State's first confirmed case. "That is inevitable."

All of these events sparked a run on medical supplies over the weekend, a worrying prospect given the CDC has indicted there could be a global deficit of personal protective equipment such as surgical masks, goggles, full-body coveralls, and N95 respirators, the only CDC-approved face guard, which are designed to filter 95 percent of airborne particles.

"We're concerned that countries' abilities to respond are being compromised by the severe and increasing disruption to the global supply of personal protective equipment, caused by rising demand, hoarding, and misuse," Dr. Tedros Adhanom Ghebreyesus, WHO director-general, said at a press briefing at the agency's headquarters in Geneva on Tuesday. "Prices of surgical masks have increased sixfold, and N95 respirators have more than tripled, and gowns cost twice as much."

What's more, even if U.S. medical centers obtain the necessary supplies, a second shortage of medical specialists may emerge if this respiratory outbreak spreads even more dramatically.

Taking stock

The panicked demand and lack of supplies was predictable. China manufactures roughly 50 percent more medical and pharmaceutical supplies than its nearest competitor, the U.S., according to data supplied to National Geographic by Euromonitor International. But the Asian country now needs those precious supplies for its tens of thousands of cases, at a time when manufacturing has slowed across the country.

"The fundamental point that's exposed in situations like that is that autarky—the idea of self-sufficiency—is lovely in theory, but it almost never actually works in practice, because we tend to not appreciate supply chains," says Parag Khanna,

a global strategy advisor and author of Connectography and Technocracy in America.

Much of the world has become accustomed to same-day delivery without thinking about the bundles of transactions that support such a system. Some global industries can circumvent major blockages or delays in supply chains caused by the coronavirus outbreak. But other supply chains and industries—like automobiles, travel, and medical supplies—are too tightly bound across borders in what Khanna calls a supply circuit.

"China's a manufacturer of intermediate products . . . but what they're really manufacturing on a wider scale is starting material for active pharmaceutical ingredients," says Scott Gottlieb, a former U.S. FDA commissioner and resident fellow at the American Enterprise Institute. "These manufacturers have one to 3 months of supply, so they're going to be able to continue to manufacture for a period of time, but eventually they're going to run out."

"The irony is that some of the other countries who could do these things very quickly, like Japan or South Korea, are also affected by the virus," says Khanna, who has also noted that the coronavirus appears to be spreading along China's "new silk road"—echoing what happened with the Black Death in the 1300's. He and other experts expect India, Thailand, Indonesia, and Vietnam to swoop in to capitalize on China's deficit.

On Friday, the FDA announced the first drug shortage due to the coronavirus. And for nearly a month, the CDC has warned about the fragility of supply circuits for personal protective equipment, as manufacturers struggle to meet orders for face masks and N95 respirators. That's possibly because the CDC conducted a thought experiment 5 years ago that offers a clear warning for the situation unfolding today. Back then, the public health agency wanted to predict how many resources the U.S. might need over the entire course of a hypothetical outbreak of a severe flu virus. (Learn about how coronavirus compares to flu, Ebola, and other major outbreaks.)

The result was a series of models built with parameters that bear an uncanny resemblance to what is currently happening with the coronavirus. From disease transmission rates down to the lack of specific antivirals or vaccines, the CDC papers offer a rough guide on what preparedness needs to look like to combat an emerging respiratory pandemic.

"In terms of the amount of masks, gowns, gloves, [and] respirators that would be needed, this influenza model is a good way to estimate that at this point," says Eric Toner, a senior scientist at the Johns Hopkins Center for Health Security who wasn't involved with the CDC papers. "I don't see any reason to think that we would need a different number of those things than we do for a severe pandemic flu."

Based on the models, U.S. health care workers would need two to seven billion respirators for the least—to most—severe possible scenarios. That's up to 233 times more than what's currently in the Strategic National Stockpile.

"The demand that would be required in a severe pandemic is so unlike the amount that's used on a day-to-day basis," says Lisa Koonin, an epidemiologist and founder of Health Preparedness Partners. She worked for the CDC for more than 30 years and is a co-author on these reports. "For the respirators and surgical masks, we're talking orders of magnitude greater need for a severe pandemic."

The WHO has shipped nearly half a million sets of personal protective equipment to 27 countries, but it says supplies are rapidly depleting. The global health agency estimates that each month 89 million medical masks will be required for the COVID–19 response, along with 76 million examination gloves and 1.6 million goggles. The WHO estimates that supplies of personal protective equipment need to be increased by 40 percent globally.

Special staff

"In a severe pandemic, we certainly could run out of ventilators, but a hospital could just as soon run out of respiratory therapists who normally operate these devices."—Eric Toner, Johns Hopkins Center for Health Security

Along with the billions of respirators, the CDC predicted that U.S. patients and health care workers might need as many as 100 to 400 million surgical masks, as well as 7,000 to 11,000 mechanical ventilators. The latter are used during life support for the most severe cases of respiratory disease, after a patient's lungs stop working on their own. A report published Friday in the New England Journal of Medicine states that about 2.3 percent of early coronavirus patients underwent mechanical ventilation.

But ventilators, respirators, and even basic masks are only helpful when used by expert hands—and that presents another potential shortfall for the U.S.

"In a severe pandemic, we certainly could run out of ventilators, but a hospital could just as soon run out of respiratory therapists who normally operate these devices," says Toner. The Bureau of Labor Statistics estimates that the U.S. employs 134,000 respiratory specialists, or approximately 20 of these technicians for every hospital in America. (Will warming spring temperatures slow the coronavirus outbreak?)

"One of [the CDC's] conclusions was, it's not so much the number of ventilators as the number of people needed to operate the ventilators. That's the choke point," Toner adds.

Resource demands at a single hospital could also be substantial as coronavirus cases increase in the U.S. Three years ago, the Mayo Clinic—a prestigious medical system based in Rochester, Minnesota—asked Toner and his colleagues to assess what kind of individual stockpile might be required during a severe influenza pandemic.

Unlike the CDC papers, their model ran through 10,000 scenarios, each with slightly different settings for epidemiologic variables such as hospitalization rates, hospital length of patient stays, how much time patients spend on mechanical ventilation, and case fatality rate.

"A model like this can't tell you the right thing to do. But it can tell you the range of possibilities," Toner says.

For example, if the Mayo Clinic stockpiled 4.5 million gloves, 2.3 million N95 respirators, 5,000 doses of a potent antiviral, and 880 ventilators, those supplies would cover the clinic's facilities for 95 percent of the likely outcomes—everything except the absolute worst-case scenarios for a respiratory pandemic.

"We go through a lot of gloves in health care, and the numbers can be staggering," Toner says. "Particularly with a disease like this where some people are advocating double gloving, you'll burn through gloves twice as fast."

But he emphasizes that every hospital's demands would be different. The Mayo Clinic is large, boasting more than 63,000 staff members that not only serve Minnesota, but accept specialty patients from around the world.

"We can't stop COVID–19 without protecting our health workers," WHO director-general Ghebreyesus says. "Supplies can take months to deliver, market manipulation is widespread, and stocks are often sold to the highest bidder."

Resilient circuits

The actual demand and supply for health care equipment during this outbreak will depend on myriad variables, one of which is an outbreak's attack rate. As of this moment, that is a mystery for COVID–19.

The attack rate is what percentage of a population catches an infectious disease overall. If a hundred people live in a city, and a virus' attack rate is 20 percent, then 20 citizens would be expected to get sick. Both the CDC papers and Toner's models rely on attack rates ranging from 20 to 30 percent, a standard estimate for severe pandemics. (Learn about the swift, deadly history of the Spanish Flu pandemic.)

But the attack rate for COVID–19 is still unknown because it takes time to measure. Scientists must develop a test—known as a serology assay—that can detect whether a person caught the coronavirus even if they never reported symptoms.

"In terms of quantifying that specifically, it's still quite early days," Maria Van Kerkhove, an infectious disease epidemiologist and the technical leader for WHO's Health Emergencies Program, said at a press briefing at the WHO headquarters in Geneva on Monday. Van Kerkhove added those serologic surveys must be conducted across large populations, so attack rates can be determined for individual age groups.

Because the attack rate reveals how much of a population is likely to catch a disease, it can be crucial in determining how to allocate resources locally, nationally, and globally. Van Kerkhove added that the necessary surveys are underway, and the World Health Organization hopes to see some preliminary results in the coming weeks.

In the meantime, Vice President Mike Pence, the Trump Administration's newly appointed coronavirus czar, on Saturday announced a deal with the Minnesota-based corporation 3M to produce 35 million masks a month. And the managers for the Strategic National Stockpile have asked companies to submit data on their inventories of personal protective equipment, in case the coronavirus crisis escalates. They also hope their recent request for 500 million respirators and masks will promote the growth of local manufacturers.

"This purchase will encourage manufacturers to ramp up production of personal protective equipment now with the guarantee that they will not be left with excess supplies once the COVID–19 response subsides," says Stephanie Bialek of the Stra-

tegic National Stockpile. "In an emergency, the SNS can send these products to areas in need as requested by State health officials."

Editor's Note: This story has been updated with the latest case counts as of March 4 and with the new estimate for the global death rate. The story was originally published on March 3.

Ms. JACKSON LEE. Thank you.

Mr. PAYNE. Mr. Neuwirth, we have heard the—that the Federal Government has been ineffectively communicating, and providing contradictory guidance to the local and State governments during this outbreak. What has your experience been, and how can communication with the State and locals be improved?

Mr. NEUWIRTH. So our experience has been one of—you know, there have been challenges up until this point ensuring that we are able to effectively implement the policy decisions of the Federal Government in a timely and consistent matter.

We are in lockstep with our regional Federal representatives at the U.S. Department of Health and Human Services and the CDC, of course. But there—you know, there have been, since the beginning of this in January, instances where, you know, additional lead time on information coming from the Feds would have provided the State of New Jersey additional time to prepare and respond in an even more efficient manner.

Up until this point we have been very proactive in our implementation of the crisis management team and the coronavirus task force, so we have been prepared to respond on a moment's notice. But additional lead time of information coming from the Feds on important decisions such as screening at the airports, the joint base, and the testing kits would be tremendously valuable.

Mr. PAYNE. Yesterday we learned that the CDC has delayed confirming presumptive coronavirus cases in New Jersey. Has this issue been resolved?

Mr. NEUWIRTH. This issue has not been resolved. To date the CDC has not confirmed any presumptive positive case in New Jersey.

Mr. PAYNE. Thank you. To Mr. Klain and Mr. Neuwirth also, the roll out of the testing kits has been flawed, obviously; we have 2 in New Jersey. What could the Government have done better to ensure that local and State laboratories could test Americans for coronavirus?

Mr. Klain, you want to start?

Mr. KLAIN. You know, Mr. Chairman, as I said a minute ago, I think that we could have made a decision to adopt the testing protocols and kits used in other countries that have allowed them to ramp up very quickly. We made a different decision here that didn't work out.

We also could have made it a higher priority to really focus on that. I just think we lost time. We are behind.

I think the decision to bring in private labs is a positive decision. It certainly increases the capacity, but that is only going to deal with people who are in a diagnostic or clinical setting. Your doctor sends you and says, "Go get a lab," and we really need to be doing surveillance. We need to be going out in the community and finding the cases, finding the cases in nursing homes, and community centers, and where older people congregate. I think that is really a

weakness of relying on private labs as the principal solution for testing.

Mr. NEUWIRTH. I concur with Mr. Klain. It is important to recognize that the State public health environmental laboratories, of which—there is a network of them across the country—are—primarily serve as surveillance laboratories, not clinical diagnostic laboratories. We do not, as State labs, have the clinical throughput that these third-party commercial labs have.

So it is important to bring on-board and bring on-line these third-party commercial laboratories for the clinical diagnostic piece that they can test tens of thousands of individuals at any given time, and allow the State's public health and environmental laboratories to conduct a very progressive and very, you know, comprehensive surveillance activities across the State to ensure we remain ahead of where these cases are.

Mr. PAYNE. Thank you. In the interest of time, votes have been called, and I will recognize the gentleman from New York for a question and a closing.

Mr. KING. Thank you, Mr. Chairman.

I have a question, Mr. Klain, and let me just state for the record up front that there were, obviously—the whole issue with the test kits was wrong. They should have been out. So I am asking this in not a rhetorical way, but planning toward the future with what we learned from the past.

To me, the CDC, the fact that they did not accept the WHO, was there a reason for that?

Second, is there partisan influence in the CDC, or was this an honest mistake made by scientists in the CDC, or doctors at the CDC when the test kits came out and they were obviously inadequate and they were flawed?

So what I am getting at is there can be policy mistakes, and there can be just the luck of the draw, that they did their best, and it went wrong.

So, again, any thoughts that you have on that, based on your experience?

Mr. KLAIN. Congressman, you know, I think we don't know the answers to that question. We don't know the answers to some of those questions. You would have to ask CDC why they made the choices they made, and then why the approach they took didn't work. I don't know the answer to that.

I think—I don't think this is a partisan thing. I don't think this is some conspiracy, or some political decision to go this way. But I do think—and so I don't want to overstate my criticism of the administration, but I also don't want to understate it, which is I think the signs were flashing yellow early on that the CDC approach was not going to work.

I think stronger coordination and leadership from the top, from the White House, would have said, "Hey, you know what? We have got a mess here." No one chose to make this mess. It was an accident. But we need to do something quickly to turn this around and to get this fixed.

So, you know, I don't blame anyone for the initial mistakes and the consequences. But then, you know, that is what leadership is. Leadership is saying, "Hey, this isn't working. We need to get on

top of this. We need to catch up." I think that is, I think, where, you know, again, without being partisan or political, I think that is where the policy decisions came, which was, once the lights were flashing yellow, what did we do to accelerate a response to that.

Mr. KING. I guess the only question I would add to that—and again, I don't have the answer, so I am not trying to make this a partisan debate—is if they had done that, would they have said this was politicians interfering with the scientists?

I mean, if CDC thought this was the right way to go, and the President or the Vice President or some Republican Member of Congress said, "Hey, you have got to speed this up," and then they did speed it up, and it didn't work, they would say it was politicians interfering with science.

I mean, again, I am trying to——

Mr. KLAIN. Yes. No, Congressman, I think that is——

Mr. KING. But, I mean, the people at the top, you have to——

Mr. KLAIN. No, Congressman——

Mr. KING. They are going to take the blame, I realize that.

Mr. KLAIN. That is a—look, I think, Congressman, that is a fair question. What I would say is that the role of political leadership, whether that was President Obama in the Ebola response, or President Trump and Vice President Pence now, is to ask the scientists, "How is it going? What is going on here? Why is it that I am waking up and I see that Korea has tested 50,000 people and we have tested 500?"

Mr. KING. I am asking the same question.

Mr. KLAIN. You know, like—so I don't think there is anything politicizing about science to ask your scientists, "How come I am seeing this on the news, and how come I am not seeing this here?"

Ultimately, the medical decisions, the scientific decisions should be made by them. But, you know, the Government should hold people accountable for results.

Mr. KING. Again, if I could make a semi-partisan point, maybe that is why it is important to have you and the Vice President running these things finally.

I mean, again, maybe if Mike Pence had been there from the start, they would have gotten a faster result. The bureaucrats sometimes only respond if you know that——

Mr. KLAIN. Congressman, I absolutely agree with that. I think that some kind of White House coordinator was needed. It was one of my early criticisms of the administration. I am glad they have done it.

My only criticism of the current coordination would be I think someone really needs to be on this full-time. I think, obviously, the Vice President has a lot of other responsibilities, as he should. That is not a criticism, it is just a reality. I think they brought in Ambassador Birx, who I have a great deal of respect for, to work with the Vice President. She is still doing her other job, as well, kind-of running PEPFAR. I think, whether it is her or someone, this should be a full-time job. This is a big problem for our country. Leading the response shouldn't be your side gig.

Mr. KING. I just hope, when this is all over, we have a good after-action report. Thank you for your service.

Mr. PAYNE. I thank the gentleman. I—you know, and I absolutely am a believer, in a time of crisis, we should tend to lean on people that have had some experience in the past, the near past, such as yourself, involved in these things. So thank you for your service.

I would like to thank all the witnesses for their valuable testimony, and the Members for their questions.

The Members of the subcommittee may have additional questions for witnesses, and we ask that you respond expeditiously in writing to those questions.

Pursuant to committee rule VII(D), the hearing record will be open for 10 days, without objection.

Hearing no further business, the subcommittee stands adjourned, and we are 389 not voted. Thank you.

[Whereupon, at 3:38 p.m., the subcommittee was adjourned.]