LOOKING AHEAD SERIES: OFFICE OF THE ATTENDING PHYSICIAN

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON HOUSE ADMINISTRATION

HOUSE OF REPRESERNTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

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C O N T E N T S

Looking Ahead Series: Office Of The Attending Physician

Thursday, March 23, 2023

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
COMMITTEE ON HOUSE ADMINISTRATION,
Washington, DC.

The subcommittee met, pursuant to notice, at 3 p.m., in room 1310, Longworth House Office Building, Hon. Barry Loudermilk [chair of the subcommittee] presiding.

Present: Representatives Loudermilk, Steil, Griffith, Murphy, D'Esposito, Morelle, Torres, and Kilmer.

Staff present: Tim Monahan, Staff Director; Aubrey Wilson, Deputy Staff Director and Director of Oversight; Elliott Tomlinson, Deputy General Counsel and Deputy Parliamentarian; Hillary Lassiter, Clerk; Jordan Wilson, Director of Member Services; Jamie Fleet, Minority Staff Director; Khalil Abboud, Minority Deputy Staff Director and Chief Counsel; Matthew Schlesinger, Minority Oversight Counsel; Eddie Flaherty, Minority Chief Clerk; Andrew Garcia, Minority Special Assistant; and Enumale Agada, Minority Oversight Counsel.

Chairman LOUDERMILK. The Subcommittee on Oversight will come to order.

I note that a quorum is present.

Without objection, the chair may declare a recess at any time.

Also, without objection, the meeting record will remain open for 5 legislative days. So members may submit any materials they wish to be included therein.

I thank Ranking Member Torres, a classmate of mine and came in Congress together, and members of the subcommittee for participating in what I may emphasize is the inaugural hearing of the House Administration Oversight Committee, not just the first of this Congress but the first ever. So I think that's something that we're looking forward to having, more of these.

I look forward to working together to bring robust oversight to the legislative branch, including many entities that we oversee. Unfortunately, many of these offices have not been called before our committee in years, resulting in a lack of accountability to both Congress and the American people.

We're very honored to have Dr. Monahan with us today. In fact, Dr. Monahan has not appeared before a congressional committee ever, which is a testament to why we're having hearings now. But this is not unique to him. No Attending Physician has ever been called to testify and that's changing in this Congress.

For nearly 100 years, the Office of the Attending Physician, or OAP as most of us know it, has served both chambers, offering healthcare and guidance to senators, representatives, Supreme Court Justices, and even staff and visitors during emergencies.

Prior to the 116th and 117th Congress, the OAP operated largely behind the scenes. Then COVID–19 pandemic hit us, and subsequent strains reached our nation, resulting in the OAP becoming a substantial voice with an increased sense of authority, enabled by the office of former Speaker Nancy Pelosi.

In a time when we needed true health guidance based on facts, the OAP issued what appeared to be inconsistent health and safety guidance across the two Chambers of Congress due to political pressures. Greater restrictions were placed on the House of Representatives than the Senate, even though the chambers not only operate on the same campus but physically gather on two sides of the same building.

I look forward to hearing from Dr. Monahan about how such guidance was decided upon, the pressures he faced, and what this Committee can do to insulate the Office of Attending Physician from political manipulation in the future.

Taking a step back from the polarization of health guidance, the pandemic also brought to light another issue within the office. The Attending Physician played a key role in advising House personnel on protective—personal protective equipment, or PPE as we all have come to know that term, the usage and testing requirements of PPE. However, the OAP did not hold the contracting authority to oversee the procurement and purchase of PPE or contract procurement for the COVID testing contractors.

My hope is that, as a result of this hearing, we'll be able to identify OAP authorities that need to be better defined to ensure adequate accountability and responsibility in responding to a health crisis.

Finally, with the full opening of the campus, it's time to ensure that the House's support services are back in full operations.

I look forward to receiving an update on whether all OAP offices across the House have returned to regular business hours and what the timeline is for OAP returning to offer its full medical and health support services to those on campus.

Ultimately, we must establish accountability for this office, transparency of its operations and decisionmaking, and explore reauthorization of its overall authorities.

The OAP plays an important role for congress, not only for critical health and safety support but also for continuity long term.

I'm thankful that Dr. Monahan is here to have a conversation with us about what we can do to ensure the OAP returns to being a trusted office that is strong and independent.

Thank you for being here. Let me also say, as a fellow veteran, thank you for your service to our Nation in the United States Navy.

I now recognize the Ranking Member, Mrs. Torres, for 5 minutes for the purpose of providing an opening statement.

Mrs. TORRES. Thank you, Chairman.

Welcome, Dr. Monahan.

It is a privilege to be here for the Subcommittee on Oversight's first hearing in the 118th Congress.

Oversight of our government should be a bipartisan objective, and while there is a lot of political theater happening in other committees, I am hopeful that we will lead by example in doing the important work in a bipartisan way.

Our constituents sent us to congress to work on behalf of the American people and ensure that taxpayer dollars are spent appropriately and effectively. Holding our institutions accountable when they fall short should be a bipartisan objective. With that said, I look forward to collaborating with my colleagues and the chairman on this very important work.

For today's hearing, we turn our attention to the Office of the Attending Physician, which is led by Dr. Brian Monahan. It is really good to see you again, doctor.

Dr. Monahan has occupied this role since January 2009, serving admirably under both Democratic and Republican majorities. He is certified by the American Board of Internal Medicine in internal medicine, hematology, and medical oncology, and holds the rank of rear admiral in the United States Navy.

He has served as a surgeon general specialty leader and as training program director of hematology and medical oncology at the National Naval Medical Center, National Capital Consortium.

Dr. Monahan has also served as chairman and professor of medicine and pathology at the Uniform Services University of the Health Sciences in Maryland.

Dr. Monahan is also notable for the dedicated and compassionate care that he provides to members of the House and the Senate.

Dr. Monahan, in my opinion, you are not some paper pusher hiding behind a fancy title. You are hands-on, accessible, and personable. Knowing each member and their spouses by their first name, traveling with us, visiting us when we are sick, and making yourself available at any time to discuss even a minor issue is very appreciative.

Dr. Monahan spent this past weekend, as a matter of fact, in Florida providing care and services to my republican colleagues during their annual retreat. In such a small minority, you know, it is really important to keep you healthy during this time.

In addition to the enormous responsibility of caring for every member of the House, Dr. Monahan and his team are also charged with the care of each senator, Supreme Court Justice, congressional staff, and the millions of visitors that come to our campus every year.

Over the past 3 years, Dr. Monahan has had the challenging task of guiding the House and other institutions at the heart of our democracy through a dangerous, unprecedented, and rapidly changing public health crisis.

It is important to overstate the critical role Dr. Monahan and his staff played in keeping those of us who work in the House safe, not just members but the bill clerks, maintenance workers, and staff that are the true lifeblood of this institution. Healthy and able to continue to do our work on behalf of the American people was his primary duty.

Unlike the Senate, the House was able to continue proposing, debating, and voting on legislation during the early days of the pandemic, thanks in part to the use of proxy voting, the eHopper, and remote proceedings. These were very challenging times, and with Dr. Monahan's guidance and direction, the House was able to continue to legislate on behalf of the American people.

Dr. Monahan, please extend my sincere gratitude to your team for a job well done. Still, as members, we should never miss an opportunity to examine our responses to crisis and identify lessons learned. As a former 911 dispatcher, I know how important it is for our leaders to look at a path forward, learning from past experiences, especially when it comes to public health and safety. Today's hearing provides a forum in which we can do just that.

It is my expectation that, through Dr. Monahan's testimony and answers to today's questions, we can identify ways to better support you.

Additionally, given that is a new subcommittee, today's hearing offers us a chance to learn about the office structure and operations while also laying the foundation for a collaborative and communicative oversight relationship.

Finally, the Office of the Attending Physician has proactively recommended ways that the office can be updated and better prepared for challenges ahead. I look forward, Mr. Chairman, to learning about these recommendations and the ideas that are brought forward.

With that, I yield back to the chair.

Chairman LOUDERMILK. I now recognize the chairman of the full committee, Mr. Bryan Steil, for the purpose of providing an opening statement.

The CHAIRMAN. Thank you very much, Chairman Loudermilk. It's exciting to be here on the first meeting of the Subcommittee on Oversight in House Administration. I'm excited in your role and the expertise you bring to this hearing. I think it's really important as we reflect about how we get this institution back to normal following a tumultuous few years. I think your leadership is spectacular in that regard.

Ranking Member Torres, I appreciate your comments in particular about the opportunity to have a real bipartisan approach to this as we really work to depoliticize a lot of the institutions here at the House to the benefit not only of the members, of the staff, but really of the American people to get this place up and working.

Dr. Monahan, I appreciate you being here. I know you're a rear admiral in the Navy, and we thank you for your service over your career to our country and also to your service in this part of your career to the institution of the Nation's Capitol. It's greatly appreciated.

While the Office of the Attending Physician, or OAP, has historically operated often behind the scenes, the office plays an important role, as we've noted, in the House, the Senate, and the Supreme Court as well. I would like to specifically thank you but also all of the members of your staff at the OAP for their 24-hour support for the broader congressional community.

More recently, the OAP played a very prominent role in the House's response to the COVID–19 pandemic. Unfortunately, I'm

pretty concerned that the office may have been manipulated or polarized by former Speaker Pelosi and her team during the pandemic. I think that's why, in one way, it's so important we hear directly from you today, Dr. Monahan.

Why am I concerned? So, despite being in the same Capitol Building, the House and the Senate had different and, in my opinion, inconsistent health guidance. For example, someone on the House side of the Capitol would have to wear a mask under the rules, but once you got halfway through the rotunda, you could take it off and cross into the Senate side and be in compliance with the Senate rules. I think we would all agree that that doesn't make a lot of sense.

So the lack of transparency and kind of the politicization of the guidance was really highly concerning to a lot of Members, and this Committee's work is to really look at what led to that and to prevent any abuse of health guidance in the future.

So, through our hearing today, I hope we can reestablish the accountability for this office, increase transparency of its operations and decision makings, and review its overall authorities with the goal of making the office stronger and more independent.

I look forward to working together to ensure your office meets the needs of Congress as an independent nonpolitical entity that's rooted solely in scientific fact. I appreciate your being here.

Mr. Chairman, I yield back.

Chairman LOUDERMILK. I now recognize the full committee Ranking Member, Mr. Morelle, for the purpose of providing an opening statement.

Mr. MORELLE. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for this hearing today.

I do appreciate very much, Admiral, what you do and what your team does. I think for all members who may need your services appreciate the professionalism, the expertise, the amount of care and attention that members get in a place where it's very stressful. You're away from home. Whether or not you're the primary care provider for them or you play a secondary role to those who have a healthcare provision back in their home community, I think you just do an excellent job.

I do want to point out—and I'm appreciative of the fact that you're here. I think all of us here on both sides of the aisle always want to be looking at the things that we do, and this committee, particularly, has responsibility for the administrative tasks of the House, and I think we should always be open to suggestions about how to improve, how to make sure that we're having transparency, that we're asking the right questions about what you do and what your very talented team does.

I also think that—and we'll get into this on questions, and I appreciate the time, and I won't take up much time here, but the fact that you provide services for both Houses, as well as the Supreme Court, and that the two Houses and the leadership of the two Houses may look differently at your recommendations, when I think the question here for all of us to answer is: Are you providing the same guidance to both leaders and then allow them, particularly as my colleague and good friend, the Chairman of the stand-

ing committee has mentioned, why there were differences in the implementation of different procedures during the pandemic?

Was that decisions that you made? Were the recommendations you made to the two Houses different, or did they simply make different decisions with the recommendations that you gave? I think that's really an important question for us to answer, and some may have abided by the science and some may not have.

That's not a decision for you to make, as I understand it, but, obviously, one would have questions about what recommendations you made, particularly during the pandemic, and how did you come to make those recommendations? Were you following the science? Kind of what was your strategy in making those recommendations to the two different Houses?

I think that will be important, probably as well as whatever recommendations you made to the chief justice and the administrative team in the Supreme Court. So I think those are important questions. I'm looking forward to your answer.

Again, I just appreciate your service to the country and certainly appreciate your service to those of us here in Congress.

So, with that, I yield back, sir.

Chairman LOUDERMILK. Thank you.

Now, without objection, all other members' opening statements will be made part of the hearing record if they are submitted to the committee clerk by 5 p.m. today.

Pursuant to paragraph (b) of Committee Rule 6, we'll now move to swearing in of the witness.

If, Dr. Monahan, you'll please stand and raise your right hand.

[Witness sworn.]

Chairman LOUDERMILK. Thank you.

Let the record show that the witness answered in the affirmative.

I will now proceed to introduce the Honorable Dr. Monahan.

Rear Admiral Dr. Brian Monahan, who was appointed in 2009, is the seventh Attending Physician of the U.S. Congress and the U.S. Supreme Court.

Following his service with the U.S. Marine Corps 3d Battalion, 6th Marine infantry regiment, Rear Admiral Brian Monahan completed his internal medicine residency at the National Naval Medical Center where he was selected as chief of residents.

Dr. Monahan completed his training in hematology and medical oncology at the National Cancer Institute and National Naval Medical Center in 1996, and serves as a professor of medicine and pathology at the Uniform Services University of Health Sciences in Bethesda, Maryland.

His public health leadership—in his public health leadership capacity, Dr. Monahan is the physician responsible for the medical welfare of members of Congress, Justices of the Supreme Court, and directed to the coronavirus pandemic response protocols for the legislative branch of the U.S. Government.

The Attending Physician is instrumental in security planning with the Architect of the Capitol, Senate Sergeant at Arms, House Sergeant at Arms, United States Capitol Police, and other congressional officials to ensure medical support during contingency operations and natural and manmade disasters.

Dr. Monahan, we appreciate you being here today and look forward to your testimony.

As a reminder, we have read your written statement, and it will appear in the full hearing record. Under Committee Rule 9, you are to limit your oral presentation to a brief summary of your written statement, unless I extend this time period in consultation with Ranking Member Torres.

Please remember to press the button on the microphone in front of you so that it is on and the members can hear you, which is important, and we all tend to forget that sometimes.

When you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow. When the red light comes on, your 5 minutes has expired. We would ask you to then just—if you need to wrap up at that point, we'll give some leeway there.

I might remind my colleagues there are 41 House hearings going on today. So we do plan on having two rounds of questions. So, if you can, keep your questions within the 5 minutes. We'll have a little leeway, but being on time is important for those who have to move back and forth between the different committee hearings.

At this point, I recognize Dr. Monahan for 5 minutes.

Dr. Monahan.

STATEMENT OF BRIAN MONAHAN, ATTENDING PHYSICIAN

Dr. MONAHAN. Mr. Chairman, Ranking Member, thank you for the opportunity to address the subcommittee.

The Office of Attending Physicians, or the OAP, was established in 1928, following the unexpected deaths of several members and in recognition of the need for medical care in Congress by Speaker Longworth. Since my appointment in 2009, it has been my honor to serve as the seventh attending physician.

The OAP is a small office of fewer than 50 people with many responsibilities for health, safety, and medical care here on the Capitol complex. I would like to speak briefly about those services, other than the classified programs.

The OAP provides comprehensive medical care to Members of Congress and the Supreme Court. Staff are accessible 24 hours a day, 365 days a year. The OAP is voluntarily accredited by the Joint Commission, achieving the gold seal of approval continuously since 2014.

We provide preventative care, vaccinations, first aid, and nursing services to members and staff through our health units located throughout the Capitol complex. We supervise and equip all of the lactation suites and provide first aid, CPR, and naloxone rescue training classes.

OAP personnel supervise air quality, water quality, food safety, pest control, and overall workplace comfort and safety issues. For example, our staff conducts health inspections of all food service establishments and virtually every meal served on Capitol Hill.

We also work with the Capitol Police and Architect to ensure individuals are compliant with environmental health education and medical surveillance programs.

We provide medical expertise for congressional travel and contingency support planning, such as medical threat assessments for staff delegation travel and congressional delegation travel.

The OAP provides medical care for large special events, such as the State of the Union Address, the Presidential Inauguration, joint sessions of the congress, large scale ceremoneys, member retreats, and party national nominating conventions.

The OAP is also tasked with providing medical emergency care to staff, visitors, and other members of the public. We triage and stabilize individual patients and manage mass casualty situations. For example, the OAP provided care for numerous heat injuries during the outdoor memorial service for Senator John McCain and managed the response to the 2001 anthrax attack, and the April 2013 ricin episode.

We are often the first on scene for serious and violent events. For example, we mobilized to provide emergency care in 2013, when a driver was shot and critically wounded outside the Hart Office Building and the OAP recovered the infant in their car, and in 2016, for a shooting in the Capitol Visitors Center.

We were the first responders in the 2018 Crozet, Virginia, Amtrak collision derailment with dozens of injured members and staff, as well as a fatality and life-threatening injuries on the ground.

In 2021, we responded and provided critical support to Capitol Police officers rammed by a vehicle. One Capitol Police officer sadly died in that incident. We also responded to numerous serious injuries to police officers and members of the public on January 6, 2021, in support of the Congress' return to normal operations.

In March 2020, healthcare systems and providers across the nation, including the OAP, were faced with the largest international public health crisis in a century: the SARS-CoV–2 coronavirus pandemic. Many members and staff have been exposed to or contracted COVID–19. Sadly, I am aware of at least 5 deaths in the congressional community among our 3,361 COVID–19 cases.

Other members and staff have had serious ongoing health challenges. At times, the staff at the OAP has been available 24 hours a day to provide both remote and in-person care and advice to Members with COVID, their staff, and their families.

In March 2020, the OAP was tasked with an advisory participation in the Joint congressional Continuity Board, known as the JCCB, that established a bicameral response plan for the early weeks of the pandemic and the operational posture of the entire Congress organization.

The Committee on House Administration also required the OAP to create a physician-and nurse-staffed COVID response center which responded to queries 24 hours a day and delivered contact tracing services to all the contacts, both the quarantined and the cases.

As an organization that principally provides primary care, the OAP staff does not include any pandemic-related scientific staff, such as epidemiologists, et cetera. We do not have the expertise or resources to develop ad hoc public health recommendations.

Rather, the OAP sought the advice of national and regional experts at the Centers for Disease Control and Prevention, the National Institutes of Health, and other agencies. Ongoing dialog with

these experts ensured the OAP was knowledgeable of current Federal COVID response guidelines.

The OAP also coordinated with local government partners who were essential for sustainment of congressional activities. The OAP sought to maximize congressional operations while reducing the spread of disease and death.

The OAP made recommendations to reduce spread at large gatherings, including voting procedures, procedures for caucus meetings, and solemn ceremoneys, such as those of Congressman John Lewis, Senator Robert Dole, Harry Reid, and Justice Ginsburg.

The OAP sought at all times to enable the business of the Congress without excess COVID cases or deaths. At a time when COVID testing resources were scarce or unavailable, the OAP successfully made them possible with a rapidly scalable capability. This enabled Members to obtain PCR test results very rapidly and provided insight to limit disease spread.

Currently, the Capitol COVID testing center provides the gold standard PCR results within minutes. The present test positivity rate is less than 1 percent. Since March 2020, the OAP has performed over 159,000 PCR tests.

The development of COVID vaccines through Operation Warp Speed represents an astonishing medical success. The OAP was instrumental in ensuring Congress was prioritized in the national security-based program for continuity of government vaccine access and delivered immediate large-scale distribution. This required acquisition, installation of ultra cold storage chain, developments for a protocol for operating COVID immunization clinics, and handling thousands of calls per day with the invaluable assistance of many Library of Congress personnel.

The OAP has administered over 32,400 coronavirus vaccinations. As COVID treatments were developed, mechanisms were put in place to immediately prescribe medications locally and in home districts. Non-COVID health needs, including both mental and physical health conditions, were continuously addressed.

The OAP was also tasked with COVID-related communications. We endorsed interventions recommended by the CDC and, thus, was not immune to changes or reversals in COVID–19 guidance.

The OAP recommendations were the same to both Chambers of Congress. Leadership of each Chamber operationalized these recommendations with respect to their independent and unique bodies. This result was communicated in my Dear E-Colleague letters.

In conclusion, I would like to thank my 48 OAP staff for their remarkable, uncommon dedication and altruism in support of individual good health and the congressional mission while placing themselves at direct increased health risk. I am appreciative of each and every one of them.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Monahan follows:]

Mr. Chairman and Members of the committee, thank you for the opportunity to testify here today.

The Office of Attending Physician or OAP was established in 1928, following the unexpected deaths of several Members and recognition of the need for medical care in Congress. Since my appointment in 2009, it has been my honor to serve as the seventh Attending Physician. The OAP is a small office of fewer than 50 people, with many responsibilities for health, safety and medical care on the Capitol Complex. I would like to speak briefly about the services the OAP provides other than the classified programs.

The OAP provides comprehensive medical care to Members of Congress (House and Senate) and the Supreme Court. Staff are accessible 24 hours a day, 365 days per year. In-person medical visits are available to Members whenever the House or Senate is in session and during business hours when out of session. The OAP is voluntarily accredited by the Joint Commission. The OAP achieved the Gold Seal of Approval in 2014 and has been continuously accredited since that time.

We provide preventive care, vaccinations, first aid and nursing services to Members and staff through our Health Units located throughout the Capitol complex. We supervise and equip all of the lactation suites. We also provide First Aid, CPR and Naloxone classes.

OAP personnel supervise air quality, water quality, food safety, pest control and overall workplace comfort and safety issues. For example, our staff conducts health inspections of all food service establishments. We also work with the Capitol Police and the Architect to ensure individuals are complaint with environmental health educational and medical surveillance programs.

We provide medical expertise for Congressional travel and contingency support planning, such as medical threat assessments for STAFFDEL and CODEL travel, medical care for CODEL travel and other classified contingency support.

The OAP provides medical care for large special events, such as the State of the Union Address and Presidential Inauguration, Joint Sessions of Congress, large scale ceremonies, Member retreats and Party National Nominating Conventions.

The OAP is also tasked with providing medical emergency care to staff, visitors and other members of the public. We triage and stabilize individual patients and manage mass casualty situations. For example, the OAP provided care for numerous heat injuries during the outdoor Memorial Service for Senator John McCain and the West Front Peace Officer Memorial assemblies. The OAP also managed the response to the 2001 Anthrax attack and April 2013 Ricin episode.

We are often first on the scene for serious and violent events. For example, we mobilized to provide emergency care in 1998 when two Capitol police officers were shot and killed, in 2013 when a driver was shot and critically wounded outside the Hart Office Building (OAP recovered their infant in the car), and in 2016 for a shooting in the Capitol Visitors Center. We were the first responders in the 2018 Crozet Virginia Amtrak collision/derailment with dozens of injured Members and staff, as well as a fatality and life-threatening injuries on the ground. In 2021, we responded and provided critical support to Capitol police officers rammed by a vehicle. One Capitol Police officer sadly died in that incident. We also responded to numerous serious injuries to police officers and members of the public on January 6th, 2021 and supported Congress's return to normal operations.

In March 2020, healthcare systems and providers across the nation, including the OAP, were faced with the largest international public health crisis in a century: SARS-CoV-2 or Coronavirus. Many Members and staff have been exposed to or contracted COVID-19. Sadly, I am aware of at least 5 deaths in the Congressional community among our 3361 COVID-19 cases. Other Members and staff have had serious ongoing health challenges. At all times, the staff of the OAP has been available 24-hours a day to

provide both remote and in-person care and advice to Members with COVID and their families, as well as resources for staff members and occasionally constituents.

In March 2020, the OAP was tasked with advisory participation in the Joint Congressional Continuity Board (JCCB) that established a Bicameral response plan for the early weeks of the pandemic and the operational posture of the organization. The Committee on House Administration also required the OAP to stand up a physician and nurse staffed COVID Response Center which responded to queries 24 hours a day and coordinated contact tracing activities. This resource remains available today to address any questions or concerns.

As an organization that principally provides primary care, the OAP staff does not include any epidemiologists, immunologists, microbiologists, infectious disease specialists, public health specialists, statisticians or other scientific staff. We do not have the expertise or resources to develop ad-hoc public health recommendations. Rather, the OAP sought the advice of national and regional experts at the Centers for Disease Control and Prevention, the National Institutes of Health, the National Institute of Occupational Safety and Health and the Department of Defense. Ongoing dialogue with these experts ensured the OAP was knowledgeable of current federal COVID response guidelines. The OAP also coordinated with local government partners who were essential for sustainment of Congressional activities.

The OAP sought to maximize Congressional operations while reducing disease spread. The OAP made recommendations to reduce spread at large gatherings, including voting procedures, procedures for caucus meetings, as well as solemn ceremonies such as those for Congressman John Lewis, Senators Robert Dole and Harry Reid and Justice Ginsburg. The OAP sought at all times to enable the business of the Congress without excess COVID cases.

At a time when COVID testing resources were scarce or unavailable, the OAP successfully located a vendor for offsite and onsite testing COVID testing with a rapidly scalable capability. This enabled Members to obtain PCR test results rapidly and provided insight into disease spread. Currently, the Capitol COVID testing center provides gold standard PCR results within minutes. The present test positivity rate is less than 1%. Since March of 2020, The OAP performed 158,917 PCR tests.

The development of COVID Vaccines through Operation Warp Speed represents an astonishing medical success. The OAP was instrumental in ensuring Congress was prioritized in the national security based program for continuity of government vaccine access. This required acquisition and installation of an ultra-low cold storage chain, development of a protocol for operating the COVID Immunization Clinic, handling thousands of calls per day, with the invaluable assistance of many Library of Congress personnel, and development of an online scheduling tool. Today, COVID vaccines are available to Members and staff on a walk-in basis. OAP has administered over 32,400 coronavirus vaccinations.

As COVID treatments were developed, mechanisms were put in place to immediately prescribe medications locally and in home districts. Non-COVID health needs, including both mental and physical health conditions, were continuously addressed.

The OAP was also tasked with COVID-related communications, although certain other organizations such as the House Administration Committee and the Sergeant at Arms also communicated such information at certain times. The OAP communications endorsed interventions recommended by the CDC, including hand hygiene, social distancing, masking, cleaning, testing, and travel. The OAP thus was not immune to changes or reversals in CDC guidance.

The OAP health recommendations were the same to both Chambers of Congress. Leadership of each Chamber operationalized these recommendations with respect to their independent and unique bodies and the result was communicated via a Dear E-Colleague communication from the OAP.

I would like to conclude by recognizing the OAP staff for their uncommon dedication and altruism in support of individual good health and the Congressional mission while placing themselves at a direct increased health risk. I am appreciative of each and every one of them.

Chairman LOUDERMILK. Thank you, Dr. Monahan.

I will begin our questioning today, followed by the Ranking Member, and then we'll alternate between parties.

I now recognize myself for the purpose of asking questions of our witness.

Dr. Monahan, thank you again for your service here. I know I have used, on occasion, the Office of Attending Physician, which is something for me because there's three professions that I have never really cared to do business with. The first is a funeral director. The second is doctors, and the third are lawyers. However, the first one is inevitable, but I will only ever use it one time. The second will actually delay the time that I go to the funeral director, and the third usually drives you closer.

So, with that, I do have an appreciation for the work that you and others in the medical profession do for those of us.

Now, Dr. Monahan, during the pandemic, the House Sergeant at Arms, in consultation with your office, issued health guidance and restrictions for the House Office Buildings and the House floor. Because, as you heard, there is appearance of political influence there, that's really what we're trying to get at, is to find out how things actually work.

Can you explain to us how the guidance was determined and the approval process that the guidance went through prior to being pushed out to the House community?

So, when you're working with the Sergeant at Arms, what was the process to come up with the guidance?

Dr. MONAHAN. The initial episode, going back to March 2020, specifically between March 8th and March 11th, was a very hairy time in the Congress of all the first responders and communities in the House and the Senate to rapidly position the organization to respond to a growing and frightening situation with, you know, hundreds or thousands of deaths in Europe coming—and with a fear they would come toward us with the growing concerns.

In the Congress, we have limited forums to have a campuswide response to an event. One such forum is the Capitol Police Board. The other forum we have is the Joint congressional Continuity Board. They often operate in a classified fashion.

They came together with all the stakeholders on the campus community, and that involves the House Sergeant at Arms, Senate Sergeant at Arms, and about probably 30 people in a large room, and we began to look at the Federal guidance for COVID–19, Department of Defense related instructions with regard to concerns, and other national experiences for COVID–19 issues.

From that, we created a posture as to how the organization would respond that all the joint leadership then reviewed and embraced, and we created a circumstance of sentinel events that we were watching for. These were defined by key metrics that would occur.

From that, we would derive one of three operating conditions for the Congress. Condition one was enhanced social distancing. Simple things like no handshaking, 6-foot separations, limitation of gatherings at that sort of thing at regular business.

No. 2, condition two would be reduced operating capacity.

No. 3 would be the essential operating capacity for the legislative branch to perform their functions. So that was how it first started. That was the first guidance that started.

As the pandemic arose, we participated in the executive branch led initiatives to crush the curve, diminish physical activities, and shut down to a very low level of activities everywhere.

Right around March 17th or so, the Congress had its last big session, a late night session, and then the members returned to their home districts. Then we went into like a pause or like a legislative recess.

During that time, each chamber wanted to come back into session as quickly as possible to address these needs, the House and the Senate. The Senate wanted to come back first. So the Senate leadership came to me to say: Dr. Monahan, we need to have operating practices that will allow us to come back into session and operate as safely as possible and do our work for the American people.

The House echoed the same sentiment with, you know, a strong instruction that we're not going away. We're going to be here and get the work done.

So, from that, I began a process to create the first edition of the pandemic social guidelines. These guidelines are, essentially, the CDC guidelines. They have some operational elements that are unique to our organization and the work that the Congress does. So that's why they are shaped—they are essentially the same by way of: What is isolation? What is quarantine? How many days if you're sick, et cetera? Six foot separations, hand washing, maintenance of a daily health inventory before coming to work, sick people stay home, et cetera.

From that, then I went through a process back and forth of both the majority and minority on the Senate side, and immediately the majority, minority on the House side to come to a consensus.

The first edition reflects broad consensus involving the U.S. Capitol Police, all the agencies within the Congress, such as the Architect of the Capitol, Office of the Clerk, and many, many talented people. So it took a long time for me and thousands of phone calls to come up with this, you know, 10, 12 pages how we're going to operate.

So that went out first. Then the Senate came back into session. The House came back into session. My guidance to each Body, both House and the Senate was the same. However, as a student of the Congress for the past 15 years, just kind of watching them, there is a profound difference between the House and the Senate. It's not a simple matter of terms of election and terms of office service, but, rather, their policies, their Chamber operations are very unique.

Each leadership group would take my same advice and operationalize it, and that's how you see some variations from the House and the Senate.

Things went along pretty well, and you saw the additions of my guidelines go on with further things, and one thing I would stress throughout this is the coronavirus was novel, meaning previously not seen, with unknown features. There were many judgments made at the start of coronavirus that turned out to be not fully accurate as to how it would spread, what the risks were, some of its

response to various seasons, how much it would strike the American people.

So it's constantly changing. So you'll notice in the guidelines, as the CDC updates their response for new and emerging science, my guidelines would update also.

Then, I would say, moving along—if I could have a few more minutes, Mr. Chairman, I will tell you moving along to some critical events into 2020, when we get to the summer of 2020, there starts to be, like, more issues, more deaths, more sickness, more issues, prolonged shutdowns, suffering of the American people, deaths, hospitalizations, National Guard mobilized to keep our hospitals open, intensive care units built in parking garages, et cetera.

In the middle of that, each Chamber was meeting in session, having their votes, et cetera, and trying to do the best they could to minimize the spread of disease.

On the House side, there were significant other—there were significant differences also in the Chambers. The House having four times more members, more travel, more reaches out to every corner of the United States to gather back again and have this large gathering of people and inside spaces.

The Centers for Disease Control would often characterize risk levels, and the House floor turned out to be the highest risk scenario: Members of varying stages of health traveling throughout the United States from varying high risk/low risk areas, et cetera, coming together in an enclosed space. So they required quite a bit of suggestions with regard to best practices. Again, the leadership had their roles of enforcing those things.

So there is a difference, between guidelines I provide the same to both Chambers, operational aspects about how they function as unique bodies, and, last, enforcement was different between the House and the Senate, how the members chose to enforce these practices.

Chairman LOUDERMILK. So you provided the same guidance, both to the House and the Senate. Was the leadership of the House and the Senate and the House Sergeant at Arms consulted by your office at the same time?

Dr. MONAHAN. Yes, sequentially. So there were within—I can't talk to people on these conference calls all at once, but I would talk to them sequentially, go back and forth, share documents, ask for input, synthesize, go back another round, and it finally would come to a thing we could all agree upon.

Chairman LOUDERMILK. You—same guidance of the House, same guidance went to the Senate——

Dr. MONAHAN. Yes.

Chairman LOUDERMILK [continuing]. at the same time?

Okay.

Dr. MONAHAN. There's a slightly different forum—Mr. Chairman, one last thing I would say. We don't have communication tools to the entire organization. The Senate doesn't have a Dear E-Colleague letter or any kind of broadcast tool to communicate instruction. So I used a joint Senate leader letter written to both leaders.

The House has a tool called the Dear E-Colleague electronic distribution system, for which we don't have access. So you'll notice my first remarks in this regard come through the Sergeant at

Arms because we didn't have access to the system initially, but CHA subsequently changed that.

Chairman LOUDERMILK. Okay.

Well, my time has expired. Thank you for the very detailed answer. I think that was helpful.

I now recognize the ranking member, Mrs. Torres, for 5 minutes.

Mrs. TORRES. Thank you, Chairman.

Dr. Monahan, I think you've answered part of my first question, which is the House of Representatives has 441 Members who meet with scores of constituents every week, travel from every part of the country. We congregate on the House floor, in committee rooms. During votes, the entire House membership, along with some staff members, can be on the floor at the same time.

So how, if at all, did all of these characteristics impact the COVID–19 risk associated with in-person coverings?

Dr. MONAHAN. They would constitute the CDC predefined category as the very highest risk: the inside meeting of people at close proximity from different areas of the United States, some experiencing very high rates of COVID disease, others lower rates, but together, all at once, the highest risk.

Our members also have quite a few of the defined risk factors for predictive of bad outcomes, such as death or hospitalization, predominantly ailing to average age and other factors, such as their general health and some serious underlying health conditions, immunosuppression, et cetera.

Mrs. TORRES. The average age of our members of Congress in the 117th Congress was 58 years old. Many of our members are on some type of medication, high blood pressure, low blood pressure, whatnot. So all of these health risks was something that you looked into as you provided information and advice to the leadership of both Houses?

Dr. MONAHAN. That's correct. The Congress looks just like the American people, since that's where they're derived from, and they reflect variations of age, health, whether that's some are athletes. Some are suffering from metastatic cancer. Some are on chemotherapy. Some are immune suppressed. All of those together raise the risk.

My goal was to make the assemblage of people at the lowest possible risk. So I have to pay a lot of attention to those at the highest risk, that the organization keeps the entire group at the safest, like, status.

Mrs. TORRES. Thank you, Dr. Monahan.

I'm going to yield back.

Chairman LOUDERMILK. I thank the ranking member for returning the amount of time that I went over.

So, at this point, we're going to take a quick 5-minute hospitality break before our next round of questions. I ask members to please return promptly, as we need to continue going.

So this committee stands in recess, subject to the call of the chair, which will be about 5 minutes.

[Recess.]

Chairman LOUDERMILK. Thank you all. The Oversight Committee Subcommittee will come to order.

I now recognize Mr. Griffith for 5 minutes for the purpose of questioning our witness.

Mr. GRIFFITH. Dr. Monahan, thank you for being here. I greatly respect you as my physician and appreciate the Office of the Attending Physician serving the members of Congress and staff.

I understand your office is relatively autonomous, and I like that, and, in fact, I asked you about it one time when I was in visiting because I was concerned how could you give a good advice to the House and the Senate, the legislative branch, when you were, as a naval officer, subject to the orders of the Commander in Chief.

You explained to me that there was a different chain of command, that you weren't in the chain of command, and that the president couldn't give you orders, that it was the Senate and the House that gave you orders.

Can you give me some more information on that? The reason I ask is, in discussing that, as I joined this committee, several members said: That's not our understanding because we've been told several times on other issues—I don't remember what they were—that you were bound by naval guidelines, naval rules and regulations.

So can you help me explain that?

Dr. MONAHAN. Yes. It's a very unique situation. I'm an Active Duty naval officer. I follow all regulations and customs. I don't appear in uniform for you today, as I run a hybrid office of both military and civilian personnel and appear as the head of a congressional office or agency.

Mr. GRIFFITH. So, on medical issues related to the House and the Senate, are you subject to any naval regulations or to commands by the Commander in Chief?

Dr. MONAHAN. No. I work directly for the four joint leaders of the bicameral leadership of the legislative branch.

Mr. GRIFFITH. Alright. Let's talk about that.

You testified earlier that you spoke with about the COVID regulations—as time moved on, you spoke with both the majority leader in the—excuse me—the Speaker of the House and the minority leader of the House. Is that accurate?

Dr. MONAHAN. Yes.

Mr. GRIFFITH. About all the changes and what was going on with the guidelines, you spoke with them and took their advice?

Dr. MONAHAN. Yes. Many times in person with them and many times with their staffs.

Mr. GRIFFITH. Alright.

So, you know, you talked a little bit earlier about your process on all that, but there was a lot of consternation because of the two different decisions. Was that a decision that Kevin McCarthy participated in? Or was he just consulted or told what was happening? Is that something that, basically, then Speaker Nancy Pelosi dictated the difference that we have in the House and the Senate?

Dr. MONAHAN. I spoke with all parties. I listened intently to both the majority leader—I'm sorry, the Speaker of the House and the minority leader. It was impressed upon me that the House operates in a way that has a majority and minority, and when it comes to the operational based decision making, the majority interest prevailed.

Mr. GRIFFITH. I'm not fussing at you. I'm just trying to get the facts.

So this was Nancy Pelosi's decision to do all of that stuff based on your advice?

Dr. MONAHAN. I gave her advice, and then the execution came through the leadership of the House——

Mr. GRIFFITH. That would be Nancy Pelosi?

Dr. MONAHAN [continuing]. that——

Mr. GRIFFITH. That would be Nancy Pelosi.

Okay. So that brings up the question of swearing in 2021. We had a special goofy box up in the gallery.

Dr. MONAHAN. Oh, there's a Plexiglass——

Mr. GRIFFITH. The Plexiglass. It looked like one of those soundproof boxes on a game show.

So I'm asking you, was that your advice to do that?

Dr. MONAHAN. No. I was consulted before the start of the Congress——

Mr. GRIFFITH. You advised against it, didn't you?

Dr. MONAHAN. I saw it the first time you saw it. So I walked in, in the morning when the floor began, and there it was, the plexiglass assembly at the corner of the gallery.

Mr. GRIFFITH. That's not something you cooked up, and you never certified that as being safe, did you?

Dr. MONAHAN. Well, I was consulted on a range of things as to how could members come to the House floor, in a quarantine state, if that were necessary. At that time, the guidelines for quarantine were just as severe as isolation. So Members could be pulled out into isolation just by being within 6 feet for more than 15 minutes of a known positive case.

That changed later in the coronavirus to make things better, but at that time, at the start of the Congress, there was that issue.

So I was asked by the leadership office to say, is there a way someone in a quarantine position, if necessary, could fulfill their constitutional duties and cast their vote on the House floor? The constitutional duty thing held very strongly with the members, and on the first day of the Congress, I was told there was not a proxy kind of system; you had to be there in person to exercise your duties.

So, at that point, we said, is there a contingency way that we could have a way for a person who was COVID test negative at possible risk of disease but not, in fact, ill to be present in the House Chamber to cast their vote?

I replied: There may be a way to do that if we took advantage of a corner of the room with high-flow ventilation, if we took special precaution as to how the person entered the building, from the east front plaza through a surveyed route. I gave advice like that, but I didn't specify——

Mr. GRIFFITH. You may or may not be aware of this—and my time is running out, but isn't it true that there were some members who had been exposed and would later have the disease who came into the Capitol without going through any special thing? Now, they might have gone up to the booth, to the goofy booth, but they came into the Capitol and exposed everybody to COVID. And isn't

it true that several members of Congress came down with COVID shortly thereafter?

Dr. MONAHAN. Well, people could develop exposure through any route, through travel and meeting with their family——

Mr. GRIFFITH. I understand that. But yes or no, were there a lot of people who traveled through who probably should have been excluded or had special means to get in who just came in? Isn't that true?

Dr. MONAHAN. You could say that about any of the members, sir.

Mr. GRIFFITH. Alright.

Isn't it true that there was a small majority, and so the speaker did that because she wanted to make sure she had every vote on the floor?

Dr. MONAHAN. No one told me anything like that, sir.

Mr. GRIFFITH. Okay.

Dr. MONAHAN. This was a general discussion as to how——

Mr. GRIFFITH. Would you have recommended, if they had asked you about the special booth, that maybe you would have two or three special booths in the gallery so that you didn't have people exposed to other people who were in the booth?

Dr. MONAHAN. Only one person was allowed to be in the booth at one time. I wasn't given any contingencies as to the numbers that would be required.

Mr. GRIFFITH. Did they wipe the booth down in between a person going into the booth?

Dr. MONAHAN. Yes, the booth was cleansed between people there, and people in the booth had to wear a mask, and they had to be COVID test negative before they came.

Mr. GRIFFITH. Mr. Chairman, if you'll give me just—because I'm not going to be able to stay for the second round. If you'll give me just another minute.

So, when voting was taking place later, just a few days later, we were told we had to go up in the gallery. We couldn't stay on the floor in order to make objections if we wanted to make an objection to a parliamentary procedure—I was told this—because of the COVID regulations, and yet, on the day of the swearing in of the Speaker and the vote on the Speaker, none of that pertained. Isn't that correct?

Dr. MONAHAN. I don't know precisely that answer, sir. I know there's a difference between day one——

Mr. GRIFFITH. The answer is yes, but I understand you may not know it. I have to yield back because my time is up.

Thank you so much for being here today.

I yield back, Mr. Chairman.

Chairman LOUDERMILK. The gentleman yields back.

I now recognize Mr. Morelle for 5 minutes.

Mr. MORELLE. Thank you, Mr. Chairman.

Again, thank you, Admiral, for being here. I do want to—I'll admit I'm perplexed. I don't think I even understand the last set of questions. But I do know this, that on the day when there is a Speaker vote—and I think we experienced this, this year, several days of Speaker votes, there are no rules in the House. So you can't set up the procedures that we had already adopted for the previous Congress on the day that there is a Speaker vote. I think we all

understand that because we experienced it in a lengthier situation here today.

But and, just to be clear, I think—let me look at my numbers. But, in January 2021, the month in question, there were 7.1 million Americans who had reported that they had COVID. So the number of cases in the United States was 7.1 million, much higher than the previous month, much higher than the next month. 105,000 Americans died in the month of January.

So I'll just note that as a context for whatever decision was being made relative to trying to do the greatest, in my view, the greatest physical safety situation that you could have while you're compelling Members.

Obviously, in the previous Congress, we were—you know, there was an ability to vote remotely, and there were different ways of addressing. I think we were voting remotely even then.

But then, when we come back on January 4, the organizing of the House, that's when the problem was because you couldn't continue the existing rules until you adopted the rules package again. So I just make that point. I don't need—unless you want to comment on it, but I think that's what was happening at that moment.

Dr. MONAHAN. That's correct, sir. There was this technical issue of the first day of the Congress, you need to have the members to vote on a rule package.

Mr. MORELLE. Alright.

Just out of curiosity, do you know, did anybody keep track of whether more Democrats or Republicans utilized the plexiglass structure?

Dr. MONAHAN. Several of each did, sir.

Mr. MORELLE. I beg your pardon?

Dr. MONAHAN. I would say about equal numbers did.

Mr. MORELLE. Equal numbers?

Mr. MORELLE. Republicans and Democrats.

Mr. MORELLE. Okay. So it's not as though only Democrats availed themselves of it?

Dr. MONAHAN. I looked at it as a way for people to exercise their constitutional duty on the first day of the Congress, as a way to—how can we accommodate that? I thought it was a reasonable and safe thing for the members and did not increase the risk to the larger collective.

Mr. MORELLE. Yes, I guess I look at it the same way, Admiral, and I appreciate your comments. I don't think there is anything insidious about it. I think to your point, we're trying to make sure that people were safe who had been exposed and trying to make sure that people could and should, because they are representing 700,000 constituents each, that those constituents have their voices represented by folks before the House could pass rules, which, as we learned this year, you can't pass rules if you're not even really a sworn member until the Speaker's vote has been successfully concluded.

Just a couple—and I only have a couple minutes, so I'll do these quickly.

In June 2020, your office issued guidance that included a requirement that face coverings be used during meetings in an en-

closed space for more than 15 minutes. Do you know was that guidance in line with the guidance established by the CDC?

Dr. MONAHAN. Yes, sir. It was the exact guidance.

Mr. MORELLE. The CDC, I just note parenthetically, in June 2020, would have been an appointee of at the time President Trump.

Dr. MONAHAN. Yes, sir.

Mr. MORELLE. The following month, in July, the House implemented a requirement that all individuals entering House Office Buildings or the House Chamber wear a face covering. Was that consistent with CDC guidelines?

Dr. MONAHAN. Yes, it was, sir.

Mr. MORELLE. The next major change to House policy on masking was in May 2021. At that time, guidance changed to eliminate the requirement that fully vaccinated individuals wear face coverings in the House and after the floor staff was fully vaccinated in the House Chamber. Was this change consistent with CDC guidance?

Dr. MONAHAN. Yes, sir, it was.

Mr. MORELLE. In July 2021, the Delta variant became widespread. I understand that variant was more contagious than prior strains. Is that true, sir?

Dr. MONAHAN. That's correct.

Mr. MORELLE. Was the face covering requirement reinstated at that time?

Dr. MONAHAN. Yes. The Director of the CDC issued like an urgent declaration on or about the 27th of July to make—to reinstitute mask wear for the vaccinated, a dramatic reversal of that practice from the preceding 2 months.

Mr. MORELLE. Again, I would note that at that time, the then ranking Republican member of this committee wrote an op-ed in The Washington Examiner demanding the Capitol be reopened. He also sent a Dear Colleague letter to the Republican Conference stating that the reinstitution of the mask in the House was not grounded in science and accused Speaker Pelosi of being authoritarian.

Can you just describe, was reinstituting the face covering justified in your mind and in line with the CDC guideline?

Dr. MONAHAN. It was, sir. You could look back at the time that I think about the crisis in coronavirus communications; the worse possible days were beginning on the 27th of July through the 30th of July based upon the CDC's growing concern for the American people of risk of reinfection if vaccinated with the new emerging Delta variant virus.

They had evidence about that for the preceding weeks, and a case cluster began developing in the city of Provincetown, Massachusetts. That scared them that that was actually happening, that people who were vaccinated could acquire the virus. It would grow in their nostrils and nose up to a high level and spread to other people. They had evidence of that. They moved forward with that.

There were some drafting errors in the guidance and some misstatements that a reasonable person could look at very intently and suddenly wonder, was science being arbitrary, or was this really some other process taking place that wasn't scientific?

So I would have to say that I don't know anything about authoritarianism. I never experienced that from my talking with any of the leadership, but I have to say that a reasonable person would take a lot of issue with the way science showed itself through these communications from 27 July through the 30th of July of that year.

Mr. MORELLE. I thank the chair for allowing the admiral to answer that question.

I yield back.

Chairman LOUDERMILK. The gentleman yields.

The chair now recognizes Mr. D'Esposito for 5 minutes.

Mr. D'Esposito. Thank you. Thank you, Chairman.

Admiral, thank you for your service to this nation.

On July 27th, 2021, your office issued guidance that mandated mask usage for the House, clearly stating, in quotes, to be clear, for meetings in an enclosed U.S. House of Representatives' controlled space, masks are required, end quote, but only recommended that masks should be worn in the Senate. Why?

Dr. MONAHAN. The House choose to enforce the recommendation—I gave the same guidance to both Chambers. The Senate would not consider requirements. The House leadership, through the majority mechanism, made it a requirement that they would. I agreed with that.

My goal was that it was necessary for people to wear a mask in inside spaces. The House had a requirement because they had a enforcement mechanism for that purpose.

Mr. D'Esposito. Okay.

So you've been the attending physician for over a decade, correct?

Dr. MONAHAN. Yes, sir.

Mr. D'Esposito. Now has it ever been normal in the past where the House and the Senate would take your guidance and decide on it on an individual basis?

Dr. MONAHAN. That's their operating posture. People commonly—each Chamber preserves their prerogatives to act, and sometimes there's variations every day, but in most—in serious health guidance, there generally is not.

Mr. D'Esposito. Alright.

What does the current state of COVID testing and treatment look like on campus? Do you think it's currently running effectively and efficiently?

Dr. MONAHAN. Yes. We have the most efficient, high-quality testing system in the nation. It's running very efficiently. But the need is diminishing. Like, as in the most recent couple of days, we've had zero positive cases.

Mr. D'Esposito. That's a good thing.

Dr. MONAHAN. Eventually our testing program will sunset as we head into May of this year.

Mr. D'Esposito. What makes it the most effective testing procedure in the nation?

Dr. MONAHAN. Its accuracy, its speed, and its return of results to the individual in a timely enough basis to make a change in their behavior, to limit spread in their families and limit spread in their colleagues.

Mr. D'Esposito. Alright. Thank you.

Thank you, Chairman. I yield back.

Chairman LOUDERMILK. The gentleman yields.

The chair now recognizes Mr. Kilmer for 5 minutes.

Mr. KILMER. Thank you, Chairman.

Thanks, Admiral, for being with us. I appreciate the work you and your team do.

I'm actually just curious what sort of lessons were learned. You know, God willing, we don't have another pandemic, but we sure might. Any key lessons that——

Dr. MONAHAN. I'd say the No. 1 lesson is humility in the face of uncertainty, and this virus changed, its variant viruses and its threat to people, its response to our vaccines, the development of vaccines. So constant change, humility, and I think communications are the single greatest lessons about this issue.

You can't have better—you can't have good enough communications with this. That's a really powerful thing that led to a lot of our issues. My suggestions were based primarily upon having a communications mechanism to get the word out to people in a way that was nonpartisan and equally distributed.

Mr. KILMER. I'm just curious if you feel like, as an institution, we're adequately prepared, just from a continuity of operations standpoint, should something like this happen again? Obviously, this was unprecedented and felt a little like—I think in part because we were—sort of making it up on the fly. Anything the institution should do just from a continuity of operations standpoint?

Dr. MONAHAN. Well, there are several things that would be helpful such as, No. 1, prepositioning of supplies; developing supply chains that don't depend on a single vendor in a foreign country, for instance, that would help. Also, communication with executive branch agencies, legislative efforts that Congress can undertake that would help my office forge those crucial links early in the course of the pandemic, rather than have to negotiate them on an ad hoc basis through great labor every single time.

Mr. KILMER. The only other thing I wanted to ask—and I really appreciated that, even in the midst of the pandemic, you and your team sent a letter to the Select Committee on the Modernization of Congress saying: Here are some areas where we could modernize the operations of the OAP and how Congress can better engage when we have a pandemic like this. I'm just curious if there's any update on OAP's modernization efforts and anything this committee can do to help?

Dr. MONAHAN. Yes, sir. I think in my written comments I'll give you several suggestions along those lines. We currently have incorporated many of our lessons as far as how we lean forward for testing selection, how we've come to work very closely with very great professionals here in the Congress, the Office of the Chief Administrative Officer, the Clerk of the House, the Architect of the Capitol's Office. I had the privilege to work with many, both skilled and gracious people and staffs throughout the House and Senate in this work.

Mr. KILMER. Super. Chairman, I yield back. Thank you again, Admiral.

Chairman LOUDERMILK. The gentleman yields.

I now recognize the chairman of the full Committee, Mr. Steil for 5 minutes.

The CHAIRMAN. Thank you very much, Mr. Chairman.

Thank you very much for being here, Dr. Monahan. Again, please express to your broader team our appreciation for how hard they often work on our behalf, in particular during a really difficult period of time throughout the COVID pandemic. I know a lot of members on your team really stepped up, and so, if you would, share my appreciation for the work that they do day in and day out for this institution.

I want to go back to, kind of, COVID guidance. There's a lot of frustration—some lingering frustration amongst folks and see if I got this correct. I was going to ask you if there was inconsistencies in your guidance, but I think what you have actually told us is that your guidance to both Chambers was consistent, but the implementation of your consistent guidance was inconsistent. Not trying to make a joke there, but your guidance was consistent to the Chambers. They implemented it differently; is that right?

Dr. MONAHAN. That's correct, sir.

The CHAIRMAN. Did you ever feel political pressure in the drafting and preparation of your guidance?

Dr. MONAHAN. I was subject to the full diversity of views that I appreciated, and incorporated those. Some would call it pressure; I would just call it opportunities to listen more closely.

The CHAIRMAN. So you were engaged in dialog—people—folks from both sides of the aisle, both sides of the Capitol, in the process while you were developing that guidance. Is that a fair assessment?

Dr. MONAHAN. That's correct, sir. Yes.

The CHAIRMAN. Okay. At any point, did you get into discussions of potential quarantine of members?

Dr. MONAHAN. Yes, sir, I did. There were CDC guidelines that affected quarantine recommendations to general Americans, and that would apply to members of congress and our staff, et cetera, and we had those discussions.

The CHAIRMAN. Did the Speaker's Office advise you ever not to use the term "quarantine"?

Dr. MONAHAN. Never. They never altered my language or made language suggestions.

The CHAIRMAN. Say that again. I apologize.

Dr. MONAHAN. They did not alter my language or make language suggestions.

The CHAIRMAN. So you were in dialog with the speaker's office, probably with the Senate side as well regarding the guidance, but they did not alter any of the text or language?

Dr. MONAHAN. No. We had a lot of debates, and it's, you know, trying to always draft a better document, more clear, et cetera.

The CHAIRMAN. Okay. So, at the end of the day, your guidance issued during COVID across the House was your guidance, but the Speaker's Office put forward the guidelines with which were the rules of the House?

Dr. MONAHAN. That's correct, sir, how they enforced at various times.

The CHAIRMAN. Okay. If I can go back—I know Mr. Griffith was asking you a question particularly as it relates to January 3d of

2021. So I'm going to take us back just over 2 years. As you may recall, that day we were in the middle of the pandemic. My colleagues on the other side of the aisle had a close Speaker's vote. We can now relate on our side of the aisle on the broader challenges to get folks across the line, but in that is we arrived into the Capitol Chamber, there's what I call the penalty box, for lack of a better term, kind of a Plexiglass area in the House Chamber. As you're standing at the dais looking out, it would be to your upper right.

Were you involved in recommendations that would be medically advised to have people behind plexiglass?

Dr. MONAHAN. Yes. I discussed the general concept of how could a person in a quarantine status who was diseased negative come to the floor and a cast their vote. I said: Well, there's a way we could devise such a thing.

But I didn't specify dimensions, materials, and the fabrication, et cetera.

The CHAIRMAN. You gave general, kind of, guidance and ideas of how something may be implemented, which is probably within your medical realm?

Dr. MONAHAN. Yes, sir.

The CHAIRMAN. But the actual decision making implementation was that of the Speaker's Office?

Dr. MONAHAN. Yes, sir.

The CHAIRMAN. So the first time you saw it, you came in, like maybe we all did, on January 3d, 2021?

Dr. MONAHAN. I was impressed of the quality of the workmanship. I said, wow, I couldn't have done that as good.

The CHAIRMAN. That location was for members that tested negative but were in a quarantine. Was that your recommendation?

Dr. MONAHAN. That was for members who were in a quarantine status due to exposure who felt well, who would test negative, and I specified they had to enter the Capitol through a surveyed route, free of contact with other people, exit the same route and maintain that just with appearance in that gallery and then leave.

The CHAIRMAN. Did you offer any advice for any member that potentially tested positive?

Dr. MONAHAN. Yes. I told them not to—I told them they should follow the CDC guidelines and remain in isolation in their homes and not report to the Congress.

The CHAIRMAN. Do you know if people followed that advice?

Dr. MONAHAN. Yes, sir. I believe every time it came to that, I would have extensive dialogs with the members, and each time, the member of Congress would generally follow my advice. I was very impressed with their dedication to support the CDC guidelines.

The CHAIRMAN. Thank you very much. I don't have further questions, just again, really appreciate you taking the time here. I know how much work and effort goes into your broader office, and appreciate your testimony. I yield back.

Chairman LOUDERMILK. Thank you, Mr. Chair. I now recognize the other physician in the room, Dr. Murphy for 5 minutes—ish.

Mr. MURPHY. Ish, give or take.

Thank you, Mr. Chairman. Thank you, Dr. Monahan. Nice to see you again. I appreciated our discussion the other day. I hope that

calmed your fears about what this interrogation and meeting was going to be about. We're not here to scare anybody.

I do think it's important that we ask hard questions. The status and the trust in the American medical system has been decimated, absolutely decimated, because of the partisanship that we saw during the pandemic. It was—it's terrible, and sadly enough, I'm just going to say the perception was that, either by coercion or participation, there was thought to be some partisanship seen in the House Physician's Office by some of these actions.

I'm just going to drill down a little bit on this Plexiglass thing because I was absolutely blown away by it. Do you think that was appropriate to bring someone in on an airplane? At that time, we didn't know about transmissibility, whether if you were COVID positive, COVID negative, whether you were infectious, not infectious or what. Do you as a physician talking to another physician think that was an appropriate action?

Dr. MONAHAN. For people in quarantine, they should not travel on airplanes and commercial transport. I wouldn't——

Mr. MURPHY. So the answer's no?

Dr. MONAHAN. Could you repeat the question again, sir?

Mr. MURPHY. Do you think the actions taken by the Speaker at that point in time to have someone who had just had COVID, whether they tested positive or not—I have a little bit of question as to whether that was—do you think it was appropriate, given your medical opinion and the standard of care that that person—transporter went on an airport, went through an airport, came through the House Chamber, and went up into that Plexiglass room; do you think that was an appropriate action?

Dr. MONAHAN. Theoretically, sir, I would say no. I was not aware of that scenario that you describe occurring.

Mr. MURPHY. Yes. I would say no in my medical opinion, and I would do that in a court of law. I thought it was absolutely inappropriate. This, again, shows to the partisanship that we saw, bending the rules in COVID that was seen in so many different areas.

You said you relied on the CDC a lot. Did you ever speak personally with Dr. Fauci about any of this?

Dr. MONAHAN. I talked to him perhaps three times over the 3 years, sir.

Mr. MURPHY. His recommendations at certain points were what? Do you recall?

Dr. MONAHAN. Well, mostly just to reinforce existing CDC guidelines. He didn't share with me any insight more than was in the guidelines.

Mr. MURPHY. Okay. He is a quite polarizing figure, and I think personally—and I'll say this from a physician standpoint—done more to undermine distrust in our medical system than any other person in medical history, but that's a different aside.

In your office, can you tell us a little bit about how you are able to access specialty care for individuals, patients who need it?

Dr. MONAHAN. Yes, sir. Members of Congress have multiple options here in the Washington, DC, region. We have a large number of specialists, university medical centers, military medical centers, civilian practices. I try to find the best possible consulting available

for the member based on my understanding of this community and what the members' needs are. Members can avail themselves through their health insurance fee-for-service deductibles with any specialist in this area that I arrange. They also have the option to seek medical care at one of our local military centers without charge.

Mr. MURPHY. Alright. Well, thank you. I don't want to beat a dead horse because I think a lot of the questions previously—it's obvious that the House Physician's Office is deeply appreciated, hopefully never needed as far as in a time—emergency. I was quite—I don't want to say alarmed—but just surprised that you guys have such a large carriage area for anything that would happen in a large area.

Do you have folks that are trauma trained?

Dr. MONAHAN. Yes, sir. I have an emergency medicine physician who's trained for all kinds of trauma responses. I have emergency medicine technicians who are trained in trauma response, patient transport, et cetera.

Mr. MURPHY. They're here just when the House is in session or the Senate's in session?

Dr. MONAHAN. No, sir. They're here throughout business hours and when the House and Senate are in session.

Mr. MURPHY. Okay. I'll ask one last question. This is somewhat of a personal one. I'm a board certified, still practicing, urologist. I had a conversation with you a couple months ago about being able to maybe just use a room because I had a congressional colleague ask me for an expert opinion about something. You were reluctant to allow that at that point in time. I hope we can get individually to a point where the answer would be yes. We have 19 medical professionals in this building, and sometimes expertise, since you don't have specialty care and it would be referred out, would be of interest and in the best interest of members of Congress. So I hope you and I offline can come to some type of agreement where that expertise could be given to our fellow Members.

Dr. MONAHAN. I'd like to get to yes, sir.

Mr. MURPHY. Alright.

Thank you, Mr. Chairman. I have no further questions.

Chairman LOUDERMILK. Thank you, doctor.

Thank you, Dr. Monahan.

At this point, we'll proceed into the second round of questions, and I'm going to defer to the Ranking Member, Mrs. Torres, for 5 minutes.

Mrs. TORRES. Thank you, Chairman.

I would like to start by, Mr. Chairman, I ask unanimous consent to enter into the record the following documents; June 20th—I'm sorry—June 2020 guidance from the CDC entitled "Considerations for Events and Gatherings"; July 2021 guidance from the CDC entitled "Science Brief: COVID–19 Vaccines and Vaccination," which informed the Office of Attending Physician's guidance to the congressional community; and February 2022 transcript of the CDC media telebriefing on COVID–19.

Chairman LOUDERMILK. Alright. Without objection.

[The information referred to follows:]

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Coronavirus Disease 2019 (COVID-19)

Considerations for Events and Gatherings

As some communities in the United States begin to plan and hold events and gatherings, the CDC offers the following considerations for enhancing protection of individuals and communities and preventing spread of coronavirus disease 2019 (COVID-19). Event planners and officials can determine, in collaboration with state and local health officials, whether and how to implement these considerations, making adjustments to meet the unique needs and circumstances of the local community. Because COVID-19 virus circulation varies in communities, these considerations are meant to supplement—**not replace**—any state, local, territorial, or tribal health and safety laws, rules, and regulations with which gatherings must comply. Organizers should continue to assess, based on current conditions, whether to postpone, cancel, or significantly reduce the number of attendees for gatherings.

Guiding Principles

- A gathering refers to a planned or spontaneous event, indoors or outdoors, with a small number of people participating or a large number of people in attendance such as a community event or gathering, concert, festival, conference, parade, wedding, or sporting event.
- The *more people* an individual interacts with at a gathering and the longer that interaction lasts, the higher the potential risk of becoming infected with COVID-19 and COVID-19 spreading.
- The *higher the level of community transmission* in the area that the gathering is being held, the higher the risk of COVID-19 spreading during a gathering.
- The size of an event or gathering should be determined based on state, local, territorial or tribal safety laws and regulations.

The risk of COVID-19 spreading at events and gatherings increases as follows:

Lowest risk: Virtual-only activities, events, and gatherings.

More risk: Smaller outdoor and in-person gatherings in which individuals from different households remain spaced at least 6 feet apart, wear cloth face coverings, do not share objects, and come from the same local area (e.g., community, town, city, or county).

Higher risk: Medium-sized in-person gatherings that are adapted to allow individuals to remain spaced at least 6 feet apart and with attendees coming from outside the local area.

Highest risk: Large in-person gatherings where it is difficult for individuals to remain spaced at least 6 feet apart and attendees travel from outside the local area.

Targeting COVID-19's spread

SARS-CoV-2, the virus that causes COVID-19, is thought to be mostly spread by respiratory droplets released when people talk, cough, or sneeze. It is thought that the virus may also spread to hands from a contaminated surface and then to the nose, mouth or eyes, causing infection. Therefore, personal prevention practices (such as handwashing, staying home when sick, maintaining 6 feet of distance, and wearing a cloth face covering) and environmental prevention practices (such as cleaning and disinfection) are important ways to prevent the virus's spread.

These prevention principles are covered in this document. They provide event planners and individuals with actions to help lower the risk of COVID-19 exposure and spread during gatherings and events.

Promoting Healthy Behaviors that Reduce Spread

Event planners should consider implementing strategies to encourage behaviors that reduce the spread of COVID-19 among staff and attendees.

- **Staying Home when Appropriate**
  - Educate staff and attendees about when they should stay home.
    - Advise employees and attendees to stay home if they have tested positive for COVID-19 or are showing COVID-19 symptoms.
    - Advise employees and attendees to stay home and monitor their health if they have had a close contact with a person who has symptoms of COVID-19 within the past 14 days.
    - Develop policies that encourage sick employees to stay at home without fear of reprisal, and ensure employees are aware of these policies.
    - CDC's criteria can help inform when employees should return to work:
      - If they have been sick with COVID-19
      - If they tested positive for COVID-19 but had no symptoms
      - If they have recently had a close contact with a person with COVID-19
    - Consider developing flexible refund policies for attendees for events that involve a participation fee.

- **Hand Hygieneand Respiratory Etiquette**
  - Require frequent employee handwashing (e.g., before, during, and after taking tickets; after touching garbage) with soap and water for at least 20 seconds and increase monitoring to ensure adherence.
  - If soap and water are not readily available, employees can use hand sanitizer that contains at least 60% alcohol and rub their hands until dry.
  - Encourage staff to cover the mouth and nose with a tissue when coughing and sneezing. Used tissues should be thrown in the trash and hands washed immediately with soap and water for at least 20 seconds.
  - Encourage attendees to wash hands often and cover coughs and sneezes.
  - Attendees often exchange handshakes, fist bumps, and high-fives at meetings and sporting events. Display signs (physical and/or electronic) that discourage these actions during the event.

- **Cloth Face Coverings**
  - Require the use of cloth face coverings among staff. Cloth face coverings are **most** essential in times when physical distancing is difficult (e.g., when moving within a crowd or audience).
  - Provide all staff with information on proper use, removal, and washing of cloth face coverings.
  - Advise staff that cloth face coverings should **not** be placed on:
    - Babies or children younger than 2 years old
    - Anyone who has trouble breathing

        - Anyone who is unconscious, incapacitated, or otherwise unable to remove the cloth face covering without assistance
    - Encourage attendees ahead of the event to bring and use cloth face coverings at the event.
    - Cloth face coverings are meant to protect other people in case the wearer is unknowingly infected but does not have symptoms. Cloth face coverings are not surgical masks or respirators. They are not personal protective equipment.
    - Cloth face coverings are strongly encouraged in settings where individuals might raise their voice (e.g., shouting, chanting, singing).

- **Adequate Supplies**
    - Ensure adequate supplies to support healthy hygiene behaviors. Supplies include soap, water, hand sanitizer containing at least 60 percent alcohol, paper towels, tissues, disinfectant wipes, cloth face coverings (as feasible), and no-touch trash cans.

- **Signs and Messages**
    - Post signs in highly visible locations (e.g., at entrances, in restrooms) that promote everyday protective measures and describe how to stop the spread of germs by properly washing handsand properly wearing a cloth face covering .
    - Broadcast regular announcements on reducing the spread of COVID-19 on public address systems.
    - Include messages (for example, videos) about behaviors that prevent spread of COVID-19 when communicating with staff, vendors, and attendees (such as on the event website and through event social media accounts).
    - Consider developing signs and messages in alternative formats (e.g., large print, braille, American Sign Language) for people who have limited vision or are blind or people who are deaf or hard of hearing.
    - Find freely available CDC print and digital resources about COVID-19 on CDC's communications resources main page.

Maintaining Healthy Environments

Event planners should consider implementing several strategies to maintain healthy environments.

- **Cleaning and Disinfection**
    - Clean and disinfect frequently touched surfaces within the venue at least daily or between uses as much as possible—for example, door handles, sink handles, drinking fountains, grab bars, hand railings, and cash registers.
    - Clean and disinfect shared objects between uses—for example, payment terminals, tables, countertops, bars, and condiment holders.
    - Consider closing areas such as drinking fountains that cannot be adequately cleaned and disinfected during an event.
    - Develop a schedule for increased, routine cleaning and disinfection.
    - Plan for and enact these cleaning routines when renting event space and ensure that other groups who may use your facilities follow these routines.
    - If transport vehicles like buses are used by the event staff, drivers should practice all safety actions and protocols as indicated for other staff—for example, washing hands often and wearing cloth face coverings and maintaining social distance of bus riders. To clean and disinfect event buses, vans, or other vehicles see guidance for bus transit operators and drivers for hire, and adapt as needed.
    - Ensure safe and correct use and storage of cleaners and disinfectants to avoid harm to employees and

other individuals. Always read and follow label instructions for each product, and store products securely away from children.

- Use EPA-approved disinfectants against COVID-19 .
- Cleaning products should not be used near children. Staff should ensure that there is adequate ventilation when using these products to prevent attendees or themselves from inhaling toxic vapors.
- Use disposable gloves when removing garbage bags or handling and disposing of trash.
  - After using disposable gloves, throw them out in a lined trash can.
  - Do not disinfect or reuse the gloves.
  - Wash hands after removing gloves.

- **Restrooms**
  - Consider limiting the number of people who occupy the restroom at one time to allow for social distancing.
  - Do not allow lines or crowds to form near the restroom without maintaining a distance of at least 6 feet from other people. It may be helpful to post signs or markers to help attendees maintain the appropriate social distance of at least 6 feet.
  - Ensure that open restrooms are:
    - Operational with functional toilets.
    - Cleaned and disinfected regularly, particularly high-touch surfaces such as faucets, toilets, stall doors, doorknobs, countertops, diaper changing tables, and light switches.
      - Clean and disinfect restrooms daily or more often, if possible, with EPA-approved disinfectants against COVID-19.
      - Ensure safe and correct application of disinfectants and keep products away from children.
    - Adequately stocked with supplies for handwashing, including soap and water or hand sanitizer with at least 60% alcohol (for staff and older children who can safely use hand sanitizer), paper towels, tissues, and no-touch trash cans.
      - If you are providing portable toilets, also provide portable handwashing stations and ensure that they remain stocked throughout the duration of the event. If possible, provide hand sanitizer stations that are touch-free.

- **Ventilation**
  - Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible, for example, by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk to staff or attendees (e.g., risk of falling or triggering asthma symptoms).
  - If portable ventilation equipment like fans are used, take steps to minimize air from them blowing from one person directly at another person to reduce the potential spread of any airborne or aerosolized viruses.

- **Water Systems**
  - To minimize the risk of Legionnaires' disease and other diseases associated with water, take steps to ensure that all water systems and features (e.g., sink faucets, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown. Drinking fountains should be cleaned and sanitized, but encourage staff and attendees to bring their own water, as feasible, to minimize touching and use of water fountains.

- **Modified Layouts**
  - Limit attendance or seating capacity to allow for social distancing, or host smaller events in larger rooms.
  - Use multiple entrances and exits and discourage crowded waiting areas.

- Block off rows or sections of seating in order to space people at least 6 feet apart.
- Eliminate lines or queues if possible or encourage people to stay at least 6 feet apart by providing signs or other visual cues such as tape or chalk marks.
- Prioritize outdoor activities where social distancing can be maintained as much as possible.
- Offer online attendance options in addition to in-person attendance to help reduce the number of attendees.

- **Physical Barriers and Guides**
  - Provide physical guides, such as tape on floors or sidewalks and signs on walls, to ensure that individuals remain at least 6 feet apart in lines and at other times (e.g., guides for creating one-way routes).
  - Install physical barriers, such as sneeze guards and partitions, in areas where it is difficult for individuals to remain at least 6 feet apart. Barriers can be useful at cash registers and other areas where maintaining physical distance of 6 feet is difficult.
  - Change seating layout or availability of seating so that people can remain least 6 feet apart.

- **Communal Spaces**
  - Stagger use of shared indoor spaces such as dining halls, game rooms, and lounges as much as possible and clean and disinfect them between uses.
  - Add physical barriers, such as plastic flexible screens, between bathroom sinks and beds, especially when they cannot be at least 6 feet apart.
  - Clean and disinfect bathrooms regularly (e.g., in the morning and evening or after times of heavy use) using EPA-registered disinfectants .
  - For more information on communal spaces in event housing (e.g., laundry rooms, shared bathrooms, and recreation areas) follow CDC's guidance for Shared or Congregate Housing.

- **Food Service**
  - There is no evidence that COVID-19 is spread by food. However, people sharing utensils and congregating around food service areas can pose a risk.
  - If the event includes food service, refer to CDC's COVID-19 considerations for restaurants and bars.
  - Use touchless payment options as much as possible, if available.
  - Ask customers and employees to exchange cash or card payments by placing them on a receipt tray or on the counter rather than by hand to avoid direct hand-to-hand contact.
  - Clean and disinfect frequently touched surfaces such as pens, counters, or hard surfaces between use and encourage patrons to use their own pens.
  - Provide physical guides, such as tape on floors or sidewalks and signs on walls, to ensure that individuals remain at least 6 feet apart when waiting in line to order or pick up.
  - If a cafeteria or group dining room is used, serve individually plated meals or grab-and-go options, and hold activities in separate areas.
  - Use disposable food service items including utensils and dishes. If disposable items are not feasible or desirable, ensure that all non-disposable food service items are handled with gloves and washed with dish soap and hot water or in a dishwasher.
  - Individuals should wash their handsafter removing their gloves or after directly handling used food service items.
  - Avoid offering any self-serve food or drink options, such as buffets, salad bars, and drink stations. Consider having pre-packaged boxes or bags for each attendee.

- **Shared Objects**
  - Discourage people from sharing items that are difficult to clean, sanitize, or disinfect.
  - Limit any sharing of food, tools, equipment, or supplies by staff members.
  - Ensure adequate supplies to minimize sharing of high-touch materials to the extent possible; otherwise, limit use of supplies and equipment to one group of staff members or attendees at a time, and clean and disinfect them between use.

Maintaining Healthy Operations

Event organizers and staff may consider implementing several strategies to maintain healthy operations.

- **Regulatory Awareness**
  - Be aware of local or state regulatory agency policies related to group gatherings to determine if events can be held.

- **Protections for Staff and Attendees who are at Higher Risk of Severe Illness from COVID-19**
  - Offer options for staff at higher risk for severe illness (including older adults and people of any age with underlying medical conditions) that limit their exposure risk. For example:
    - Offer telework and modified job responsibilities for staff, such as setting up for the event rather than working at the registration desk.
    - Replace in-person meetings with video- or tele-conference calls whenever possible.
  - As feasible, offer options for attendees at higher risk for severe illness that limit their exposure risk (e.g., virtual attendance).
  - Consider limiting event attendance to staff and guests who live in the local area (e.g., community, city, town, or county) to reduce risk of spreading the virus from areas with higher levels of COVID-19. If attendance is open to staff and guests from other communities, cities, town or counties, provide information to attendees so they can make an informed decision about participation.
  - Put policies in place to protect the privacy of people at higher risk for severe illness regarding their underlying medical conditions.

- **Limited, Staggered, or Rotated Shifts and Attendance Times**
  - Consider ways to significantly reduce the number of attendees.
  - Use flexible worksites (e.g., telework) and flexible work hours (e.g., staggered shifts) to help establish policies and practices for social distancing of 6 feet between employees, volunteers, and others.
  - Rotate or stagger shifts and arrival times to limit the number of employees in a venue at the same time.
  - Stagger and limit attendance times to minimize the number of guests at the venue.

- **Travel & Transit**
  - Encourage employees to use transportation options that minimize close contact with others (e.g., walking or biking, driving or riding by car – alone or with household members only). Consider offering the following support:
    - Ask employees to follow the CDC guidance on how to Protect Yourself When Using Transportation, including public transit.
    - Allow employees to shift their hours so they can commute during less busy times.
    - Ask employees to wash their hands as soon as possible after their trip.

- Reconfigure parking lots to limit congregation points and ensure proper separation of employees (e.g., closing every other parking space).
- Encourage rideshare drivers to clean and disinfect frequently touched surfaces in the vehicle and avoid providing pooled rides or picking up multiple passengers who would not otherwise be riding together on the same route.

- **Designated COVID-19 Point of Contact**
  - Designate an administrator or office to be responsible for responding to COVID-19 concerns. All staff and attendees should know who this person or office is and how to contact them.

- **Communication Systems**
  - Put systems in place to:
    - Encourage staff and attendees to self-report to event officials or a COVID-19 point of contact if they have symptoms of COVID-19, a positive test for COVID-19, or were exposed to someone with COVID-19 within the last 14 days, in accordance with health information sharing regulations for COVID-19 (e.g., see "Notify Health Officials and Close Contacts" in the **Preparing for When Someone Gets Sick section below**), and other applicable privacy and confidentiality laws and regulations.
    - Advise attendees prior to the event or gathering that they should not attend if they have symptoms of, a positive test for, or were recently exposed (within 14 days) to COVID-19.
    - Notify staff, attendees, and the public of cancellations and restrictions in place to limit people's exposure to COVID-19 (e.g., limited hours of operation).
    - Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information to event staff and participants. Tailor information so that it is easily understood by various audiences and is available in alternative formats and languages.
    - Learn more about reaching people of diverse languages and cultures by visiting: Know Your Audience. You also can learn more about communicating to staff in a crisis at: Crisis Communications Plan.

- **Leave (Time Off) Policies**
  - Implement flexible sick leave policies and practices that are not punitive and enable employees to stay home when they are sick, have been exposed, are caring for someone who is sick, or who must stay home with children if schools or child care centers are closed.
  - Examine and revise policies for leave, telework, and employee compensation as needed.
  - Ensure that any relevant policies are communicated to staff.

- **Back-Up Staffing Plan**
  - Monitor absenteeism of employees, cross-train staff, and create a roster of trained back-up staff.
  - Develop policies for return-to-work and event facilities after an employee has COVID-19. CDC's criteria to discontinue home isolation and quarantine can inform these policies.

- **Staff Training**
  - Train staff on all safety protocols. Consider using CDC's Interim Guidance for Businesses and Employers as a guide.
  - Conduct training virtually to ensure that social distancing is maintained during training.
  - If training needs to be done in person, maintain social distancing. Virtual training is clearly better for infection control when feasible.

- **Recognize Signs and Symptoms**

- If feasible, conduct daily health checks (e.g., temperature screening and/or symptom checking) of staff and attendees safely and respectfully, and in accordance with any applicable privacy laws and regulations.
- Event administrators may consider using examples of screening methods in CDC's General Business FAQs as a guide.

- **Sharing Facilities**
  - Encourage any organizations that share or use the same venue toalso follow these considerations and limit shared use, if possible.

- **Support Coping and Resilience**
  - Promote employees' ability to eat healthy foods, exercise, get enough sleep, and find time to unwind.
  - Encourage employees to talk with people they trust about their concerns and how they are feeling.
  - Consider posting signs for the national distress hotline: 1-800-985-5990, or text TalkWithUsto 66746; The National Domestic Violence Hotline: 1-800-799-7233 and TTY 1-800-787-3224; and The National Suicide Prevention Lifeline: 1-800-273-TALK (8255).

- **Lessons Learned After the Event**
  - Meet with the emergency operations coordinator or planning team for your venue to discuss and note lessons learned.
  - Determine ways to improve planning and implementation processes if the event will happen again.
  - Update your plans regularly according to the state and local situation and orders.

Preparing for When Someone Gets Sick

Event planners should consider several strategies to implement when someone gets sick.

- **Advise Sick Individuals of Home Isolation Criteria**
  - Communicate to sick staff members that they should not return to work until they have met CDC's criteria to discontinue home isolation.

- **Isolate and Transport Those Who are Sick**
  - Make sure that staff and attendees know that they should not come to the event and that they should notify event planners (e.g., the designated COVID-19 point of contact) if they become sick with COVID-19 symptoms, test positive for COVID-19, or have been exposed to someone with symptoms or a suspected or confirmed case.
  - Immediately separate staff and attendees with COVID-19 symptoms (e.g., fever, cough, shortness of breath) at the event. Individuals who are sick should go home or to a healthcare facility, depending on how severe their symptoms are, and follow CDC guidance for caring for themselves.
  - Individuals who have had close contact with a person who has symptoms should be separated, sent home, and advised to follow CDC guidance for community-related exposure (see "Notify Health Officials and Close Contacts" below). If symptoms develop, individuals should follow CDC guidance for caring for themselves.
  - Planners may follow CDC's Guidance for Shared or Congregate Housing for any staff who live in event housing.
  - Work with venue administrators, local officials, and healthcare providers to identify an isolation area to separate anyone who has COVID-like symptoms or who has tested positive but does not have symptoms. Event healthcare providers should use Standard and Transmission-Based Precautions when caring for sick people. See: What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible COVID-19 Infection.

- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility. If you are calling an ambulance or bringing someone to the hospital, call first to alert them that the person may have COVID-19.

- **Clean and Disinfect**
  - Close off areas used by a sick person and do not use these areas until after cleaning and disinfecting them (for outdoor areas, this includes surfaces or shared objects in the area, if applicable).
  - Wait at least 24 hours before cleaning and disinfecting. If 24 hours is not feasible, wait as long as possible. Ensure safe and correct use and storage of cleaning and disinfection products, including storing them securely away from children.

- **Notify Health Officials and Close Contacts**
  - In accordance with state and local laws and regulations, event planners should notify local health officials, staff, and attendees of any case of COVID-19 while maintaining confidentiality in accordance with the Americans with Disabilities Act (ADA) and other applicable laws and regulations.
  - Advise those who have had close contact with a person diagnosed with COVID-19 to stay home, self-monitor for symptoms, and follow CDC guidance if symptoms develop.

Other Resources

- Latest COVID-19 Information
- Cleaning and Disinfection
- Guidance for Businesses and Employers
- Guidance for Schools and Childcare Centers
- Guidance for Park Administrators
- Shared and Congregate Housing
- COVID-19 Prevention
- Handwashing Information
- Face Coverings
- Social Distancing
- COVID-19 Frequently Asked Questions:
- Persons at Higher Risk
- Managing Stress and Coping
- HIPAA and COVID-19
- CDC communication resources
- Community Mitigation
- Transportation
- Interim Guidance for Communities of Faith
- Crisis Communications Plan.
- Restaurants and bars
- Americans with Disabilities Act (ADA) and other applicable laws and regulations

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Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

COVID-19

Science Brief: COVID-19 Vaccines and Vaccination

Updated July 27, 2021 Print

Summary of Recent Changes

Last updated July 27, 2021

- Data were added from studies published since the last update that demonstrate currently authorized mRNA vaccines provide protection against variants of concern, including the Delta strain that is now predominant in the United States. Vaccine effectiveness against hospitalization and death is high for all current SARS-CoV-2 variants; emerging data suggest lower effectiveness against confirmed infection and symptomatic disease caused by the Beta, Gamma, and Delta variants compared with the ancestral strain and the Alpha variant.

Key Points

- All COVID-19 vaccines currently authorized in the United States are effective against COVID-19, including serious outcomes of severe disease, hospitalization, and death.
- Available evidence suggests the currently authorized mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna) are highly effective against hospitalization and death for a variety of strains, including Alpha (B.1.1.7), Beta (B.1.351), Gamma (P.1), and Delta (B.1.617.2); data suggest lower effectiveness against confirmed infection and symptomatic disease caused by the Beta, Gamma, and Delta variants compared with the ancestral strain and Alpha variant. Ongoing monitoring of vaccine effectiveness against variants is needed.
- A growing body of evidence indicates that people fully vaccinated with an mRNA vaccine (Pfizer-BioNTech or Moderna) are less likely than unvaccinated persons to

acquire SARS-CoV-2 or to transmit it to others. However, the risk for SARS-CoV-2 breakthrough infection in fully vaccinated people cannot be completely eliminated as long as there is continued community transmission of the virus.

- Studies are underway to learn more about the effectiveness of Johnson & Johnson/Janssen vaccine.
- At this time, there are limited data on vaccine effectiveness in people who are immunocompromised. People with immunocompromising conditions, including those taking immunosuppressive medications, should discuss the need for personal protective measures after vaccination with their healthcare provider.
- This updated science brief synthesizes the scientific evidence supporting CDC's guidance for fully vaccinated people and will continue to be updated as more information becomes available.

Background

COVID-19 vaccination is a critical prevention measure to help end the COVID-19 pandemic. COVID-19 vaccines are now widely available in the United States, and CDC recommends all people 12 years and older be vaccinated against COVID-19. Three COVID-19 vaccines are currently authorized by the U.S. Food and Drug Administration (FDA) for emergency use: two mRNA vaccines (Pfizer-BioNTech, Moderna) and one adenoviral vector vaccine (Johnson & Johnson/Janssen vaccine). People are considered fully vaccinated if they are ≥2 weeks following receipt of the second dose in a 2-dose series (mRNA vaccines), or ≥2 weeks following receipt of a single-dose vaccine (Johnson & Johnson/Janssen).*

Public health recommendations for people fully vaccinated with authorized COVID-19 vaccines must consider evidence of vaccine effectiveness against symptomatic and asymptomatic COVID-19, as well as vaccine impact on SARS-CoV-2 transmission. Other individual and societal factors are also important when evaluating the benefits and potential harms of additional prevention measures among vaccinated individuals. The Advisory Committee on Immunization Practices and CDC routinely consider factors such as population values, acceptability, and feasibility of implementation when making vaccine recommendations.[1] These factors were also considered when developing CDC's interim public health recommendations for fully vaccinated people.

In this scientific brief, we summarize evidence available through July 24, 2021, for the currently authorized COVID-19 vaccines (administered according to the recommended schedules) and additional considerations used to inform public health recommendations for fully vaccinated people, including:

- Vaccine efficacy and effectiveness against SARS-CoV-2 infection
- Vaccine performance against emerging SARS-CoV-2 variant viruses
- Impact of other prevention measures in the context of vaccination

Accumulating evidence indicates that fully vaccinated people without immunocompromising conditions are able to engage in most activities with low risk of acquiring or transmitting SARS-CoV-2. The benefits of avoiding disruptions such as unnecessary quarantine and social isolation might outweigh the low residual risk of becoming ill with COVID-19, generally with mild disease.

COVID-19 vaccine efficacy and effectiveness

Vaccine efficacy refers to how well a vaccine performs in a carefully controlled clinical trial, whereas effectiveness describes its performance in real-world observational studies. Evidence demonstrates that the authorized COVID-19 vaccines are both efficacious and effective against symptomatic, laboratory-confirmed COVID-19, including severe forms of the disease. In addition, a growing body of evidence suggests that mRNA COVID-19 vaccines also reduce asymptomatic infection and transmission. Substantial reductions in SARS-CoV-2 infections (both symptomatic and asymptomatic) will reduce overall levels of disease, and therefore, viral transmission in the United States. However, investigations are ongoing to assess further the risk of transmission from fully vaccinated persons with breakthrough infections.

Animal challenge studies

Rhesus macaque challenge studies provided the first evidence of the potential protective effects of Pfizer-BioNTech, Moderna, and Johnson & Johnson/Janssen COVID-19 vaccines against SARS-CoV-2 infection, including both symptomatic and asymptomatic infection. Vaccinated macaques developed neutralizing antibodies that exceeded those in human convalescent sera and showed no or minimal signs of clinical disease after SARS-CoV-2 challenge.[2-4] In addition, COVID-19 vaccination prevented or limited viral replication in the upper and lower respiratory tracts, which may have implications for transmission of the virus among humans.[2-4]

Vaccine efficacy from human clinical trials

Clinical trials subsequently demonstrated the authorized COVID-19 vaccines to be efficacious against laboratory-confirmed, symptomatic COVID-19 in adults, including severe forms of the disease, with evidence for protection against both symptomatic and asymptomatic SARS-CoV-2 infection [5-11] (**Box**). Recent trial data demonstrated 100% efficacy of the Pfizer-BioNTech vaccine against laboratory-confirmed, symptomatic COVID-19 in adolescents 12–15 years old, although this estimate was based on small numbers of cases.[12]

Box 1. Summary of vaccine efficacy estimates for authorized COVID-19 vaccines

All authorized COVID-19 vaccines demonstrated efficacy (range 65% to 95%) against symptomatic, laboratory-confirmed COVID-19 in adults ≥18 years.

- For each authorized COVID-19 vaccine, efficacy was demonstrated across different populations, including elderly and younger adults, in people with and without underlying health conditions, and in people representing different races and ethnicities.
- The Pfizer-BioNTech COVID-19 vaccine also demonstrated high efficacy against symptomatic, laboratory-confirmed COVID-19 in adolescents aged 12-17 years.

All authorized COVID-19 vaccines demonstrated high efficacy (≥89%) against COVID-19 severe enough to require hospitalization.

All authorized COVID-19 vaccines demonstrated high efficacy against COVID-19-associated death.

- In the clinical trials, no participants who received a COVID-19 vaccine died from COVID-19; the Moderna and Johnson & Johnson/Janssen trials among adults ≥18 years each had COVID-19 deaths in the unvaccinated placebo arm.

Preliminary data from the clinical trials among adults ≥18 years old suggest COVID-19 vaccination protects against symptomatic infection and may also protect against asymptomatic infection.

- In the Moderna trial, among people who had received a first dose, the number of asymptomatic people who tested positive for SARS-CoV-2 at their second-dose appointment was approximately 67% lower among vaccinees than among placebo recipients (0.1% and 0.3%, respectively)
- Efficacy of Johnson & Johnson/Janssen COVID-19 vaccine against asymptomatic infection was 74% in a subset of trial participants.

No trials have compared efficacy between any of the authorized vaccines in the same study population at the same time, making comparisons of efficacy difficult.

- All Phase 3 trials differed by calendar time and geography.
- Vaccines were tested in settings with different background COVID-19 incidence and circulating variants.

Real-world vaccine effectiveness

Multiple studies from the United States and other countries have demonstrated that a two-dose COVID-19 mRNA vaccination series is highly effective against SARS-CoV-2 infection (including both symptomatic and asymptomatic infections) caused by ancestral and variant strains and sequelae including severe disease, hospitalization, and death. Early evidence for the Johnson & Johnson/Janssen vaccine also demonstrates effectiveness against COVID-19 in real-world conditions.

Table 1a. Effectiveness of COVID-19 Vaccination Against SARS-CoV-2 Infection and Symptomatic Disease

Country	Population	Vaccine	Outcome	Vaccine Effectiveness*
United States[13]	General adult population	Pfizer-BioNTech or Moderna	SARS-CoV-2 infection	89%*[1]
United States[14]	General adult population	Pfizer-BioNTech or Moderna	SARS-CoV-2 infection	86%*[2]
United States[15]	General adult population	Pfizer-BioNTech or Moderna	Hospitalization	96%*[1]
United States[16]	Healthcare workers	Pfizer-BioNTech	SARS-CoV-2 infection	97%*[2]
		Moderna	SARS-CoV-2 infection	99%*[2]
United States[17]	Healthcare workers, first responders, and other essential and frontline workers	Pfizer-BioNTech or Moderna	SARS-CoV-2 infection	90%*[2]
United States[18]	Healthcare workers	Pfizer-BioNTech	SARS-CoV-2 infection	96%*[1]
United States[19]	Healthcare workers	Pfizer-BioNTech or Moderna	Symptomatic disease	94%*[1]
United States[20]	Healthcare workers and residents in a skilled nursing facility	Pfizer-BioNTech	Residents: symptomatic disease	87%*[2]

			Residents: hospitalization	94%*2
			Healthcare workers: symptomatic disease	87%*2
United States[21]	Hospitalized adults ≥65 years old	Pfizer-BioNTech or Moderna	Hospitalization	94%*2
United States[22]	Health system members ≥18 years old	Johnson & Johnson/Janssen	SARS-CoV-2 infection	77%*2
United Kingdom[23]	Healthcare workers	Pfizer-BioNTech or AstraZeneca	SARS-CoV-2 infection	90%*2
United Kingdom[24]	Healthcare workers	Pfizer-BioNTech	SARS-CoV-2 infection	86%*1
United Kingdom (Scotland)[25]	Healthcare workers	Pfizer-BioNTech or AstraZeneca	SARS-CoV-2 infection	92%*2
United Kingdom[26]	Adults aged ≥ 80 years, including those with multiple underlying conditions	Pfizer-BioNTech	Symptomatic disease	85%*2
Israel[27]	HMO members >16 years old	Pfizer-BioNTech	SARS-CoV-2 infection	89%*1
Israel[28]	Health system members	Pfizer-BioNTech	<60 years old: SARS-CoV-2 infection	93%*2
			≥60 years old: SARS-CoV-2 infection	92%*2
Israel[29]	General adult	Pfizer-BioNTech	SARS-CoV-2	92%*1

	population		infection	
			Symptomatic disease	94%*[1]
			Hospitalization	87%*[1]
			Severe disease	92%*[1]
Israel[30]	General population ≥16 years	Pfizer-BioNTech	SARS-CoV-2 infection	93%*[1]
			Hospitalization	94%*[1]
			Severe disease	94%*[1]
Israel[31]	General population ≥16 years	Pfizer-BioNTech	Symptomatic disease	97%*[1]
			Severe/critical disease	98%
			Hospitalization	97%
			Death	97%
Israel[32]	Healthcare workers	Pfizer-BioNTech	Symptomatic disease	97%*[1]
Israel[33]	Healthcare workers	Pfizer-BioNTech	Symptomatic disease	90%*[3]
Italy[34]	Healthcare workers	Pfizer-BioNTech	Symptomatic disease	95%*[1]
Denmark[35]	Long term care facility residents	Pfizer-BioNTech	SARS-CoV-2 infection	64%*[1]
	Long term care facility staff	Pfizer-BioNTech	SARS-CoV-2 infection	90%*[1]
Sweden[36]	General adult population	Pfizer-BioNTech	SARS-CoV-2 infection	86%*[1]

*Only studies including estimates of vaccine effectiveness ≥7 days following a completed vaccination series are included here. Studies examining multiple vaccines for which a single estimate of vaccine effectiveness is reported did not assess vaccine effectiveness by product type.

[1]≥7 days after second dose

[2]≥14 days after second dose

[3]≥11 days after second dose

In addition to the studies listed in Table 1a, further evidence of the impact of vaccination with Pfizer-BioNTech and Moderna COVID-19 vaccine has been demonstrated among healthcare workers, with major reductions in SARS-CoV-2 infections among those receiving two doses of COVID-19 vaccine even when community transmission was increasing. [37-39]

Table 1b. Effectiveness of COVID-19 Vaccination Against Asymptomatic SARS-CoV-2 Infection

Country	Population	Vaccine	Outcome	Vaccine effectiveness
United States[40]	General adult population	Pfizer-BioNTech or Moderna	Asymptomatic infection	80%*[1]
United States[18]	Healthcare workers	Pfizer-BioNTech	Asymptomatic infection	90%*[2]
Israel[31]	General adult population	Pfizer-BioNTech	Asymptomatic infection	92%*[2]
Israel[32]	Healthcare workers	Pfizer-BioNTech or AstraZeneca	Asymptomatic infection	86%*[2]
Israel[33]	Healthcare workers	Pfizer-BioNTech	Asymptomatic infection	65%*[3]

[1]≥0 days after second dose
[2]≥7 days after second dose
[3]≥11 days after second dose

Data from multiple studies in different countries suggest that people vaccinated with Pfizer-BioNTech COVID-19 vaccine who develop COVID-19 have a lower viral load than unvaccinated people.[41-44] This observation may indicate reduced transmissibility, as viral load has been identified as a key driver of transmission.[45] Two studies from the United Kingdom found significantly reduced likelihood of transmission to household contacts from people infected with SARS-CoV-2 who were previously vaccinated for COVID-19.[25, 46]

Vaccine effectiveness in immunosuppressed people

Evidence of reduced antibody response to or reduced immunogenicity of COVID-19 mRNA vaccination has been observed in the following groups: people taking certain immunosuppressive medications like rituximab [47-50] or mycophenolate [50-53], people with hematologic cancers [54, 55], and hemodialysis patients [56]. At this time, data on vaccine protection in people who are immunocompromised are limited; in addition, the impact of immune suppression on COVID-19 vaccine effectiveness may vary by condition.[55, 57] Complete data on which immunocompromising conditions might affect response to COVID-19 vaccination are not available; in addition, there is no established immune correlate of protection against SARS-CoV-2 so the risk of infection in people who respond incompletely to COVID-19 vaccination cannot be quantified using immunogenicity data. People with immunocompromising conditions, including those taking immunosuppressive medications, should discuss the need for personal protective measures after vaccination with their healthcare provider.

Emerging SARS-CoV-2 viral variants and vaccine performance

SARS-CoV-2 variants of concern (VOCs: Alpha (B.1.1.7), first detected in the United Kingdom; Beta (B.1.351), first detected in South Africa; Gamma (P.1), first detected in Japan/Brazil; and Delta (B.1.617.2), first detected in India) have emerged with mutations that alter the receptor binding domain of the spike protein and have a negative impact on vaccine effectiveness (notably the N501Y mutation occurring in Alpha, Beta and Gamma variants, the E484K and E417T/N mutations in Beta and Gamma, and the L452R mutation in Delta).[58]

Similar mutations also occur in SARS-CoV-2 variants of interest (VOIs: Epsilon (B.1.427/B.1.429), first detected in the United States-California; Iota (B.1.526), first detected in the United States-New York; Eta (B.1.525), first detected in the United Kingdom/Nigeria; and Kappa (B.1.617.1) and B.1.617.3, first detected in India)[58], but these variants currently have limited prevalence or expansion in the United States or other countries and still lack clear evidence of increased transmission, disease severity, or impact on available vaccines, therapeutics, or diagnostic tests.[58] Vaccine performance against emerging SARS-CoV-2 variants is an important consideration when evaluating the need for prevention measures in vaccinated people and will require continued monitoring. When evaluating risk, considering regional and local circulation of SARS-CoV-2 variants is also relevant; current data can be found on CDC's website.

Vaccine-induced neutralizing antibody activity

Sera from mRNA COVID-19 vaccine (both Pfizer-BioNTech and Moderna) recipients have demonstrated minimal to large reductions in antibody neutralization activity against a variety of mutations [59-126]; one related meta-analysis has been published [69]. Across studies of VOCs, the greatest reductions were observed for Beta, followed by Gamma and Delta; reductions for Alpha were minimal. A limited number of studies were available for some VOI that demonstrated greater reductions for Eta and Kappa, and minimal reductions for Epsilon and Iota. The E484K/Q and L452R mutations alone or in combination with other mutations in the receptor binding domain have been shown to account for the majority of reduction in vaccine-induced neutralizing antibody activity for the Beta, Gamma, and Delta variants.[71, 77, 91, 109, 112, 127, 128] Alpha and Iota variants with E484K mutations, which have been detected in the United Kingdom, United States, and other countries, have shown further reductions in neutralization above Alpha and Iota alone, respectively.[62, 68, 70, 71, 90, 114, 115, 118] For two-dose COVID-19 vaccines, multiple studies have shown greater neutralization against variants after the second dose (i.e. among fully vaccinated people) compared with the first dose (partially vaccinated).[59, 71, 72, 77, 78, 86, 99, 103, 105-107, 119, 129]

Two studies have shown that six months after receiving the Moderna vaccine, higher proportions of people had undetectable neutralization activity against Beta and Gamma compared with the ancestral strain.[130, 131] However, a recent study showed that people who received the Johnson & Johnson/Janssen vaccine had minimal decline in neutralizing titers against Beta, Gamma, and Delta at 8 months post-vaccination and that there was evidence of expanded breadth of neutralizing antibody response against variants over this time period, likely through B cell maturation.[64] Another study comparing antibody responses to different vaccines at 2.5–3 months post-vaccination showed comparatively lower neutralizing titers against Beta and Delta for Johnson & Johnson/Janssen (an adenovirus vector vaccine) compared with the mRNA vaccines.[132] More evidence is still needed in this area, including understanding potential differences in the kinetics of immune response related to different vaccine platforms.

Robust correlation has been demonstrated between vaccine efficacy and neutralizing antibody levels induced by different vaccines.[133, 134] Based on evidence from clinical trials, the correlate of protection, or antibody threshold providing protection against severe disease, has been estimated to be much lower and less likely to be affected by differences in initial vaccine efficacy than that required for protection against confirmed infection.[134] However, in the absence of an accepted biological correlate of protection, it is difficult to fully predict how reduced neutralizing activity may affect COVID-19 vaccine effectiveness. Across studies, antibody neutralizing activity of sera from vaccinated people was generally higher than that observed for convalescent sera from people who have recovered from COVID-19.[71, 75, 80, 83, 101-103, 105, 107, 112, 118, 127, 128] However, some variants may reduce neutralizing antibody titers to near or below the protective threshold, resulting in lowered vaccine efficacy, increased breakthrough infections (i.e., infections in vaccinated persons), and shortened duration of immunity. For example, a modeling study estimated that a 5-fold lower neutralizing titer against a particular variant was predicted to reduce efficacy from 95% to 77% in a high efficacy vaccine, or from 70% to 32% for a lower efficacy

vaccine [134]; however, this assumes that antibody neutralization is the only major mechanism of protection, and this reduction may be mitigated where neutralization and cellular immunity both play a role in protection.

Vaccine-induced cellular immunity

Several studies have assessed CD4+ and CD8+ T cell responses from Moderna or Pfizer vaccine recipients to the ancestral SARS-CoV-2 strain compared with the Alpha, Beta, Gamma, and Epsilon variants; these studies observed modest or no defects in cellular immune recognition of the variants.[78, 85, 105, 135-139] Thus, cellular immunity may help limit disease severity in infections caused by variants that partially escape neutralizing antibodies. Polymorphisms in human leukocyte antigen alleles have been observed to result in variation of the T cell response to specific variants, which may impact different subpopulations differently based on higher genetic prevalence.[140-145]

Efficacy and effectiveness

A growing number of studies in Israel, Europe, and the United Kingdom have demonstrated high real-world effectiveness (>85%) of two doses of Pfizer-BioNTech COVID-19 vaccine while Alpha was prevalent.[24, 29-31, 33, 36, 146-148] Studies from Qatar have demonstrated high effectiveness against documented infection with Alpha and Beta ≥14 days after receiving the Pfizer-BioNTech vaccine (90% and 75%, respectively) and the Moderna vaccine (100% and 96%, respectively); importantly, both vaccines were 96%–100% effective against severe, critical, or fatal disease, regardless of strain.[149, 150] Clinical trial data suggest that the Johnson & Johnson/Janssen COVID-19 vaccine may have reduced overall efficacy against the Beta variant. Although sero-response rates were similar between U.S. clinical trial participants and those from Brazil and South Africa, vaccine efficacy after ≥14 days was 74% in the United States, 66% in Brazil (where ~69% of infections were due to Zeta [P.2]), and 52% in South Africa (~where 95% of infections were due to Beta). [151] Notably, Johnson & Johnson/Janssen vaccine showed good efficacy against severe or critical disease (73%–82%) across all sites. In three studies from Canada, one demonstrated 79% effectiveness for mRNA vaccines against confirmed infection during a time when Alpha and Gamma represented most infections, while another two demonstrated 84% and 88% effectiveness, respectively, against symptomatic infection caused by Gamma/Beta.[152-154]

For the Delta variant, recent studies from England and Scotland have noted reduced effectiveness of the Pfizer-BioNTech vaccine against confirmed infection (79%) and symptomatic infection (88%), compared with Alpha (92% and 93%, respectively).[146, 147] During two recent rounds of a national population survey in England when Delta was the dominant stain, 2-dose vaccine effectiveness against PCR-confirmed infection was 72% and 73%, respectively.[155] A study from Canada demonstrated 87% effectiveness against symptomatic illness ≥7 days after receipt of the Pfizer-BioNTech vaccine. [153] Press releases from Israel have noted further decreased effectiveness of vaccines against infection and illness caused by Delta; these differences may in part reflect differences in study methodology, but more technical information is needed to allow full interpretation. Notably, in the United Kingdom, Canada, and Israel, vaccine effectiveness against

hospitalization related to Delta was 93%–100% and comparable to that observed with Alpha.[148, 153] Data from the United Kingdom observed that the recent resurgence in COVID-19 cases is being driven by replacement of Alpha with the Delta variant and infections occurring in unvaccinated children and young adults.[155]

Breakthrough infections

Despite high efficacy, vaccine breakthrough cases are rare but inevitable, including infections caused by circulating variants. From January through May 2021, COVID-NET data from laboratory-confirmed COVID-19-associated hospitalizations in adults ≥18 years of age, for whom vaccination status is known, showed <3% of hospitalizations occurred in fully vaccinated persons. CDC conducts nationwide monitoring of vaccine breakthrough cases resulting in hospitalization or death. In general, symptoms and duration of illness in vaccine breakthrough infections have been attenuated compared with cases among unvaccinated people.[156] Among hospitalized or fatal breakthrough cases reported to CDC as of July 19, 2021, 74% were aged 65 years or older. One U.S. study observed that 44% of breakthrough infections were among people who were immunocompromised, similar to results reported from Israel.[157, 158] Breakthrough infections may boost immunity; four weeks after an outbreak in a long-term care facility, fully vaccinated residents who experienced breakthrough infections were found to have significantly higher antibody levels than vaccinated individuals who did not experience breakthrough infections.[159]

The proportions of VOCs observed among breakthrough cases has been similar to that observed in CDC's national genomic surveillance,[160] but interpretation of these data is challenging because of local variation and changes in variant proportions over time. An Israeli study of VOC infections in adults fully vaccinated with Pfizer-BioNTech compared with unvaccinated matched controls, during a time when Alpha was the dominant strain and Beta was detected in <1% of all specimens, found a higher proportion of Beta in fully vaccinated cases (matched odds ratio = 8.0) and a higher proportion of Alpha in partially vaccinated cases (matched odds ratio = 2.6), though small sample sizes, especially for Beta, were noted as a limitation.[161] A study from Houston, Texas observed that Delta caused a significantly higher rate of breakthrough infections in fully vaccinated people compared with infections from other variants, but noted that only 6.5% of all COVID-19 cases occurred in fully vaccinated individuals.[162] Studies from India with vaccines not authorized for use in the United States have noted relatively high viral loads and larger cluster sizes associated with infections with Delta, regardless of vaccination status.[96] These early data suggest that breakthrough Delta infections are transmissible. Unpublished data are consistent with this, and additional data collection and studies are underway to understand the level and duration of transmissibility from Delta vaccine breakthrough infections in the United States and other settings.

Impact of prevention measures in the context of vaccination

Individual and community-level prevention measures in addition to vaccination have been shown to help reduce the spread of SARS-CoV-2.[163-167] However, there can be individual and societal costs related to physical distancing, quarantine, school and business closures, and other prevention measures.[168-175]

Modeling studies suggest that adherence to other prevention measures, such as wearing masks and physical distancing, continues to be important in the context of vaccine implementation.[176-184] In one study, complete relaxation of prevention measures for the entire population prior to adequate vaccination coverage (60-80% depending on the population considered) resulted in essentially no reductions in SARS-CoV-2 infections.[178] However, in the context of rapid vaccine implementation, the benefit of non-pharmaceutical interventions decreases: preliminary data from one study found prevention measures in the United States could begin to be relaxed 2-3 months after vaccination began if a rate of 3 million doses administered daily were attained[185]. Correspondingly, preliminary data suggest that increasing vaccination rates may allow for the phasing out of some prevention measures as coverage increases.[184] With high vaccine effectiveness and increasing vaccination coverage, preliminary modeling studies conducted prior to emergence of the Delta variant predicted that vaccinated people returning to normal activities will have minimal impact on the course of the pandemic.[185, 186]

Conclusions

COVID-19 vaccines currently authorized in the United States have been shown to be effective against SARS-CoV-2 infections, including asymptomatic and symptomatic infection, severe disease, and death. These findings, along with the early evidence for reduced viral load in vaccinated people who develop COVID-19, suggest that any associated transmission risk is likely to be substantially reduced in vaccinated people. While vaccine effectiveness against emerging SARS-CoV-2 variants remains under investigation, available evidence suggests that the COVID-19 vaccines presently authorized in the United States offer protection against known emerging variants, including the Delta variant, particularly against hospitalization and death. Data suggest lower vaccine effectiveness against confirmed illness and symptomatic disease caused by the Beta, Gamma, and Delta variants compared with the ancestral strain and Alpha variant.

Evidence suggests the U.S. COVID-19 vaccination program has the potential to substantially reduce the burden of disease in the United States by preventing serious illness in fully vaccinated people and interrupting chains of transmission. The risks of SARS-CoV-2 infection in fully vaccinated people cannot be completely eliminated where community transmission of the virus is widespread. Vaccinated people can still become infected and spread the virus to others. Current efforts to maximize the proportion of the U.S. population that is fully vaccinated against COVID-19 remain critical to ending the COVID-19 pandemic.

*Note: CDC guidance for fully vaccinated people can also be applied to COVID-19 vaccines that have been listed for emergency use by the World Health Organization (e.g. AstraZeneca/Oxford). This brief summarizes evidence related to vaccines authorized for emergency use in the United States.

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Note: Preprints have not been peer-reviewed. They should not be regarded as conclusive, guide clinical practice/health-related behavior, or be reported in news media as established information.

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Previous Updates

As of May 27, 2021

- Data were added from studies published since the last update that further demonstrate currently authorized COVID-19 vaccines are effective against SARS-CoV-2 infection, symptomatic and severe disease, and hospitalization with COVID-19.
- Data were added suggesting that currently authorized mRNA vaccines provide protection against variants of concern, including the B.1.1.7 strain that is predominant in the United States.
- Data were added from studies published since the last update that further demonstrate people who are fully vaccinated with a currently authorized mRNA vaccine are protected against asymptomatic infection and, if infected, have a lower viral load than unvaccinated people.

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Transcript for CDC Media Telebriefing: Update on COVID-19

Press Briefing Transcript

Friday, February 25, 2022

- Audio recording [MP3 – 7 MB]

Please Note: This transcript is not edited and may contain errors.

0:00 / 39:16

Operator:

Welcome and thank you for standing by. At this time, all participants are on listen only mode during the Q&A session. If you'd like to ask a question, you may press star one on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. Now I'd like, turn the call over to Mr. Benjamin Hayes. Sir, may begin.

Benjamin Haynes:

Thank you, Ted. And thank you all for joining us for today's COVID 19 update. We're joined by CDC Director, Dr. Rochelle Walensky and Dr. Greta Massetti from the COVID 19 Incident Management Team, both will provide opening remarks before taking your questions. I would now like to turn the call over to Dr. Walensky.

Dr. Walensky:

Thank you, Benjamin and thank you all for joining us today. Today, CDC is updating its framework to monitor the level of COVID 19 and communities. We're in a stronger place today as a nation with more tools to protect ourselves in our communities from COVID 19, like vaccination, boosters, broader access to testing, availability of high quality masks, accessibility to new treatments, and improved ventilation. Over 200 million people have received a primary vaccine series and nearly 100 million have been boosted and millions more have had prior disease. With widespread population immunity, the overall risk of severe disease is now generally lower. Now, as the virus continues to circulate in our communities, we must focus our metrics beyond just cases in the community and direct our efforts toward protecting people at high risk for severe illness and preventing COVID 19 from overwhelming our hospitals and our healthcare systems. This new framework moves beyond just looking at cases and test positivity to evaluate factors that reflect the severity of disease, including hospitalizations and hospital capacity, and helps to determine whether the level of COVID 19 and severe disease are low, medium, or high in a community.

Dr. Walensky:

The COVID 19 community level we are releasing today will inform CDC recommendations on prevention measures like masking and CDCs recommendations for layer prevention measures, and will depend on the COVID 19 level in the community. This updated approach focuses on directing our prevention efforts towards protecting people at high risk for severe illness and preventing hospitals and healthcare systems from being overwhelmed. To find your community level, we are updating the CDC's website to reflect this framework. So people will be able to go to www.cdc.gov or call 1-800-

CDC-INFO to find your community level and what prevention strategies are recommended, including where or when to mask. Please remember that there are people who remain at higher risk for COVID 19 and who may need additional protection. Those who are immunocompromised or have underlying health conditions, those who have disabilities, or those who live with people who are at risk. Those people might choose to take extra precautions regardless of what level their community is in. So with that, I'm going to turn things over now to Dr. Greta Massetti, who will walk us through this framework and the science behind it. Thank you.

Dr. Massetti:

Thank you, Dr. Walensky. The updated metrics in this framework provide a current picture of COVID 19 disease in a community. They also include strong predictors of the potential for strain on the healthcare system. A community's COVID 19 level is determined by a combination of three pieces of information: new hospitalizations for COVID 19, current hospital beds occupied by COVID 19 patients or hospital capacity, and new COVID 19 cases. These metrics will tell us if the level is low, medium, or high. Let me walk you through what we are recommending at each level. Regardless of level, we continue to recommend that people stay up to date on vaccines and get tested if they're sick.

Dr. Massetti:

At the low level, there is limited impact on the healthcare system and low amounts of severe disease in the community. People should stay up to date with their vaccines and get tested if they're sick. At the medium level, more people are experiencing severe disease in the community and they're starting to see more impact on the health healthcare system. At this level, CDC recommends that people who are high risk, such as someone who is immunocompromised, should talk to their healthcare provider about taking additional precautions and may choose to wear a mask. As communities enter into the high level, there is high amount of people experiencing severe disease and high potential for healthcare systems strains. At the high level, CDC recommends that everyone wear a mask indoors, in public, including in schools. Communities can use these metrics, along with their own local metrics, such as wastewater surveillance, emergency department visits, and workforce capacity, to update and further inform their local policies and ensure equity and prevention efforts. And these categories help individuals assess what impacts COVID 19 is having on their community so that they can decide if they need to take extra precautions, including masking based on their location, their health status, and their risk tolerance.

Dr. Massetti:

We should all keep in mind that some people may choose to wear a mask at any time based on personal preference. And importantly, people who wear high quality masks are well protected, even if others around you are not masking. And there are some situations where people should always wear a mask. For example, if they have symptoms, if they tested positive for COVID 19, or if they have been exposed to someone with COVID 19. Today, we're also updating our recommendations for schools. Since July, 2021, CDC recommended universal masking in schools, no matter what level of impact COVID 19 was having on the community. With this update, CDC will now only recommend universal school masking in communities at the high level. Importantly, COVID 19 community levels and public health prevention strategies can be dialed up when our communities are experiencing more severe disease and dialed down when things are more stable. So what do these updated metrics mean for where we are as a country, as of today, more than half of counties representing about 70% of Americans are in areas with low or medium COVID 19 community levels. This is an increase from about one third of counties at low or medium community levels last week and we continue to see indicators improve in many communities. Thank you. And I will now hand it back to Dr. Walensky.

Dr. Walensky:

Thank you, Dr. Massetti, before we take your questions, I would like to leave you with a few final thoughts. None of us know what the future may hold for us and for this virus and we need to be prepared and we need to be ready for whatever comes next. We wanna give people a break from things like mask wearing when our levels are low and then have the ability to reach for them again, should things get worse in the future. We at CDC will continue to follow the science and epidemiology to make public health recommendations and guidance based on the data. Our new framework was rigorously evaluated both with current data and retrospectively during the Alpha, Delta and Omicron waves and these new metrics have demonstrated predictive capacity for weeks into the future. We will continue to evaluate how well they perform in our communities. This new framework will best way for us to judge what level of preventive measures

may be needed in our communities. If or when new variants emerge or the virus surges, we have more ways to control the virus and protect ourselves and our communities than ever before. Thank you. I'll now turn it back over to you, Benjamin.

Benjamin Haynes:

Thank you, Dr. Walensky and thank you, Dr. Massetti. Ted, we are ready to take questions.

Operator:

The phone lines are now open for questions. If you would like to ask a question over the phone, please press star one and record your name. We also ask that you just limit yourself to one follow up question. If you would like to remove your question, please press star two. One moment please. And the first question accused from Dr. Jon LaPook with CBS news, your line is not open.

Dr. Jon LaPook:

Hi, thank you. Thanks for this update and we've heard that, you know, the best mask is the one people will wear, but let's assume somebody's incentivized to wear the best mask they can and they're gonna try to get it well fitted. Can you be more granular about which mask provide the best protection is an N 95, KN-95, KF-94. surgical cloth. What should people who want to protect themselves the most, which of the masks they should be using? Thanks.

Dr. Walensky:

Maybe I'll start with that. Thank you, Dr. LaPook. Of course we've said in our prior masking guide that infiltration are key in those, the N-90-

Dr. Massetti:

It sounds like we might have lost Dr. Walensky. I think what she was noting was that we often have emphasized that fit and filtration are really critical and there are a variety of ways to achieve that. One way is to use a respirator, um, like an N-95 or a KN 95. They provide good fit and filtration for people, and they provide high protection to the wearer. There are other options as well, including using a surgical mask or a surgical mask layered with a cloth mask. And also we have on our website resources to show people how to knot and tuck the ear loops on mask to improve fit and filtration as well.

Dr. Jon LaPook:

Right, no, of course, we all, thanks. We all see people with wearing just sort of a plain cloth and maybe it's underneath the nose, but I was just wondering if you wanted to emphasize what's the best case scenario for people since, since it just says, wear a mask.

Dr. Massetti:

So CDC recommends that that people should wear the mask that has the best protection and filtration for them and that they will wear consistently.

Dr. Jon LaPook:

Thanks.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Ron Lin with the Los Angeles Times, your line is now open.

Ron Lin:

Hey, I was wondering, can you go into how you came up with the details of the metrics for those three levels and what the science is based off of them in terms of numbers. And where would a place like LA county, which has tied its local mask mandate to CDCs old mask recommendations? Where would they lie? Would they no longer be required to no longer be recommended to wear masks? Thanks.

Dr. Walensky:

I'm back. So maybe I'll get started and pass it over to you, Dr. Massetti, thanks for filling in there. So, one of the things that was really important is we have more and more people and more and more immunity in the population. We wanted to make sure that we were focusing on severe disease because we do want to prevent severe disease. We want to prevent hospitalizations. We want to prevent our hospitals from becoming overwhelmed. So our metrics were really with that in mind, what are severe, how much severe disease is happening, and then to use those metrics to understand, can we find levels where we can predict outcomes in the future where we might be able to act on them now to avert those outcomes in the future. Bad outcomes, like ICU stays, high levels of death. So maybe I'll pass it over now back. So Dr. Massetti to give you more granular detail.

Dr. Massetti:

Great. Thanks so much, Dr. Walensky. So as Dr. Walensky noted, we were really focused on measures of healthcare strain and severe disease. And so we conducted an extensive review of all data systems that are reported to CDC and often available on our website on COVID data tracker. We reviewed all data sources and really assess them against several criteria, including do they measure severe disease or healthcare strain? How well do they provide data that is available at the local level where it can really inform local decisions? And do we have national coverage for all counties in the United States? And are they reported frequently enough to be able to inform timely decisions? And based on that thorough review, we refined the list and came up with these indicators, including new hospital admissions and hospital beds utilized and complimented them with case incidents to really create a package of metrics to be able to understand happening at the local level.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Drew Armstrong with Bloomberg News, your line is now open.

Drew Armstrong:

Hi, Drew Armstrong from Bloomberg news. I'm wondering, thinking ahead, are there other COVID metrics or measures that CDC has using or collecting that should be overhauled or refined as we move into whatever this next phase of the pandemic is? And, if so, what are some potential examples of that?

Dr. Walensky:

So we have, we certainly look at comprehensive data and we get a whole stream of data, some that are different by jurisdiction. So for example, we just last week posted our wastewater data, and we anticipate that our wastewater data, while we have 400 sites posted, and that represents about 53 million Americans, that is still focal. And we really want are working to expand that. So we intend to double that over the next month or so. Syndromic surveillance would be another way that we could expand some of these metrics again. As Dr. Massetti said, it's really important as we come up with national metrics that we have coverage from every county, not every county is reporting syndromic surveillance, although we're working to scale that up as well. So we have on our eye on many different metrics, which is why we hope that these metrics that we're releasing today will be very helpful for policy makers, but we also hope that local jurisdictions will take into account all the information that's available to them.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Helen Branswell with STAT. Your line is now open.

Helen Branswell:

Hi, thank you very much for taking my question. I know, I think this is gonna be an irritating question, but when you talk about, you know, the metrics about, you know, the percentage of people in hospital beds who are, there because of COVID, is that for COVID or with, I mean, will the with COVID people also be part of those calculations?

Dr. Walenksy:

Helen, that's a great question. We have spent a lot of time thinking about this. And let me tell you sort of where we landed and why. First, we are considering anybody in a hospital bed with COVID, regardless of the reason for admission and that the reason that we landed there is multifold. First many jurisdictions can't differentiate. So that was important for us to recognize and realize. Second, whether or not a patient is admitted with COVID or for COVID, they increase the hospital capacity and they're resource intensive. They require an isolation bed. They require PPE. They probably require a higher staff ratio. And so they are more resource intensive and they do take a COVID bed potentially from someone else. Interestingly, as well, as we have less and less COVID in certain communities, the amount of people who are coming into the hospital with COVID will necessarily decrease.

Dr. Walensky:

We will not have as many people walking around asymptomatically because there will just be less disease out there. So increasingly as we have less disease in the community, we anticipate that more of the people who are coming into the hospital are going to be coming in because of COVID. And then finally, as we have even less disease in the community, we anticipate that not every hospital is going to screen every patient for COVID as they walk in the door, especially if we have less and less disease in the community. And when that happens, we won't actually be able to differentiate. In fact, people who are coming in, who are tested will necessarily be coming in for COVID. So for all of those reasons, comprehensively, we decided to say with anybody coming in with a COVID diagnosis.

Helen Branswell:

Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Cheyenne Haslett with ABC News, your line is now open.

Cheyenne Haslett:

Hi, thank you for taking my question. Dr. Walensky can you explain the decision to include schools in the loosening of the mask recommendations? And as a follow up, on public transportation, do you expect that recommendation for masks to expire on March 18th or be extended?

Dr. Walensky:

Um, so maybe I'll take the first, the second question first and then pass the school question to Dr. Massetti. The COVID 19 community levels are intended for communities, they're not intended for our travel quarters, as you note, those expire in the middle of March, and we will be revisiting that in the weeks ahead. And then maybe Dr. Massetti, do you want to take the school question?

Dr. Massetti:

Yes. Thank you, Dr. Walensky. So, we've been reviewing the data on COVID illness in children for two years of a pandemic. And we have seen that although children can get infected and can get sick with COVID, they're more likely to have asymptomatic or mild infections. So fortunately we know that when schools implement layered prevention strategies, that they can prevent SARS COV-2 two transmission or transmission of the virus that causes COVID 19 in schools. And we know that also because children are relatively at lower risk from severe illness that schools can be safe places for children. And so for that reason, we're recommending that schools use the same guidance that we are recommending in general community settings, which is that we are recommending people wear a mask in high levels of COVID 19. But that, the medium level that the recommendation is primarily based on whether somebody wants to talk to their healthcare provider about whether they're high risk.

Cheyenne Haslett:

Thank you.

Benjamin Haynes:

Next question, please, Ted.

Operator:

Next question is from Allison Aubrey with NPR. Your allow is now open.

Allison Aubrey:

Hi, thanks for taking my question. I'm wondering if the updated page where you're sort of saying the map of this is low, medium or high community, is this being updated with new data all of the time? So it's always up to date? And will this be updated sort of in perpetuity? We know that COVID is not being eradicated. There's talk of, we could see outbreaks at any point in the future. Just talk about sort of those, how actively this is maintained and for how long.

Dr. Walensky:

Thank you, Allison. We intend to keep this updated. Of course, not every county reports every metric every day. So we intend to keep this updated on a weekly cadence. And we intend to do so for the foreseeable future. Of course, this virus has dealt us many a curve balls but for the foreseeable future is what we're looking at right now.

Allison Aubrey:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from John Woolfolk with San Jose Mercury News. Your line is now open.

John Woolfolk:

Hi. So, the new metrics that you all are talking about sound like they're based mostly on the strain on the health bureaucracy and not, I mean, our readers are mostly interested in your guidance for what it means for them to avoid getting COVID and spreading it. And based on the metrics and the rules that were in place as of this morning, before announcement, that would mean like pretty much all of California where we are, "you should wear a mask if you don't want COVID" recommendation. And it sounds like I haven't seen what your new metric says for our area, but it sounds like it's now saying, well, that's not operative anymore. Go ahead and take the mask off. Is that are people safe going in and around in public indoors without masks in places where your metrics now say it's a high transmission situation?

Dr. Walensky:

Thank you, John. So first and foremost, I'd like to go back to what Dr. Massetti said, which is anybody is certainly welcome to wear a mask at any time, if they feel safer wearing a mask. So we are absolutely endorsing if you feel more comfortable wearing a mask, feel free to do so. And we should encourage people to have that liberty to be able to do so. The intent of these community guidance is to look at really severe disease – people who are coming into the hospital. We know that there's going to be transmission of COVID 19 out there. And what we wanna do is make sure that our hospitals are okay and that people are not coming in with severe disease, but of course, is important to note that the volume of severe disease in the hospital is likely representative of the volume of disease in general in the community. So they are very much linked. Certainly it's also linked to vaccination rate as well, but certainly if people are interested in wearing a mask to feel safer, they certainly can, and anyone can go to the CDC website, find out the volume of disease in their community, and then make that personal decision.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Meg Tirrel with CNBC, your line is now open.

Meg Tirrel:

Well, thank you. I'm just wondering how dependably counties are reporting all of these metrics, particularly with case numbers. Is there enough testing going on for that to be a reliable metric and you know, the same question for the hospitalizations reporting?

Dr. Walensky:

Dr. Massetti? Do you want to take that one?

Dr. Massetti:

Sure. Yeah. So to the question about the hospitalization metrics. So those are actually reported by healthcare facilities. There are 6,000 hospitals in the United States that are required to report those data every day – Monday through Friday. And usually there's better than 95% coverage on any given day. So hospitals are very consistently compliant with reporting those data. We do have very high completion of those data. So we're quite confident that those data are continuing to flow in and reflect what's happening in those hospital. The case data are also largely reported from public health laboratories and have really reflected that the the nucleic acid amplification test results. They do not reflect in many places do not reflect at home tests, which are not reported, but those are the laboratory test results are continuing to be reported fairly consistently.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Catherine Roberts with consumer reports. Your line is now open.

Catherine Roberts:

Thanks for taking my question. I'm wondering, um, to what extent, if at all, um, does this new metric account for people who may have been seriously, um, disabled or sort of long term sick due to like long COVID, but who've never actually been hospitalized with acute COVID, is that factored into this at all?

Dr. Walensky:

Um, it's a good question. We, you know, we're not looking historically about at prior hospitalizations. What we're looking at is, um, hospitalizations now and hospital capacity. Now.

Catherine Roberts:

Is there any way to sort of account for those folks who know the folks who may have gotten a, some kind of disability from COVID, but who aren't, you know, taking up capacity? Is that, is that in the, in the works basically?

Dr. Walensky:

Um, so CDC has many different cohort studies to examine long COVID. We know that this is critically important. The NIH two is examining long COVID, and we are doing this through collaborations with states on survey data, long-term, prospective cohort data, um, and, and, uh, um, hospitalization and, and, uh, data from hospitals as well. So we are looking into this for sure. And, and we know much work in what many studies need to be done for long COVID specifically, but in terms of hospital capacity today to forecast what would happen six weeks from now, um, in our, in our COVID 19 community levels, the, that is not accounted for.

Catherine Roberts:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Dave McKinley with w G R Z Buffalo, New York. Your line is not open.

Dave Mckinley:

Yeah. Hi there. I hope you can hear me. Um, you have these, uh, uh, metrics where you would establish whether community was high, uh, medium, uh, subs or high, substantial, moderate low, and there were specific numbers attached had, have those numbers changed in term in determining high or, or substantial or moderate, or are those numbers, you know, where it was fewer than 100, as opposed to fewer than 50, are, are those changing at all? And, and the second part of my question has to do with air airplanes and stuff like the in buses. I, I, you may have addressed that, uh, and I may have missed it.

Dr. Walensky:

Yeah. So first of all, just take the easy one, which is this addresses communities, but not our travel corridors. So nothing will change in our travel corridors. With regards to where we were in our prior community transmission, those were different metrics. They were based on only cases and percent positivity that led us to those, blue, yellow, orange, red. And so cases will still be a part of it, but we need to recognize that, you know, cases we're counting cases differently now than we did, you know, over a year ago when we established those prior metrics. So now our case thresholds is going to be over 200 per hundred thousand, rather than the 100 per hundred thousand

Dave Mckinley:

That's high.

Dr. Walensky:

Again, it's not, yeah, it's not just, well, it's not just cases. It is cases of well as hospitalizations as well as hospital burden. So it's the, it's the, intersection of all of those that leads you to a green, yellow, or orange color in these new metrics.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Erin Garcia with science news. Your line is open.

Erin Garcia:

Hi. Um, thanks for taking my question. I was kind of curious how the method that we're using that you guys are switching to for COVID -19 compares to how we're surveilling for influenza, for instance, did you pull on any of the expertise from how we look at flu or is this completely separate?

Dr. Walensky:

Dr. Masetti, do you wanna take that?

Dr. Massetti:

Sure. Thank you, Dr. Walensky, and thank you for the question. So we talked to a lot of experts in flu surveillance and flu measurement. We have a lot of, wonderful experts both within the, within CDC and outside CDC to really understand kind of what is the future of surveillance for COVID- 19 and what can we learn from and apply from the, um, from the flu model? The metrics that we specifically are relying on here for these COVID- 19 community levels, don't , reflect data that were stood up in summer of 2020, specifically for pandemic response data collection and through the unified hospital data system. So this is really a phenomenal data source that allows us to on a daily basis assess how many new hospitalizations that have been, in, in hospitals for people with confirmed COVID- 19 and the percent hospital capacity, and hospital beds been used by people with COVID- 19. And so that is, that's not a data, that that includes flus, that has not a, a data surveillance system that, that has been used for flu, but we're really interested in expanding and, and also collecting, seeing how this model can also apply to other respiratory illnesses in the future.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Julie Steenhuysen with Reuters. Your line is now open.

Julie Steenhuysen:

Thanks for taking my call. So I'm interested in knowing, like how does the CDC arrive at the conclusion that hospitalization and capacity were the key issues that, you know, we need to focus on now and preventing transmission is less important and, won't this be challenging, to get compliance if there's another variant that comes along, that is more virulent than the one we have now.

Dr. Walensky:

Certainly maybe I'll start with the first, the second question first, and just say, we recognize that we need to be, flexible and to be able to say, we need to be able to relax our, our, layer prevention measures when things are looking up when we have fewer cases in fewer hospitalizations, and then we need to be able to dial them up again, when we might have, should we have a new variant or a new surge? And I think that that's a really important message that we're trying to get across here. What we do know about the current moment, um, with we saw certainly a severity a decreased severity associated with, we had many, many more cases than we had hospitalizations, as we saw than we saw with alpha or Delta. And in that backdrop, we also had much more population immunity by vaccination boosting and, and prior infection. And so many, many of our infections did not result in severe disease. It did not result in, increased hospital capacity. And it was in that context that we made this pivot.

Julie Steenhuysen:

Thank you.

Operator:

Next question is from Meg winger with the Denver post. Your line is open.

Meg Wingerter:

Hello. Thanks for taking my question. I wanted to ask about, so it sounds like for the hospital capacity, you're specifically looking at people hospitalized, um, with COVID. Um, but what we're having in Colorado right now is very low, pretty low at any rate COVID hospitalizations, but are beds are still 90% full any given day. Is there any way you want communities to factor in that overall level of capacity where even a, a smaller surge could be a bigger problem because there's not much left. Thank you.

Dr. Walensky:

Maggie. You actually hit the nail exactly on the head. So not only are we looking at hospital admissions but also hospital capacity, those who are admitted with COVID-19, what fraction of their bed. So if you're at 90% in Colorado that, ou know, we would be taking that exact, uh, parameter into account.

Speaker 19:

Next

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Michael Imani with K O M U. Your line is now,

Micheal Imani:

Hi, how are you? This might be for both of you, but I actually wanted to hear from Dr. Walensky as well. But this is in relation to the new metrics or the new, excuse me, the new, holistic view of risk from coronavirus, to the community. And I was wondering how you guys are making that change. I know you kind of detailed it in your opening, but I was wondering if you can get into specifics with regards to that.

Dr. Walensky:

So thank you. So we are looking at, fraction of hospitalizations that are COVID, we're looking at number of admissions for a hundred thousand, that are COVID. And then we're also looking at cases. And so all three of those together, we have thresholds that we've measured. Then Dr. Massetti has a, has discussed, and we created those thresholds based on their ability to be predictive of, ICU safe hospitalizations and deaths in three to six weeks in the future, so that we could take action. So, all of that work together leads us into three different colors, green, yellow, and orange. Those colors will reflect low, medium, and high community levels, and then those levels get matched to our recommendations and our guidance.

Micheal Imani:

Thank you, doctor. I appreciate it.

Dr. Walensky:

Dr. Massetti, anything, anything to add there?

Dr. Massetti:

No, I think that's a, that covers it really well. Thank you, Dr. Walensky.

Operator:

Thank you. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Tom Howell with the Washington times, your line is not open.

Tom Howell:

Hey, thanks for doing the call. Can you give the immediate geographic impact of the guidance? Um, what percentage of counties are in the low category? What percentage are in medium and what percentage are in high? Thank you.

Dr. Walensky:

Dr.Massetti, you have those numbers.

Dr. Masetti:

I do, just right in front of me. So, these are as of, the latest data. 23% of counties are at low, 39.6% of counties are at medium, and 37.3% of counties are at high levels.

Tom Howell:

So all about 37.3 is high, your recommendation is that everyone wear masks in indoor public settings in those places? Is that correct?

Dr. Massetti:

Yes, that's correct.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Adriana Rodriguez with USA Today. Your line's now open.

Adriana Rodriguez:

Hi, thank you so much for taking my question. I was wondering why, vaccination rates weren't included in these metrics or in this equation to calculate, community COVID risk, and if maybe that will be included in the metrics sometime in the future.

Dr. Walensky:

So, you know, what we're really focused on is risk of severe disease and risk of, being admitted into the hospital risk of your hospitals, becoming full, truly vaccination rates do sort of fall on the causal pathway if you will, for risk of severe disease. So if someone is unvaccinated and has underlying health conditions, they certainly are at high risk of severe disease. And so, it, it is part of the equation. It's not sort of among the things that that's listed, but, certainly it is reflected in who will come into the hospital with severe disease. And, and of course we would always recommend that if you're

unvaccinated, you and you're eligible for vaccination, you should get vaccinated. And if you're eligible for boosting, you should get boosted to remain up to date. And that of course would decrease is your risk of hospitalization. In fact, our most recent data have demonstrated that if you are boosted you're 97 times less likely to die of COVID than if you're unvaccinated.

Adriana Rodriguez:

So if, if a person is in one county and the hospitalization rates are the same as another person in another county, but vaccination rates are vastly different, mask guidance would be the same?

Dr. Walensky:

They would.

Adriana Rodriguez:

Thank you.

Benjamin Haynes:

Ted. We have time for two more questions.

Operator:

Okay. The next question is from Stephanie Innes with Arizona Republic, your line is open.

Stephanie Innes:

Uh, yes. Thanks for taking my question. I wanted to know if this framework takes into account people who work in high-risk jobs like grocery stores and restaurants, should they be considering if it's green, they don't need to wear a mask and should businesses think that way as well?

Dr. Walensky:

So certainly all of those all of our recommendations, are translated into policy at the local and jurisdictional level. And we would say any, any, local, business certainly has the, ability to make, recommendations based on or policy based on where they are, whether they have, they may have more information based on wastewater or high risk communities or, or equity for many different, for many different reasons. But, our guidance would say that if you are in a green community, that ,that community in general would not need to be wearing a mask. Certainly of course, anybody can wear a mask at any time if they choose to protect themselves that way.

Stephanie Innes:

Thank you.

Benjamin Haynes:

And the last question, please?

Operator:

Yes. The last question is from Dan Petro with the Chicago Tribune, your line is now open.

Dan Petro:

Can you address, the timing of this decision and perhaps the public perception that, CDC is being pulled along here by the, the governors in, in many states who didn't wait for these new recommendations before making changes to what was being done at the state level?

Dr. Walensky:

Yes, absolutely. First I will say that we at the CDC, and I think you've heard me talk publicly about this, have been thinking about, shifting our metrics to hospitalizations for some time. Now we've been talking about this for some time. Certainly we know that many governors made announcements several weeks ago, but many of those announcements actually were phased in. And in fact, didn't acutely say they were gonna take masks off, but they were going to take masks off at the end of February or in early March or in the middle of March. So ,I would say our guidance actually probably very much intersects exactly where many of those phase approaches are going to be in that many of those governors, when they're, when their, policies are at play, will coincide with exactly what we are recommending.

Benjamin Haynes:

Thank you, Dr. Walensky, and thank you Dr. Massetti. And thank you all for joining us today. If you have further questions, please contact the media office at 4 0 4 6 3 9 3 2 8 6 or email media@cdc.gov. Thank you.

Operator:

This concludes today's call. Thank you for your participation. May disconnect at this time.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Last Reviewed: February 25, 2022

Committee on House Administration
Subcommittee on Oversight
Hearing - "Looking Ahead Series: Office of the Attending Physician."
Majority Questions for the Record

Please submit responses to the Committee no later than May 2, 2023.

Questions for the Record: Series #1

Currently, the Centers for Disease Control and Prevention (CDC) considers individuals up-to-date with COVID vaccines if an individual has completed the COVID-19 vaccine primary series as well as the most recent booster dose. Further, the CDC recommends getting the most recent booster dose even if you had or currently have COVID-19.

Question #1: Is the Office of the Attending Physician (OAP) recommending people receive COVID-19 boosters in line with the current CDC recommendations?

Question #2: If so, why is the OAP recommending boosters, even if an individual has acquired some degree of natural immunity and measurable antibodies?

Question #3: How is this authority defined during a pandemic versus during day-to-day operations? How will this recommendation be altered post-pandemic?

Questions for the Record: Series #2

On July 28, 2021, the Office of the Chief of Police issued a bulletin, #21.96, regarding the mandatory wearing of masks in interior spaces on Capitol Grounds (see document). As stated in this bulletin, the Office of the Attending Physician (OAP) advised Congress to follow CDC's current guidance to require masks.

In this same bulletin, it outlined that failure by a congressional staff member or visitor to wear a mask shall be denied entry, and "any person who fails to either comply or leave the premises after being asked to do so would be subject to an arrest for Unlawful Entry."

Question #1: What role did the OAP play, if any, in the drafting of this bulletin?

Question #2: Does the OAP agree with the Office of the Chief of Police to arrest congressional staff members and visitors for failing to wear a mask?

Questions for the Record: Series #3

The OAP oversees the management of the Mothers' Suites across Campus.

Question #1: Does the OAP currently have any plan to update the Mothers' Suites to increase comfort, cleanliness, and usability?

Question #2: What current activities does the OAP undertake to gain feedback from mothers to ensure that the Suites are meeting mothers' needs and assess potential upgrades to Suites?
Question #3: What can the Committee do to further support the OAP in modernizing Mothers' Suites?

Committee on House Administration
Subcommittee on Oversight
Hearing - "Looking Ahead Series: Office of the Attending Physician."
Minority Questions for the Record

1. During normal session days, thousands of visitors visit the Capitol. Cafeterias are packed to capacity, Members, staff, and visitors stand shoulder to shoulder in hallways, and constituents meet with their Representatives in enclosed spaces.

    a. **Please describe the risks that would have been associated with not enacting any public access restrictions during the COVID-19 pandemic.**

    b. **What impact, if any, would refusal to follow guidelines related to masks and face coverings have on these risks?**

2. Congress began to "reopen" during the 117th Congress, using a phased approach.

    a. **Was the decision to not restore full pre-pandemic access to the Capitol during the 117th Congress a public health decision based on your guidance, or were there other considerations?**

    b. **If there were other considerations, do you know if they were communicated to bipartisan House Leadership?**

3. In July 2021, then-Minority Leader Kevin McCarthy said, in response to face covering requirements in the House, "Make no mistake, the threat of bringing masks back is not a decision based on science, but a decision conjured up by liberal government officials who want to continue to live in a perpetual pandemic state."

    a. **Please describe the decision-making process that resulted in your recommendations related to masks and face coverings, including the factors you considered in making these recommendations.**

    b. **Are you aware of any government officials who wished to continue to live in a perpetual pandemic state?**

4. A January 2023 Cochrane Review study entitled, "Physical interventions to interrupt or reduce the spread of respiratory viruses" has been cited by commentators, including

Members of Congress, as standing for the proposition that "masks don't work." However, according to Cochrane, this is an "inaccurate and misleading interpretation."

a. **Are you aware of the Cochrane Review study referenced above?**

b. **If so, can you briefly describe the study's findings related to the effectiveness of masks?**

c. **In your professional opinion, are masks effective at mitigating the spread of COVID-19?**

5. You testified that you provided the same health recommendations to both the House and Senate during the pandemic, and that the differences between the bodies led them to operationalize your recommendations differently. For example, the Senate did not institute a mask mandate and it required all votes to take place in person on the Senate Floor. The House, on the other hand, instituted a mask mandate and enacted a remote voting by proxy regime to minimize the number of individuals on the House Floor at one time. **Which chamber's mitigation strategies tracked more closely to the recommendations set forth by the Centers for Disease Control and Prevention?**

6. **How does OAP ensure personally identifiable information (PII) and other patient data stored electronically is secure?**

7. **How many visitors does OAP treat on an average session day?**

8. **Does OAP have telemedicine capabilities? If so, please describe.**

9. On July 14, 2020, your office sent a letter to the Select Committee on Modernization outlining modernization recommendations based upon the office's management of Congress' COVID-19 pandemic. These recommendations concerned the OAP's policy/operations, information technology, and facilities. **Which modernization recommendations do you consider to be the highest priority?**

Majority Question Responses

Question 1A: Yes, the OAP does recommend individuals receive COVID-19 boosters in line with current CDC recommendations. Please Refer to dear E colleague letter of April 27, 2023 announcing vaccine availability and recommendations of the CDC for specific categories of recipients.

Question 1B: The OAP recommends receiving COVID 19 boosters irrespective of natural immunity or antibodies. This is in line with CDC recommendations. The rationale for this approach is based in the goal of maximizing individual protection and minimizing harm in a setting of developing science. While recent research has shown that recent infection with COVID 19 provides protection from re-infection for a number of months, immunity at the individual level is variable. I am unaware of any current research that has defined an antibody titer level above or below which an individual is considered protected or unprotected from re-infection, making it difficult to determine how much of a protective benefit an individual patient has received from a primary infection. Additionally, some studies have indicated a booster provides an additive protective effect against re-infection. The degree of protection provided by natural immunity from an earlier COVID 19 viral infection may not protect against current coronavirus variants that are specifically targeted in new vaccine formulations. Given the excellent safety profile of the COVID 19 vaccine booster and the potential risks of severe acute COVID re-infection and/or ongoing complications of long COVID, the OAP continues to recommend vaccinations as a means to maximize individual protection in line with CDC guidelines. The OAP also remains committed to continuing review of ongoing research and adjusting recommendations based upon evolving science.

Question 1C: Authority to administer a vaccination product is consistent with either the FDA licensed product package insert (during regular operations only fully licensed vaccines are recommended) or during the pandemic the FDA emergency use authorization vaccine products are employed. In terms of individual medical recommendations as part of the patient-physician relationship, the OAP provides recommendations directly to patients based upon their individual health circumstance at the time of a medical encounter in both day to day and pandemic operations. Public health recommendations are conveyed to leadership for consideration as part of an overall response plan that may include multiple offices. The CDC and FDA have made extensive modifications to their pandemic coronavirus vaccine programs both from its emergency use authorized products (for example: vaccination agent modifications for new coronavirus variants, age-specific vaccines for infants and children, schedules and recommendations for booster doses of vaccine). The FDA also issues licenses to other fully approved labeled vaccine commercial products. The OAP conveys these recommendations published by CDC as the basis of individual patient recommendations.

Question 2A: The OAP was not involved in the drafting of U.S. Capitol Police Bulletin #21.96.

Question 2B: The OAP limits its role to providing medical-based recommendations to mitigate a health threat. An opinion on an appropriate means to enforce or penalize individuals for not executing recommendation is outside the scope of this office. The OAP has never recommended a category of individuals subject to arrest.

Question 3A: The mother's suites are spaces which are constructed, equipped, and cleaned on a regular basis by the Architect of the Capitol. The Office of Attending Physician supervises access control to the area by interacting with candidates to use the space and renewing their access to it on a 6-month basis as long as they may require. The OAP Registered Nurses inspect the suites each day for general cleanliness and serviceability of equipment. Issues of cleanliness and usability are addressed immediately when discrepancy arises. Larger matters such as decor, furnishings, climate control, and location would be matters to review with the Architect of the Capitol.

Question 3B: The office of attending physician maintains a daily usability and cleanliness inspection. The office receives occasional feedback from mothers during times of initial application for access to the space and during periodic access renewal on an *ad hoc* basis. The OAP provides all users of the mother's suites point of contact telephone numbers and e-mails points of contact to offer any suggestions, at any time. Concerns regarding access, cleanliness, or serviceability are addressed immediately by OAP. Other suggestions (décor, furniture, climate control, color schemes, etc.) are forwarded to the Architect of the Capitol for consideration with regard to their process for remodeling etc. The OAP has repeatedly recommended that all mother's suites be secured by proximity ID card electronic access to provide enhanced security, user accountability and approved access control; however, many of the mother's suites lack of this access control and rely upon a shared combination code for a Cypher lock on the door. The OAP restricts 24/7 access to the Congressional office building's mother's suites to Congressional ID card holders only. All authorized individuals have access to the mother's suites at all times. Mothers no longer requesting access to the suites are automatically disenrolled from the access list. (This could be a problematic area in the mother's suites secured only by cypher locks). Visitors and other categories of users needing the mother suites are accommodated for lactation space access by the OAP nurses in individual health units through accommodations during business hours only.

Question 3C: The matter of the modernization of the physical structure, furnishings, etc. of the mother's suites would require the Architect of the Capitol's involvement as the OAP does not have a budget or authority for that endeavor.

Minority Question Responses

Question 1A: Understanding COVID 19 is transmitted from infected individuals via droplets and aerosolized particles emitted from the nose or mouth and landing one another individual's nose or mouth, or landing on a surface which is then touched by someone else and carried to their face helps to frame the risks certain settings may pose. Areas that are enclosed or poorly ventilated, facilitate close physical contact between individuals, or facilitate activities where increased shedding may occur have been associated with increased transmission. Additionally, Capitol Hill entertains visitors from across the country and across the globe. People travelling from COVID hotspots may have an increased risk of being infected compared to non-hot spot areas. Mitigation efforts, including public access restrictions, were recommended to reduce the potential risk of infection to essential personnel on the complex.

Question 1B: There is a reasonable likelihood that infected, unmasked individuals who are unmasked would shed more particles into the environment and potentially increase exposure to others when compared to masked individuals. Quantifying any relevant risk deduction is difficult with existing

information. Early in the pandemic, in the absence of vaccine, the only mitigation measures available with those recommended by CDC regarding mask wear, social distancing, and surface cleansing.

Question 2A: Decisions regarding the reopening of the Capitol Hill complex were not made based solely on pandemic related medical conditions. During the period of pandemic operations, following widespread vaccine adoption and other physical measures, the OAP withdrew recommendations limiting campus wide attendance, and the building access limitations were a necessity imposed by security force staffing considerations.

Question 2B: My recommendations were personally conveyed to the bipartisan House Leadership at joint meetings. Security force planning officials were present at those meetings and answered questions from the Leaders directly regarding the security force personnel limitations requiring continued access restrictions.

Question 3A: On July 27, 2021, the CDC announced a reversal of their previous recommendation to wear masks in indoor spaces and regions characterized by high disease transmission risk without regard to previous vaccination status. Three months previously, the CDC relaxed mask wear requirements for those who have been vaccinated; however, a 4th of July weekend series of breakthrough Delta variant coronavirus cases from Provincetown, Massachusetts came to CDC attention. This cohort of patients demonstrated high viral levels in the nostrils of vaccinated and unvaccinated individuals alike and also showed transmission from vaccinated asymptomatic individuals to other individuals. Based upon concerns about the Provincetown cohort, the CDC acted in the best public health interests and recommended a reversal of their previous mask wear instruction that individuals should wear a mask when inside. The Delta agent coronavirus was far more contagious than any previous variant and the actual prevention of infection by vaccination was not supported. The benefits of vaccination were limited to reduction in the risk of serious adverse outcomes such as hospitalization or death. The Delta variant and subsequent variants led to reconsideration of the role of vaccination and recognition of virus evasion of the current vaccine immune protection.

Considerable confusion arose when CDC erroneously inserted a reference to a vaccine study in India (May 2021) as a basis for their mask wear reversal action rather than state their unpublished information from the Provincetown cohort. I can understand how a reader could interpret a reversal of previous guidance based on unpublished information and erroneous references from the country of India, as inconsistent. The CDC director subsequently issued clarifying statements to explain the basis of her decision on July 30,2021.

My considerations at the OAP on July 27th 2021, were not to revalidate the recommendations of the CDC but to act promptly to limit spread of disease among a highly vulnerable population in circumstances where disease transmission and breakthrough infection risk was established to be high, and for which multiple different geographic regional incidences of coronavirus were relevant (The Congress is a highly migratory population). I forwarded the CDC mask wear recommendation reversal when CDC published its recommendation on July 27th. In the 3 months after this decision, the delta variant coronavirus led to the deaths of over one hundred thirty-two thousand Americans, and increased attention to nonpharmaceutical control measures was a necessary intervention.

Question 3B: I am not aware of any person who wishes to live in a perpetual pandemic state.

Question 4A: Yes

Question 4B: In summary, the cited January 30, 2023 Cochrane Library article published findings from a review of 78 different randomized controlled trials and cluster randomized controlled trials that investigated the effect of physical interventions to interrupt or reduce the spread of respiratory virus. This study was built upon a prior review in 2020 to include some additional studies related to the COVID 19 pandemic. Specific outcome subsets included comparison of medical/surgical masks to no mask, N95 masks compared to medical/surgical masks, and hand hygiene compared to control. Related to masking, the authors findings report little to no difference between mask wear and the control group in terms of how many people caught a flu-like illness or confirmed flu/COVID. The authors note their confidence in these mask findings is low to moderate for subjective outcomes and moderate for more precisely defined laboratory diagnoses. They identify the following possible reasons for the reviewed studies did not observe a reduction in disease transmission with mask use: poor study design; insufficiently powered studies arising from low viral circulation in some studies; lower adherence with mask wearing, especially amongst children; quality of the masks used; self-contamination of the mask by hands; lack of protection from eye exposure from respiratory droplets allowing a route of entry of respiratory viruses into the nose via the lacrimal duct; saturation of masks with saliva from extended use promoting virus survival in proteinaceous material; and possible risk compensation behavior leading to an exaggerated sense of security.

Subsequent publications by the Editor-in-Chief of the Cochrane review group on March 10th,2023 indicated that the 3rd party summaries of this review of studies had inaccurately portrayed the Cochrane Jan 2023 conclusions stating there was no difference between wearing a mask or not. The actual finding from the Jan 2023 Cochrane review was that the collection of published studies had numerous limitations such that a definitive conclusion regarding the protective value of wearing a mask was not possible.

> "Many commentators have claimed that a recently updated Cochrane Review shows that 'masks don't work', which is an inaccurate and misleading interpretation," Dr. Karla Soares-Weiser, the editor-in-chief of the Cochrane Library, said in a March 10 statement.

Question 4C: Individuals properly wearing a high quality (N95 or KN 95), well fitted mask in interior spaces with others present, should be confident in the mask's ability to reduce the risk of acquiring coronavirus disease. Health care providers rely upon proper mask wear, high quality masks, and personal protective equipment every day to manage infectious diseases in medical centers throughout the world.

Question 5: Each Chamber promoted social distancing guidelines to best reduce risk of coronavirus in conjunction with Centers for Disease Control guidelines. The guidelines do not speak to parliamentary processes such as voting but highlight the increased risks for individuals of advanced age and medical conditions to assemble in close quarters in interior spaces during times of high disease transmission risk. The manner of conducting the business of the Congress, having individuals travel throughout the country several times per week, and then meet in interior spaces such as committee hearings or in legislative Chambers, falls into the highest risk of disease transmission requiring risk mitigation efforts. The OAP

did not engage in any discussion regarding the Members of Congress location to record their votes. Each Chamber provided measures of compliance and each Chamber provided challenges for improvement.

Question 6: Patient privacy and the security of medical personally identifiable information (PII) are high priorities for the OAP. The OAP utilizes an electronic medical record (EMR) supplied by a well-established third-party vendor that provides service to large proportion of similar sized medical practices in the United States. The OAP works with Housecall and House IT security to enact a layered security approach while protecting PII. The PII dataset is currently housed on an isolated hard wired internal House server with limited access. Contrary to many medical record implementations, it is not a "cloud-based" system. Internet connection or data transfer is not permitted. Any data transmitted to external services is limited in scope and conducted via an air gap process. The EMR application may only be accessed via designated OAP workstations, and staff must undergo a multifactor authentication process for entry. Once accessed, internal permissions allow staff to access only relevant records and functions to perform their required duties. Finally, access and keystroke logs provide an ability to review activities as needed.

Question 7: Approximately 120 per day

Question 8: The OAP employs limited telemedicine capabilities. If unable to conduct an in-person visit, Members may contact and interact with a physician 24 hours a day, 7 days a week via telephone audio and/or video from any location of their choosing. An appropriate treatment plan may be devised based on this interaction. However, telemedicine based diagnostic assessments, such as the ability to take vital signs or conduct advanced portions of the physical exam requiring more than visualization with the naked eye, are not available. If a patient's presentation requires a more advanced assessment, patients are directed to seek an in-person exam at an appropriate interval.

Question 9:

1. Enable specific obligation in legislation where Executive Branch Agencies shall support OAP when requested.

2. Create a non-partisan/non-political, bicameral subcommittee to absorb medical recommendations and implement changes throughout the Capitol complex during times of public health emergency.

3. Immediately augment OAP with a dedicated communications staff and publication staff for concise and prompt public health information during times of public health emergency.

3. Evaluate feasibility of a unified incident command structure (bicameral if possible) for public health emergencies similar to that used during fire/security threats.

5. Create senior-level direct supporting resource conduits to the OAP from the Centers for Disease Control and Prevention, National Institutes of Health, Department of Health and other entities as needed during all hazard public health emergencies.

6. Establish pre-existing relationships with local medical and public health resources to augment OAP personnel with on-site subject matter expertise and clinical support as needed.

7. Establish pre-existing relationships with local occupational health entity to interact with Hill-wide personnel flagged for additional review during daily health inventory screening.

Mrs. TORRES. Thank you.

I have to agree with some of my colleagues on the other side of the aisle. I have pushed back on some advice that you have given me in the past: yellow fever, vaccination, getting my COVID vaccine here versus in California. But we have always been respectful to each other back and forth, and, ultimately, you have led me to do the right thing for myself. So thank you, once again, for being the mature person in the room when dealing health issues for members.

The day after the issuance of the mask guidance related to the Delta variant, Dr. Monahan, there were 80,701 new cases in the U.S. Is that correct?

Dr. MONAHAN. That sounds right to me, ma'am.

Mrs. TORRES. Which Chamber's COVID mitigation procedures tracked more closely with CDC guidelines?

Dr. MONAHAN. The enforcement clearly in the House was more close to that. The spirit of the guidelines was in the Senate also, just the enforcement was slightly different.

Mrs. TORRES. That could be that, you know, we have four and a half times more members gathering than they do?

Dr. MONAHAN. That's correct. You also had approximately four and a half times more cases of active disease.

Mrs. TORRES. Okay. Can you also walk us through that—I don't know, what did we call it, that specialized area that was created for Members to show up and vote in the gallery, which was one of my demise issues during January 6th. We couldn't lock that door.

But could you walk us through that again? Members of Congress could have been—could have come into contact with somebody that was COVID positive while they were here in D.C., not necessarily traveling from California to Congress?

Dr. MONAHAN. Yes. That's correct.

Mrs. TORRES. Okay. That is the extent of my questions, so thank you, again.

I yield back to the chair.

Chairman LOUDERMILK. The gentlelady yields.

I'll now recognize myself for the purposes of asking what will be the final questions of the day, Dr. Monahan, unless other members come back. This is what happens when you usually do two rounds of questions, especially when there's 41 committee hearings going on on Capitol Hill. So it's no reflection on you. It's just how busy things are, as you are aware.

I'd like to shift—just for a moment—I may come back to the—and to the ranking member, on our side of the aisle, we referred to it as the penalty box because it resembled a penalty box in hockey—and as I was advised, they did too.

Actually, before I shift over to some other parts, let me just make sure—I want to close out this issue of the penalty box and all that, of all the discussions we talked about, whether you're positive or negative, but was the decision to allow Representative Gwen Moore to be on the House floor for the Speaker vote only days after testing positive for COVID in contradiction to the guidance at the time, your decision or the Speaker's Office decision?

Dr. MONAHAN. Sir, I couldn't answer that question in a forthright way because I could not get into speaking about a specific mem-

ber's health status. If you could rephrase it without the reference to the person, I could——

Chairman LOUDERMILK. If there was someone who had tested positive for COVID only days before, would it have been within the guidance to allow them to come in and be in the penalty box?

Dr. MONAHAN. I'm not aware of that case occurring, but if someone were to ask me that question, I would say it would not be within the guidance. I would not recommend a recently positive person to enter the Congress.

Chairman LOUDERMILK. Okay. I thank you for not only for the answer but also protecting the privacy of others. Privacy is something that's very important to me.

Now, I'll shift over to kind of more the operations. So, as we've seen throughout the Federal Government, we've had agencies that were very slow to get back to operations, and that's something that we've been focused on is getting some of the different agencies back to work, back in the office. This has been bipartisan as the mayor of D.C. has also been supportive of our efforts to do that.

So, have—of all the health units across House office buildings and the Capitol and the Congressional Visitors Center, I know that you have personnel throughout. I've experienced it even in the Rayburn office building in times past when I needed help: Have all these health units returned to regular hours of operation since the COVID–19 pandemic?

Dr. MONAHAN. Yes, sir.

Chairman LOUDERMILK. Okay. Do you have any staff that are currently teleworking?

Dr. MONAHAN. No, I do not.

Chairman LOUDERMILK. That's good to hear as well. Have health units returned to offering the full suite of specialty services to patients, particularly those paying the monthly or annual fee?

Dr. MONAHAN. That's in progress now, sir. Some of our consultants kind of fell out because of the highly personalized care. Their access to individual one on one care in a small office, say for instance, chiropractic care, for instance, that was suspended. I'm working on resuming that now. I have to setup a contract, establish a provider, et cetera.

Chairman LOUDERMILK. What about physical therapy, was that resumed?

Dr. MONAHAN. Yes, sir, it has. That was never interrupted.

Chairman LOUDERMILK. Okay. I'm glad to know about the chiropractic coming back too. This place causes me to need one now and then.

One last question: Is there anything that your office can provide that we're not currently providing as far as what you've seen maybe a change in the needs of certain specialties, or is there anything that you would—if you were able to make a change in the services you provide, or the way you operate, what change would you recommend?

Dr. MONAHAN. Well, sir, I'd like to be certain that our services are aligned to what the needs are of the population. As you know, as Americans notice, the representation of men versus women who are serving the Congress has changed in the recent decade. So I'd like to have a greater focus on women's healthcare and more spe-

cialty interest in that from buy in from the group that would most benefit from it.

Chairman LOUDERMILK. Well, thank you.

With that, I appreciate you being here today. Members of the subcommittee may have some additional questions for you, and we ask you please respond to those questions in writing.

Without objection, each member will have 5 legislative days to insert additional material into the record or to revise and extend their remarks. If there is no further business, I thank the members for their participation.

Without objection, the committee stands adjourned.

[Whereupon, at 4:21 p.m., the subcommittee was adjourned.]

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