House Homeland Security Subcommittee on Emergency Preparedness, Response and Recovery Holds Hearing on Coronavirus Response

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SPEAKERS:

REP. DONALD M. PAYNE JR. (D-N.J.), CHAIRMAN

REP. CEDRIC L. RICHMOND (D-LA.)

REP. MAX ROSE (D-N.Y.)

REP. LAUREN UNDERWOOD (D-ILL.)

REP. AL GREEN (D-TEXAS)

REP. YVETTE D. CLARKE (D-N.Y.)

REP. BENNIE THOMPSON (D-MISS.), EX-OFFICIO

REP. PETER T. KING (R-N.Y.), RANKING MEMBER

REP. JOHN JOYCE (R-PA.)

REP. DANIEL CRENSHAW (R-TEXAS)

REP. MICHAEL GUEST (R-MISS.)

REP. MIKE D. ROGERS (R-ALA.), EX-OFFICIO

[*]PAYNE: The Subcommittee on Emergency Preparedness Response and Recovery will come to order. The subcommittee is meeting today to receive testimony on community perspectives on coronavirus preparedness and response. Without objection, the chair may declare the subcommittee in recess at any point. Without objection, members not sitting on the subcommittee will be permitted to participate in today's hearing. I now recognize myself for an opening statement.

House Homeland Security Subcommittee on Emergency Preparedness, Response and Recovery Holds Hearing on Coronavirus Response

Good afternoon. We are here today to discuss the coronavirus, also known as COVID-19. We are at a critical point in responding to the coronavirus crisis that is facing our nation. Americans are concerned. Hundreds of Americans are sick. Sadly, there are families mourning the loss of loved ones from the coronavirus, and our hearts are with them. The nation is seeing cases on the rise, and experts say the outbreak is getting worse. In New Jersey, we were just informed that we had our first death from coronavirus, and at least two dozen schools are closing for coronavirus preparation. And we have seen an increase in presumed cases.

State and local governments are working tirelessly to limit the spread of the coronavirus in our communities. At the federal level, we have seen our experts at the CDC and others--other agencies working to address this issue. Unfortunately, we have also seen federal officials offer mixed messages on the seriousness of the coronavirus. We are not here today to point any fingers, but we must tell the truth.

The American public needs to be able to trust the information coming from all levels of government. It is now more important than ever for our leaders to trust science and speak with clarity and precision, so that Americans can trust what they are hearing. It is helpful (PH) to the outbreak response for the administration's staff to state as recently as last week that the virus is contained when we know that is not true, because cases are on the rise.

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

Let's be clear, I want the federal response to the coronavirus to be robust. No one is rooting for failure, but I have seen--what I have seen is leading me to believe--leading me to become very concerned. With that said, the goal of today's hearing is to understand what as members of Congress can do to minimize the coronavirus outbreak for the American public. We need to hear today how Congress can support state and locals in preventing the spread of this virus.

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

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

KING: Thank you, Mr. Chairman, and I also want to welcome and thank all of our witnesses today for taking the time to be here. All of us have a lot to learn on this, and I look forward to your testimony. The novel coronavirus or COVID-19 has already claimed thousands of lives across the globe, including over 20 here in the United States. And I think as we realize, those numbers could be changing by the hour. They could be different by the end of this hearing, for all we know.

This is not the first time, though, our country has had to deal with an outbreak, and it likely won't be the last. And we've been preparing for a situation such as this. Last year, the Department of Health and Human Services conducted the Crimson Contagion 2019 Functional Exercise, a multistate whole-of-government exercise to assess the nation's ability to respond to a large-scale outbreak. Last summer, the president signed into law the Pandemic and All-Hazards Preparedness Act. And since 2015, under Republican and Democratic leadership, funding for infectious disease response has increased by 70 percent. That's 70 percent in five years.

While the virus is here now in the United States, we didn't see the first case until mid-January. Implementing travel restrictions bought us time, and mandatory quarantine helped us to initially contain the spread of the virus. Unfortunately, through community spread, positive cases for COVID-19 have now been reported in over 30 states. The New York State Department of Health is reporting over 140 positive cases. Again, that's as of this morning. At the rate they're going, I think there's already several more just in my county today. And a state of emergency was declared just this past weekend.

Blind panic won't help us stop the virus from spreading. Cooperation, information sharing, and strong leadership are what is critical to successfully deal with a situation of this magnitude. We must ensure that proper protocols are put in place and that the federal government works hand-in-hand with our state and local partners. As recommended, a National Blueprint for Biodefense by the Bipartisan Commission on Biodefense, I was pleased to hear last week's panel of witnesses agree with the president's selection of the vice president to lead the Coronavirus Task Force. To achieve a whole-of-government coordinated response to this outbreak, it is important that the person in charge has visibility of the entire government and a direct line to the president. The vice president is the right choice.

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

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

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

And at the federal level, and I would disagree with the Ranking Member on this as far as muzzling, I think it is important to get a coordinated response out. And again, there's valid criticism that can be made, but I think we should try to keep it in focus and try to find ways to go forward. Otherwise, you have one side attacking the other and then it goes back, and the American people get more confused than ever.

So I'm not here to make excuses, I'm not here to explain away things, but I think it's important that we try to treat this as the serious issue that it is. And again, the more briefings we get, the more serious we realize it is, and we should try to keep that focus in that way.

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

PAYNE: Thank you, and did you mean--

KING: I meant chairman; I was lost in the past.

PAYNE: --in the reference to muzzling, did you mean the ranking member or the chairman?

KING: I was lost in the past, in the glorious past when I was chairman and you were ranking member.

PAYNE: Glory days, glory days. Yes, okay. Thank you.

KING: I certainly commend you as our chairman.

PAYNE: Thank you, sir.

KING: I see you've got laughing over there.

PAYNE: Other members of the subcommittee are reminded that under the committee rules, opening statements may be submitted for the record. I want to welcome our panel of witnesses today. Our first witness is Mr. Ron Klain who is, among many other positions in public service, was the White House ebola response coordinator during the Obama Administration, and can provide lessons learned from his time battling a previous public health emergency.

We also welcome today Mr. Christopher Neuwirth, the assistant commissioner of the Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness for the New Jersey Department of Health. In his role, Mr. Neuwirth provides strategic and operational leadership to coordinate New Jersey's hospital and public health disaster resilience laboratory services, and emergency preparedness and response. Welcome.

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

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

GUEST: Thank you, Mr. Chairman. It is an honor for me to introduce fellow Mississippian, Dr. Thomas E. Dobbs, III. Dr. Dobbs is the state health officer at the Mississippi State Department of Health. Dr. Dobbs has served in this role since 2018. Dr. Dobbs has also held previous positions as the health state officer and the state epidemiologist. He is board certified in internal medicine and infectious disease, and practiced in Mississippi before joining the Department of Health. Dr. Dobbs holds a doctorate of medicine and a masters in public health from the University of Alabama at Birmingham.

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

Thank you, Mr. Chairman, and I yield back.

PAYNE: And thank the gentleman. Without objection, the witnesses' full statements will be inserted into the record. And now I ask witness to summarize his or her statement for five minutes, and we are going to keep strict time today, beginning with Mr. Klain.

KLAIN: Thank you Mr. Chairman, Ranking Member King. Thank you for having me here today. Before I begin, I'd like to make two preliminary points. The first, as frustrating as it may be, there's still a great deal we do not know about the coronavirus and the disease it causes. In fact, we know less about the coronavirus today than we did about ebola in 2014. Scientists are working at breakneck speed to improve our understanding, but as we learn more, our response to the virus will have to change.

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

With those two preliminary points made, I want to move on to how we can use the lessons we learned in the ebola response to approach the current threat. To be clear, the ebola response itself was not without problems and mistakes, but ultimately, President Obama mustered an all-of- government response to the challenge, authorized the first ever deployment of U.S. troops to combat an epidemic, and pointed me to lead a team of talented and dedicated professionals at the White House to coordinate the effort.

In the end, that epidemic was tragic. 11,000 people or more died in West Africa. But in September of 2014, there was a forecast that 1 million lives would be lost. America's actions as part of a global response saved hundreds of thousands of lives. The ongoing legacy of this work is enormous. With congress's support, we implemented a national four-tier network of hospitals and medical facilities that remain prepared to this day to identify, isolate, and treat cases of dangerous infectious diseases. Nothing like that existed in 2014, before we started, and work on vaccines and therapeutics as well.

Now, the challenge we face from the coronavirus epidemic is different in many ways, but it contains some similarities, and so I think it's worth thinking about the lessons that can be applied in this case. First, in a complex rapidly evolving scenario like we're seeing, there is no substitute for White House coordination and leadership.

At the end of my tenure as ebola response coordinator, President Obama accepted my recommendation to create a permanent pandemic preparedness and response operation inside the National Security Council that continued through the first year of the Trump administration. But in July of 2018, that unit was disbanded.

The administration's decision now to go through a series of different structures, first no task force, then a task force led by Secretary Azar, then a task force led by Vice President Pence, then Ambassador Birx coordinating the response, has produced uneven results. And certainly, has contributed to the largest fiasco in the U.S. response, the failure to promptly enable widespread testing for the virus, which definitely is a result of some lack of coordination between the CDC and FDA. There is simply no reason, none, why the United States lags behind nations like South Korea and Singapore in protecting its people.

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

Third, the U.S. has to lean forward in fighting this epidemic oversees, as that I think will become an increasing priority. Unlike what happened in West Africa in 2014, the nations of China or Italy where it's--or South Korea--do not need our help in responding. But this disease could easily spread to Africa and to other countries where we might have to step up and do the same kind of things we did in 2014.

Fourth, the administration must move quickly to implement the emergency funding bill passed by Congress last week. Congress deserves great credit for acting with unprecedented speed in funding this response. But passing a funding bill is only the first step, not the last step. Congress needs to make sure that the administration is getting that money out and getting it out quickly and effectively.

Too often, bills get passed and they don't get implemented. That has to be a priority. The White House Task Force should report regularly to the American people on the pace and deployment of the funding Congress provided. Where is the money? When is it getting out? What's going to be done?

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

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

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

Thank you, Mr. Chairman.

PAYNE: Thank you. The chair now recognizes Mr. Neuwirth to summarize his statement for five minutes.

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

I'm here before you as the assistant commissioner for the Division of Public Health Infrastructure, Laboratories, and Emergency Preparedness. I'm responsible for public health emergency management, emergency medical services, and the public health and environmental laboratories.

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

Throughout January, the Department of Health actively monitored the public health situation arising from Wuhan City, China. Our public health experts and epidemiologists readily identified a concerning novel pathogen that undoubtedly had the potential to escalate into a global pandemic. Under the leadership of Commissioner Persichilli on January 27 I established an internal crisis management team using national incident management system principles to coordinate preparedness and response activities from across the department.

Shortly thereafter on February 3, Governor Murphy signed executive order 102 creating a statewide coronavirus task force led by the commissioner of health. Since their creation the crisis management team and coronavirus task force have provided the State of New Jersey with an intimate command structure that has allowed all the parties to effectively organize, coordinate and prioritize their preparedness and response activities. Simply stated, New Jersey continues to successfully manage the public health crisis because of our strategic organization, subject matter expertise and our collective institutional knowledge.

While I certainly could continue describing all the great work New Jersey is actively doing, I must draw your attention to the two most important aspects of any nationwide public health response. Coordination and communication, on Sunday February 2 during the afternoon of Super Bowl Sunday the New Jersey Department of Health was notified that North Liberty International Airport would officially be designated as the 11th funneling airport in the United States with the first arriving flights arriving within 24 hours with more than 350 travelers onboard from China.

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

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

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

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

But, despite our great partnership with our federal colleagues, the State of New Jersey expends more than $1.8 million per month responding to novel coronavirus. While our CDC award of $1.75 million is greatly appreciated, it certainly will not cover the continued expenses incurred by the state or the healthcare and public health infrastructure, including our acute care facilities, EMS agencies and local health departments. Recognizing that medical supplies are facing a historic shortage and that healthcare supply chains is nearly frozen for respirators, disinfectants and other personal protective equipment, we urge you to consider additional funding to New Jersey and the distribution of items from the strategic national stockpile.

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

Thank you.

PAYNE: Thank you, sir. And our next witness, which I was told by my staff that I butchered your name, so I will try to do better, Ms. Gracia. I'm sorry about that. I now recognize you to summarize your statement for five minutes.

GRACIA: Thank you, Chairman Payne, Ranking Member King and all the members of the subcommittee, good afternoon. My name is Dr. Nadine Gracia and I'm the executive vice president and chief operating officer at Trust for America's Health, also known as TFAH. TFAH is a non-profit, non-partisan public health organization, which among our priorities has focused attention on the importance of a strong and effective public health emergency preparedness system. Over the past nearly two decades TFAH has published an annual report called Ready or Not, Protecting the Public's Health from Diseases, Disasters and Bioterrorism. In our most recent report we identified areas of strength in our emergency preparedness, as well as areas that need attention at the federal and state levels. Discussion of our report findings, including our state assessments, can be found in my written testimony or on our website.

I would like to highlight some of TFAH's policy recommendations to build our nation's preparedness for our public health emergencies and improve the national response to the novel coronavirus disease or COVID-19.

First, we applaud Congress for rapidly approving a robust emergency federal funding package. Federal agencies should be preparing now to quickly distribute funds to states and other partners. Second, Congress must prioritize ongoing investment in core public health annual appropriations. The nation's ability to respond to Covid-19 is rooted in our level of public health investment in the last decade.

The nation has been caught in a cycle of attention when an outbreak or emergency occurs, followed by complacency and disinvestment in public health preparedness infrastructure and workforce. The public health emergency preparedness line, which supports frontline state and local public health preparedness has been cut by over 20 percent since fiscal year 2010, adjusting for inflation and on top of steady cuts since 2004.

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

Third, we need to ready the healthcare system for outbreaks. Health systems across the nation are beginning to identify, isolate and care for patients with Covid-19. Healthcare must prioritize the protection of patients and healthcare workers, including appropriate training on infection control practices, personal protective equipment and surge capacity.

Unfortunately, funding for the hospital preparedness program, which helps prepare the healthcare system to respond to and recover from emergencies has been cut nearly in half since 2003.

Fourth, Congress should support the medical counter measures enterprised including BARTA (PH) and the strategic national stockpile, which build the pipeline of vaccines, treatment, medical equipment and supplies for health security threats.

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

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

In fact, only 55 percent of the workforce has access to paid time off. Congress should pass a federal law to require employers to offer paid sick days as soon as possible. Finally, science needs to govern the nation's COVID-19 response led by federal public health experts who have years of experience in responding to infectious disease outbreaks. Keeping the public and partners informed will be critical. We encourage elected officials and community leaders at all levels to make policy and communications decisions based on the best available science, understanding that the situation is evolving rapidly and messages may change.

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

The full extent of this outbreak in terms of public health, healthcare and the economic and societal costs remains to be seen. We do know that taking immediate steps to mitigate the effects of this outbreak will save lives and prevent harm.

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

PAYNE: Thank you. I now recognize Dr. Dobbs to summarize his statement for five minutes.

DOBBS: Chairman Payne, Ranking Member King, distinguished members of the committee, thank you all so much for having me. Let me get a little closer. Yeah, is that better? All right, great, thanks.

Hey, thank y'all for having me. I really look for the--look forward to the opportunity to talk a little bit about why public health is important, why is it different from healthcare, why is it really relevant to what we're talking about right now.

When I was in medical school back in the nineties, I thought I was going to be a medical scientist and I spent, in my initial part of my career and much of what I was doing, I was working on HIV control and tuberculosis control, not only in the American south, but also too, in southeast Asia and--and in Russia. And, learned a lot not only about medical things, but the value of public health.

If you want to have an impact on what goes on in a community, you can't look simply at the individual, you have to look at the community and the environment that surrounds that person. And, it's this public health investment that allows us to do the work that we need to do to make sure that the public, the community, and the individual is maximally protected.

Now, switching a little bit to the coronavirus conversation, so coronavirus is a virus and although most people will get over it without a lot of (INAUDIBLE), it will be very impactful, especially for our older folks, as we've seen the mortality rate among older people infected has been--has been really bad. And, we need to make sure that we--we tailor our responses to those that are going to be most affected.

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

The things that we've learned year after year from not only our sort of micro outbreak responses, but also, too, from these major things like H1N1, we're talking about Ebola, Zika, chikungunya, we build up expertise. We build up capacity. We build up tools.

When we talk about Ebola virus, we scrambled, right, because it was a new thing and what do you do and we're--you know, the community is really scared about what's going to happen with people in the community. So, we--we basically put together technology to do home monitoring using mobile devices.

But, building on that foundation, we were then able to go on to use this for our folks coming over for coronavirus. These historical lessons help us work to the future. But, one of the challenges that we face is this bolus of funding up and down where sometimes we will get specific money to address a specific issue, like Zika or like Ebola, but then as that crisis resolves or sort of diminishes, then we have to contract back to a state of acceptable but not sufficient readiness.

When we look at what's going on in Mississippi right now, we have activated our agency emergency response functions and we are working closely with our state and emergency management agencies. Within Mississippi and other states, we have a pandemic response plan that's tailored around influenza, but we know that the elements within that plan are well suited to the response for a pandemic of coronavirus.

And, pulling together different experts within our state, especially under the Governor Reeves passed an executive order, putting a new planning committee, we are going to leverage that information that we got from responding to H1N1, making sure we're prepared for that next flu pandemic to move forward.

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

Also, let's talk about innovation. I think innovation is very important, making sure that we innovate not only in technology for surveillance, because the things that we use for public health are high tech, data rich environments. We just recently, in Mississippi, invested in artificial intelligence business analytics, trying to look at what's going on with outbreaks in our state.

These are things that are not inexpensive, but it's not only the software. It's also the people that you have to do that. If you want to have the best people doing the most important job, we need to make sure that we build up our public health workforce and have the people there that can do what they need.

And, then telehealth, I would like to really say I appreciate the--the creativity of expanding telehealth options as we're looking at this COVID response, because what's going to be better than making sure people can be taken care of in their home even if they're unable to get out or if they're ill or if they're being monitored. But, also, too, these older folks who might need to be coming in for other non-medical reason besides a viral illness, they can stay home and be cared for and not come into the healthcare environment where they're going to be exposed to these potentially dangerous things.

And, we're proud in Mississippi to have a Telehealth Center of Excellence where we are advancing telehealth capabilities to reach people in all sorts of areas, and the Department of Health has--has partnered with them.

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

PAYNE: Thank you. I'll now recognize myself for five minutes of questioning. (OFF-MIC) Thank you.

This--this question would be to all the panelists. Many--many have criticized the administration's outbreak response for being too slow to realize the severity of the threat. How would you assess the U.S. government's response? And, what aspects of the government's response could you--could be improved upon? Mr. Klain?

KLAIN: You know, Mr. Chairman, I'd say there's two things where we're lagging quite badly. The first is this testing issue. Again, as I said in my statement, there's no reason why other countries, South Korea, are so far ahead of us, hundred thousand plus tests in South Korea, less than five thousand in the United States, and I think that's a product of some bad decisions made at the CDC and a lack of a real effort to accelerate testing around the country.

The second thing I think is hospital preparedness. In various communities, our hospitals are going to see an influx of cases and I don't think they've been prepared for dealing with that, whether that's working with FEMA to temporarily ramp up capacity in those hospitals or to do things like they're doing in Korea and Germany with drive-thru testing, other things.

We need to be creative and flexible about really increasing the capacity of our system to deal with the influx of cases we're going to see.

PAYNE: Thank you. Mr. Neuwirth?

NEUWIRTH: So, I would agree with Mr. Klain in that the testing capabilities of each state are something that, you know, needs to be addressed. Here in New Jersey, we've only received two test kits to date, recognizing that, you know, our nine million residents are actively dealing with SARS-CoV-2, novel coronavirus.

We would expect additional capacity in the state of New Jersey to effectively and efficiently test everybody that needs to be tested. And, to date, those two tests--two test kits, you know, are something that needs to be addressed.

The second is that recognizing how fast moving the situation was, even back in January, it's important that information be shared in a timely manner as effectively as possible and ensuring that decisions made at the federal level are effectively communicated to the state to ensure that the states are in a position and maintaining a posture to implement those policy decisions made at the federal level.

The greater lead time that the states are given, the more effective and appropriate those implementations are.

PAYNE: Thank you. Ms. Gracia?

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

Secondly, the importance of continuing to rely on the science and the evidence to make decisions, whether it's policy decisions, public health guidance that is being put out by the federal agencies, that we continue to rely upon the expertise and the experience of the scientists, as well as the medical and public health experts.

PAYNE: So, we need to believe and trust the science that is coming along. Thank you. Dr. Dobbs?

DOBBS: Thank you. You know, it's been a very complicated and rapidly evolving situation. I understand it's very challenging. By and large, CDC has been very responsive to our needs. I can call the leadership pretty quickly.

We, in Mississippi, we're a little bit behind in the sense that we don't have much in the way of testing, but we do have adequate testing capabilities at this time. I would say that early on, if we were given some more flexibility in who we test, I think that would have been good. There were pretty strict guidelines at the--at the beginning.

The other thing is, you know--and this is part of preparedness to begin with. I think the CDC coordination with border patrol was a little bit difficult at the very first when we were getting our travelers in. We had a little bit of hiccups with that.

But, they've been very responsive and it's a difficult situation and I just really do appreciate the work of CDC and--and the assistance that they give us.

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

KING: Thank you, Mr. Chairman. Let me just, I guess, ask Mr. Neuwirth and Dr. Dobbs. Again, you sort of touched on this already. But, what improvements could be made in coordination with the federal government now? I mean, allowing for whatever has gone wrong in the past, but as of today forward, the last several days going forward, how do you see the level of coordination and what improvements can be made?

DOBBS: Well, I think the coordination, even among federal agencies, would be good, because we have seen some miscommunications between those levels, which then kind of--which kind of trickles down to us that can be a little bit difficult. You know, quick communications are very important and by and large, I think that's--that's been very good.

I think clear understanding--understanding of what funding is going to be available and what we can use it for, and also I can't say how much I support the hospital preparedness program. I think that that's been cut some over the years. That's really a foundational element for these sorts of responses.

We have pulled back from, I think, actually cashing up as many supplies and PPEs as we had in years past because the priority on that has shifted a little bit. I think that would be very important.

PAYNE: Mr. Neuwirth?

NEUWIRTH: Specifically referencing Joint Base McGuire--Joint Base McGuire-Dix-Lakehurst, you know, this is a--a base used by, you know, our federal partners as a potential housing solution for quarantined individuals. New Jersey has put forth a remarkable amount of support and resources to ensuring that this housing solution remains intact and fully functional to meet the demands of the situation.

And, you know, the base was operational for an initial two week period and the state, up until the absolute deadline of Friday at 8 AM, was unaware whether or not the base would remain operational for the quarantine--as a quarantined housing solution. So, ensuring that, you know, New Jersey can appropriately support, you know, this housing solution moving forward, you know, this is one example of where understanding where the federal government sits as far as (INAUDIBLE) and how we can best support it is important to us.

PAYNE: Mr. Neuwirth, since New York and New Jersey are so close, I have very parochial interest in this, and we have probably tens of thousands of more commuters back and forth every day. How--what's the level of coordination between the states and also I know Governor Cuomo has gotten approval for New York to do its own testing. Has New Jersey applied for that approval?

NEUWIRTH: Yes. So, we're--we are doing our own testing in--in the state, right now as of today. The state's public health environmental laboratories is the one in New Jersey performing the tests in state and ensuring a rapid turnaround time as best we can.

We are in lockstep with our New York City and New York State partners. You know, we have--you know, historically, we have had a phenomenal relationship with the city and the state, just because of our close proximity,

the way we manage and deal with the risk together, how we conduct our preparedness response activities are often in lockstep.

And, so it's the historical relationships that we've been able to leverage for this event that has ensured the relationship has been maintained and leveraged so that both sides of the river are fully aware of what the other side is doing so that we're--we remain in lockstep.

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

And, Governor Cuomo announced something today. I just wonder if this was ever contemplated, if the Ebola virus had not been contained the way it was. He has actually ordered the National Guard into Westchester County and (INAUDIBLE) going to be a one mile containment zone. Basically, it originates from a synagogue and it's--I think now there must be 50 to 100 cases, if not actually diagnosed, but certainly people being tested from that area.

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

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

I do think, though, that this subcommittee should look at the issue raised by this, you know, kind of quasi quarantine of New Rochelle and what other measures could effective. And, I also think thinking about the National Guard or FEMA to help increase hospital capacity, tent hospitals or rapid treatment centers, I think, you know, we're going to need person power to help respond and at a time when our healthcare system, you know, we're going to see doctors and nurses drop out because they're sick. They're going to get the virus too.

So I think, you know, thinking creatively about who can really help power this response is an important thing.

KING: So as far as--oh, I'm sorry. My time is--I yield back. Thank you very much.

PAYNE: Thank you. The chair now recognizes the gentle lady from New York, Ms. Clarke.

CLARKE: Thank you very much, Mr. Chairman. I thank our ranking member and our expert panelists for coming in to share your expertise with us today. We know that America needs a fully funded whole of government response to stay safe against the coronavirus. In my home state and steady city of New York, we're in the midst of an unprecedented health crisis.

Leaders should not minimize or exaggerate the scale of the task before us. We can be the coronavirus, but the administration needs to set politics aside and put scientists in the driver seat. Having said that, Mr. Klain, after weeks of stating that enough resources were available to fight the coronavirus, the Trump administration finally announced that it was seeking an admin emergency supplemental to make additional resources available. This request was made more than a month after the first recorded case of coronavirus was discovered in the United States. How would a timelier response--or how would a timelier request, excuse me, have helped the U.S. respond better?

KLAIN: Congresswoman, I think that's a good question. I testified before the foreign affairs subcommittee about a month ago and said that the request should already be here and Congress should be acting on it. I do think that more funding might have accelerated this testing situation, it might be helping states more quickly, and I think it's important to know, again, Congress deserves great credit for passing this funding quickly, but the real question is how quickly does it go from Washington out to the states?

The gentlemen and ladies to my left here, you know, they're going to have to actually make this work on the ground and they can't unless that money moves from Washington to them. And I think that's really where we should be focused on now is once Congress did this incredible thing of in two weeks writing and passing a bill is the money really getting out there to ramp up testing, to ramp up healthcare systems, to help the people who are going to need the help.

CLARKE: Very well. So this question is for both you and Dr. Gracia. I think many of us in Congress were shocked and disappointed that the administration's initial proposed amount for the emergency supplemental was only $2.5 billion. Luckily, Congress passed an $8.3 billion supplemental was significantly more robust and then the administration's request.

What more can the government do to ensure that there's enough funding to support state and local outbreak response efforts? And I'd add to that, leaving an infrastructure in place so that we are not rebuilding the infrastructure time and time again as the outbreaks occur, because certainly there will be others.

KLAIN: You know, Congressman, I agree with that. So strongly and I kind of agree with what Dr. Dobbs said earlier. The issue sometimes is the amount of money and the other issue is the consistency of the funding. We today are in the middle of an epidemic and that's what we're focused on, as we should be. But we're only three years away from the next one and three years from the one after that and three years from the one after that.

And it's these boom and bust cycles and funding that really undermine our preparedness. And I think--I hope that what Congress will take out of this is great job on the emergency supplemental, but what are we doing to prepare for the big threat that is out there in the future?

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

We look at, for example, the public health emergency preparedness grant that's the administered by the CDC. That that has experienced cuts over the years 20 percent more than 20 percent over the past decade or the hospital prepared preparedness program, which has been cut in half since 2003. These are important funds to really be able to support public health over time to be able to continue to have the type of emergency preparedness response infrastructure for surveillance for the workforce.

It's very difficult to hire individuals for the short short-term and be able to guarantee that they are going to be able to stay on board and really build that training and capacity within the public health departments. And there also is a need for--for more funding as a relates to the core capabilities and public health. Things like pandemic preparedness, but also communications expertise, epidemiology and surveillance expertise. The ability to bring together coalitions, these types of areas are truly fundamental for core public health.

CLARKE: The Trump administration has repeatedly attempted to cut funding to public health. Could you describe how chronic underfunding a public health makes the United States more vulnerable to outbreaks? Yeah, I'm sorry. Ms. Gracia

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

But as I--as I noted earlier, what we need to do is really build on the expertise from these previous outbreaks and other types of public health threats. These are the individuals who have been through these types of outbreaks and other public health emergencies in the past and recognizing the need to have stability in that funding so that it is not at risk, we have seen, for example, over the past decade the budget to the Centers for Disease Control and prevention has declined by 10 percent and a large percentage of CDC's budget goes to state and local health departments.

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

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

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

DOBBS: (OFF-MIC) part of it may be that the timing was advantageous, but we were able to bring up the COVID testing pretty quickly. Our public health lab within a week of getting the reagents and the guidance was able to get the testing activated. So far, we haven't done a ton of tests.

We got about 50, but they're all negative. We've got many coming in every day. We think we have sufficient capacity to meet demand for the near future, but also forcing now with private lab capacity coming online like LabCorp and others. That will help with the clinical environment and I'm looking forward to the opportunity where public health can fulfill a different role, which is mostly going to be surveillance so we can have a better understanding of what's going on in different communities and also maybe acute testing. You know, we can--we can run it in about four hours after we get a specimen. So if there's something that needs to happen right away, we can't--we can execute that.

GUEST: And can you talk a little bit about your response that you've received so far from CDC?

DOBBS: In response to the testing, it's been good. The information that they've been giving us has been very helpful. Their guidance has been very good, especially their guidance documents for clinical scenarios. I will say their website is kind of cumbersome. I need to talk to them about that.

It doesn't come as fast as you'd want it, honestly. I mean, we were always sitting on go for the next thing, but the quality of the work has been good from our perspective.

GUEST: And Dr. Dobbs, you talked in your opening statement and some of your questioning and then in your written statement about the use of Telehealth and you say here that Telehealth will greatly assist in community mitigation efforts by improving efficiencies, permitting ill patients to stay home and allowing non- COVID-19 patients access to healthcare without coming into physical contact with a clinical environment. Could you--could you explain that very briefly again?

DOBBS: You bet. If--if you think about who is at risk for bad outcomes from COVID-19, it's going to be older folks, primarily. People with chronic medical conditions, and these are people that are going to access the healthcare system quite frequently. And a lot of it is going to be non-urgent, things that can be done through a Telehealth platform.

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

GUEST: And is it conceivable that Telehealth could be used to help screen individuals as they are coming into the country through ports of entry?

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

GUEST: And Dr. Dobbs, you talked about the importance of the hospital preparedness program. Could you expand on that just a little bit?

DOBBS: If we think about who's the boots on the ground, who are the people that are going to respond locally when something goes--goes awry, it's going to be those local community folks. It's going to be the local emergency management folks. It's going to be the hospital's. It's going to be the clinic. It's going to be the people who are in that area and the hospital preparedness fund helps--lets us organize these healthcare coalitions so that we can have a reach into the communities and respond but also make sure that hospitals are ready not only in supplies but also planning because they're going to be at the front line.

And the thing that worries me more about this than anything is going to be resource utilization within our hospitals in intensive care units. Even now if we have a bad flu year, we run out of intensive care unit beds. So having that core infrastructure to make sure that we're ready when something above and beyond happens is going to be very important.

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

DOBBS: Yes, absolutely. And then--and also even within the HPP program, there are some flex abilities that might help like, for instance, we have that warehouse of PPE that we sit--that we keep--we have about 200,000 masks that we can distribute immediately if we need too. So we're ready to go. But based on some of the structure of that HPP program, we only can use 10 percent of over--of it for overhead administration, but they count rent for the warehouse as overhead. The menstruation. So we would welcome flexibility and funding for HPP as well.

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

DOBBS: Yes. We have got a laundry list of things that we want to do. We want to expand surveillance, we want to increase lab capacity, we want to expand on our informatics. We've already started doing some advanced analytics using bioscience to figure out where cases are going to be. We want to make sure that we have resource allocated for like PPE or other things to support hospitals.

We want to--I've already brought on three doctors. I don't know how I'm going to pay for them, but I guess this is how. And then nurses, boots on the ground to get the work done and then advancing technology and equipment and other PPE needs.

GUEST: Thank you, Dr. Dobbs. Mr. Chairman, I yield back.

PAYNE: Thank you. The chair now recognizes the gentlewoman from Illinois, Ms. Underwood.

UNDERWOOD: Thank you, Mr. Chairman. And thank you to all of our witnesses for being here today. It's a pleasure to see my former colleagues from the Obama administration here today as we try to a path for Congress to lead the response to the coronavirus. Mr. Klain, what essential leadership functions must our federal government fill when it comes to helping the public, state, and local public health departments, employers, and our healthcare system navigate this public health crisis?

KLAIN: Congresswoman, I think it's a question of both confidence and confidence. So I think on the competence side, the government has to provide that leadership and the funding to deliver this response. This is going to be a giant project to manage these cases, to rule out testing as the panel has discussed, to help our healthcare system get prepared for the influx of cases, and to deal with all the other things. The contact tracing in the state and local health departments are going to do as we move towards containment and all these other things.

And so the government--the federal government has to provide expertise in the form of the CDC and people at Asper and BARDA and other agencies. It has to provide funding, it has to provide leadership. But also has to provide confidence. I think we need to see from Washington clear direction and messaging so the American people can panic less and can understand that there is a plan in place and a way of attacking it and so on and so forth. And I think both those things we just have not hit the mark on that yet and we need to do better on both those fronts.

UNDERWOOD: Thank you. Dr. Gracia, you recently published a report evaluating state's ability to respond to public health emergencies like the coronavirus. What did you learn from publishing that report about the actions the federal government must be taken to support state and local public health departments in addition to providing supplemental funding?

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

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

So when we think about what the federal government can be doing, it's really helping to support that capacity for state and local health departments, ensuring that there is that stability of funding so that that type of coordination, that expertise in that capacity can continue to be built in states and localities to do exactly as, for example, Dr. Dobbs has spoken about, is having the workforce that is trained, having a laboratory capacity, the surveillance that's needed.

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

GRACIA: Yes. You know the flu and--and what we see, for example with seasonal flu outbreaks demonstrates a couple of points. One, it shows how public health departments often are having to deal with multiple types of crises at the same time and so how they can be stretched with regards to really being able to respond to the needs of the public.

But secondly, because with the flu vaccine, it is a vaccine that is recommended for almost the majority of the population. It is recommended by the CDC for individuals who are six months and older. It also demonstrates what our vaccine infrastructure looks like in particular with regards to if we were in need of doing a mass vaccination campaign, for example, for adults. With children, children are seeing their physicians and--and other healthcare providers more frequently, with adults that may be more difficult.

And so in looking at how we are actually doing with seasonal flu which as a nation the--the average, national average for seasonal flu vaccination is 49 percent whereas the actual recommendation from the Department of Health and Human Services in healthy people 2020 is to reach 70 percent. We recognize that there are

shortcomings and gaps with regards to that infrastructure that entails public health departments, healthcare, commercial entities as well to ensure that the--that the population is vaccinated.

UNDERWOOD: And do you want to speak about why flu vaccination is so--such an important part of our response to this threat?

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

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

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

PAYNE: Thank you. The chair recognizes the gentleman from Texas, the Longhorn state, Mr. Crenshaw.

CRENSHAW: Thank you, Mr. Chairman. Thank you all for being here on this important topic. This question goes to the gentleman from New Jersey and the gentleman from Mississippi. I just want to get your take on--on the proper roles at the state level and the federal level. We--we--we hear they are unprepared, we hear we are way unprepared or we here we are doing pretty well. It--it is all relative in the end how--how well prepared we are. So I want to get an idea from you at the state level what does preparedness look like at a reasonable at--at a reasonable standard? And--and what is the different function of--of a local county public health center versus the state level versus the federal level? How--how--what is the best way to interact?

NEUWIRTH: So first and foremost preparedness looks like having the funding and resources needed at all levels of government to adequately respond to what we are seeing day to day, and that requires our acute care facilities, our hospitals, our long-term care facilities, our health departments having whatever they need immediately to conduct their job, continue providing high-quality clinical care to those that are ill, allow the resources and staffing and--and information needed at the local health departments to ensure appropriate case management, contact tracing and--and overall management of you know the pathogen in the communities as--as needed.

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

CRENSHAW: Can--can we get an example and then I kind of want to dig into the preparedness because you basically just said when everything is really perfect that is prepared but--but that is not reasonable. I ask for a reasonable standard, so you know so I mean like how--how much better can we be reasonably? I mean, you know I want to have reasonable conversations here.

Of course, I could--we could quadruple your funding, and then you would be more and more prepared, and you will come back next time and ask for even more money. I know how this goes, and that's all fine. Of course, we want to keep getting better but within a reason--within a reasonable construct what does prepared look like? How many masks? How many pieces of equipment are reasonable to ask for and that we should have had ready prior? What is--what exactly are we not--is the federal government not communicating to you effectively?

NEUWIRTH: What has been said moments ago that continued funding over the past several years to continue to maintain what we have built upon from previous outbreaks such as Ebola, Zika, the opioid crisis there has been a

lot of work that has been maintained, but the increases and decreases of funding year-over-year degrades the preparedness activities that we have put into place and so ensuring that again that the resources are available to the states (INAUDIBLE)

CRENSHAW: That the federal--it is the federal government's job to make sure these states have the resources but--but so what--what--where is the state's role in that and why--why can't you be ready to the standard that you have set yourself--set for yourself?

NEUWIRTH: We are ready to the standard we have set for ourselves. It is a matter of maintaining that level of preparedness year-over-year because in between those years the states are managing disasters, public health, natural disasters, technological that we use those resources and those preparedness activities to respond to and so it requires tight coordination and support from the federal government to ensure that you know year-over-year as the states prepare for and respond to various disasters that that capability is rebuilt and you know exercised and ready for the next disaster.

CRENSHAW: I'm just trying to get more details because I'm trying to get examples on exactly what--where did we fall short and--and what exactly was it and how--how can we do better the next time. I understand that we always need to do more coordination and that we can talk in vague terms and say more funding and more coordination and all of that. We are really trying to get into some specifics here. Maybe the gentleman from Mississippi could give us some--some insight from Mississippi.

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

The other thing that has happened I think almost philosophically as--as we have worked to expand insurance coverage to people which is--which is important and I think people need health care, but there's been an assumption that public health and healthcare are the same thing and they are not at all the same. I have about half of the nurses I had four years ago, and so how do you respond to a crisis when I can't pull nurses to go to houses and check on people? So I think this--this sort of communication about healthcare versus public health has distracted a little bit from some of our core needs.

And then the other thing I think relationships is so important so sometimes some places we have great relationships with the local folks in the counties and stuff and when we have those relationships prebuilt it is not just a money thing it--it is a slow investment so that when things do go bad, we just call Joe and say hey, we've got this going on and we know what to do together and again I think that gets to the stability and the steadiness of how much better it is just to have a slow and steady approach than having a more reactive approach.

CRENSHAW: I'm out of time. Thank you, Mr. Chairman.

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

RICHMOND: Thank you, Mr. Chairman. I will pick up where my colleague left off talking about specific examples and Mr. Klain and I will ask you, but not having enough tests is--ex--explain to me was that necessary, was that incompetence, was it just oversight? Tell me how it is that Korea has more tests than the United States.

KLAIN: Congressman, I think this is, as I said in my statement, a singular failure of U.S. policy and execution. The president imposed travel restrictions on people coming here from China, and those travel restrictions though uneven and not complete slowed the pace of the disease. It bought us time.

Buying time works if you use the time productively, and we knew in December and early January, we were going to need millions of tests. I have said we should test 30 million people in the United States seniors, people who have

access to seniors, people in nursing homes doing surveillance as some of them have said, not just waiting for people to raise their hands and say test me. And we knew we needed that in January and the CDC pursued building its own test that turned out to be flawed, it didn't adopt the WHO test, and we don't really know what significance there was in the messages that the president sent that this wasn't a big deal. He said as recently as 15 days ago, there are only 15 cases and it is almost resolved.

So you have a series of management failures, bureaucratic failures, execution failures that leave us so far behind other countries. This isn't a scientific problem. If they can test 150,000 people in South Korea, America can test people too. They don't have any wisdom that we don't have here, so that's--that's--that is a failure of execution in this country.

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

DOBBS: Thank you for the question that--that's--that's an enormous challenge and we have been engaging with business communities especially businesses that have a lot of hourly workers and not that we have a resolution to this at all, but it is a big challenge because people who work hour--hourly and get paid and don't have sick leave are--are not going to do it. At the state level of the state government, you actually have to take a vacation day before you can take a sick day and so people are not going to want to take their vacation days.

So we are looking at best part of any emergency declaration to actually do away with that so with government there are I think opportunities to address those inequities. But in the business community it--it is a real challenge, and I think we as a country and as a state really need to look at options we can do to make sure people can have paid sick leave and then the other thing to think about, and this is not an easy answer to this either--either is when people have to go home and are out without a job for two weeks who is going to pay the power bill, and you know we are working with nonprofits, and I know there are some capabilities to do that but it can be a big issue and might cost a lot of money.

RICHMOND: Let me ask you a question, and I am completely thinking out of the box, but in New Orleans, we are accustomed to natural disasters whether it's hurricanes, whether it's BP, whether it's you know levees that is where FEMA steps in with either individual assistance or public assistance and they start off with a certain amount and then you have to go and prove your need and all of the other things. Is FEMA the agency that we could task with providing either individual assistance, public assistance if needed, and proved? Somebody out there if we want to be responsible with this somebody out there is going to have to provide some assistance. So could FEMA do that under the individual assistance program?

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

RICHMOND: (INAUDIBLE)

KLAIN: Congress--Congressman, if I could five years ago, I wrote a piece where I said that Congress should amend the Stafford Act to add epidemics as a disaster for the purpose of the Stafford Act. Right now FEMA could do what you suggested if you saw another hurricane in your state or an earthquake or a fire, but epidemics are not a natural disaster under the Stafford Act and to go back to a question Congressman Crenshaw asked I think that is a zero cost--I mean not ultimately a zero cost as you draw it out but the kind of thing that we should be doing to get prepared because whether it's this one or another one someday we are going to face an epidemic that really is a FEMA-triggering disaster, and the Stafford Act should catch up with that.

RICHMOND: Thank you and--and to the former chairman when I got here Mr. King from New York one of the last recommendations that we still have not adopted from the 9/11 commission is to put all of the jurisdiction to

responding to natural disasters and others and putting the Stafford Act back under Homeland so that we could night and I think now may be the time for us to raise that issue in a bipartisan manner to get Homeland the jurisdiction that it should have.

KING: I agree. It is long overdue, and I appreciate the gentleman raising that issue again. Thank you.

RICHMOND: Thank you. I yield back.

PAYNE: Thank you. Let's see. Mr. Neuwirth and I believe (INAUDIBLE)--I'm sorry. I've done that once before too. The chair recognizes the gentleman from Texas, Mr. Green.

GREEN: Thank you, Mr. Chairman, and I thank the Ranking Member as well. I thank the witnesses for appearing. There are times when we are not as alert as we should be.

KLAIN: (INAUDIBLE) very quickly. We made a different decision here that didn't work out. We also could've made it a higher priority to really focus on that. I just think we lost time, we're behind. I think the decision to bring in private labs is a positive decision.

It certainly increases the capacity. But that's only going to deal with people who are in a diagnostic and clinical setting. Your doctor sends you and says, go get a lab, and we really need to be doing surveillance. We need to be going out into the community and finding the cases, finding the cases in nursing homes and community centers and where older people congregate. And I think that's really a weakness of relying on private labs as the principal solution for testing.

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

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

PAYNE: Thank you. And in the interest of time, votes have been called, and I will recognize the gentleman from New York for questioning and closing.

KING: Thank you, Mr. Chairman. I had a question, Mr. Klain, and let me just state for the record up front that there were obviously a whole lot--the issue of the test kits was wrong. They should've been out. So I'm asking this. and not in a rhetorical way but planning for the future what we learned from the past. To me, the CDC, the fact that they did not accept the WHO, was there a reason for that?

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

So what I'm getting at is, there can be policy mistakes and there can be just the luck of the draw, that they did their best and it went wrong. So again, any thoughts you have on that based on your experience.

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

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

And I think stronger coordination and leadership from the top, from the White House, would've said hey, you know what, we've got a mess here. No one chose to make this mess; it was an accident. But we need to do something quickly to turn this around and to get this fixed.

And so, you know, I don't blame anyone for the initial mistakes and the consequences, but then, you know, that's what leadership is. Leadership is saying hey, this isn't working. We need to get on top of this. We need to catch up. And I think that's--that's, I think, where--you know, again, without being partisan or political, I think that's where the policy decisions came, which was once the--lights were flashing yellow. What did we do to accelerate a response to that?

KING: I guess the only question I would add to that--and again, I don't have the answer, so I'm not trying to make this a partisan debate--is if they had done that, would they have said this was politicians interfering with the scientists? I mean, if CDC thought this was the right way to go, and the president or the vice president or some Republican member of Congress said, hey, you've got to speed this up, and then they did speed it up and it didn't work, they'd say it was politicians interfering with science. Again, I'm trying to--

NEUWIRTH: Yeah. No, Congressman, I think that's--

KING: --but with people at the top, you have to--because no one will take the blame, I realize that.

NEUWIRTH: Look, I think, Congressman, I think it's a fair question. And what I would say is that the role of political leadership, whether that was President Obama in the ebola response or President Trump and Vice President Pence now, is to ask the scientists how's it going? What's going on here? Why is it that I'm waking up and I see that Korea has tested 50,000 people and we've tested 500?

KING: Let me ask you the same question.

NEUWIRTH: You know, so I don't think there's anything politicizing about science to ask your scientists, how come I'm seeing this on the news and how come I'm not seeing this here? Ultimately, the medical decisions, the scientific decisions, should be made by them. But, you know, the government should hold people accountable for results.

KING: Again, if I could make a semi-partisan point, maybe that's why it's important to have you and the vice president running these things finally. I mean, again, maybe if Mike Pence had been there from the start, they would've gotten a faster result. Because bureaucrats sometimes only respond if they know that--

NEUWIRTH: Congressman, I absolutely agree with that. I think that some kind of White House--White House coordinator was needed. It was one of my early criticisms of the administration. I'm glad they've done it. My only criticism of the current coordination would be, I think someone really needs to be on this full time. And I think obviously the vice president has a lot of other responsibilities, as he should. That's not a criticism, it's just a reality. I think they brought in Ambassador Birx, who I have a great deal of respect for, to work with the vice president. She's still doing her other job as well, and kind of running PEPFAR. And I think whether it's her or someone, this should be a full-time job. This is a big problem for our country, and leading the response shouldn't be your side gig.

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

PAYNE: Thank the gentlemen. You know, and I absolutely am a believer in a time of crisis, we should tend to lean on people that have had some experience in those--in the past, the near past, such as yourself involved in these things. So thank you for your service, and I'd like to thank all the witnesses for their valuable testimony and the members for their questions.

The members of the subcommittee may have additional questions for witnesses, and we ask that you respond expeditiously in writing to those questions. Pursuant to committee rule 7d, the hearing record will be open for 10 days without objection. Hearing no further business, the subcommittee stands adjourned, and we are 389 not voted. Thank you.

House Homeland Security Subcommittee on Emergency Preparedness, Response and Recovery Holds Hearing on Coronavirus Response

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