PANDEMIC RESPONSE: CONFRONTING THE UNEQUAL IMPACTS OF COVID–19

HEARING

BEFORE THE

SUBCOMMITTEE ON EMERGENCY PREPAREDNESS, RESPONSE, AND RECOVERY

OF THE

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PANDEMIC RESPONSE: CONFRONTING THE UNEQUAL IMPACTS OF COVID–19

Friday, July 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 12:20 p.m., via Webex, Hon. Donald M. Payne, Jr. (Chairman of the subcommittee) presiding.

Present: Representatives Payne, King, Thompson, Richmond, Rose, Underwood, Green, and Bishop.

Also present: Representative Jackson Lee.

Mr. PAYNE. Subcommittee on Emergency Preparedness, Response, and Recovery will come to order.

Good afternoon, and thank you for joining us today. First, I would like to say my thoughts are with those who have lost loved ones from the COVID–19 pandemic.

Also, with Tropical Storm Fay making its way through the northeast, I hope everyone is staying safe.

Our Nation is facing a crisis of unprecedented proportions. The novel corona pandemic has already infected over 3 million and killed over 100,000 Americans. The scale of the loss is staggering, and efforts to produce a life-saving vaccine continue, but not all Americans have been impacted equally. Communities of color are not only more likely to be infected by the COVID–19, but they are also more likely to be killed by the virus.

In my home State of New Jersey, African Americans disproportionately make up the COVID–19 fatalities. This disturbing trend is observed not only in New Jersey, but also across the Nation. Data from the CDC shows that African Americans and Hispanic populations are three times more likely to be infected and twice as likely to die from COVID–19 than White population.

This administration's response to the outbreak has been an utter failure on a multitude of levels. Nowhere is this more acute than in its neglect of minority health.

Since the onset of the outbreak, it has been clear that communities of color are disproportionately impacted. However, the impacts on these communities have been obscured by critical data gaps. Even with this knowledge, the administration has been painfully slow in setting requirements for collection of racial and ethnic demographic information of COVID–19 infections. The example is

just one of many that demonstrate the administration's lackluster outbreak response, especially when it comes to minority health.

Even CDC director Dr. Robert Redfield admitted the failures of the administration to collect demographic information on COVID–19 infections and deaths, is an apology at another Congressional hearing—made that apology at another Congressional hearing last month. I would say, Dr. Redfield, that the American people need more than that.

While much of the focus of the administration's response to minority health during the pandemic is centered around the Department of Health and Human Services, the Department of Homeland Security's Federal Emergency Management Agency, FEMA, is playing a vital role as the lead Federal agency for response. Americans are counting on FEMA to get it right.

Unfortunately, FEMA has had costly missteps in the past when it comes to not factoring in the needs of communities of color, and the researchers have continuously found that FEMA's recovery programs exacerbate existing disparities. While these disparities long precede COVID–19, the effect they are having on minority communities is a National emergency in itself—one, I worry about FEMA is not doing enough to meet. As we speak, lives are being lost in the country to long-standing health inequities, and that is unacceptable.

At today's hearing, I hope we can explore this problem and hear potential solutions from our panel of experts.

[The statement of Chairman Payne follows:]

STATEMENT OF CHAIRMAN DONALD M. PAYNE, JR.

JULY 10, 2020

Our Nation is facing a crisis of unprecedented proportions. The novel coronavirus pandemic has already infected over 3 million and killed well over 100,000 Americans. The scale of loss is staggering and efforts to produce a life-saving vaccine continue. But not all Americans have been impacted equally.

Communities of color are not only more likely to be infected by COVID–19, but they are also more likely to be killed by the virus. In my home State of New Jersey, African Americans disproportionately make up the COVID–19 fatalities. This disturbing trend is observed not only in New Jersey but also across the Nation. Data from the CDC shows that African Americans and Hispanic populations are 3 times as likely to be infected and twice as likely to die from COVID–19 than white populations. This administration's response to the outbreak has been an utter failure on multiple levels. Nowhere is this more acute than in its neglect of minority health.

Since the onset of the outbreak, it has been clear that communities of color are disproportionately impacted. However, the impacts on these communities have been obscured by critical data gaps. Even with this knowledge, the administration has been painfully slow in setting requirements for the collection of racial and ethnic demographic information on COVID–19 infections.

This example is just one of many that demonstrate the administration's lackluster outbreak response, especially when it comes to minority health. Even CDC director Dr. Robert Redfield admitted the failures of the administration to collect demographic information on COVID–19 infections and deaths in an apology at another Congressional hearing last month. I would say to Dr. Redfield that the American people need more than that.

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Unfortunately, FEMA has had costly missteps in the past when it comes to not factoring in the needs of communities of color and researchers have continuously found that FEMA's recovery programs exacerbate existing disparities. And while

these disparities long precede COVID–19, the effect they are having on minority communities is a National emergency in itself—one I worry that FEMA is not doing enough to meet.

As we speak lives are being lost in the country to long-standing health inequities and that is unacceptable. At today's hearing, I hope we can explore this problem and hear potential solutions from our panel of experts.

Mr. PAYNE. The Chairman now recognizes the Ranking Member of the subcommittee, the gentleman from New York, Mr. King, for an opening statement.

Mr. KING. Thank you, Chairman Payne. I appreciate the opportunity, and I think this is a very significant hearing, an important hearing. I will make my remarks brief. I have a prepared statement, so I ask my staff that they submit it for the record.

Let me just say that New York has been hit particularly hard. We have over 400,000 confirmed cases. In my district alone, there is more than 20,000 confirmed cases. There is probably 12- to 1,300 deaths in the district.

Now, in particular, the focus of this hearing, as far as how it is impacting the minority community, that is particularly true in my district. The average community in the district, excluding the minority communities for the purpose of this debate, discussion, is between 15 and 20 cases per 1,000. In the minority communities of Brentwood, Central Islip, and Wyandanch, it has gone from 62 to 70 cases per 1,000. So that is 3, 4, 5 times higher in the minority communities.

Now, the immediate reason for that seems to be that many of the front-line workers, the grocery workers, transit workers are minorities, so they are right on the front lines. They are the front-line warriors, and they are getting impacted directly.

I think some of the long-term reasons, though, are that the underlying health conditions, such as diabetes and high blood pressure, heart disease, are illnesses that, for a long time, go undetected, and people may not know they have them, and there is a lack of health care in the minority communities.

That is why I think it is important—and I worked with Congresswoman Yvette Clarke on this, too. We have to increase the use of community health centers. To me, you have to have them. They are in the community where the people living in that community feel safe and secure going to them. They don't feel they are going to be—check the immigration status or anything else. They can just go.

Also, having it nearby is—just makes it more comfortable. Also, these are people who very often have low incomes and really don't want to be going to doctors. They can't afford it, and, if they don't feel sick, they are not going to go looking for it, and that is why it is important to get check-ups, be tested, and I think community health centers are extremely important.

Now, we really began to realize this in early April, the extent of the pandemic in the minority communities, so we did put—I worked with local Suffolk County. They put a testing center in Wyandanch, and also in Brentwood, which, again, are two of the most impacted communities, especially Brentwood.

Also, I have been—emphasize that, whenever other partisanship is going on, fortunately, on Long Island, Congressman Suozzi, Congresswoman Rice, Congressman Zeldin, Congressman Greg Meeks,

and I have been working extremely closely on this. Also, I have been working with the State senator who represents Central Islip and Brentwood, Senator Monica Martinez, who is a Democrat. We have been trying to work as closely as we can.

But, again, you know, sooner or later, we are going to come out of this pandemic, but the fact is, that is only the beginning, because we have to realize this can certainly occur again, and, as you pointed out, what this has brought out is the underlying conditions as far as lack of proper health care for people in the minority communities. So we are going to have to address that as we go forward.

As far as the Federal response, I haven't seen that be an issue on Long Island. Again, both of our county executives are Democrats. I have worked with them. I have not heard that there has been a lack of funding from the Federal Government as far as one community against another, and we did fight hard to get the ventilators and the gloves and masks, but I—that—so far, I don't see that being an issue, but I am not ruling it out.

But I do think the underlying, long-term issue is going to be the issue of proper health care, and we have to take that into account, strongly into account. We have to find ways to rectify that going forward.

So, with that, let me yield back, and I look forward to the testimony.

Thank you, Mr. Chairman.

[The statement of Ranking Member King follows:]

STATEMENT OF RANKING MEMBER PETER T. KING

JULY 10, 2020

The novel coronavirus or COVID–19 has already claimed half a million lives across the globe, and here in the United States, nowhere has been hit harder than New York. With over 32,000 deaths, my home State and District have been ravaged by this virus.

While there has been a vigorous Federal, State, and local response, as our knowledge of the virus continues to mature, data has shown that COVID–19 is disproportionately affecting certain communities. In an April Coronavirus Task Force briefing, U.S. Surgeon General Jerome Adams acknowledged the increased risk of coronavirus to racial minority populations. The CDC states: "Long-standing systemic health and social inequities have put some members of racial and ethnic minority groups at increased risk of getting COVID–19 or experiencing severe illness, regardless of age."

It is important that we understand and recognize which communities coronavirus is affecting most severely so that we can rally behind our neighbors and support them as we work to overcome this pandemic together.

In May, I joined the New York Delegation on a call with the NAACP that focused on recovery from the pandemic with special emphasis on communities such as Wyandanch, North Amityville, Central Islip, and Brentwood. These communities with major minority populations have had far more coronavirus cases than most others in Long Island. I also joined colleagues in urging HHS to provide dedicated funding to community health centers which oftentimes serve as the primary care provider within communities of color.

Further, I was proud to cosponsor the Pandemic Heroes Compensation Act, which creates a compensation fund for all essential workers and personnel who have been injured or impacted by COVID–19. As we virtually meet today, we must have greater appreciation for the suffering and sacrifice that our front-line workers face daily. Not only do police, firefighters, EMS workers, and health care workers put themselves in danger, but grocery store clerks, delivery workers, janitorial personnel, and transit workers risk their health and safety every day to serve the rest of us. And data highlights that minorities are disproportionately represented in essential front-line jobs, which increases their exposure to the virus.

I commend all the first responders, medical personnel, essential workers, and public health officials who have—and continue to—courageously put their lives on the line throughout this pandemic. I look forward to hearing from our panel today to understand more about the effects of the coronavirus and to possibly inform further work with the bipartisan Regional Recovery Task Force that I co-lead.

Mr. PAYNE. I thank the Ranking Member for his candor and honesty, which is one of the reasons why I appreciate his service to this country so much. Thank you, sir——

Mr. KING. Thank you, Chairman.

Mr. PAYNE [continuing]. Once again, and I would like to work with you on the community health center issue. That is something that has been very important to me, and it is good to hear that you are interested in that, and look forward to working with you on those issues.

Mr. KING. Great. Thank you.

Mr. PAYNE. OK. So Members are reminded that the subcommittee will operate according to the guidelines laid out by the Chairman and Ranking Member in their July 8 colloquy. With that, I ask unanimous consent to waive committee rule 8(a)(2) for the subcommittee during the remote proceedings under the covered period designated by the Speaker under House Resolution 965. Without objection, so ordered.

The Chairman now recognizes the Chairman of the full committee, the gentleman from Mississippi, Mr. Thompson, for an opening statement.

Mr. THOMPSON. Thank you very much, Mr. Chairman. Good afternoon to my colleagues as well as our witnesses.

I would like to thank both of you and the Ranking Member for holding today's hearing on health disparities in the COVID–19 pandemic. The COVID–19 pandemic did not create health disparities in this country. Instead, the pandemic is further exposing these disparities and their tragic effects on minority and disadvantaged communities.

Today's hearing provides an opportunity to examine the Federal response to the pandemic, and what must be done to confront the disproportionate impacts of the pandemic in these communities.

In March, FEMA was tasked with being the lead Federal agency for COVID–19 response. I have been concerned about FEMA's past emergency response efforts where it failed to adequately address the needs of minority and economically disadvantaged communities. The complexities of the pandemic put this troubling history in starker view.

In April 2020, FEMA published a new civil rights bulletin intended to ensure civil rights during the COVID–19 response. While the publication is an encouraging step, continued Congressional oversight of the agency's efforts and operations is necessary to ensure response effort—responsive efforts to provide equitable assistance to minority and economically disadvantaged communities.

Of course, direction to FEMA and the entire Federal Government on pandemic response flows from the top. Unfortunately, President Trump's response to the worsening pandemic has been a failure by any reasonable measure. Failure to address minority and economic health disparities is a significant part of the shortcomings.

The administration has even struggled to provide policy makers with COVID–19 case and morbidity data outcomes by race and eth-

nicity. In fact, it took pressure from Members of Congress and the public for the Centers for Disease Control and Prevention to release its first Nation-wide preliminary case on morbidity estimates by race and ethnicity on June 15, 2020, well into the pandemic.

Communities of color and the economically disadvantaged have to contend not only with the deadly virus and failed Federal response, but also systematic inequities that put these communities at greater risk for COVID–19-related hospitalizations and death.

On April 29, 2020, every Democratic Member of this committee sent a letter to the Department of Health and Human Services, Office of Inspector General, requesting they look at this issue and ways the Federal Government can better address health disparities in emergencies.

Katrina taught us a lot. I thought we had learned a good bit about communities of color during emergencies, but, obviously, we still have some work to do.

So I look forward to our witnesses' testimony today, and I yield back, Mr. Chairman.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

JULY 10, 2020

The COVID–19 pandemic did not create health disparities in this country. Instead, the pandemic is further exposing these disparities and their tragic effects on minority and disadvantaged communities. Today's hearing provides an opportunity to examine the Federal response to the pandemic and what must be done to confront the disproportionate impacts of the pandemic in these communities.

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Of course, direction to FEMA and the entire Federal Government on pandemic response flows from the top-down. Unfortunately, President Trump's response to the worsening pandemic has been a failure by any reasonable measure. Failure to address minority and economic health disparities is a significant part of the shortcoming. The administration has even struggled to provide policy makers with COVID–19 case and morbidity data outcomes by race and ethnicity. In fact, it took pressure from Members of Congress and the public for the Centers for Disease Control and Prevention (CDC) to release its first Nation-wide preliminary case and morbidity estimates by race and ethnicity on June 15, 2020, well into the pandemic.

Though the data is still incomplete, CDC's estimates suggest what many non-governmental reports already show—African Americans, Latinos, Indigenous people, and Alaska Natives are disproportionately affected by the pandemic. Communities of color and the economically disadvantaged have had to contend not only with a deadly virus and failed Federal response, but also the systemic inequities that put these communities at greater risk for COVID–19-related hospitalization and death.

On April 29, 2020, every Democratic Member of this committee sent a letter to the Department of Health and Human Services Office of Inspector General (OIG), requesting they look at this issue and ways the Federal Government can better address health disparities in emergencies. I look forward to the Inspector General's findings on our request.

Today, I am pleased we are joined by our distinguished witnesses today. I hope we have a frank discussion about how the Federal Government can do more to include communities of color and the economically disadvantaged in its preparation, response, and recovery efforts for COVID–19 and other emergencies.

STAFF. We can't hear you, sir.

Mr. PAYNE. I thank the Chairman for his opening statement, and I appreciate his leadership.

Now, Mr. Rogers will not be joining us today, so I will move on to introducing the witnesses. Member statements may be submitted for the record.

Our first witness is Dr. Georges Benjamin, who serves as executive director of the American Public Health Association. Dr. Benjamin's experience includes having been Secretary of the Maryland Department of Health & Mental Hygiene and the former chief of emergency medicine at the Walter Reed Army Medical Center. He is also a member of the National Academy of Medicine. Welcome.

Our second witness is Dr. Leana Wen. Dr. Wen is an emergency physician and visiting professor of health policy and management at the George Washington University's Milken School of Public Health, where she is also a distinguished fellow at the Fitzhugh Mullan Institute of Health Workforce Equity. She also previously served as Baltimore's health commissioner. Thank you for being here.

Our third and final witness is Chauncia Willis. Ms. Willis is the co-founder and CEO of the Institute for Diversity and Inclusion in Emergency Management. She is a certified emergency manager, a master exercise practitioner, and serves as the immediate past president of the International Association of Emergency Managers, region 4. Welcome.

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, beginning with Dr. Benjamin.

STATEMENT OF GEORGES C. BENJAMIN, M.D., EXECUTIVE DIRECTOR OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BENJAMIN. Chairman Thompson, Chairman Payne, and Ranking Member King, first, thank you very much for allowing me to spend some time with you this morning.

I am—you have my full testimony. I am going to focus on three areas: Disparate impact and the cause of it, some concerns I have about on-going co-occurring preparedness activity, and then, of course, the importance of rebuilding our public health infrastructure.

As you know, this has devastated our Nation. Over 3 million cases, over 130,000 deaths, and they are growing at 60,000 cases a day. If you look at the minority community, we have been devastated disproportionately. For African Americans, over 13 percent of the population with 24 percent of the deaths. Hospitalizations are 5 times for African Americans than non-Hispanic Whites, and 4 times for Hispanics than non-Hispanic Whites. The Native American population is also substantially being devastated by this outbreak.

I think that we ought to think about this epidemic as though we have 3 of them. No. 1, we obviously have this big infectious disease epidemic. We also have an infodemic, which I am going to come back and talk about, which is a lot of misinformation and disinformation. Clearly, fear plays a predominant role in our com-

munity, a lot of it because we don't know what is going on. It is a new disease. There is lots of issues that—and, quite frankly, we need to strengthen the National leadership that we have had on this outbreak.

Obviously, the impact has not just been on health; it has also been on the economy, it has been on the social welfare, et cetera. There are 3 main reasons for this: Higher exposure because of public-facing jobs for minorities, susceptibility because of a long history of chronic diseases, and social determinants of health. You know, 80 percent of what makes you healthy occurs outside the doctor's office.

So, people are set up not to be able to have good health, and that includes things such as having to work multiple jobs because of pay inequalities, because of the lack of paid sick leave, the housing, which prohibits you from being able to really physically distance, even if you get infected in your home. These are all concerns that we have to address if we are going to go forward.

Our response has been challenged in many ways. We have had inadequate testing. We have had absolutely inadequate data so we can target our resources and target our responses. Contact tracing is well behind where it needs to be. In terms of education, we have not really done a great job of educating the public on what is going on and how to address this as we go forward.

I remain concerned that, should we get hit with something this summer, like a severe storm or another hurricane, wildfires, or an earthquake, that our ability to simply manage that will be severely stressed. Imagine being in a shelter where you can't really manage face coverings very well, hand washing, and physical distancing. We haven't really planned adequately for that.

Finally, we need to fix our broken public health system. I was the health officer in Maryland on 9/11. We had a pretty good public health system, but even Congress and the administration at the time buffered and improved our public health system.

But we, as a Nation, have allowed that to erode away substantially over the last several years. It has impacted our response to COVID. It stands to impact our response to natural disasters, and I remain concerned that the coordination and the leadership isn't there for us to address these things as we go forward.

With that, I would be kind enough to stop and, you know, take questions during the question-and-answer period.

Thank you, Chairman, and Members of the committee.

[The prepared statement of Dr. Benjamin follows:]

PREPARED STATEMENT OF GEORGES C. BENJAMIN

JULY 10, 2020

Chairman Payne, Ranking Member King, and Members of the subcommittee, thank you for the opportunity to address you today on the impact of the COVID–19 pandemic on communities of color. I am Georges C. Benjamin, MD, executive director of the American Public Health Association in Washington, DC. APHA champions the health of all people and all communities. We strengthen the public health profession, promote best practices, and share the latest public health research and information. We are the only organization that combines a nearly 150-year perspective, a broad-based member community and the ability to influence policy to improve the public's health.

The "outbreak of pneumonia of an unknown cause" was first reported in Wuhan, China on Dec. 31, 2019, and was in the United States by mid-January. The pneu-

monia was found to be caused by a novel coronavirus, which has been named and classified as SARS–2. This virus causes a disease, named COVID–19, which enters the body primarily through the respiratory route and causes a severe pneumonia as its major physiological impact. We now know the virus is able to attack many different organ systems, causing a range of clinical problems. To date it has stricken over 3 million individuals and caused over 131,000 deaths in the United States alone. We know that this virus is one of a family of coronaviruses that causes mild diseases like the common cold and also much more severe infections like Middle Eastern Respiratory Syndrome (MERS) and its less severe but also lethal cousin Sudden Acute Respiratory Syndrome (SARS–1). It remains infectious on a variety of surfaces from hours to days but degrades easily under certain environmental conditions. It is easily deactivated by common household cleaning and desanitizing products.

We currently have 3 co-occurring epidemics associated with this crisis: The infectious pandemic; an "infodemic" of misinformation and disinformation; and an epidemic of fear. The epidemic of fear is caused by a combination of things: Fear of the virus, but also fear arising from the uncertainties around its spread and other unknown factors, and fear stoked by the poor and inconsistent risk communication from some political leaders.

The epidemiology of this virus shows it is actively spreading throughout the community and that each person can infect on average at least 2 other people. It is more infectious than most influenza strains and causes mild to no symptoms in about 80 percent of cases, with 15–20 percent having more severe disease. The case fatality rate in the United States is about 4.6 percent (39.6 deaths/100,000 population). This rate will probably reduce as the number of asymptomatic and mild cases becomes clearer. We now know that at least 40 percent of infected people are asymptomatic or presymptomatic spreaders. The virus can spread in 3 main ways, most frequently from large particulate respiratory spread, fine respiratory aerosols, and fomites. Fomite spread occurs when a person contaminates their hand or another object with respiratory secretions.

People of all ages are at risk of getting this disease; however, children have been shown in general to have less severe symptoms. There is, however, a syndrome that is under investigation in a very small number of children and young adults of a hyper-immune disease triggered by the virus. The impact on pregnant women and children is less well-defined but appears at this time not to cause very severe disease. However, there needs to be much caution to interpreting these early observations as many clinical impacts on newborn children and pregnant women can be delayed.

The biggest impact from COVID–19 has been its disproportionate toll on communities of color. Early in the outbreak it became clear that African Americans and Hispanics were being impacted by both a higher incidence of this disease and a higher percentage of premature deaths when compared to the overall population. Data from a recently published paper in the Annals of Epidemiology reinforces the finding that African Americans are harder hit in this pandemic. The study from researchers at amfAR, The Foundation for AIDS Research, looked at county-level health outcomes, comparing counties with disproportionately Black populations to all other counties. Their analysis showed that while disproportionately Black counties account for only 30 percent of the U.S. population, they were the location of 56 percent of COVID–19 deaths. Even disproportionately Black counties with above-average wealth and health care coverage bore an unequal share of deaths.[1]

Another analysis from the U.S. Centers for Disease Control and Prevention has also shown this disparity on a National basis, especially in hospitalized patients.[2]

The COVID Tracking Project has been tracing this phenomenon as well *(https://covidtracking.com/race).* They have found that 24 percent of the deaths where race is known are from African Americans, which comprises 13 percent of the U.S. population. More recently, CDC reported that as of June 12, 2020, age-adjusted hospitalization rates for non-Hispanic Blacks or American Indian/Alaska Native per-

[1] Millett GA, Jones AT, Benkeser D, Baral S, Mercer L, Beyrer C, Honermann B, Lankiewicz E, Mena L, Crowley JS, Sherwood J, Sullivan P, Assessing Differential Impacts of COVID–19 on Black Communities, Annals of Epidemiology (2020).

[2] Garg S, Kim L, Whitaker M, et al. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID–NET, 14 States, March 1–30, 2020. MMWR Morb Mortal Wkly Rep 2020; 69: 458–464.

sons are approximately 5 times that of non-Hispanic whites and 4 times higher for Hispanic or Latino persons than that for non-Hispanic whites.[3]

A recent white paper by scholars at Harvard University found that Black Americans under the age of 65 have lost, collectively, 45,777 years of life as a result of COVID–19. Hispanics and Latinos lost 48,204 years of life, while white Americans under age 65 have lost, collectively, 33,446 years of life.[4]

This disparity in the impact of COVID–19 is not surprising in its presence, only in its scope. There are several reasons for this disparity. The first is greater exposure among communities of color due to their occupations. During this outbreak, more minorities have held pubic-facing occupations that put them at a higher risk of exposure as the Nation moved to a stay-at-home posture. For example, grocery store clerks, transit workers, hotel workers, meatpacking plant workers, poultry workers and sanitarians were defined as essential workers and have continued to work and therefore have had higher risks of novel coronavirus exposures overall.

The second issue was a higher susceptibility to more severe disease should they get infected. Early evidence from the Chinese experience showed that the 15–20 percent of people with more severe disease tended to have pre-existing chronic diseases like heart disease, hypertension, lung disease, and diabetes. This tendency to more severe disease for infected people with chronic diseases has played out similarly in the United States. We know that African Americans are 25 percent more likely to die from heart disease, 72 percent more likely to have diabetes, 20 percent more likely to have asthma, and 2 times more likely to develop hypertension than non-Hispanic whites. We also know that many of these diseases develop at an earlier age as well. Hispanics have less heart disease and cancer than whites but have a 50 percent higher incidence of diabetes and are more likely to lack health insurance.

The third issue is the "infodemic" I earlier spoke about. We know misinformation is rampant in minority communities. Some of it is purposeful. Early rumors that African Americans were immune from the disease as well as rumors about false treatments and cures are wide-spread on social media and are even being spread via flyers and brochures. One example of a flyer that targeted the citizens of New Jersey in minority, Jewish, and Muslim communities is shown in the link in this testimony. This flyer falsely included the logos of the U.S. Centers for Disease Control and Prevention and the World Health Organization shown here: *https://www.njhomelandsecurity.gov/covid19.* Similar flyers and disinformation more specifically targeting African Americans have been found in cities like New Orleans and on social media sites. In these cases people have been encouraged not to get tested or get the COVID–19 vaccine when it becomes available. The disinformation often tells people that testing is being done to track people to give them the disease. Another widely-spread myth: The future vaccine will make one sterile. The anti-vaccine movement is amplifying these messages to others to discourage vaccine use. Many of these efforts are designed to build on existing mistrust of authority figures and create a sense of confusion and further loss of trust within the community.

The fourth reason for these health disparities is the presence of long-standing inequities in the social determinants of health that have created the conditions for ill health in minorities and disadvantaged people for years. A recent study by a team of noted researchers from the Harvard University Center for Population and Development Studies looked at the relationship between social determinants and excess mortality from COVID–19. It showed higher mortality from COVID–19 in cities and towns that had higher rates of poverty, household crowding, percentage of populations of color and higher racialized economic segregation.[5]

Finally, we know that place matters and can put individuals at higher risk for infection. Examples include nursing homes full of elderly individuals with chronic diseases and jails and prisons where confinement and limited access to handwashing and respiratory protections increase risk. Of course the Nation's prisons house a disproportionate number of men of color because of unjust criminal jus-

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[3] *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html,* Accessed on-line July 5, 2020.

[4] Bassett, MT, MD, MPH, Jarvis T. Chen, ScD, Nancy Krieger, PhD, The unequal toll of COVID–19 mortality by age in the United States: Quantifying racial/ethnic disparities, June 12, 2020 *https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1266/2020/06/20__Bassett-Chen-Krieger__COVID-19__plus__age__working-paper__0612__Vol-19__No-3__with-cover.pdf,* Accessed on-line July 5, 2020.

[5] Jarvis T. Chen, ScD, Pamela D. Waterman, MPH and Nancy Krieger, PhD, entitled, COVID–19 and the unequal surge in mortality rates in Massachusetts, by city/town and ZIP Code measures of poverty, household crowding, race/ethnicity, and racialized economic segregation. *https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1266/2020/05/20__jtc__pdw__nk__-COVID19__MA-excess-mortality__text__tables__figures__final__0509__with-cover-1.pdf,* Accessed on-line June 2, 2020.

tice policies. Awareness about this long-standing injustice has contributed to recent efforts to deinstitutionalize non-violent offenders and unadjudicated individuals in custody to reduce their risk of infection.

We can address these disparities through sound public health strategies. First, we need broad promotion of physical distancing, wearing masks and other respiratory protections, handwashing, and following sound science in disease prevention and control as we reemerge from our homes back into public spaces. We have to ensure robust testing for symptomatic individuals and individuals at high risk due to occupation or place. Testing locations must be accessible to all communities. In the early roll out of testing when the availability of tests was limited, many testing sites were not available equally to all communities. This was a particular problem for the drive-by testing sites, which were often not easy to get to and required the use of a car. These factors can play a huge role in determining who gets tested. Those making decisions about the location of testing sites should always vet these choices with representatives of the entire community to ensure they address any potential barriers.

Testing for the virus must be followed up by adequate contact tracing and sound programs for the isolation and quarantine of infected and exposed individuals. The use of culturally competent messages and messengers (including lay messengers, community health workers, faith community leaders, barbers, beauticians, and social workers) is critical to address the misinformation and other issues of concern. Communities should use more radio, social media, and age-appropriate vehicles for community health education. Materials should be prepared in a range of languages to reach people for whom English is not their first language (Spanish, Haitian, Chinese, Portuguese, etc.).

Importantly, we must adequately collect demographic and occupational data, including race and ethnicity, on who gets tested and where, the prevalence of the disease, comorbidities, hospitalizations, and deaths from individuals tested for or diagnosed with COVID–19. This information is critical to ensuring that public health authorities and other decision makers can make data-driven decisions on where to place services and resources to reduce and ultimately eliminate health inequities.

Also, we must acknowledge how racism in all of its forms has created a legacy of unequal access to a range of health services, resulting in differences in the quality of care received, health-seeking behaviors and in the social factors that affect one's health. This must be addressed as a component of any solution to reduce the unequal impact of COVID–19 on communities of color.

There is a great deal of concern that the Nation-wide mass protests that occurred after the murder of George Floyd at the hands of Minneapolis police would result in disease spikes because, as I noted earlier, increased exposure is a risk factor for increased disease in communities of color, with higher morbidity and mortality. These increased exposures were complicated by police crowd control actions like the use of tear gas, pepper spray, and corralling and detaining protesters into large groups. These actions further increase the risks of COVID–19 infection.

The presences of mass gatherings in the face of a severe pandemic do create a perceived health risk paradox. It raises the question, why would people choose to increase their risk of infection and get sick with COVID–19 in order to participate in mass protests, and what is the trade-off they are making? Many people believe the protesters are making a trade-off between the potential health risks of them becoming infected with COVID–19 with the real risk of them and their neighbors experiencing police brutality. For many, the magnitude of ending police violence, racial profiling, and verbal harassment driven by racism overshadows the risk of getting COVID–19.

It remains to be seen if the protests will result in increased disease spikes. Nationally, we have begun to see increases in disease positivity and hospitalizations as the Nation continues to reopen. It will be difficult to determine the relative roles the mass protests and reopening are playing in these exacerbations of the pandemic. However, it is clear that the health impact from COVID–19 has had a disparate impact on communities of color, and we must remain vigilant in our response.

I am concerned about how we plan for several potential health threats that could hit the United States during the pandemic over the next 6 months. This summer we are expecting a higher-than-normal hurricane season, and this fall we will have the seasonal return of influenza. Climate change has caused more severe storms, floods, wildfires, and increased the spread of other climate-sensitive infectious diseases. All of these have been shown to have a disparate impact on communities of color when they occur. The increase in toxic air from wildfires and the increase in water-borne and mosquito-borne diseases all pose an increased risk to COVID–19-compromised patients. Finally, the traditional approach to managing emergencies will require more thought and planning as the ability to provide and use non-

pharmacological interventions (masking, handwashing, and physical distancing) is much more difficult in emergency shelters during heat waves or mass evacuations. I am aware the Federal Emergency Management Agency has begun to look into this, but the opportunity to begin educating the public on what to do differently in an emergency is now.

In order to ensure our States, cities, and territories are better prepared for the next emergency, it is essential that Congress increase funding for CDC's Public Health Emergency Preparedness Cooperative Agreement and ASPR's Hospital Preparedness Program. Unfortunately, PHEP funding has decreased from $939 million in fiscal year 2003 to $675 million in fiscal year 2020, while HPP has been slashed from $515 million in fiscal year 2003 to $275 million in fiscal year 2020. The COVID–19 pandemic has demonstrated how essential HPP and PHEP are to the public health and health care systems' ability to respond quickly and efficiently to emergencies. The investments from the Public Health Emergency Preparedness Cooperative Agreement created the response systems and infrastructure that enable States, cities, and territories to respond to public health emergencies. PHEP has invested in capabilities critical to the COVID–19 response, such as incident management, epidemiological investigation, laboratory testing, community preparedness and recovery, and medical countermeasures and mitigation. By having staff in place and trained prior to an emergency, public health departments can respond without delay. Although supplemental funding is needed during this pandemic, base PHEP funding allows health departments to hire and retain expert staff. HPP is the only source of Federal funding for regional health care system preparedness, minimizing the need for supplemental State and Federal resources during a disaster. HPP provides funding and technical assistance to every State, 4 cities, and U.S. territories to prepare the health care system to respond and recover to events such as COVID–19. We are calling on Congress to provide at least $824,000,000 for the PHEP cooperative agreement and at least $474,000,000 for HPP in the fiscal year 2021 Labor, Health and Human Services, and Education Appropriations bill.

A strong public health infrastructure and workforce are also essential to helping us reduce health inequities related to COVID–19 and other health threats. In order to better ensure our public health infrastructure is adequately prepared for addressing the current pandemic, future pandemics and other public health emergencies, we must seriously look at fixing our vastly underfunded public health system. APHA is calling on Congress to provide $4.5 billion in additional long-term annual mandatory funding for CDC and State, local, Tribal, and territorial public health agencies for core public health infrastructure activities.[6] [7] This funding would support essential activities such as: Disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response, policy development and support, communications, community partnership development and organizational competencies. This funding is critical to ensuring our State and local health departments have broad core capacity to not only respond to the current pandemic but to better respond to the many other public health challenges they face on a daily basis. For far too long we have neglected our Nation's public health infrastructure, and we must end the cycle of temporary infusions of funding during emergencies and provide a sustained and reliable funding mechanism to ensure we are better prepared to protect and improve the public's health, including our most vulnerable communities, from all threats.

Congress should also authorize and appropriate funding in fiscal years 2020 and 2021 for a public health workforce loan repayment program. This program was authorized, but not appropriated in the HEROES Act passed by the House of Representatives.[8] Providing funding for this important program will help incentivize new and recent graduates to join the Governmental public health workforce, encourage them to stay in these roles, and strengthen the public health workforce as a whole. The public health workforce is the backbone of our Nation's governmental public health system at the county, city, State, and Tribal levels. These skilled professionals deliver critical public health programs and services. They lead efforts to

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[6] Organization letter to House and Senate leaders urging a significant, long-term investment in public health infrastructure in future legislation to speed the response to the COVID–19 pandemic. April 3, 2020. Available at: *https://apha.org/-/media/files/pdf/advocacy/letters/2020/200403__ph__infrastructure__covid__stimulus.ashx.*

[7] Public Health Leadership Forum. Developing a financing system to support public health infrastructure. Available at: *https://www.resolve.ngo/docs/phlf__developingafinancingsystemtosupportpublichealth636869439688663025.pdf.*

[8] Organization letter to House and Senate leaders supporting the inclusion of the Public Health Workforce Loan Repayment Program in the HEROES Act. May, 14, 2020. Available at: *https://apha.org/-/media/files/pdf/advocacy/letters/2020/200514__ph__workforce__loan__repay- ment.ashx.*

ensure the tracking and surveillance of infectious disease outbreaks, such as COVID–19, prepare for and respond to natural or man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ public health nurses, behavioral health staff, community health workers, environmental health workers, epidemiologists, health educators, nutritionists, laboratory workers and other health professionals who use their invaluable skills to achieve health equity and keep people in communities across the Nation healthy and safe.

Finally, we should support and enact legislation that directly targets existing disparities and promotes health equity. This would include legislation that provides support and coordination at the Federal level for addressing the social determinants of health that underlie many existing racial and ethnic health disparities. We also need legislation that addresses these disparities directly through promoting equity in health care access, workforce representation, data collection, and other areas. Existing legislation that would further these efforts includes H.R. 6637, the Health Equity and Accountability Act of 2020, and H.R. 6561, the Improving Social Determinants of Health Act of 2020.

I thank you for the opportunity to testify before you on this important issue. I look forward to answering any questions you may have.

Dr. WEN. Chairman, I am not sure we heard you.

Mr. PAYNE. Thank you, Dr. Benjamin, for your testimony.

I now recognize Dr. Wen to summarize her testimony. Thank you.

STATEMENT OF LEANA WEN, M.D., VISITING PROFESSOR OF HEALTH POLICY AND MANAGEMENT, GEORGE WASHINGTON UNIVERSITY MILKEN INSTITUTE SCHOOL OF PUBLIC HEALTH

Dr. WEN. Thank you very much, Chairman Payne, Ranking Member King, and distinguished subcommittee Members. Thank you for addressing the intersection of racial disparities and the COVID–19 pandemic.

So I come to you from the city of Baltimore, where I am a practicing physician and had the honor of serving as its health commissioner. In my city, children born today can expect to live 20 years more or less depending on where they are born and the color of their skin. There are racial disparities across every metric of health. That is a result of structural racism and inequities.

COVID–19 is a new disease that has unmasked these long-standing health disparities, and the evidence is clear that African Americans, Latinos, Native Americans, and other minorities bear the greatest brunt of this pandemic.

My written testimony outlines 10 actions that Congress can take now to reduce the disproportionate impact of the pandemic on people of color. I would like to highlight 6 of them that are directly relevant to the work of the Homeland Security Committee.

First, target testing to minority and underserved communities. Testing must be free, widespread, and easily accessible, yet it is estimated that we need 10 times the amount of testing that we currently have. Congress must instruct FEMA to ramp up testing and to set up testing facilities all across the country. Existing hotspots should be the priority initially, but the key is to have enough testing everywhere to prevent clusters from becoming outbreaks and outbreaks from becoming epidemics.

Second, provide free facilities for isolation and quarantining. We know the key to reining in the virus is testing, tracing, and isolation. Well, if someone tests positive, we tell them to self-isolate.

What do you do if you live in crowded, multigenerational housing, as minorities disproportionately do? Other countries have addressed this by setting up field hospitals and converting unused hotels into voluntary self-isolation facilities. Congress should request FEMA to do the same.

Third, institute stronger worker protections. Minorities constitute a larger percentage of essential workers. The CDC has issued watered-down guidelines, and OSHA has not met its mission to protect workers. Your committee can ensure that workplace protections are followed for Federal workers, like TSA employees. This includes universal masking for all passengers in airports, as this will protect the employees as well as the public. You can also institute stronger protections to limit the spread of COVID–19 in DHS-run immigration detention facilities. That includes access to PPE and appropriate protocols for isolation and quarantining.

Fourth, suspend immigration enforcement for those seeking medical assistance for COVID–19. Public health hinges on public trust. Undocumented immigrants who fear deportation will be scared to seek help if they exhibit COVID–19 symptoms, and pose a risk not only to themselves, but to their families and communities.

Congress should prohibit ICE from accessing records at facilities of those seeking care for COVID–19. Congress should also ask for temporary cessation of the Trump administration's public charge rule.

Fifth, prepare for the next surge. It is a National shame that we ran out of masks and other PPE to protect our health care workers. There was no excuse in March, and even less of an excuse now. PPE should not only be available to doctors and nurses. Why shouldn't grocery cashiers, bus drivers, nursing home attendants, who are disproportionately people of color, have protection too? Congress must urge the Trump administration to have a National strategy. This includes activating the Defense Production Act to ensure that PPE, ventilators, and other critical supplies are produced in sufficient quantity. Lack of action affects everyone, but, in particular, minority communities.

Sixth, and finally, support local public health. Funding for public health preparedness has been cut by half over the last decade, forcing local officials to make impossible tradeoffs between critical programs. I think we can all agree that treating COVID–19 should not come at the expense of preventing cardiovascular disease and reducing overdose deaths. I urge that your committee also consider the public health safety net to be part of the backbone of critical infrastructure and National security in the United States.

I would like to end my testimony by thanking all of you for focusing on tangible solutions. There are systemic problems that we must address that will take sustained commitment and dedicated effort, but we are facing the biggest public health crisis of our time, literally a life-and-death threat facing our communities of color now. We cannot just ignore problems. Now is the time to take action to reduce disparities in COVID–19 outcomes and, in so doing, improve health for all.

Thank you.

[The prepared statement of Dr. Wen follows:]

PREPARED STATEMENT OF LEANA WEN

JULY 10, 2020

Chairman Payne, Ranking Member King, and distinguished Members of the Subcommittee on Emergency Preparedness, Response & Recovery: Thank you for convening this important conversation to address racial disparities during the COVID–19 pandemic.

The numbers are clear. We can plainly see the devastating impact of COVID–19 that disproportionately affects African-Americans, Latino-Americans, Native Americans, and other communities of color. According to new data published in the *New York Times* this week, Latino and African-Americans are 3 times as likely to be infected as their white neighbors. They are twice as likely to die from the virus.

A Brookings Institution report found that in some age groups, African-Americans have 6 times the mortality than whites. In some States, Hispanics have more than 4 times the expected rate of infection based on their share of the population. In California, Pacific Islanders face a death rate from COVID–19 that is 2.6 times higher than the rest of the State. In South Dakota, the rate of COVID–19 among Asian Americans is 6 times what would be predicted based on demographic data, on a backdrop of surging racism and xenophobia directed toward Asian Americans across the country. Other minority communities are also disproportionately affected, including in New Mexico, where Native American people comprise about 11 percent of the population yet account for nearly 60 percent of COVID–19 cases. These harrowing numbers are only the tip the iceberg; there are lot of data missing that would more fully illustrate the impact of COVID–19 on communities of color.

Why are there such rampant health disparities? I'd like to introduce a concept we in medicine know well: "acute on chronic". In medical practice, this refers to a patient who has a long-standing medical condition that is exacerbated by an acute illness. This is the case for COVID–19: It is a new disease, a global pandemic, that has unmasked long-standing underlying health disparities.

Let me give you the example from a city I know well, my home city of Baltimore, Maryland, where I previously served as the Health Commissioner. A child born today can expect to live 20 years more or less depending on the neighborhood he or she is born into. There are racial disparities in just about every metric of health, whether it's death from cardiovascular disease or maternal or infant mortality. In my city, and all across the United States, we live in a world where the currency of inequality is years of life.

This is the existing situation, of rampant health disparities. Now, we have a new disease that is rapidly transmitted from person to person. It is not surprising that areas with many individuals who are essential workers, that also have higher density and crowded living and working conditions, will have higher rates of transmission; after all, social distancing is a privilege that many people do not have. On top of that, COVID–19 causes the most severe illness in people with underlying medical conditions. Racial minorities who experience higher rates of high blood pressure, diabetes, and other conditions as a result of food deserts, lack of accessible care and other environment conditions will be disproportionately affected once again.

Add on to this that COVID–19 has resulted in stopping key social programs that are lifelines in my community and all across the country, like schools and senior centers. Home visitation programs that have been instrumental to reducing infant mortality and lead poisoning have been put on hold. Many who have chronic conditions faced additional problems of accessing care: Not only care for physical health conditions but also mental health as well. The acute impacts of COVID–19 worsen the underlying conditions in individuals and communities. Our solutions must therefore focus on both aspects.

In this testimony, I emphasize 10 actions that Congress can take now to reduce the disproportionate impact of the pandemic on people of color. When possible, I emphasize (in the underlined text) the agencies and entities that are directly under the jurisdiction of the Homeland Security Committee.

(1) Target testing to minority and underserved communities.

There must be free, wide-spread, and easily accessible testing that's directed toward the most impacted communities—in this case, specifically communities of color that will experience the disproportionate impacts of COVID–19. Not only should these tests be available at no cost, they must also be easy to obtain. Testing locations shouldn't just be at hospitals and doctor's offices; they should be in the community, where people live and work. This, indeed, is a tenet of public health, to go to where people are.

Reducing the racial disparities in COVID–19 outcomes requires that public health officials be attentive to detecting COVID–19 cases early to prevent a cluster from becoming an outbreak. Efforts must be made to increase testing sites throughout minority and underserved communities, including with creative outreach efforts: For example, testing drives at churches, community centers, and public housing complexes. Given existing disparities in accessing the health care systems, tests should be made available without a doctor's prescription.

State and local officials cannot do this work alone; it's estimated that we need 10 times the amount of testing that we currently have. Congress must instruct FEMA to ramp up testing and to set up testing facilities all across the country. Existing hotspots should be the priority, but emphasis should be placed to ensure that community spread is detected early on to prevent clusters from becoming outbreaks and outbreaks from becoming epidemics. In addition, FEMA must coordinate efforts to ensure that the supply chain remains intact, and that surges in infections do not result in swabs and testing reagents from becoming limiting factors.

(2) Track demographic information to ensure equitable resource allocation.

There have been many calls to make publicly available racial demographic data for infections, hospitalizations, and deaths from COVID–19. I agree with this, and add one more data point that's critical: The demographic data for testing. The other metrics are important too, but they measure what has happened with disease spread, as opposed to testing, which measures the actions that are in our control to prevent the spread in the first place.

Public health experts generally agree that sufficient tests are performed when the positive rate falls below 10 percent. That is to say, the net is cast wide enough when less than 10 percent in a population test positive. I would like to see this testing data broken down by race and zip code. That way, if we see the positive rate in the population in a community is at 10 percent, but African-Americans are still testing positive at a rate of 20 percent, that means African-Americans are under-tested compared to others. Similarly, neighborhood data would allow for better targeting of tests and resources to specific areas.

My ideal scenario is to have a dashboard that is updated in real time, and that's coordinated by the Federal Government with data uploaded by State and local officials. This provides important information and also offers the transparency and accountability that are needed to ensure that communities most in need are receiving the resources they require. Federal funding can be tied to the availability of these data, adding a strong incentive for compliance.

The CDC would be the ideal entity to coordinate such a dashboard. FEMA can also play a role in tracking this information, especially if it becomes instrumental (as I hope it does) in ensuring wide-spread testing.

(3) Hire contact tracers from minority communities.

As efforts ramp up to recruit, train, and deploy contact tracers, there must be recognition that effective contact tracing depends on community trust. Every effort should be made to recruit contact tracers from the communities they serve, and to deploy contact tracers based on community need. Those who are the most "credible messengers" must also have language ability that reflects the needs of those they serve. This will also serve as an opportunity for employment in communities hardest hit by the economic impacts of COVID–19 as well.

While contract tracers should come local communities, the coordination can be done Nationally. It makes no sense to have 50 different protocols for recruitment, training, and deployment. A National strategy for contact tracers could, in theory, come under the purview of the Department of Homeland Security, which has experience in mass deployment for critical infrastructure and security needs.

(4) Provide free facilities for isolation and quarantine.

Individuals who test positive for COVID–19 must be placed in isolation and those with significant exposure must be quarantined for the length of time that they are potentially infectious. Many may not be able to do so safely at home, if they live in close quarters and multi-generational housing. Facilities should be made available free of charge to those who choose to isolate/quarantine elsewhere, including through the use of empty hotels and dormitories, and resources should be made available to reduce the economic impact of isolation and quarantine.

Previously, I joined a group of bipartisan leaders to put forth a proposal to establish such isolation/quarantine facilities and to replace wages with a small sum—equivalent to what is paid for jury duty—to incentivize individuals to isolate and quarantine. Such a proposal is particularly needed for those who face substantial barriers to housing and who experience economic hardship. Importantly, it addresses the needs of individuals for whom missing work or finding alternate housing could mean sacrificing food on the table or shelter for their families.

Establishing these facilities, rapidly, is something that should be led by FEMA. FEMA has shown that it can rapidly set up field hospitals. Isolation and quarantine facilities are just as critical for controlling the outbreak, and Congress should urgently request FEMA to oversee these efforts.

(5) Suspend immigration enforcement for those seeking medical assistance for COVID–19.

Public health hinges on public trust. Undocumented immigrants who fear deportation will be scared to seek help if they exhibit COVID–19 symptoms, thereby posing a risk not only to themselves but their families and communities. Congress should prohibit ICE from accessing records of those seeking care for COVID–19 or in any way having access to facilities that offer testing and care for patients.This should also be made clear through public education campaigns in minority communities.

Congress should also ask for temporary cessation of the Trump administration's public charge rule. This rule will serve to further delay legal immigrants from seeking necessary health care. It should be suspended for a 2-year period given the immediacy of the COVID–19 pandemic.

(6) Institute stronger worker protections.

As a former local health official, I depended on the CDC for unambiguous guidance in the time of public health crises. At the beginning of the COVID–19 crisis, the CDC held daily briefings that were informative and instructive. Unfortunately, these briefings stopped at the beginning of March. Subsequent guidance from the CDC was delayed, and the language used in the guidelines was not the specific, directive, and clear guidance that I am used to seeing from them.

What I would like to see from the CDC is, frankly, what I'm used to seeing from them in past administrations. For example, with States reopening, employees are told to go back to work. Exactly what standards must be met? People should not just be "encouraged" to do social distancing. What exact standards must be met in different types of workplaces, i.e. office environments vs meat-packing plants? Masks should not be worn, "if feasible". They should be required. I want to see a clear statement, such as: If these 15 criteria cannot be met, then reopening isn't safe and employees shouldn't be allowed back in these spaces. The Occupational Health and Safety Administration (OSHA) should then enforce these rules, as should local and State regulatory entities. If not, it is people of color and those who already face systemic disparities who will suffer the most.

Congress must instruct CDC and OSHA to return to their mandates of protecting the health of the public and specifically workers. It should also do its part through agencies in the immediate purview of its committees. The Homeland Security Committee can, for example, ensure that all workplace protections are followed for TSA employees. This includes universal masking for all passengers in airport facilities, as this will protect the employees as well as the public. Such policies can set an example for not only the Federal Government but also private industries to secure protections for workers and the public—and in so doing, protect those most vulnerable including minorities.

Furthermore, there must be stronger protections to limit the spread of COVID–19 in DHS-run immigration detention facilities. This includes ensuring access to PPE, appropriate protocols for isolation and quarantine, and criteria for release of detainees if cases reach a certain point determined by public health experts. As with all other workplaces, protecting the staff will also protect those they come into contact with and reduce community spread.

(7) Prepare for the next surge.

In March 2020, our country faced a situation that I never thought I'd experience as a health care provider: That we'd run out of personal protective equipment (PPE) and have to put our front-line clinicians in harm's way without something as basic as masks. We also came to the brink of running out of ventilators and other critical equipment. States were forced to bid against each other for these and other critical supplies, such as swabs and reagents for tests.

There are a number of reasons why we were not prepared the first time around. Perhaps it was excusable then. But it is no longer. We know what is needed now, and we know that a second surge will almost certainly happen, especially with the convergence of COVID–19 with the flu season.

Hospitals need to do their part to prepare for the second surge. Local and State policy makers must gird for this too. The Federal Government needs to urgently develop and implement a National, coordinated effort to secure needed supplies and have a plan for procurement and distribution. PPE should not only be available to front-line hospital workers, but also to others who must interface with many people everyday: Why shouldn't grocery cashiers, bus drivers, and nursing home attendants all have protection for themselves? Lack of action will affect everyone, but in par-

ticular those in our society who are the most vulnerable and who already face the greatest brunt of disparities.

The Federal Government also needs to think now about issues that will come up in months to come. If there is an effective treatment developed, how will it be equitably distributed? If a limited supply of a vaccine becomes available, how can we ensure that it's not only those who are privileged who will access it? Lack of thoughtful planning will inevitably lead to a situation where those who are well-connected and well-resourced can obtain scarce resources, leaving many others to go without.

Congress must take prompt action to urge the Trump administration to have a National coordinated strategy. This includes activating the Defense Production Act to ensure PPE, ventilators, and other critical supplies are produced in sufficient quantity.

(8) Support safety-net public health systems.

Primary care and community-based health care organizations have suffered substantially during the COVID–19 crisis, and it is not at all certain that many will survive in its aftermath. Home visitation and other community outreach programs have also had to curtail their work; many others may not be financially sustainable either. Efforts must be made to support these community-based programs that serve as the safety net for many.

Already, local public health is chronically underfunded, with less than 3 percent of the estimated $3.6 trillion in annual health care spending directed toward public health and prevention; CDC funding for public health preparedness and response programs has been cut by half over the last decade, forcing local public health officials to make impossible tradeoffs between critical, life-saving programs that serve communities in need. There is an urgent need to strengthen local public health infrastructure not only to ensure a robust response to COVID–19 and future crises, but also so that those interventions do not come at the cost of health and well-being and thus further perpetuate racial disparities.

Flexibility is key in future funding. This pandemic has evolved quickly and local jurisdictions still best know the needs of their individual communities. They need to be able to adapt and respond to the needs they have rather than having to find justification to meet Congressional spending mandates.

There must also be attention to previously marginalized areas of health care. Mental health is already a neglected area, and the need for behavioral health services can only be expected to rise with the convergence of health, economic, and societal crises. Any discussion of health care reform must take into account mental health as an equivalent need to physical health. There must be funding for programs to address trauma and build resiliency. And there needs to be recognition of the fact that racism is a public health issue—indeed a public health crisis in and of itself.

As the Homeland Security Committee considers threats to critical infrastructure, I urge that you also consider the public health safety net to be part of National security and the backbone of critical infrastructure in the United States and around the world.

(9) Increases health insurance coverage.

More than 45 million people have lost their jobs during the pandemic, and with those jobs, many of them lost health insurance. That's on top of 27 million who were previously uninsured. Lack of insurance leads to a delay in treating underlying medical problems, which increases the likelihood of severe illness and death from COVID–19. Since minorities constitute a higher percentage of the uninsured, increasing coverage will prevent further amplification of disparities. States can do this through expanding Medicaid and allowing open enrollment in exchanges.

Congress must ensure health care coverage for all Americans, starting with frontline Federal workers. It should also press for National policies around evidence-based public health practices that reduce infection risk, including universal mask-wearing.

(10) Target resources to address social determinants of health, with a focus on areas of greatest need.

Disparities in health are inextricably linked to housing instability, food deserts, and lack of transportation access. These are all issues that contribute to poor health broadly and to disparities associated with COVID–19 specifically.

Any reform of the health care system must take into account that these social determinants contribute even more to health than the health care that one receives. For example, there needs to be examination of affordable housing through investment in the construction and repair of potential housing options and support of policies that extend debt forgiveness and prevent eviction. Food insecurity can be addressed by expanding eligibility and granting waivers for food assistance programs

such as WIC and SNAP, investing in local food banks, and incentivizing food delivery for low-income and vulnerable neighborhoods, while education should be made a priority by ensuring access to books, technology, and internet, all essential components of virtual instruction. As it relates to the aftermath of COVID–19, resources provided in the wake of the pandemic should also be specifically targeted to areas of greatest need.

CONCLUSION

To some, the 10 steps outlined here will seem too small in scope. I agree that there must be attention to longer-term issues like housing instability, income inequality, and structural racism that are inextricably linked to health disparities. But the COVID–19 pandemic is the life-or-death threat facing communities of color right now. The perfect cannot be the enemy of the good when there are specific actions that policy makers can take that will reduce disparities in COVID–19 outcomes and, in so doing, improve health for all. The world that we strive for should be one in which the currency of inequality no longer equals years of life: One in which where children are born and what race they happen to be no longer determines whether they live.

Mr. PAYNE. Thank you for your testimony.

I now recognize Ms. Willis to summarize her statement for 5 minutes.

STATEMENT OF CHAUNCIA WILLIS, CO-FOUNDER AND CHIEF EXECUTIVE OFFICER, INSTITUTE FOR DIVERSITY AND INCLUSION IN EMERGENCY MANAGEMENT

Ms. WILLIS. Chairman Thompson, Chairman Payne, Ranking Member King, and Members of the Emergency Preparedness, Response, & Recovery Subcommittee, thank you for the opportunity to testify on this important topic.

We are experiencing a paradigm shift across the United States as we respond to a pandemic, civil unrest, and systemic racism with an uncertain outlook for recovery or an adequate recovery plan. The issues plaguing America, including the disparities associated with COVID–19, are a result of policies enacted that have historically lacked diversity, inclusion, and equity.

Of all the emergency management policies, only a few mention the word "equity," and none address using equitable strategies to produce better outcomes for vulnerable groups. Disasters do not discriminate; however, people do. The health disparities seen during this pandemic can only be improved if we understand and operationalize equity.

Equity must be present in all plans, policies, programs, and practices within the field of emergency management. Equity in all things. Equity is different from equality. For example, equality is about giving everyone a shoe. Equity is giving everyone a shoe that fits.

In disaster management, it can no longer be about doing the most for the most, because, when we do the most for the most, it leaves a gap, and it [inaudible] who have the least. There are existing inequities within our country's very fabric that lead to disproportionate death and negative impacts for the most vulnerable groups among us.

These inequities are rooted in systemic racism and an antipoverty mindset that exists. For example, the racist policy redlining has led to a lack of access to health care, exposure to environmental hazards, and so forth. The field of emergency management lacks diversity in representation, which influences the way

policies and programs are crafted and negatively impacts outcomes in disaster for underrepresented groups.

Currently, emergency management policies indicate that White male is the default setting and baseline standard for disaster response and recovery. In fact, the field of emergency management is overwhelmingly White, made up of over 80 percent White males in leadership positions. However, the communities we serve as emergency managers are very diverse, and the impacts of COVID–19 on diverse populations is significant.

Current data shows that Black and indigenous Americans have experienced the highest rate of COVID–19 deaths in America. If they had died of COVID–19 at the same actual rate as Whites, about 16,000 Blacks, 2,200 Latinos, and 400 Native Americans would still be alive.

America's disabled population is also suffering, because they lack access to testing and non-urgent health care. In addition, although people with disabilities are at high risk for COVID–19, there is a data gap in reporting that prevents equitable strategy development.

Also, the needs of rural areas are unique, because they tend to have older populations with more chronic health conditions that raise the risk of developing more severe cases of COVID–19. They have fewer health care providers and more uninsured residents, meaning they must wait longer for treatment.

The emergency management system must incorporate operationalized equity as a foundational principle for policies using social determinants of health to address the needs of diverse population. Our organization, I–DIEM, recommends the following: A thorough review of current emergency management policies, including an assessment of the intended and unintended effects of these policies; No. 2, intentional measurable integration of equity into FEMA doctrine, programs, grants, and contract awards; No. 3, ensure Federal funding is tied to demonstrated diversity, inclusion, and equity in all things, especially grants and contract awards. In addition, disaster plans and programs should be evaluated and held accountable, based on the performance of the equity strategy.

No. 4, integrate equity and culturally competent thinking into emergency management curriculum and continuing education.

Finally, invest a majority of preparedness, mitigation, and recovery funding in the most vulnerable communities, including communities of color. Emergency management must make diversity, inclusion, and equity a priority so that lives will be saved and not sacrificed in disaster.

Thank you for your time.

[The prepared statement of Ms. Willis follows:]

PREPARED STATEMENT OF CHAUNCIA WILLIS

JULY 10, 2020

Chairman Thompson, Ranking Member King, Subcommittee Chairman Payne, and Members of the Emergency Preparedness, Response, and Recovery subcommittee, thank you the opportunity to testify on the direly important topic of health disparities and the novel coronavirus pandemic. My name is Chauncia Willis, and I am the co-founder and chief executive officer of the Institute for Diversity and Inclusion in Emergency Management (I–DIEM). As a career emergency manager, I have over 20 years of experience at the Federal, State, and local level, and within

the private sector emergency management enterprise where I have experienced, first-hand, the disparate outcomes of disasters and crises. It is this experience that was foundational to the creation of I–DIEM, which works with local, State, and Federal agencies, research institutions, local organizations, the private sector, and philanthropy to eradicate bias and discrimination within emergency management and proactively develop data-driven, equitable solutions for underserved populations (women, people of color, people with disabilities, LGBTQ, various religious beliefs, low-income, and disadvantaged communities) before, during, and after disasters.

We are experiencing unique circumstances across the United States as we respond to a pandemic, civil unrest, and systemic racism with an uncertain outlook for recovery or an adequate recovery plan. The issues plaguing America currently, including the disparities associated with COVID–19, are a result of policies enacted that have historically lacked diversity, inclusion, and equity. The negative outcomes that we see are not a result of crisis or disaster. Disasters do not discriminate, but people do. The health disparities seen during the COVID–19 pandemic are not a result of the pandemic, but of policy that has failed. Policy, that can only be improved if we understand and operationalize equity.

From the start, the writing was on the wall and it was well understood that there would be disproportionate outcomes for marginalized groups. On March 12, the day before he took the reins of the COVID–19 response, I personally travelled to FEMA headquarters on behalf of I–DIEM and met with Administrator Gaynor to offer assistance in crafting an equitable FEMA response policy and measures to address the outbreak. Our organization, and its network of emergency managers and equity experts, has been actively supporting the response from the very beginning of the COVID–19 crisis. I–DIEM held 3 National Coronavirus Virtual Convenings early on to focus on the impacts of the pandemic on vulnerable communities and provide equitable response solutions for community organizations and government. Based on emergency management's history of inequitable responses, we knew COVID–19 would devastate underserved groups. Leadership should be guided by equity and it must be integrated into all disaster management policies.

Equity refers to fairness, justice, and impartiality. Not be confused with equality, which refers to equal sharing and division that keeps everyone at the same level, equity is a needs-based approach. Equality is not affected by the needs of people or society as it promotes sameness.[1] Historically, America has not held true to the phrase "all men are created equal," and that pivotal piece of the Constitution was not referencing women or people of color who were seen as less than white men. Foundationally, the Constitution and its policies created a system of class and privilege that resulted in the outcomes that we see today. America must be held accountable for its response to disasters that have historically sacrificed black and brown people of color as seen in the Yellow Fever outbreak of New Orleans in 1850 where people of color were said to be "immune to the disease" as a justification for their continued slavery during an outbreak because it benefited the economy. Or, the slavery of an essential worker designation as people of color are more likely to work in service industries placing a vulnerable population at increased risk for illness or death given the disparities data for COVID–19. At what point are the lives of underserved populations no longer acceptable losses?

We have to break away from utilizing "white" as the default setting for policy and action. Creating policy based on how the rest of society compares to white men is a fight for equality and sameness; a fight that focuses on doing the most for those with the most. America has shown that we are not all treated the same and this on-going inequitable approach to policy and practice has shown us that doing so is ineffective. The United States spends more money on health care globally, but has worse health outcomes than comparable countries around the globe.[2] We spend billions on the rising costs of disasters, without much significant change in disaster mortality since the 1940's.[3] This pandemic demonstrates that current policies are ineffective and inequitable. In addition, it must be acknowledged that emergency management has experienced a failed response in partnership with public health due to political interference and decreased reliance on scientific data to inform response. Consequently, the COVID–19 response is an indictment against the emergency management profession and its failure to integrate equity in all policies.

It is my hope, that as we address COVID–19 from an emergency management perspective, we begin to understand the importance of social determinants of health

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[1] Adhikara, S. (2017). Equity vs. Equality. Health Programs and Policies.

[2] American Public Health Association [APHA] (n.d.). Health rankings. *https://www.apha.org/topics-and-issues/health-rankings.*

[3] Roberts, P.S. (2013). Disasters and the American State: How politicians, bureaucrats, and the public prepare for the unexpected. Cambridge University Press: New York, NY.

(SDOH) in the emergency management enterprise as they are the underpinnings of vulnerability, disparity, and inequity. Incorporating social determinants of health in emergency preparedness, response, and recovery enhances resilience which can improve disaster outcomes. As COVID–19 impacts our economy and society, we will see an increase in newly vulnerable populations while conditions worsen for previously vulnerable populations. This will prove costly for the upcoming disaster season if we continue to function without operationalizing equity. Moving forward, key areas of my testimony include:

- The Impact of COVID–19 from a Social Determinants of Health Perspective
- Solutions and Strategies for Improving Equity During the COVID–19 Pandemic
- Success Stories: Highlight Successes in Equitable Approaches to Emergency Management.

THE IMPACT OF COVID–19 FROM A SDOH PERSPECTIVE

Social determinants of health (SDOH) are conditions in the environment in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life (QOL) outcomes and risks.[4] These determinants are a balance between our social lives and physical environments that impact our QOL including:

- Availability of resources to meet basic needs (safe housing and food markets)
- Access to educational, economic, and job opportunities
- Access to health care
- Availability of community-based resources in support community living (recreational opportunities and activities)
- Transportation options
- Public safety (Police, Fire, EMS, 911 Communications)
- Social norms and attitudes (e.g. discrimination, racism, and distrust of the government)
- Exposure to crime, violence, and social disorder
- Socioeconomic conditions (e.g. poverty, low-income housing)
- Language/literacy
- Access to information and technology
- Culture
- Natural environment (e.g. green space) and weather (climate change)
- Built environment
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to hazards (toxic, physical), and
- Physical barriers (people with disabilities).[5]

As SDOH impact up to 80 percent of health outcomes,[6] when differences in any of these factors exist and create barriers between the general population, typically non-Hispanic white males as the control group, and the most vulnerable populations we see disparity.[7] As emergency managers, we plan with many of these of factors in consideration. We perform risk analysis, risk assessments, develop flood plans that include housing and our built environments, coordinate efforts with transportation, and examine potential barriers, however, we do this as an overall function our emergency management responsibility. Emergency managers give equal attention to these issues is a structured approach to handling crisis and disasters. However, this approach does not view disasters through an equitable lens. Equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged because of socially-determined circumstances.[8] Emergency management planning will not truly be effective without equity which takes accounts for disparities that exist based on social determinants of health. Historically, this has been an on-going issue and the COVID–19 pandemic has further exposed the reality of health disparities in the United States.[3]

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[4] Centers for Disease Control and Prevention [CDC] (2018). Social determinants of health: Know what affects health. CDC. *https://www.cdc.gov/socialdeterminants/index.htm.*

[5] Healthy People 2020 (2020). Social determinants of health. Office of Disease Prevention and Health Promotion (ODPHP). *https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.*

[6] Alleyne, K.R. (2020). We must address the social determinants affecting the black community to defeat COVID–19. The Washington Post. Published: April 26, 2020.

[7] World Health Organization [WHO] (2012). Emergency risk management for health: Overview. Global Platform: Emergency Risk Management for Health Fact Sheets—2013.

[8] CDC (2020). Health equity. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). *https://www.cdc.gov/chronicdisease/healthequity/index.htm.*

From a public health perspective, the poor and socially vulnerable disproportionately suffer the burden of disease.[9] [10] [11] [12] From a disaster science perspective, populations that were suffering prior to disaster tend to experience relatively poor outcomes.[13] Combined, the concept of social vulnerability has become a growing theme in emergency management giving rise to frameworks such as the Social Determinants of Vulnerability Framework.[14] Social vulnerability is the susceptibility of social groups to the impacts of hazards such as suffering disproportionate death, injury, loss, or disruption of livelihood, as well as resiliency, or ability to adapt from disaster.[15] The framework examines 7 inter-related factors that drive vulnerability: Children, people with disabilities, elderly, chronic and acute medical illness, social isolation, low-to-no income, and practical approaches to risk reduction.[11] Each of these are directly related to social determinants of health and highlight at-risk populations, particularly, as they relate to COVID–19.

Attention to disparities in incidence, prevalence, and mortality associated with COVID–19 in racial/ethnic communities is increasing. Blacks comprise 13 percent of the U.S. population but account for 28 percent of COVID–19 cases and 33 percent of hospitalizations.[16] These numbers are increasingly alarming in local, community settings. A recent study in Queens, NY highlighted that COVID–19 cases were 30 percent greater in communities with extremely high cases versus moderate cases.[17] Out of 6 communities (Extremely high cases=3; Moderate cases=3), communities with extremely high cases were predominantly black vs. predominantly white, had a significantly higher percentage of persons with less than a high school diploma, were 40 percent more uninsured, and had higher rates of chronic and acute conditions (diabetes, obesity, and hypertension).[14] [15] In Chicago, more than 50 percent of COVID–19 cases and nearly 70 percent of deaths involve black individuals, although blacks only comprise 30 percent of the population. In Louisiana, 70.5 percent of deaths have occurred among Black persons although they only comprise 32 percent of the State population, and in Michigan, 40 percent of deaths have occurred among Black individuals who comprise 14 percent of the population [18]

Accounting for 18 percent of the U.S. population, Hispanics/Latinx populations comprise 28 percent of COVID–19 cases in the United States and are among the highest rates of mortality in the Nation. Specifically, Hispanic/Latinx populations have a mortality rate 4 times than that of non-Hispanic whites only following Blacks and American Indians/Alaskan Natives who are 5 times more likely to be hospitalized or die as a result of COVID–19.[19] As of June 12, 2020, age-adjusted hospitalization rates are the highest among American Indian/Alaskan Native populations [16] which is consistent, despite sparse data although highlights from data available through the Indian Health Service show disproportionate rates of infection among States with higher concentrations of Native Americans.[13] This data is consistent beyond the United States as Data from the National Office of Statistics in the United Kingdom show that Blacks are 4.2–4.3 times more likely to die from COVID–19 than whites in England and Wales while also highlighting that Bangladeshis, Pakistanis, Indians, and those of mixed ethnicities are at increased

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[9] Adler, N. & Stewart, J. (2010). The biology of disadvantaged: socioeconomic status and health. Ann NY Acad. Sci., 1(1186), 275.

[10] Braveman, P., Egerter, S., & Williams, D.R. (2011). The social determinants of health: coming of age. Annual Review of Public Health, 32(1), 381–398.

[11] Marmot, M. (2005). Social determinants of health inequities. Public Health, 365, pg. 6.

[12] Mikkonen, J., Raphael, D. (2010). Social determinants of health: The Canadian facts. York University School of Health Policy and Management.

[13] Tierney, K. & Oliver-Smith, A. (2012). Social dimensions of disaster recovery. International Journal of Mass Emergencies and Disasters, 30(2), pp. 123–146.

[14] Martin, S.A. (2014). A framework to understand the relationship between social factors that reduce resilience in cities: Application to the city of Boston. International Journal of Disaster Risk Reduction, 12, 53–80.

[15] Cutter, S.L. & Enrich, C.T. (2006). Moral hazard, social catastrophe: The changing face of vulnerability along the hurricane coasts. Ann. Am. Acad. Polit. Sci., 604(1), 102–112.

[16] Turner-Musa, J., Ajayi, O., & Kemp, L. (2020). Examining social determinants of health, stigma, and COVID–19 disparities. Healthcare, 8(168), 1–7.

[17] Harlem, G. & Lynn, M. (2020). Descriptive analysis of social determinant factors in urban communities affected by COVID–19. Journal of Public Health, 1–4.

[18] Yance, C.W. (2020). COVID–19 and African-Americans. JAMA—Journal of the American Medical Association, 323(19), 1891–1892.

[19] CDC (2020). COVID–19 in racial ethnic and minority groups. Coronavirus Disease 2019 (COVID–19). *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.*

risk of death from COVID–19.[13] Each of these disparities have commonalities that link them when examining social determinants of health.

Social determinants affecting these populations are believed to make them more vulnerable to the virus including lack of access to health care, economic insecurity, poor neighborhood and housing conditions, and availability of resources.[13] Lower access to health care is correlated to uninsured populations, testing, and chronic conditions. Decreased access to health care contributes to decreased testing and testing sites which is alarming as 30 million people do not have health insurance and this is highly likely to be the case in low-to-no income communities that are characterized by racial/ethnic minorities. Additionally, among the risk factors for COVID–19 are chronic conditions such as cardiovascular disease, chronic respiratory disease, hypertension, and cancer which are all associated with an increased risk of death[20] of which Blacks have higher mortality rates in all categories.[21] Lack of access to transportation and reduced train and bus schedules in COVID–19 places more people onto fewer transports decreasing the ability for proper social distancing[3] while also increasing the risk of infection due to overcrowding.

Housing and neighborhood density also contribute to overcrowding where racial/ethnic minorities are more likely to live in densely-populated areas increasing contact with other people. Moreover, racial/ethnic minorities are more likely to live in neighborhoods with a lack of healthy food options, recreational facilities, safety, and lighting which contributes to health conditions such as diabetes and obesity which are risk factors for COVID–19.[13] Much of this is a result of income inequality where we see disparities in the labor and economic system.

In the United States, white workers earn 28 percent more than Black workers and 35 percent more than Hispanic/Latinx workers. Moreover, along racial/ethnic minorities, blacks and Hispanics or more likely to have service, transportation, or jobs in sales which classifies them as "essential workers" who must continue to work during the pandemic without "work-from-home" options, paid sick leave, or adequate health coverage. This is further exacerbated by job loss during the pandemic while research shows that Blacks and Hispanics/Latinx populations are less likely to have savings to cover living expenses for at least 3 months[22] suggesting that these populations may not have access to the health care or necessities needed which could worsen outcomes.[13]

Each of these social determinants are considerations that must be included in planning. Measures that do not account for social determinants of health have contributed to the disparities and negative outcomes totaling $802 billion dollars in disaster funding over the last decade[23] and a 17.7 percent expenditure of the Gross Domestic Product (GDP) on health care[24] which does not justify the costs versus poor health outcomes. The focus on "flattening-the-curve" instead of addressing risk and vulnerability can have negative effects. Solutions should focus on not producing new forms of inequity and disparity by focusing on segments of the population that are already vulnerable, such as racially marginalized, and economically disadvantaged populations, as a foundation for equitable strategies.[25]

SOLUTIONS AND STRATEGIES FOR IMPROVING EQUITY DURING THE COVID–19 PANDEMIC

Social determinants of health are present through all aspects of the COVID–19 pandemic. As the Federal Emergency Management Agency (FEMA) leads whole-of-America coronavirus operations,[26] along with White House Coronavirus Task Force, and the Department of Health and Human Services (DHHS), the pandemic high-

[20] Jordan, R.E., Adab, P., & Cheng, K.K. (2020). COVID–19: Risk factors for severe disease and death. British Medical Journal, 368(1198), 1–2.

[21] Cunningham, T.J., Croft, J.B., Liu, Y., Lu, H., Elke, P.I., & Giles, W.H. (2017). Vital signs: Racial disparities in age-specific mortality among blacks or African Americans—United States, 1999–2015. Morbidity and Mortality Weekly Report (MMWR), 66(17), 444–456.

[22] Parker, K., Horowitz, J.M., & Brown, A. (2020). About half of lower-income Americans report household job or wage loss due to COVID–19. Pew Research Center: Social and Demographic Trends. *https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-COVID-19/*.

[23] Smith, A.B. (2020). 2010–2019: A landmark decade of U.S. billion-dollar weather and climate disasters. National Oceanic and Atmospheric Administration. *https://www.climate.gov/news-features/blogs/beyond-data/2010-2019-landmark-decade-us-billion-dollar-weather-and-climate.*

[24] Rollston, R. & Galea, S. (2020). COVID–19 and social determinants of health. American Journal of Health Promotion, 34(6), 687–689.

[25] Rangel, J.C., Ranade, S., Stucliffe, P., Mykhalovskiy, E., Gastaldo, D., & Eakin, K. (2020). COVID–19 policy measures—advocating for the inclusion of the social determinants of health in modelling and decision making. Journal of Evaluation in Clinical Practice, 1–3.

[26] FEMA (2020). FEMA leads whole-of-America coronavirus operations. FEMA. *https://www.fema.gov/blog/2020-03-24/fema-leads-whole-america-coronavirus-operations.*

lights the very important intersection of public health and emergency management that could benefit from integrative policies and approaches but often operate in silos negatively impacted by flow of information and coordination between the CDC and ASPR guidelines under DHHS, while emergency management follows guidelines from the Department of Homeland Security (DHS) which has an entirely different focal area.[27] Fortunately, and unfortunately, COVID–19 has exhibited that this silo between public health and emergency management cannot exist as both disciplines operate with similar goals and coordinated response which is why emergency management planning should focus on social determinants of health which can improve coordinated efforts in key issues such as pandemic response and recovery. In such, solutions in pandemic response should focus on 5 key components:

- Thoroughly reviewing current emergency management policy, including the intended and unintended effects of policies.
- Integrating equity into the current FEMA doctrine and programs, including grants, to provide recommendations on areas of opportunities for future practice and funding.
- Integrating diversity, inclusion, and equity on disproportionate impacts of crisis and disaster into FEMA's planning, guidance, and priorities including equity-related performance measures in EM grants and other grant requirements.
- Implementing equity and culturally-competent thinking into emergency management curriculum (academia) and continuing education/training (practice).
- Investment in integrative technology toward predictive modeling to prevent inequitable outcomes.

THOROUGHLY REVIEWING CURRENT EMERGENCY MANAGEMENT POLICY, INCLUDING THE INTENDED AND UNINTENDED EFFECTS OF POLICIES

Throughout history, emergency management policy has been a constant battle between civil defense and terrorism, and natural disasters. What remains constant in this wavering battle are policies based on a white-default setting. The majority of emergency management policy has not been inclusive of people of color. This is of paramount importance because the lives of Black, brown, and indigenous people in America depend on these policies. As evident by the protests, people of color are tired of seeing the worst outcomes. This includes life and disaster that has impacted the United States including COVID–19. Being a racial/ethnic minority should not be a death sentence. It is a clear sign that policy is ineffective toward underserved, marginalized populations.

Federal emergency management laws and policies govern or affect State emergency preparedness and response activities. Key laws and policies include the: Emergency Management Assistance Compact (EMAC), Federal Employees Compensation Act (FECA), Federal Tort Claims Act (FTCA), National Emergencies Act (NEA), Pandemic and All Hazards Preparedness Act (PAHPA), Public Health Service Act Section 319, Public Readiness and Emergency Preparedness Act (PREP), Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), Social Security Act Section 1135, Volunteer Protect Act, Homeland Security Policy Directives (HSPDs) and Presidential Policy Directives (PPDs), National Incident Management System (NIMS), National Response Framework (NRF), and National Strategy Documents. Content analysis of each of these laws and policies reveal that each policy lacked context on the terms minority, vulnerable, diversity, inclusion, underserved, ethnic, ethnicity, black, Hispanic, indigenous, and marginalized. A few, such as the Stafford Act, included 'race' in a standard non-discriminatory statement. The term 'equity' was commonly used in policies and laws regarding housing assistance in disasters, but not regarding equitable strategy. This is evident in a the current state of disaster loans which entrench disparities in black communities by basing loans on credit scores which results in black home and business owners receiving fewer Federal loans than white counterparts.[28]

This is unacceptable. It is imperative that we thoroughly examine how policies have been crafted and implemented within emergency management to determine whether equity has been integrated. An analysis of policy can highlight areas within policy that is inequitable, unjust, and promotes oppression within the policy system. Identifying how policy contributes to vulnerability can help reshape an equitable

[27] Jacobson, P.D., Wasserman, J., Botoseneanu, A., Silverstein, A., & Wu, H.W. (2012). The role of law in public health preparedness: Opportunities and challenges. Journal of Health Politics, Policy, and Law, 37(2), 297–328.

[28] Frank, T. (2020). Disaster loans entrench disparities in Black communities. Policy and Ethics. *https://www.scientificamerican.com/article/disaster-loans-entrench-disparities-in-black-communities/*.

line of thinking into the policy process; one that is diverse, inclusive, culturally competent, and improves resilience to crisis and disasters.

INTEGRATING EQUITY INTO THE CURRENT FEMA DOCTRINE AND PROGRAMS, INCLUDING GRANTS, TO PROVIDE RECOMMENDATIONS ON AREAS OF OPPORTUNITIES FOR FUTURE PRACTICE AND FUNDING

Similar to law and policy, we must thoroughly review and seek to integrate equity into FEMA doctrine, programs, grants, and contracts. FEMA programs, grants, and contracts are huge investments, however, failure to invest in equitable solutions is a waste of time and money. Typically, those who write the best grants will receive those grants without respect to the needs of the community. Grants supporting the development and implementation of programs should be an investment that is based on the current state of our communities. For example, an investment into local, community-based business would support the local economy post-disaster, improve recovery, and improve resilience. However, awarding grants to key figures negates the community overall. Further, contracts awarded should be representative of a diverse portfolio of minority-owned businesses and contractors. Previously, contracts awarded have been disproportionate as evident by the 1 percent of contracts awarded to minority contractors in response to Hurricane Katrina. It would be interesting to note the percentage of women and minority contractors that have received COVID–19 response/recovery funding, thus far. Our investment should be one that builds resilience which cannot be ascertained without addressing vulnerability. This was a key focal point in I–DIEM's commentary and contributions to the Building Resilient Infrastructure and Communities (BRIC) program in which I–DIEM advocated for equitable community capacity building to improve resilience. Failure to incorporate equity in programs, grants, and contracts results in high investment spending that leads to higher spending in response and recovery. In such, examining doctrine, programs, grants, and contracts can identify whether equity is integrated within the system, identify further solutions that are equitable, and recommend more impactful alternatives for program, grants, and contract funding that promotes reducing vulnerability and increasing resilience through equity.

INTEGRATING DIVERSITY, INCLUSION, AND EQUITY ON DISPROPORTIONATE IMPACTS OF CRISIS AND DISASTER INTO FEMA'S PLANNING, GUIDANCE, AND PRIORITIES INCLUDING EQUITY-RELATED PERFORMANCE MEASURES IN EM GRANTS AND GRANT REQUIREMENTS

Eighty percent of emergency management leadership is comprised of white males. Thus, the decision making behind FEMA's planning, guidance, and priorities lacks diversity, is not inclusive of the voices affected by these decisions and is not equitable. With 21 years of emergency management experience, I truly believe that emergency managers have a huge job and huge responsibility with a desire to do what's best, but politicians are politically focused often overlooking the recommendations of emergency managers. I have experienced this on many occasions where I have recommended that our Government focuses on underserved populations. I have been told, on many occasions, that marginalized groups are not a major focus in the list of priorities for Government. Unfortunately, marginalized groups do not have a seat at the table or a microphone to voice their concerns, especially in emergency management. Subsequently, as emergency management aims to reduce the harmful effects of all hazards including disasters including the loss of life and property, it is our responsibility to represent the populations that we intend to protect as public servants. For this reason, we have an obligation to be representative of the populations that we serve which is best facilitated through diversifying our leadership. This allows for the integration of diversity, inclusion, and equity in FEMA's planning, guiding, and priorities. This approach should be all-inclusive, which the FEMA's Whole Community Approach recommends, with respect to looking at communities from an equitable perspective.

Further, large-scale grant funding in the health sector is requiring outreach and engagement components to be included in grant proposals as a requirement for funding. Additionally, monitoring and measuring systems are integrated into grants that ensure compliance. Emergency management planning, guidance, and funding should focus on incorporating equity into emergency management planning that ensures that funding results in actionable, equitable solutions. Performance monitoring and measures should be incorporated to ensure compliance. More importantly, most emergency management grants and programs do not include an evaluation component that would be beneficial to identifying strengths, weakness, opportunities, and threats for the overall program as well as specific equity-related goals and objectives.

IMPLEMENTING EQUITY AND CULTURALLY COMPETENT THINKING INTO EMERGENCY MANAGEMENT CURRICULUM (ACADEMIA) AND CONTINUING EDUCATION/TRAINING (PRACTICE)

The COVID–19 pandemic spotlights how failure to incorporate research and data-driven science to make risk-informed decisions a priority over risk-based decisions can have negative effects. The rising number of confirmed cases and deaths earmarked by notable disparities suggests that social determinants of health, cultural-competence, and an understanding of public administration and policy are imperative to improving emergency management outcomes. As emergency management continues to grow in the world of academia, it is important that we begin incorporating social determinants of health into emergency management curriculum as we prepared the next generation of future emergency management leaders. The growth of emergency management programs across the country at the associates, bachelors, masters, and doctoral level represents an investment in emergency management enterprise. We are doing a disservice to the field if we do not adequately focus on the root causes of disparity and vulnerability that is counterintuitive to the outcomes we seek to achieve. This same notion applies to continuing education/training for emergency managers. As practitioners, it is essential that we stay educated and current in our practice of emergency management. We see this in tabletop exercises and drills across the field of emergency management that maintain level of preparedness necessary to negate the devastating effects of disasters. Implementing social determinants of health and equity into continuing education and training is beneficial for both emergency managers and the communities we serve.

INVESTMENT IN INTEGRATIVE TECHNOLOGY TOWARD PREDICTIVE MODELING TO PREVENT INEQUITABLE OUTCOMES

Emergency Management must rethink its focus on excessive spending on incident response technology and focus more on research-driven, community data that is already available. This data can inform predictive modeling. Predictive modeling can be applied to any type of event and analyzes historical and current data to generate a model that helps predict future outcomes. To achieve this, emergency managers should seek partnerships with academic institutions and technology firms to develop more predictive technology. Many universities have the capacity and funding to develop integrative tools such as predictive modeling to assist in emergency management especially with the expansion of emergency management programs. This approach allows opportunities for collaborative community work that is mutually beneficial while also bridging the gap between emergency management academia and practice.

Additionally, partnerships with technology firms will allow for a strong research background and robust technology innovation that support equitable solutions. For example, I–DIEM's partnership with Aleria Research, a nonprofit research organization that leverages science and technology to improve diversity and inclusion, has been contributory to grant opportunities and funding that focuses on the develop of a simulated predictive modeling system that focuses on community education and preparedness as well as recovery planning. These opportunities allow for innovative and integrative approaches to equity that aim to improve the emergency management enterprise through technology.

CONCLUSION

The key to influential change is leveraging mutual aid, coalitions, leadership, and advocacy during COVID–19. Social determinants of health help identify areas of disparity and inequity and should be a focal point of emergency management moving forward, but progress cannot be made without effective change in policy. The pandemic is a devastating period for the United States, but it provides opportunity to improve upon systems that contributed to disparities and negative outcomes. In emergency management, many of the key policies have been guided by disaster. For example, the Department of Homeland Security was created in the wake of 9/11. We have the opportunity to utilize what we have always known, and what we see on full display during the pandemic, to improve. The mutual aid between FEMA and public health can be leveraged along with the many organizations involved in the response and future recovery of COVID–19.

Leadership can take more diverse, inclusive, and equitable forms as we see transitions in global responses to systemic racism and civil unrest. The time is now to understand and integrate social determinants of health into emergency management as a foundation to diversity, inclusion, and equity. This must be a focal point as the disparities present in COVID–19 are the same disparities that are present in disas-

ters. The same social determinants of health that guide advocacy for health equity are inherent in all phases of the disaster management cycle. The key to adopting these determinants into practice is operationalizing equity which is achieved by looking at all of our key decisions through an equitable lens. We should be advocating for disaster equity. We should be looking at equity in emergency management within all policies. This is a key focal point of the "Health In All Policies (HIAP)" strategy that integrates and articulates health considerations into policy making across sections to improve the health and communities of all people.[29] We must be equally as innovative in emergency management to improve disaster outcomes across our underserved, and marginalized communities. This is especially important with the impending hurricane season.

FUTURE FOCUS

America is still in the midst of response to COVID–19. Response is typically the shortest phase of disaster, but due to the lack of Federal strategy, many States are struggling to contain and mitigate the pandemic impacts. Imagine, for a moment, if equity had been considered at the start of this terrible health outbreak. Health care workers, many who are women of color, would have been prioritized in receiving personal protective equipment (PPE). A strategy to provide States with the resources they need would have been developed, rather than one that promoted competition among States. Leadership must be guided by equity, not political maneuvering and capitalism, at the expense of human lives.

Mr. PAYNE. Thank you for your testimony. I would like to thank all the witnesses for their testimony. I remind the subcommittee that we will each have 5 minutes to question the panel.

I will now recognize myself, but before I do that, I ask unanimous consent that Congresswoman Jackson Lee be permitted to sit and question the witnesses. Without objection.

So, Ms. Willis, FEMA has a history of emergency responses plagued with racial and socioeconomic disparities. Despite this history, the Trump administration has made little to no effort to assure communities that the agency will respond to the pandemic in an equitable manner. With preexisting disparities in mind, what types of emergency response strategies should our country utilize to respond to the COVID–19 pandemic?

Ms. WILLIS. Thank you, sir. That is a great question.

One of the most important strategies will be to ensure that we are training our emergency managers in equity, to assist them in focusing policy creation and implementation on equity and vulnerable groups.

Right now, within FEMA and emergency management as a whole, equity is not a priority, and, in fact, it is not seen as a priority in many areas of disaster management, and that is a significant problem that must be addressed. We need an equity revolution. We must confront the intersection of race and poverty on biased disaster management policies as well. A thorough review of policies is needed, and more funding must go into equity training and education.

Thank you.

Mr. PAYNE. Am I correct in saying that we are not asking for special treatment in these communities; we are asking for equitable treatment in these communities? Is that correct?

Ms. WILLIS. That is absolutely correct.

Mr. PAYNE. Thank you.

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[29] CDC (2016). Health in all policies. Office of the Associate Director for Policy and Strategy. *https://www.cdc.gov/policy/hiap/index.html#:~*:text=Health%20in%20All%20Policies%20-%28HiAP%29%20is%20a%20collaborative,beyond%20the%20scope%20of%20traditional%20public%20health%20activities.

Ms. WILLIS. Providing equity in disaster should not be an "other." It should be——

Mr. PAYNE. Thank you.

Ms. WILLIS [continuing]. A priority. Thank you.

Mr. PAYNE. Thank you very much.

Dr. Wen and Benjamin, when asked about racial disparities at a Congressional hearing in June, Dr. Fauci said that institutional racism contributed to the disproportionate impact of COVID–19 on African Americans and that they have suffered from race——

Ms. JACKSON LEE. How do I take this off silent——

Mr. PAYNE. Excuse me.

Ms. JACKSON LEE [continuing]. Because I don't want to miss——

Mr. PAYNE. Somebody needs to mute, please. I am sorry.

Dr. Fauci was saying that the communities suffered from racism for a very, very long period of time. If the Trump administration has known of these factors for a long time, why has the administration not done more to address these problems? Either one of you can start.

Dr. BENJAMIN. Sure. I would be happy to start.

You know, there are—if you think about the response, there are really 3 areas where the administration can step up a bit more. I know some of it, they have done, but there is still more things that they can do.

No. 1, testing. Early on, as you know, there wasn't a lot of tests, but, when we did have tests, they weren't in the hood, quite frankly. They weren't easy to get to. The drive-through testing, if you didn't have a car, you couldn't get there. You have got to make sure that testing is available to all parts of the community, to people that have shift work, to people that don't have paid sick leave, so they can actually get to the testing.

Then we need to make sure that that testing is available. You know, television pictures that we were seeing in the last couple of weeks of long lines of people waiting hours to get tested are, frankly, unacceptable for every citizen within our country, and specifically for communities of people that are at higher risk. You know, you are sitting in a line 3 hours when you have symptoms and you don't feel well, and from a clinical perspective, just makes no sense, of course.

Second, we know that the whole issue of access to care remains a big issue. I applaud Ranking Member King and you and all about community health centers, and that is wonderful, but every citizen in this country ought to have access to quality, affordable health care. That is important. We have to get Medicaid coverage to all of our low-income citizens, and we need to stop fighting about that. Health care is a fundamental human right, and we need to fix that right now.

I think the third thing is, we have got to really deal with this issue of misinformation and disinformation. One of the things we did during the AIDS epidemic is we did a lot of work educating faith leaders, barbers, beauticians, anyone who was an influencer in our community to get to communities of color, to get to communities that had languages other than English as their first language, to make sure they understand the disease process and how

they can get help, and what they can do to protect themselves. We haven't——

Mr. PAYNE. Thank you.

Dr. BENJAMIN [continuing]. Done that.

Mr. PAYNE. Thank you, sir.

Dr. Wen, I am going to—my time has expired, so——

Dr. BENJAMIN. Oh, I am sorry.

Mr. PAYNE [continuing]. I am going to have to yield. I am sorry.

I now recognize the Ranking Member of the subcommittee, the gentleman from New York, Mr. King, for questions.

Mr. KING. OK. Thank you, Mr. Chairman.

I would like to focus my questions to Dr. Wen, at least to start. In New York and Long Island, we have a particular issue with the fact of transportation.

The New York City subway system carries millions of people every day. The Long Island Railroad carries hundreds of thousands of people in and out of Manhattan to Brooklyn and back, and there is tremendous transportation back and forth. We are talking about millions and millions of people are on the trains every day.

I am trying to think about the next pandemic or the second wave of this one. What can you suggest that we do to try to anticipate the problems we are going to get from transportation, having so many people packed together on these trains, and as far as having testing sites, and ways to detect it? Because, again, that is where you have people of all economic strata, races, religions, everyone traveling together in very close quarters, both from low-income communities—low-income communities, high-income communities, from the suburbs, the inner cities, all coming together. Can you think of any way we can do it to minimize the impact of the, you know, second wave spreading or another pandemic after this?

Dr. WEN. Yes. Thank you very much, Ranking Member. This is an excellent question.

The most important thing that we can do in order to mitigate the spread on public transportation actually is the same as, I would say, if you had asked me about what can we do to keep schools open? It is the same answer, which is that we need to keep a level of COVID–19 in the community to be as low as possible, because you can imagine, when you have communities in parts of the south where one in 100 people have COVID–19, if one in 100 people have it and don't know it, and they are getting on trains or they are going to schools or really any public place, that is a lot of potential people that they could be infecting.

So we really have to do our part in order to keep the level of infection as low as possible throughout the country. At this point, we know exactly what that would mean. We know that this is a combination of physical distancing, wearing masks, also good sanitation practices and cleaning, but, ultimately, this is about keeping that level of infection down as low as possible.

Two more things quickly. Another is testing. To piggyback on what Dr. Benjamin had said earlier, we absolutely need widespread free testing available to where people are, and it needs to be rapid. It doesn't do any good when there is a test result that comes back in 5 to 7 days or even 10 days in some cases, because what is that patient supposed to do in the mean time? In that time,

they are also spreading the disease to many others, and so that rapid testing is critical.

The final point is surveillance. To your point about transportation as well, we need to know where it is that people are picking up illness, and we also have to have surveillance in the community so that we can identify some—a cluster of outbreaks or a cluster of infections before it becomes a large outbreak.

Mr. KING. Thank you, Doctor.

I will address this question to anyone who wants to answer it: In my district in particular, we have several large Hispanic American, low-income communities, with both documented and undocumented people living in those communities. I think it was you, Dr. Wen, that mentioned about multigenerational, and that they are more inclined to have multi generations living in those communities.

How is the best way to get testing into those communities, to alert the people to get the testing? Again, I am not advocating over the immigration rule, but, again, undocumented people are afraid to go to doctors. They are afraid to go for testing. Rightly or wrongly, how do we overcome that, and can we aggressively go into those communities more, not for our good, but for their good, find out, get them tested? I guess you can't force people to be tested, but really encourage it in those communities?

Anyone who wants to answer?

Dr. BENJAMIN. Sure. I—you know, a van. What you—all you need——

Mr. KING. Thank you, Doctor.

Dr. BENJAMIN. Sir, I am sorry. This is Georges Benjamin, sir.

All you need is a swab, a van, a testing, and a place to cool the sample down. So you can take mobile vans in those communities very effectively, park them on the corner, and ask people to come in, but you have got to obviously communicate with them so they don't feel threatened. Or go to schools. You have got lots of empty buildings in the community, and you can set a rapid testing clinic in.

Mr. KING. Another—I am sorry. Go ahead.

Dr. WEN. If I may add, too, I completely agree with Dr. Benjamin. You need to go to where people are. Churches, community sites, public housing. Also, it is really critical to enlist trusted members, trusted messengers in the community. To the point that you raised, Congressman, that you need individuals who have the community trust. Public education needs to be a part of that, including public education about how everyone should receive health care. This is not a time to be asking about immigration status.

Many people are going to be terrified to seek help because they think that they are going to be arrested by ICE and deported, and so it is really important to reassure them that this is not going to happen at this time, that this is about protecting not only them, but everybody else around them, too.

Mr. KING. My time is up. I yield back, Mr. Chairman.

Thank you. I thank the witnesses.

Mr. PAYNE. I would like to thank the gentleman from New York.

The Chair will now recognize other Members for questioning—questions that they may wish to ask witnesses. As previously out-

lined, I will recognize Members in the order of seniority, alternating between Majority and Minority. Members are reminded to unmute themselves when recognized for questioning.

The Chair now recognizes for 5 minutes the gentleman and the Chairman of the full committee, the gentleman from Mississippi, Mr. Thompson.

Mr. THOMPSON. Thank you very much, Mr. Chairman, and I thank the witnesses.

One of the things we have tried to work with, with FEMA is, in the issue of any National or natural disaster, they need to have a plan for the entire population, and that plan should include transportation, should include housing, health facilities, all of that.

Most of the plans we have come in contact with, or have been presented, try to look at communities as one entity, and not—as Peter was talking about, certain people stay in one area, certain people sit in another.

I guess what I am saying is we get cookie-cutter plans that many people assume will fit every situation, and what I have heard from the witnesses today is that you really have to have a greater understanding of the communities with which you are working, and your plans have to reflect it.

The best example I can tell you, I am speaking from my Congressional office, and we had a testing site that was 5 miles from my Congressional office, and we don't have public transportation. So, in the run of a day, they did 26 people because nobody could afford to get to the site. If they had just talked to somebody and said, "Where is the best place to come to do a site testing," they would say, "Well, you need to come where the people are." So, it is that comfort level sometimes that our emergency responders go to.

So can you give Members of Congress—how do we work with FEMA and other personnel in this venue to get them to understand that you have to include the entire community in your planning, especially from an emergency preparedness standpoint, because otherwise, they will get overlooked? I will just throw that out to Dr. Benjamin, Dr. Wen, and then to Ms. Willis.

Dr. BENJAMIN. I think—this is Georges Benjamin. We have to make sure that FEMA understands that real job is to build resilience and preparedness of communities, and that means that they can't do cookie cutters. They have to plan with communities, and not to communities. That means they have got to have community engagement. They have got to be part of the planning process throughout every aspect of it.

We need to make sure that—Congress can require that the Governors and emergency planners show that they engaged communities as part of the planning process. Remember the HIV/AIDS days, when we were challenged to get good HIV/AIDS plans in place? Well, Congress required planning communities be part of that planning process. So I think you can put that—link that to their funding in some way, to let—or some other mechanism to demonstrate that those communities are planned—are part of the planning process, because, as you know, there is an enormous strength in communities that are not be being used.

Mr. THOMPSON. Absolutely. Dr. Wen.

Dr. WEN. If I may add very quickly that, right now, we don't even have that cookie-cutter approach. I mean, I agree we need to have a tailored approach, but, right now, we don't even have a National strategy, really, of any kind. We need a National strategy around testing. We need a National strategy around quarantine, isolation facilities, around procuring supplies, the Defense Production Act. We need to have that strategy in order for us to save lives.

Mr. THOMPSON. Thank you.

Ms. Willis.

Ms. WILLIS. Thank you, sir.

I would say that equity must become a core competency for emergency managers, certainly in the emergency management leadership. And I would also say that we need to begin tying funding to the investments of minority communities. And right now, that is not happening. We need to invest a majority of FEMA funding for preparedness, mitigation, and recovery in our most vulnerable communities rather than continuing to overfund communities that will bring in revenue, such as tourism areas. And so, that is something that has been a—that has been a problem and continues to be a problem. There is an underinvestment and divestment in communities of color.

Thank you, sir.

Mr. THOMPSON. Great. Thank you very much. I yield back.

Mr. PAYNE. Thank you. I thank the gentleman from Mississippi.

I now recognize the gentleman from Louisiana, Mr. Richmond, for 5 minutes.

Or maybe not. OK. Well, it doesn't seem like he is here, so now we will go to the gentlelady from Illinois, Ms. Underwood, for 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman, and I am so grateful to our witnesses for appearing before the panel today. This certainly is a topic that touches close to home, as you know. So much of the disparities conversation related to COVID–19 did begin with Illinois, as we were one of the first to release our data by race and ethnicity, and that has certainly jump-started our National conversation.

In the last week, my State of Illinois surpassed 7,000 lives lost from COVID–19. Hundreds of thousands more are out of work, and every single community has been impacted. But the harm done by this pandemic has not been inflicted evenly. Communities of color are experiencing disproportionate rates of illness, hospitalization, financial loss, and death.

In Illinois, the cumulative rate of positive coronavirus tests for Hispanic residents is more than 5 times the rate for White residents. In one county in my northern Illinois district, the positive test rate for Hispanic residents has been nearly 8 times as high—8. Across the country, people of color, and particularly Black folks, are losing both their jobs and their lives at staggering rates.

To tackle these inequities head-on, we need to make culturally-relevant investment in public health and economic opportunity, which is why I introduced, with my House and Senate colleagues, the Health Force and Resilience Force Act, which would fund pub-

lic health departments to hire locally for testing and contact tracing.

Dr. Benjamin, for Latinx communities and other underserved populations, why is it so important to have local residents supporting health departments with initiatives like contact tracing and information sharing?

Dr. BENJAMIN. I don't speak Spanish. I don't speak Spanish. So it is language, it is trust, it is knowing where to go. When I was—I was the Washington, DC health officer, and I have got to tell you that we were successful in many of our efforts there to reduce a whole range of infectious diseases, because they had outreach workers that knew the community; knew who to go to; and, when people didn't want to do something, were able to convince them to follow medical advice.

That is essential in communities of color, and particularly, in communities where they are concerned about immigration, where English isn't the first language, and, frankly, right now, in these last few years, we have stigmatized.

Ms. UNDERWOOD. Yes. So we have invested billions of dollars in the search for a vaccine, but actually developing a safe and effective vaccine is only the first step. We will then need to prepare to rapidly deploy it across the country, and unfortunately, we know that Black and Latinx Americans have lower immunization rates than their White counterparts.

Dr. Benjamin, can you describe the importance of community-specific efforts to increase vaccination rates in Black and Latinx communities for recommended immunizations like measles and smallpox and flu vaccines? Also, what does the evidence from the deployment of those vaccines tell us about how we need to prepare to deploy an eventual COVID–19 vaccine to ensure strong vaccination rates among communities of color?

Dr. BENJAMIN. Well, we should start recognizing that there is a disparity in vaccine uptake in communities of color. In other words, communities of color don't get vaccinated as frequently as Whites in this country. Second, we should recognize there is an enormous amount of mistrust that currently exists. That is coupled with, primarily, the anti-vaccine community and others, though, who are sending a lot of disinformation.

Look, we have already got people in social media space and passing out flyers telling community of color don't get vaccinated, it will make you sterile, it will give you AIDS, it will give you the disease, it will kill you. So there are already a lot of disinformation out there, and we need a National effort to do that.

But, more importantly, we need a National plan. The Federal Government needs to step up to the plate and put together a plan, just like we did with H1N1, to figure out how we are going to deploy this vaccine. We have got lots of mechanisms to do that, but we have no plan.

Ms. UNDERWOOD. Well, I am so glad you said that, because, last month, I introduced the Protecting Against Public Safety Disinformation Act. This bill would help public health officials mitigate the impact of false information that can undermine efforts to keep our communities safe during this pandemic and beyond.

Dr. Benjamin, in what ways could the spread of disinformation worsen disparities, and the impact of COVID–19, particularly with respect to vaccines, but also wearing masks?

Dr. BENJAMIN. Well, again, there is a group out there who is actively working to confuse us all around vaccines, around masks. Look, there are flyers. I saw some flyers that were being passed out in New Jersey which had the CDC and the World Health Organization logo on them. They were obviously misinformation, but they are flyers that basically said, you know, If you are infected, go to a synagogue. If you are infected, go to a low-income community. If you are infected, ride public transportation. In other words, they are trying to spread the virus.

So they are giving misinformation to hurt people, and so I think we have got to push back against that kind of effort as aggressively as we can.

Ms. UNDERWOOD. In the same way that you all discussed, targeting the strategies to mitigate spread, like testing and treatment in the communities that are most—most impacted, we also need to target those same types of campaigns to spread accurate information and empower those public health officials to do the same. In May, the House——

Dr. BENJAMIN. Absolutely.

Ms. UNDERWOOD. Thank you. In May, the House passed the HEROES Act, which included nearly $7.5 billion in direct funding for public health departments, in addition to $500 billion in relief for States, and $375 billion for local government. Unfortunately, the Senate has yet to act to pass this bill.

We know that there are significant public health consequences to continued delays in passing the HEROES Act, and so we are calling on our colleagues in the Senate to rapidly take up this legislation, and empower our State and local public health departments to do this much-needed work.

With that, Mr. Chairman, I yield back. Thank you to our witnesses.

Mr. PAYNE. I would like to thank the gentlelady from Illinois for her questions. Always poignant. Please make sure my office has all of your pieces of legislation so that I can sign off.

Ms. UNDERWOOD. Yes, Mr. Chairman. Thank you.

Mr. PAYNE. Next, I believe we will recognize the gentlelady from Texas, Ms. Jackson Lee, for 5 minutes.

I thought she was on. Staff, is she available?

STAFF. Not at the moment, sir. It is just you and Ms. Underwood.

Ms. UNDERWOOD. Well, Mr. Payne, if you would yield a couple more minutes, I do have a couple more questions for our witnesses.

Mr. PAYNE. I will yield.

Ms. UNDERWOOD. Thank you so much, sir.

My next question is for Dr. Wen. In June, the CDC reported that pregnant woman might be at increased risk for severe COVID–19 illness, and the risks appear to be even higher for Black and Hispanic pregnant women.

Dr. Wen, as Congress develops another COVID–19 relief package, which policies should be considered to protect pregnant and postpartum women during this pandemic?

Dr. WEN. Thank you for that excellent question, and I know that you and I have worked closely on issues of maternal mortality. I thank you for your leadership on these really important factors.

So there is—so I think there are two separate but related issues. One is about COVID and disparities, and then the other is about maternal mortality, and now they are intersecting in this way because of the increased likelihood of severe effects among pregnant women during COVID. So I think we have to take them separately.

For COVID–19, I do think that all the recommendations that we have made thus far still stand. In this case, I would just continue to emphasize the importance of a National strategy, because right now, we have seen what happens when we have this piecemeal approach across the country, when we have, unfortunately, elected officials who are not following the advice of public health experts, and, in fact, as Dr. Benjamin said, are feeding into misinformation.

So everything that we can do, that all of you can be doing to ensure that there is a National strategy to the best of your ability would be extremely helpful, and to spread that information, too, or to counter the misinformation that is also rampant.

Then I would say, when it comes to maternal mortality, we need to be not only looking at what happens during pregnancy, which is really critical, but also, how can we be improving health for women, and, in particular, for Black women and women of color throughout their lives? I think that everything that you have done, Congresswoman Underwood, to support and improve maternal mortality would also, therefore, not only address the maternal mortality issue, but specifically, also improve outcomes during COVID–19 as well.

Ms. UNDERWOOD. Well, thank you for your leadership on this issue and all other matters of public health.

I want to return back to Dr. Benjamin. I started to raise the Heroes Act, and the significant financial investment that would be made for States and local governments. With your background in leading the American Public Health Association, can you describe the potential public health consequences of the Senate's inaction on this emergency funding for States, localities, and public health departments?

Dr. BENJAMIN. You know, here is the challenge we have. You know, we have got 3 million people with this disease, and even though, you know, we don't have as many deaths today because of the young people who are getting it who may not be as susceptible to dying, death is a lagging indicator, as you know. We do not have a public health system that can adequately trace and do the contact tracing.

This is going to get worse before it gets better—I can assure you of that—as we return to work, and so, we are going to have to build that system. We need to do that as quickly as possible. Without those funds, frankly, we are up the creek.

I was just talking yesterday to some folks about going back to school. We don't go back to school unless we get our hands around this disease process, as Dr. Wen pointed out.

Ms. UNDERWOOD. Yes. So the thing I want to make sure that the committee and the American people understand is for decades, our State and local public health systems have been systematically see-

ing their funding sources reduced. They have been working at the very top of their capacity across this country.

That was during a time of health and well-being largely, right? We were not in a pandemic environment. So these types of resource are not going toward these State and local health departments as sort of excess, right. They are to fill critical functions to protect the communities that they serve.

So, when we talk about bills like the health force, the resilience force, and hiring community members, training them and giving them a sustainable skill set to further pour into those communities that they come from, it only serves to build the capacity of those local institutions. Would you care to comment, Dr. Benjamin?

Dr. BENJAMIN. Oh, absolutely. When I was—you know, in my health department when the anthrax letters hit our Nation, my surge capacity came from my HIV/AIDS programs, my chronic disease programs, et cetera. I pulled epidemiologist and outreach workers through all of our programs, and then we had to deal with—continue to deal with HIV and STDs.

As Dr. Wen pointed out, we still have people dying. Other than COVID growing very quickly, the leading cause of death is still cardiovascular disease and cancer. Those did not go away, and we still have to address them. It is still much cheaper for our Nation to prevent these diseases than to treat them when they occur.

Ms. UNDERWOOD. That is right. Thank you again, and I yield back.

Mr. PAYNE. Thank you.

The Chair now recognizes—and can see her—the gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, thank you so very much for your kindness. Thank you to the Members. We are all doing double-duty.

Let me also say, Mr. Chairman, I am delighted with your leadership, Chairman Thompson's leadership, but I must, again, publicly say congratulations on the recent success that we had that we will be able to see you again in the year and months to come. So thank you so very much.

Mr. THOMPSON. Thank you.

Ms. JACKSON LEE. All the witnesses, I have encountered you in the past, and the Members that are on. So let me just be very clear, I am now in the COVID epicenter. I am in what would be politely called Hades—not Haiti—but in an experience that we never thought we would be in.

We opened up on May 1. The CDC guidelines were not adhered to, which is a consistent decline in COVID–19 cases. I get personal calls from constituents of Members who have died at home, or who died with, in quotes, unknown causes or something called pneumonia untested.

The Federal Government is pulling out from testing. We have only tested 2.5 million in a State of close to 30 million persons. I am in the most populous county, the most populous city of the State of Texas. I am in the 18th Congressional District, which is the heart of these issues.

So let me—I did give an opening, and I am going to ask for quick answers so that I can ask all of you. Let me say to the witnesses

that I am convinced of your position, Dr. Benjamin, on building up the public health infrastructure. I can assure you my public health officials say that.

But let me just ask you, when you said get your hands around it, if you find a pandemic of this nature in a community, would it not add to the process of getting around COVID–19, or getting your hands around COVID–19 for a stay-at-home—a reissuance of a stay-at-home order that then allows the medical professionals and others to understand where the hotspots are?

Now we have got 100 firefighters in quarantine because of their exposure. We are in restaurants. We are in various places. Let me just yield to you, what about a stay-at-home order—and you can answer it generically. I just use some facts.

Dr. Wen, I would like you to be able to focus on the fact that Latinx population, the African American population are the higher numbers, but we have Latinx persons who work every day, children who go to school, but are undocumented scared with the posture of ICE. What should be said?

I have asked for ICE to stand down. I have asked for the Federal Government—I have asked the White House task force to ask ICE to stand down. How dangerous is that when we have communities that are fearful of their accessing health care, and what should we do?

Dr. Daniels—excuse me, I am so sorry. Dr. Benjamin, would you answer that question about the viability of stay-at-home order?

Dr. BENJAMIN. Yes. Yes. Yes. Texas is in big trouble, and you folks ought to have a much tighter stay-at-home order and mandatory mask wearing any time anyone has to go out. Look, it works. It absolutely works. Every Nation in the world has demonstrated that it works. It worked in 1918. It is going to work again in 2020.

But folks are playing too much politics with this. We cannot get the economy back until we get our hands around it. You can't get your hands around it until you stop the transmission of this disease.

You get this disease from other people. That means we have to stay away from each other as much as we can in an organized way, and then as we return to trying to engage one another, we need to do so in a cautious, measured, controlled manner with facial coverings, hand washing, and physical distancing as—you know, because that is what we have right now.

Ms. JACKSON LEE. Thank you, Doctor.

Dr. Wen, would you comment on that, and I guess you might add, I mentioned the testing point, the Federal Government is pulling out of testing here, transferring it to local vendors. I certainly welcome that. But we are not at that point. How important is testing in addition to the question I gave you? Thank you.

Dr. WEN. Testing is——

Ms. JACKSON LEE. If the witness wants to answer that—I am sorry—wants to join in, Ms. Willis, please, likewise.

Dr. Wen, thank you for your services.

Dr. WEN. Congresswoman, thank you. Testing is absolutely essential. If you don't know who has the infection, how can you stop the spread, especially given that we know about asymptomatic transmission. A new study showed that up to 50 percent or even

more of all the spread occurs with people who don't even know that they have it.

So we absolutely need testing. States and local officials cannot do this alone. There is no way for them to ramp up testing without Federal support, and that is why FEMA's support in this and leadership in this is going to be so important.

To the question that you raised, Congresswoman, about Latinx and other immigrant populations, look, we cannot have policies that will scare people. We cannot have individuals who are too terrified to seek care because they think that they or their loved ones are going to be deported.

So you absolutely cannot have ICE have anything to do with testing. They cannot have anything to do with having medical records or being in hospital facilities or any health care facilities.

We also know that contact tracing, in addition to testing, is critical to reining in the infection. So when somebody calls an individual, and they are asking about their close contacts, they must be reassured that that information will never go to immigration officials of any kind.

If we do not have those policies in place, then we are not going to be able to control the infection. Of course, this is a huge problem for exacerbating existing disparities, but it is also a problem for everyone in the country if there are some people who are too scared in order to receive care.

Ms. JACKSON LEE. Mr. Chairman, if you would indulge me, I don't know if Ms. Willis wanted to answer the question.

Mr. PAYNE. Your time is expired, but I will allow you another 3 minutes.

Ms. JACKSON LEE. Oh, thank you, Mr. Chairman.

Ms. Willis, just before you answer, I would like to throw back after you answer, Dr. Benjamin and Dr. Wen, you know, we are in hurricane territory. I don't want to wish it on us, but we don't know what to expect in the coming months, August, September.

I would like you to emphasize how important it would be—I think, Dr. Wen, in your testimony, you talked about the different set-aside sites that might be for people who are asymptomatic, or maybe who have certain conditions of COVID–19 that don't warrant hospitalization, but we are going to be in the middle of a hurricane. How do we deal with handling hurricane victims that need to be placed somewhere and take care of COVID–19?

But I am going to go to Ms. Willis first, and if you all would answer that after that with my 3 minutes. Thank you, Ms. Willis, if you wanted to answer.

Ms. WILLIS. Yes, ma'am. Very quickly, I would just say that when we focus on community-center responses, we are more flexible and we have a desire to listen. So as emergency managers, we must incorporate those factors in dealing with communities, especially those who might have a fear of deportation, or a general distrust of Government. We must be sensitive and culturally competent. Thank you, ma'am.

Ms. JACKSON LEE. Thank you for the answer.

Dr. Daniels—Benjamin. Daniels, my bad. Dr. Benjamin.

Dr. BENJAMIN. Yes. Let me just add that, obviously, shelters are clearly not ideal places when we have to ask people to shelter in place. Of course, we saw this with both Katrina and Rita.

We have got to rethink and reimagine how we are going to protect people should we get hit with another hurricane or tornado or anything that we have to evacuate people and move them, even the coastal storms that we have.

We have got to figure out how we are going to make sure they have access to hand washing, how they are going to have access to potable water. You know, how they are just going to handle waste is going to be a big issue in light of this outbreak.

We need to do that planning—we should have done it months ago, but if we don't do it now with a particular focus on communities that are most vulnerable, we are going to see huge outbreaks of disease.

Trying to manage just a flu outbreak or any other infectious virus in a conjugate setting is an absolute nightmare for managers. But we know the science. We know how to not make that happen. I don't think we are doing that. I don't think we are planning for it.

Ms. JACKSON LEE. Thank you.

I have a few seconds, Dr. Wen.

Thank you, Dr. Benjamin.

Dr. WEN. We keep on reacting to what has happened instead of anticipating what is ahead. In this case, we know exactly what is ahead, and we know exactly what we need to do to control COVID–19 in the process. So, I think that is something that the Trump administration, with Congress' urging, can really do. You know what is going to be coming our way, and now it is the time to prepare.

Ms. JACKSON LEE. Thank you so very much.

Mr. Chairman, thank you for indulging.

I know that—just to put on the record—the most important part of Congress' work is to pass the Heroes Act so that we can get resources out for PPEs, testing, hospitals, and others, and we really need to get past the obstruction and the blocking by the U.S. Senate so that we can pass that legislation, get it signed for the people of the United States who need it.

Thank you, Mr. Chairman. I yield back.

Mr. PAYNE. Absolutely. You know, our thoughts and prayers are with you in Houston. We know that you are really going through it right now. You know, we had it in Jersey, so I know how horrific it can be. So hang in there and just hope we can get people to stay safe. Thank you.

Ms. JACKSON LEE. Thank you. Thank you for your kind words. Thank you.

Mr. PAYNE. Absolutely.

I have another question or two that I want to—if I may. For all of you, it is in reference to school openings. The CDC has released guidance for United States K–12 schools and children's programs to plan and prepare and respond to COVID–19.

On Tuesday, the President threatened to withhold funds from schools that did not reopen in the fall, and tweeted on Wednesday that he disagreed with the CDC's guidance, calling it very tough and expensive.

The White House is reportedly preparing its own school reopening guidance, and the CDC was reportedly considering modification to its own guidance for schools. The administration's rush to reopen schools without following all of the necessary precautions is troubling, not just to policy makers, but also to parents as well.

If schools do not reopen in a responsible way, what are the possible impacts on communities disproportionately affected by the pandemic? We will start with Ms. Willis.

Ms. WILLIS. Thank you, sir. That is an excellent question. This entire policy that the President is enforcing is actually, to me, very significantly traumatizing because I am a parent.

Mr. PAYNE. Right.

Ms. WILLIS. When I consider that my son will be exposed to COVID–19 because I am a single mother, because I do have to work, I am absolutely horrified. I know that so many other Americans are in the same position, where you have to work, and so now, your kids must be sacrificed.

To me, it is similar to the time when the President forced the meatpacking industry back to work knowing that they were going into dangerous circumstances, and there was nothing that could be done because they had to work.

It is similar to slavery, when we think about the essential workers and we think about what occurred in 1850 with the yellow fever. This concept of sacrificing those who are most vulnerable and those who do not have a voice, it is absolutely astonishing, and it is an indictment against America.

Thank you, sir.

Mr. PAYNE. Dr. Benjamin.

Dr. BENJAMIN. Yes. Let me just add, we should never cut corners. Let's be real clear, I have looked at the CDC guidance. It is not too tough. It is a good baseline, and they should not weaken that guidance at all. That is the first thing.

Second, you know, the issue around cost, you know, it is probably the least affordable of our options because if we have a bunch of kids that get sick, even if they don't get real sick, they can't go to school. Their parents can't go to work.

So all you have to do is have an outbreak in a second-grade class, all those kids are out of school, their teachers are out of school, their parents are out of work. So where is the savings? Their parent may get really sick, and so then there is a huge health, both from a humanistic perspective as well as a cost perspective for their medical care.

So I don't get the economic analysis. By the way, he is not a doctor. So, quite frankly, we should listen to the professionals that know what they are talking about and not someone whose motives that I question.

I am not making a political statement. I am a physician, and I believe that doctors and health care providers know what we ought to do, and that we ought to listen to us very well. I don't tell lawyers what to do. I don't tell teachers what to do.

Mr. PAYNE. Thank you.

Dr. Wen.

Dr. WEN. I agree completely with my colleagues. I am also the mother of two young kids. I am the daughter of a schoolteacher in

Los Angeles who has passed away, but she was a long-time school teacher. I just want to mention this in this context. It is about students. It is also about teachers and staff, too.

My mother had breast cancer. She was on chemotherapy for 8 years while she was teaching full-time. I think teachers want to get back to in-person instruction, but there are many teachers who also have chronic medical illnesses that we have to watch out for as well.

In this case, you mentioned, Chairman, about the CDC guidelines, if we are unable to meet the guidelines for safe reopening, the answer isn't let's change the guidelines. The answer is, what is the hard work that we are going to be doing in order to safely reopen?

I agree with Dr. Benjamin. We have already seen what happens when we cut corners. When we cut corners, we get rises, surges, explosive spread of infections. We should have already learned our lesson. When we muzzle scientists, when we do not listen to public health, people die.

To Ms. Willis' point, the people who will suffer the most are those for whom it is not a choice to go to work. Who are they? It is African Americans, Latinx populations, Native Americans, people of color, the ones who bear the brunt of the greatest health disparities and who, unfortunately, are suffering the greatest health disparities now, too.

Mr. PAYNE. Thank you.

One last question. Reports continue to suggest that the Trump administration and FEMA are not adequately allocating medical resources, testing, and other supplies to communities disproportionately impacted by the virus. What are some of the ways FEMA can improve its efforts to ensure communities disproportionately impacted by the pandemic are receiving all the necessary medical resources?

Let me just add to that, I have been on this committee since coming to Congress in 2012, and I have watched FEMA move through different administrations. A lot of FEMA's issue is who is in the White House right now, and their hands being tied.

So though FEMA has some issues they need to overcome internally, a lot of their problem is with the person in the White House and the restraints that he is putting on different entities of the Federal Government.

With that, what do you think FEMA is not adequately allocating in those areas, Ms. Willis?

Ms. WILLIS. Thank you, sir. That is an excellent question and an accurate observation. Politics influences emergency management way too much. The response from FEMA has been greatly influenced by the President, by the administration, and, in general, by, you know, a lack of science and informed decision making. Unfortunately, politics drives a lot of what emergency management will do in terms of response measures, including recovery and relief measures.

Unfortunately, within emergency management, equity is not a priority. It is not a core function of FEMA's mission. So the focus on vulnerable groups and using social determinants of health has never been a priority for FEMA.

That needs to change. We need to begin focusing on equity and focusing on those groups who are most vulnerable. Once we do that, everyone will benefit. Studies have shown everyone benefits when we focused on those who are most vulnerable.

Thank you, sir.

Mr. PAYNE. Thank you.

Dr. Benjamin.

Dr. BENJAMIN. Yes. You know, I am always not in the room when they are making those decisions. What I do know for one thing is that FEMA really has to beef up its situational awareness. It doesn't work very well. They really have to improve their situational awareness and their supply chain management, and their ability to make decisions very quickly.

You know, when you have a really good emergency medicine function, it works extraordinarily well. But when you have one that is politicized; when you have one that is not simply doing things because it is in the right mode to help the public; when you think your job at FEMA is only to coordinate activities and not to understand that they are really an emergency response health agency, then they are going to fail.

I used to run the EMS system for the District of Columbia when it was working. The good news is it is working now. You know, we believe that it was important to help people, to save lives. If FEMA takes that as their benchmark, then I think they will do better in the future.

Mr. PAYNE. Thank you.

Dr. Wen.

Dr. WEN. Thank you. I would only add to everything my colleagues said that we desperately need this National strategy. One thing that we haven't talked about as much today is about PPE and the supplies that I just cannot believe—we went through this once in March and April.

We saw that my colleagues, who are doctors and nurses around the country, were asking on Facebook and Twitter about who had masks that maybe they used for some home improvement project that they can be donating. Are there garbage bags and rain ponchos that they could be cutting holes out of in order to use as gowns?

I mean, it is just unconscionable that we are out of those supplies again, that we are making medical professionals go on the front lines with no armor, with nothing to protect themselves and their families.

Also, as I said in my testimony, we also desperately need those PPE for other essential workers as well. Now that we know about asymptomatic transmission, how are we still having people sitting shoulder-to-shoulder to one another in closed spaces without the protection that they desperately need?

So, that is something that FEMA can absolutely do and coordinate. Again, if we do not do that, then we also, again, know who are those who are going to be the most impacted.

Mr. PAYNE. Thank you.

I want to thank all the witnesses today for their wonderful testimony. It really helps us move forward in trying to combat these

issues around disproportionate disparities in communities of color. As you said, if we do well in those communities, everyone benefits.

So, we will continue to do what we can, and we will call on you as we need to for your expertise. But I want to thank you for being here today. The three of you have been tremendous, tremendous witnesses today, and I appreciate all your testimony.

I ask unanimous consent to enter into the record a statement from Dr. Joycelyn Elders. Without objection.

[The information follows:]

STATEMENT OF JOYCELYN ELDERS, MD, 15TH U.S. SURGEON GENERAL, AND CO-CHAIR, AFRICAN AMERICAN HEALTH ALLIANCE (AAHA)

Good afternoon Chairman Payne, Ranking Member King, and Members of the House Subcommittee on Emergency Preparedness, Response, & Recovery. I am Dr. Joycelyn Elders the 15th Surgeon General of the United States. I am also co-chair of the African American Health Alliance a nonprofit organization working to help eliminate racial and ethnic health disparities and the social determinants thereof. We thank you for convening this special hearing on Pandemic Response: Confronting the Unequal Impacts of COVID–19 along with the many other coronavirus hearings held and to be held by this subcommittee and the full committee.

COVID–19 remains a major matter of National and world-wide security, and of public health in America and world-wide. The Pandemic continues to take its deadly toll, especially across the Black community and other vulnerable populations. During COVID–19, as the United States seeks to protect National security, send workers back to work and children back to school, among the major missing factors to date remains: Safe and effective treatments and vaccines, and an overall safe, effective, and sustained public health response that includes on-going robust reliable testing, contact tracing, care and treatment, and isolating. Confronting and addressing the unequal impacts of the coronavirus must be a National priority and it requires a National plan of action.

In a whirlwind of disasters, Americans remain barraged by a world-wide pandemic of a new virus and medical unpreparedness; shortages of PPE, hospital space, and medical personnel; Government unpreparedness, economic recession, and unemployment; huge numbers of hungry and homeless people; police brutality and systemic racism. We must remember that this also impacts members of and families of our Nation's military.

Our Nation's underbelly has been exposed in COVID–19, brutal policing, racism, income insecurity, and National security. People are taking to the world's streets to demand peace with justice and an end of racism and all its consequences. The world has awakened to discover that huge numbers of people are dissatisfied with disparities that are obvious in all areas of economics, social justice, education, housing, medicine, National security, and more. Black lives do matter.

It is crystal clear that the events of the past few weeks and months have revealed the awful truth about the impact made by racial, health, and economic disparities in our country, its consequences and implications. Standing there naked in view of the world, we are humbled. However, being humble is not enough. We can see clearly how unfavorably we compare to other countries in the world, and they can see it, too. The people of the United States have not fared as well as other developed countries. Our Nation's responses to the coronavirus pandemic including its disease rates are higher and our ability to mobilize resources, identify the presence of the virus, isolate and support people while they do, is miserably deficient.

Our Nation's infection rates and death numbers are higher than many other industrialized countries. While our Nation offers hope of a vaccine that remains out there on the horizon the immediate need is for safe, effective, life-saving treatments that are accessible to all that need it. This must be coupled with an effective "Test-Trace-Treat-Isolate-Repeat" package. We must not reach a point of military vs. non-military. People across the Nation and around the world are asking how, when, where, why, and what went wrong in United States, that America has been bent so low? Especially with regard to coronavirus, it seems ridiculous, since America has the best doctors, nurses, medical teams, and research laboratories in the world. However, being the best professionals doesn't cover all our bases in providing the best health care for all our people. Why, because, all our people do not have access to this remarkable world of medicine that we have built.

Mr. Chairman, Ranking Member, and Members of the subcommittee surely you can understand my deep concerns regarding access to safe, effective, and accessible

treatments and vaccines to the Black community, other vulnerable communities, and to our military. Even before COVID–19, our Nation's delivery system, for all its wonderful medical know-how, was and remains broken. And, doctors scarcely have a word in the way health is delivered to all our people. While doctors provide medical expertise, the organizational power is given over to others in the corporate and political world.

At least for 30 years, we have been "working" on eliminating health care disparities. When Healthy People 2000 came out in 1990, eliminating Disparities in Health Care was an objective. Then, it was an objective in Healthy People 2010; then, it was an objective in Healthy People 2020. In these 30 years, we have not made much of a dent in the actual disparities. The Affordable Care Act is helping and it must be protected and strengthened. Additionally, we must address the social determinants of health. Clearly, a person is only as healthy as the least healthy person. This is true for the military as well.

Health care must be extended to everyone for public health to be good. Without it, there are added risks to protecting our Nation as well as opening America including its schools. A comprehensive response requires the appropriate tools, resources, medical and mental health teams, PPE, safe and effective coronavirus treatments as well as access to safe, effective, and affordable medications for pre-existing health conditions and more. The unintended negative consequences are real and must not be ignored. We must "test-trace-treat-isolate-repeat".

The compounding coronavirus pandemic, the economic collapse, police brutality and systemic racism, individually and collectively take their toll on all fronts. Again, while these epidemics are truly humbling, being humble is not a solution. As a Nation, we are at a dangerous low point in society and humanity. Know that when there is a vacuum, someone and/or something will fill it good or bad. We are all in this together: Doctors, nurses, scientists, clergy, elected officials, front-line workers, the public and private sectors, the military and we the people. Equity is important to the well-being of every man, woman, and child and to our Nation on every front.

Confronting the unequal impacts of COVID–19 must be a National priority. Disparities must not only be addressed; they must be eliminated. COVID–19, racism, excessive policing, and the economic disaster, continue to show us that we can no longer just re-arrange the deck chairs on the Titanic. We must conquer coronavirus, put an end to racism, reform our policing and health care system, and build a life-sustaining economy for all. Among these, that includes developing a health care system that provides health care to all and eliminates disparities in health and health care.

Now, our Nation only has a sick-care system for all, with a health care system for some. The United States cannot stop at only health care access and delivery; we must also address all the disparities in the social determinants of health. They too adversely impact those serving in our Nation's military and their families. Addressing social determinants are the backbone on which to develop the most effective response. America has not wanted to spend the money investing in health care for all and public health. Now, America is reaping the negative consequences of her reluctance to invest in people. The United States will continue paying until our Nation invests in eliminating racial and ethnic disparities.

Confronting the unequal impacts COVID–19 and the compounding intersecting adverse outcomes come as no surprise. Either we will invest in people now or pay later. The subcommittee will recall the findings of the 2002 Institute of Medicine Report "Unequal Treatment" that urged the Nation to confront racial and ethnic disparities in health and health care. As the 15th U.S. Surgeon General, co-chair of and along with the African American Health Alliance Board, we strongly believe that if the recommendations of that IOM report had been implemented the burden of coronavirus and other health disparities would not be so dire. Nevertheless, we are once again at the urgency of now and must effectively deal with this deadly novel coronavirus and confront its unequal impact head-on.

While Coronavirus has been declared a National Emergency, the void is clear racial and ethnic health disparities elimination and racism elimination have not. Surely, the deadly extent of coronavirus in the Black community and the impact of the virus across communities of color demands that racial and ethnic health disparities elimination and racism elimination must be declared National emergencies, and effectively addressed as such. To that end, from lessons learned to protecting homeland security, to the opening of places of work, schools, entertainment, and more, the African American Health Alliance submits recommendations via my testimony to this distinguished subcommittee to help our Nation better address the COVID–19 pandemic. These recommendations will help our Nation and communities better address the unequal impact of COVID–19.

It is against this collective backdrop that the African American Health Alliance urges implementation of the recommendations coupled with the accelerated development of safe, effective, accessible, and affordable to all COVID–19 treatments and vaccines, and the required wrap around services people need to benefit from them.

RECOMMENDATIONS DETAILS AND JUSTIFICATION

Coronavirus requires a National comprehensive response. Black lives do matter.

Declare Racism a National Emergency.—Declaration to provide for inclusion of racism elimination and prevention provisions in all policies, practices, and programs. This action systematically takes into account the adverse consequences of racism in policing and all social determinants impacting the quality of life. For all, the declaration limits and helps to prevent the harmful effects of racism across the lifespan. Black lives do matter.

The elimination and prevention of racism is vital to helping to ensure that all persons achieve their fullest potential, freedom, and justice. Conduct racism impact assessments, elimination efforts including engaging State and local and community workgroups for the purpose of informing decisions that promote elimination thereof as well as those that prevent elimination. Racism's consequences and protests Nation-wide and world-wide against racism support this declaration. [Within, that is AAHA's recommendation for the declaration of "Racism" and the "Elimination of Racial and Ethnic Health Disparities" National emergencies."]

DISEASE DETECTION, MANAGE, CONTROL, AND MONITOR

Coronavirus Testing: Provide Testing, Contact Tracing, Isolate, Treat, Social Distance, Repeat.—Remove barriers and provide accessible, robust rapid accurate and timely testing with accurate rapid results: Priority testing must be targeted especially for those African Americans with chronic pre-existing health conditions that place them at increased risk for coronavirus deaths and disease. Lack of testing remains a major missed opportunity to help control the spread and reduce coronavirus cases and deaths, and for making informed decisions about re-opening. This requires testing of not just those with symptoms but also those without.

Provide both COVID–19 mobile testing labs along with mobile health units. This companion effort provides for continuity of care for pre-existing chronic health conditions. Together, they are absolutely essential especially in high-risk communities, pre-existing health condition, hot spot breakout areas, crowded public housing, and front-line jobs/workplaces. Additionally, re-energize the DHHS health in public housing program. DPA: Robust test production, testing, contact tracing, and isolation are essential to help control this deadly pandemic and treat and manage pre-existing health conditions.

Coronavirus test to also include the serology test. Negatives must continue precautions including social distancing and isolation. Effective contact tracing requires that tracers also include African Americans and others from communities of color. Coronavirus testing coupled with contact tracing, monitoring, identification, isolation, diagnosis, and immediate coronavirus care, treatment and management coupled with on-going testing and treatment for pre-existing health conditions is a must solution.

State and local health departments must be supported also to help do the contact tracing and follow-up that is necessary to be effective. Directly fund each State and territory to do contact tracing and robust testing. The CDC's respiratory surveillance system is not adequate to the task. States must demonstrate a system where data is collected from all populations indicating the ability to provide rapid diagnostic services to all residents and on-going serologic monitoring the State's population including unserved and underserved areas (MUAs).

Responsible opening, care, treatment, and control are dependent upon test-trace-treat-isolate. Surely, children must be tested as well as those that teach and provide them care. Do not open schools without testing. Without it, the approach is reckless. National robust testing requires releasing the full powers of the Defense Procurement Act; that act exists to help save lives; do it now.

Engage/Command/Control/Preparedness/Emergency Response/Resilience Expert.—We strongly urge you to work with retired General Russell Honoré to develop a comprehensive Coronavirus Resilience National Strategy with emphasis on public health, the supply chain, economic security, vulnerable populations, cybersecurity, broad band and more including a build-back-better approach. General Honoré has tremendous expertise that is needed to help improve the coronavirus response.

EXTENT OF NEED: PRE-EXISTING HEALTH CONDITIONS

Pre-existing Health Conditions: Provide Health Care Access for Care and Treatment: Expand and ensure access to care and treatment.—Include Medicaid expansion; allow Medicare enrollment at age 45, allow "special open ACA enrollment season now" and permit young adults to remain on their parents' health care plan to age 30. In addition, expand existing community health centers and continue to increase the number of new centers especially in unserved and underserved communities. There must also be mobile community health satellite centers with full or near-full array of services. Coronavirus and chronic health conditions together require immediate, short- and long-term care, treatment, and follow-up.

Continuity of care is vital. Expansions in access to care and treatment with wrap-around services is necessary to respond to both the coronavirus medical, mental health conditions, and to chronic pre-existing health conditions that the virus further complicates. Overall, make sure everyone has some form of affordable health care coverage with facilitated access to it, and that effective responds to their needs.

Concern abounds about rationing.—Care, treatment, medications and testing, including that for chronic pre-existing health conditions. Unserved and underserved communities need reliable connectivity technologies to effectively accommodate and benefit from telemedicine, tele-health, tele-mental health, tele-dental, and tele-nutrition to name a few. Stable reliable internet/broad-band services are essential for health, home schooling, higher education, training in the trades, and more.

These deficiencies adversely limit health, education, and employment opportunities. In addition to care, treatment, and dire testing shortages, medication shortages are also on the rise. Addressing the overall twin conditions: Coronavirus and ongoing health needs of people in public housing, nursing homes, prisons, assisted living, the homeless, and similarly-situated environments is paramount.

DATA COLLECTION ANALYSIS AND REPORTING

EXTENT OF THE CORONAVIRUS: PROVIDE DATA COLLECTION, ANALYSES, MONITORING, AND REPORTING

Racial and ethnic health disparities are well known to Federal, National, State, local leaders, officials, and community gate-keepers and agencies. Data must be collected and documented at point of medical system and testing entry. Agencies must collect, analyze, monitor, and publicly report coronavirus racial and ethnic demographic data. Months into the coronavirus pandemic and National emergency race and ethnic data are insufficient to appropriately inform the medical, the Nation's and community's response to the deadly and highly contagious coronavirus.

The Department of Health and Human Services and its agencies must collect, compile, analyze, release, and report race and ethnic demographic data including but not limited to that on cases, deaths, location, zip code, outbreaks, hospitalizations, and testing. Data is extremely limited and seriously life-threatening-insufficient. National, State, and local coronavirus reporting must be accurate, timely, complete, and transparent. Additionally, data is an essential factor helping to identify where services and resources must be targeted and concentrated. Testing, care, and treatment data help inform efforts to improve outcomes.

WORKFORCE

Provide Hazardous Pay, Worker Protections, and Whistle-Blower Protections.—Provide hazardous pay to coronavirus front-line workers, double existing pay/salary. Months into this deadly contagious coronavirus the shortages of staff, personal protective equipment, and gear continue to place workers and their family at increasing risk for disease and death. The front-line workforce includes nurses and doctors, non-medical hospital staff; home health and nursing home workers; grocery store, postal, transportation, medical technicians, meat-packing plant workers; the list goes on and on. Direct OSHA to update issue and monitor coronavirus worker protection guidelines. Provide whistle-blower protections.

Coronavirus front-line and essential workers across all fields must be paid hazard pay, double current pay. Every day, they put their life on the line to serve the public . . . facing the deadly coronavirus head-on without hazardous pay. Months into this deadly pandemic, despite dire working conditions, still the full powers of the DPA have not been released and that deficiency has now spilled over into the extreme deadly shortage of coronavirus tests. Essential materials, equipment, test and test material remain in short supply including medical equipment, cleaning supplies, gowns, gloves, masks, and medications.

CARE AND TREATMENT

Establish Coronavirus Community Access Points.—Because of the highly contagious nature of COVID–19, the fact that it may spread before the individual becomes symptomatic, the severity of its illness, and the fact that many individuals will be at risk of becoming infected for years to come, the health system must adopt modifications immediately to respond to medical, mental health, social determinant requirements, and complications stemming from coronavirus in immediate, short-, and long-term.

Without National testing and within it African American priority is testing, the coronavirus is more deadly for all. Community Access Points must be developed to provide unserved and underserved communities with sites which will be: Highly accessible loci for services and for the provision of information regarding COVID–19; sites providing immediate testing and informing of virus status; care entry points for those testing positive; and loci for isolating, counseling, and contact tracing staff in the community. [Test-trace-treat-isolate-repeat.]

Access points must have separate waiting areas for patients and address (treat, manage, and control) pre-existing chronic health conditions. These facilities must have: Up-to-date laboratory test and equipment; access to the most up-to-date COVID–19 information provided by DHHS; ability to diagnose and quickly report COVID–19 status; a waiting room separate from non-COVID–19 patients; and ability to transport positive patients to an in-patient facility which serves symptomatic COVID–19 patients. Staffing team minimum requirements: A physician or nurse practitioner; nurse, technicians, counselor with social work training; and contact tracing staff. The unit/entity/facility should be located on the site of an established community health facility and operated by that facility collaborating with local or State health departments.

Establish Prison Coronavirus Systems.—The Federal Bureau of Prisons must develop a coronavirus plan for each of its regions. Each plan must specify mechanisms for: Identifying positive staff and inmates; separation of positive staff and inmates from the general population; isolation, contact tracing, and also on-going identification of staff and inmates missed in the initial screening; and screening of all incoming staff and new inmates and separation of positives.

Collaborating with State health departments for contact tracing purposes.—Each region must designate a COVID–19 coordinator, preferably a physician. A COVID–19 counselor must be designated within the staff of each prison's clinical facility. This counselor must have direct communication with the regional coordinator. Regions must also designate a clinical facility for patients who must be hospitalized and specific systems for transportation to the facility and management of the hospitalized inmates.

State Grants.—Make grants to each State to develop systems to manage COVID–19 within its prisons. Each plan must specify mechanisms for: Identifying positive staff and inmates; separation of positive staff and inmates from the general population; contact tracing; and on-going identification of staff and inmates missed in the initial screening; and screening of all incoming staff and new inmates and separation of positives. Collaborating with the State health department for contact tracing purposes: States must designate a COVID–19 coordinator, preferably a physician, for its prison system. A COVID–19 counselor must be designated within the staff of each prison's clinical facility. This counselor must have direct communication with the State's coordinator. States must also designate a clinical facility for patients who must be hospitalized and specify specific systems for transportation to the facility and management of the hospitalized inmates. Oversight of these State systems must be shared by the Federal Bureau of Prisons and the Department of Health and Human Services. [Test-trace-treat-isolate-repeat.]

SMALL BUSINESSES AND COMMUNITY INVESTMENT

Provide for Small Businesses.—Continuing to struggle, African American businesses are among the hardest hit. Low cash and weaker banking connections threaten their existence as they compete for PPP against much larger businesses. The combination compounding crises income, pay checks, unemployment insurance, job instability, and others seriously threaten small businesses and their staff. The disadvantage conditions collide and escalate in the coronavirus National emergency requiring automatic triggers and pathways to help save families and businesses during this National emergency that is no fault of their own. They did not choose the deadly coronavirus health and financial crises.

Invest in Community Development.—Increase investments in jobs (with living wages); quality education Pre-K through 12th grade; safe schools; meaningful employment training; job creation and placement; entrepreneurial opportunities; cre-

ation of avenues for innovation; grocery stores and transportation; business development, growth and sustainability; safe affordable housing; convenient access to quality affordable health care; safe communities; and affordable quality day care.

These interlinking investments are absolutely essential for viable productive communities. Establish and make available to communities a team of Federal Government experts from Department of Justice, to Department of Education, DHHS to EPA, to Office of Preparedness and Response, to Department of Labor, SBA, DHS, and others to work in partnership with local agencies, community leaders, business, and others. Provide technical assistance focused on helping communities identify and establish linkages and partnerships with business and industry. Fund at such sums as necessary.

Community Empowerment Zones.—Provide community partnership grants to establish community empowerment zone programs in communities that disproportionately experience over-policing. Funding provided for Black communities that seek to improve economic, race relations, health, education, environment, and policing to help reduce disparities, and other highly coronavirus-vulnerable communities. Assist community in accessing Federal programs; to obtain and coordinate the efforts of governmental and private entities regarding the elimination of racial and ethnic justice disparities and over-policing crisis.

Communities to be served by the empowerment zone program are those that disproportionately experience over-policing and economic opportunity deserts. The community establishes an empowerment zone coordinating committee: Determine priorities, establish measureable outcomes, obtain technical assistance, and utilize but not limited to community and evidence-based strategies including goals, management, implementation, monitoring, assessment, and evaluation. Submit to the Congress community empowerment zone reports. Fund at such sums as necessary.

TRAINING AND EDUCATION

Conflict Resolution Training.—Include conflict resolution in the education curriculum Pre-K through 12. The techniques learned in conflict resolution training would be beneficial across the life span. They would be helpful in encounters with police and all other relationships. Fund at such sums as necessary.

Expand Academic Opportunity and Achievement.—Have school systems, courts, and police work with the community and academic institutions to implement mentorship programs focused on youth including troubled youth to provide them with insight and opportunity to better benefit from the powerful value of education and training beyond high school. Tie college and training scholarships to these programs, and help to ensure that free community college becomes a real accessible opportunity. This investment in the individual's and America's future helps to further innovation, entrepreneurial development, research, business, industry, and technology advances on all fronts in all fields. Fund at such sums as necessary.

Provide Summer Enrichment and After-school Programs.—After-school and summers is the most unsupervised period of time facing latchkey children and teenagers. Effective programs must be implemented that provide that supervision ranging from summer jobs, to summer education and training, to sports and arts, to innovation and business, to enrichment programs and Junior Achievement. For young children, provide summer Pre-K. Overall, programs must also provide meals and transportation for those in need. Fund at such sums as necessary.

Establish National Teaching-Learning-Tutoring Corp [Establish, Provide, Conduct, Monitor, and Fine-tune as necessary].—Provide students and parents the academic assistance needed to bring students up to grade level and beyond. This must be a joint goal. The portfolio must include but is not limited to materials, computers, technologies, skilled supplemental personnel and other resources needed. Students and parents must not be penalized for the education and stress crises created by the Pandemic. Additionally, establish a family support hot-line professionally staffed to address family stress, mental and behavioral health control, and management support.

Compile, train, and provide techniques and exercises that parents and students need to help control and manage stress.—Also, identify and provide parents and students the privacy tools needed to help keep on-line schooling and socializing safe. Remain mindful that our Nation's children and parents sudden thrust into full-scale home schooling, on-line learning/educating has placed students at increased academic disadvantage and to successfully close the void they must be provided the necessary resources. Fund at such sums as necessary. Additionally, increased on-line use by the elderly also places them at increased on-line fraud. Fund at such sums as necessary.

ENHANCE COMMUNITY PARTICIPATION

State and Local Offices on Community Relations.—Establish Offices on Community Relations to help communities empower themselves: Make available technical expertise, linkages, and resources. Create and make available community relations improvement resource tool kits that communities can tailor to fit their needs.

Voting.—The African American Health Alliance would be remiss to not highlight voting. Voting no matter what form or forms it takes must be protected, voter-friendly and facilitated, and funded at such sums as necessary. Voter registration and rolls must also be respectively facilitated and protected. Every vote counts and must be counted. Also, as a Nation, we can and must improve the response to all aspects of the coronavirus National emergency. The response deficiencies are life threatening especially for Blacks and others at high risk. Clearly, everyone must be a part of the solution to the Nation's emergencies racism, policing, COVID, and the economy.

In closing, Mr. Chairman, Ranking Member, and Members of the subcommittee our collective purpose must hold us accountable to the reality that we are all in this together and we must do our part. As Dr. King's quote continues to remind us: "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."—Martin Luther King Jr.,

WHY WE CAN'T WAIT

The coronavirus pandemic requires a comprehensive National response. The African American Health Alliance thanks you for this opportunity to provide testimony for the record and recommendations. We deeply appreciate your on-going leadership and support. Black lives do matter.

Mr. PAYNE. With that, I want to thank the witnesses one more time for their valuable testimony and Members for their questions.

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

Without objection, the committee record shall be kept open for 10 days.

Hearing no further business, the subcommittee stands adjourned.

[Whereupon, at 1:44 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS FROM CHAIRMAN DONALD M. PAYNE, JR. FOR GEORGES C. BENJAMIN

Question 1. As the number of COVID–19 cases continue to rise in the Southern and Western States, what new health disparities might we observe as compared to the earlier outbreak in March and April?

Answer. Response was not received at the time of publication.

Question 2. What can the Federal Government do to help close testing disparities among minority and disadvantaged populations?

Answer. Response was not received at the time of publication.

Question 3. What can the Federal Government do to help close PPE disparities among minority and disadvantaged populations?

Answer. Response was not received at the time of publication.

Question 4. This administration has consistently undermined public health official messaging during this emergency. What are the potential impacts of this mixed messaging during a National emergency?

Answer. Response was not received at the time of publication.

QUESTIONS FROM CHAIRMAN DONALD M. PAYNE, JR. FOR LEANA WEN

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Question 3. This administration has consistently undermined public health official messaging during this emergency. What are the potential impacts of this mixed messaging during a National emergency?

Answer. Response was not received at the time of publication.

Question 4. How can FEMA "operationalize equity" so that its crisis responses are more equitable?

Answer. Response was not received at the time of publication.