House Appropriations Subcommittee on Labor, Health and Human Services and Education Holds Hearing on the New Coronavirus CDC Response

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Body

House Appropriations Subcommittee On Labor, Health And Human Services And Education Holds Hearing On The New Coronavirus Response

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House Appropriations Subcommittee on Labor, Health and Human Services and Education Holds Hearing on the New Coronavirus CDC Response

[*]DELAURO: This hearing will come to order. First, I would like to welcome our witness, Dr. Robert Redfield, director of the Centers for Disease Control and Prevention. And we thank you for being here this morning, Dr. Redfield, to discuss the CDC and the ongoing response to COVID-19. I also want to welcome the subcommittee members, Ranking Member Congressman Thomas Cole and our full committee chair, Nita Lowey. I want to thank you to subcommittee members who are here in person, as well as subcommittee members who are participating by secure video teleconference.

Before I move to my opening statement, and because this is our first labor HHS and Education Appropriations Subcommittee hearing with some members participating remotely, I would like to begin by offering a brief explanation of how it will work in order to benefit both members and the public. This hearing room has been configured to maintain the recommended six-foot social distancing between members, witnesses and other individuals in the room necessary to operate the hearing, which we have kept to a minimum.

Some members have opted to use secure video teleconferencing, which allows them to participate remotely. For those on video conference, once you start speaking there will be a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. Do not stop your remarks if you do not immediately see the screen switch over. If the screen does not change after several seconds, please make sure you are not muted.

To minimize background noise and ensure the correct speaker is being displayed, we ask that the members who are participating by video remain on mute until it is your turn to ask questions. Please remember to mute yourself at the conclusion of your question. Should you seek additional time, please unmute yourself so that I may recognize you.

I want to remind all members and witnesses that the five-minute clock still applies. If there is a technology issue, we will move to the next member until the issue is resolved, and you will retain the balance of your time. For members using the video option, you will notice a clock on the bottom of your screen that will show how much time is remaining. A one-minute remaining--at one minute remaining, the clock will turn to yellow. At 30 seconds remaining, I will gently tap the gavel to remind members that their time is almost expired. When your time has expired, the clock will turn red, and I will move to recognize the next member.

In terms of the speaking order, we will follow our traditional order, beginning with opening statements from the chair and ranking member and then the full committee chair and ranking member. We will then hear from our witness, Dr. Redfield, and then we will proceed to questions. Members present at the time of the hearing--the hearing is called to order, will be recognized in order of seniority. And finally, members not present at the time the hearing is called to order. Now I would like to move to my opening statement.

Before I make opening remarks, I want to reflect on today. This afternoon there is a memorial service for George Floyd. For the last few months around the pandemic we have been talking about how to get back to normal. However, what we can hear and the chance for justice and the cries for equality is that going back is not good enough. This tectonic moment exposes so many wrongs, deep inequality and racial wrongs, and that as we fight the COVID-19 virus before us now, we must also fight the virus of injustice.

Good morning. Welcome to the Labor, Health and Human Services and Education Appropriations Subcommittee. This is our second hearing to oversee the federal response to the coronavirus, and it is bipartisan. Let me commend my colleagues on both sides of the aisle, including the ranking member, Congressman Tom Cole. With us this morning is Dr. Robert Redfield, director of the Centers for Disease Control and Prevention, the CDC. Thank you, Dr. Redfield, for joining us today.

Our nation is in turmoil. The coronavirus is the biggest public health crisis we have experienced in at least a century. And to be blunt, the federal response has been inconsistent and incoherent. A major focus of today's hearing is getting a better understanding of what has gone right and what has gone wrong these past five months. We need to learn from mistakes, not repeat them. We cannot stop the risk from this virus overnight, but in the months to come, we can spare the American people from unnecessary misery, illness and death.

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In a typical public health emergency, and historically, the response would be led by the CDC, our nation's foremost public health agency based on science and public health expertise. I am alarmed that this administration has sidelined the CDC in our response to the pandemic and chosen political expediency over public health. As a result, the U.S. has had the worst response to coronavirus of any country in the world, and it is particularly egregious because our public health system should have been better prepared than almost any other in the world.

Over the last three years on a bipartisan basis this subcommittee has increased annual funding for the CDC by approximately $1.1 billion, an increase of 17% since 2017. That included the first year of a new public health data modernization initiative, which will transform how the CDC collects, uses and analyzes public health data. We also created an infectious diseases rapid response reserve fund to enable the CDC to respond to outbreaks quickly to protect public health. Ranking Member Cole and I have worked closely together, understanding the challenges to create that reserve fund. And it was critical to funding early response activities at the outset of this pandemic.

Since March, the Congress has provided $7.5 billion in emergency supplemental funding directly to the CDC, and I might add in bipartisan fashion. But instead of public health expertise driving our response to the pandemic, it appears CDC has been sidelined for political interests. That is dangerous. The stakes are too high. There are projections that going forward 30,000 and more could die each month. That would mean another 100,000 dead over the summer months.

Yesterday, the New York Times released a powerful and well researched expose of the consequences of the lapse in the work of CDC. The piece opened the quote, long considered the world's premiere public health agency, the Centers for Disease Control and Prevention has fallen short in its response to the most urgent public health emergency in its 74-year history.

From the moment this pandemic reached our shores, President Trump and his administration's response has been woefully inadequate, abdicating all responsibility. There was never any coordinated plan to address the pandemic, and under this dangerous lack of leadership our nation surpasses 100,000 deaths from COVID-19, the most of any country in the world. When it comes to crucial details

[*]DELAURO: on acquiring test and supplies, setting goals for how much of the population should be tested, facilitating contact tracing and isolation efforts, and assuring communities that have been hit the hardest are given the support they need. There is no national coordinated strategy.

Our federal response cannot be defended from a public health perspective. Other nations around the world from Germany to South Korea have found ways to keep people in their countries safe. It appears as if the United States is just admitting defeat. Is that acceptable or simply accepting the preventable deaths of hundreds of thousands of Americans to COVID-19? If the administration is asking us to accept that in my view the answer is a decisive know. For us to keep our people safe our response needs to be led by the scientist and the public health experts at CDC. Our response needs to be based on reliable public health principles not political appointees in the White House. It is our expectation that public health expertise must be at the forefront of our national response.

We need answers to vital questions. Why has the administration accepted the world's worst outcome and a level of preventable death that would have been unconscionable a few months ago. How is our country going to reopen when there is not a coordinated nationwide effort to test, contact trace and isolate cases? Why are states disregarding CDC's guidelines for reopening business and for social activities? Why are CDC's guidelines not at the forefront? Why did CDC's guidelines on reopening come after states started to reopen or were already reopened?

We are asking CDC to lead the way and uphold its mission and I quote that mission as the nations health protection agency CDC saves lives and protects people from health threats. To accomplish our mission CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats and responds when these arise. That is the highest mission and it is the right mission. So let me say affirmatively that this committee supports the scientist and the public health officials at the CDC. Like Doctor Nancy (INAUDIBLE) and others who are trying to provide science-based guidance to the country. What went wrong? Why has the CDC been left behind? When there was an early declaration of a public health emergency by HHS on

January 31? When Doctor (INAUDIBLE) said it is not a question of if this will happen but when this will happen? She further said disruptions to every day life may be severe but people might want to start thinking about that now. CDC produced high quality and depth publications. You need to take note of this. These CDC's morbidity and mortality weekly reports the MMWRs, CDC experts have published evidence about universal testing at skilled nursing facilities to interrupt transmission of COVID-19 as well as critically important work about super spreading events which are responsible for transmitting the majority of cases of COVID-19.

They identified the cause of some of the super spreading events, the larger events, the exposure at a choir practice where 61 people led to 32 confirmed and 20 probable cases. Attendees at a church in Arkansas, workers in meat and poultry processing facilities. We cannot have a CDC that fails to publish high-quality specific technical guidance. We cannot have a CDC that has reports shelved, edited, not scientifically driven, or redrafted to suit political purposes. We cannot have a CDC that provides spotty data collection and reporting. We cannot have a CDC that fails that transparency. We need federal leadership that is guided by public health, by that expertise, real-time, rigorous, and transparent. We need CDC and we need its scientist and its public health experts leading the way for all of us.

And I am angry that their experience and commitment have been pushed aside for a political agenda. That must change and I believe the Congress has to change it and we have to redirect the current course to set us on the path forward. So I look forward to this important conversation and appreciate Dr. Redfield you're being here and I appreciate the same for all of my colleagues and now I would like to recognize the ranking member of the subcommittee Congressman Tom Cole for any opening remarks that he would like to make.

COLE: Thank you very much Madam Chair. I want to begin by thanking you for holding this hearing in the middle of a difficult time and you are to be commended for it and certainly Dr. Redfield being here. And I want to associate my remarks or myself with your remarks about the tragic death of Mr. Floyd and frankly the health care disparities that this tragic pandemic has shown a bright light on this committee has worked on for many years and I know concern Dr. Redfield just as they concern everybody here and that is going to be clearly a major task for our committee going forward as it has been in the past but probably with a higher sense of urgency.

Good morning Dr. Redfield and I want to thank you again for coming to testify before us today. First, I would like to thank you for your public service. The director of the CDC is no easy job but leading your agency through a once in a century event compounds the challenge. You have led that agency with a steady hand in uncertain times and I want to thank you personally for your leadership.

I am going to depart from my remarks a little bit here because I think sometimes when we are in the middle of something it is hard to keep it in context but our performance has not been the worst in the world depending on how you want to measure performance. Quite frankly I am sitting here looking at literally today's latest statistics and if you wanted to measure it by the basis of the tallies per million population then the performance of the United Kingdom has been worse, the performance of Italy has been worse, the performance of France has been worse, the performance of Spain has been worse, the performance of Belgium has been worse, the performance of the Netherlands has been worse. Those are all pretty advanced countries with pretty sophisticated healthcare systems. I don't think you can really take the Chinese numbers quite frankly face value and then beyond that and I say this with no criticism of the countries involved but I do worry a lot about India and Pakistan, that part of the world. I worry a lot about sub-Saharan and Africa. I think when this is all done I worry a lot about our friends in Latin America. I think when this is all said and done we are going to see the numbers are probably worse in those places than they are in the United States just simply because we have a more sophisticated healthcare systems so I have no problem with being critical or putting a flashlight on anything. I think we learn lessons that way but you know in America we always tend to think we are either the best or the worst at everything and in this case we may not be the best but I think we are better than most and we are certainly not the worst, the numbers just simply don't bear that out.

I hope today we can focus on future steps that we can take together to ensure a sense of safety as our nation returns to work and school. After more than two months of staying inside the American people need the guidance of

the CDC more than ever to help us navigate the path ahead. Efforts to reopen our country and reignite our economic engines should be approached with caution and designed on each state's unique circumstances based on sound data. This pandemic has caused unprecedented disruptions to our families, communities and the economy and it will continue to do so for some time. The strain on our supply chains and the devastating economic impact two hard-working Americans have created challenges that will take months and in some cases years to address. However, I am encouraged to see state and local economy slowly and cautiously beginning to reopen. I also welcome the renewed focus on the need for a US-based capacity and resilient supply chains.

I look forward to working with my colleagues across the aisle to address these challenges. I also want to acknowledge the robust bipartisan congressional response. In a deeply partisan climate I am pleased to see Congress and the Trump administration work together across party lines to deliver critical resources for the American public and

[*]COLE: funding and support programs like the highly successful Paycheck Protection Program. We set aside our differences and can quickly deliver legislative action to address the pandemic, passing record sums in record time. When the consensus is clear, Congress is capable--is as capable as ever for decisive action.

The fight against COVID-19 is far from over. I hope the spirit of bipartisan cooperation can continue as we assess our past efforts and determine what more may be needed. While the federal government has provided some short-term relief to help individuals, households, businesses, and communities stay afloat during the--this period of extreme social distancing, our economies need to get moving again and Americans need to get back to work.

However, any such efforts to reopen must continue to keep the health and safety of Americans at the top of mind and not undo previous project--progress in slowing the spread of this coronavirus. This will indeed be a delicate balancing act. Until there are working treatments, effective therapeutics, and ultimately a vaccine to control COVID-19, the risk and the danger of the disease remains. Fortunately, I see real progress in all of those areas.

Returning to more regular functions and operations requires gradual action, completed in phases and based on data. President Trump and the coronavirus task force established phased in and data-based recommendations and criteria for states are reopening efforts. The administration recognized now is not the time for a one-size-fits-all model for each state.

They're leaving key decisions to each governor to make is appropriate for the circumstances of their communities based on their needs, their supplies, and local capacity. And as states develop their plans, the administration is fortifying the supply chain for testing supplies and ensuring each state has access to the supplies needed for reopening, often shipping testing supplies directly to each state.

Finally, it's critically important that the federal government learns from this crisis and actively prepares to face down another pandemic in the future. While I'm proud that Congress has generously invested in were the tools and response resources to strengthen our readiness in recent years, it must be an even higher priority in the days ahead. Though the United States was prepared to face an emergency, you can never be fully prepared for what you don't know is coming.

In the future, we must not just prepare for the emergency at hand, but leave our nation better prepared for the emergencies ahead. Sustained, predictable, robust funding for research, preparedness, and US-based capacity are vital components to this approach, and something that this committee in a bipartisan fashion has worked on well over several years.

I want to thank the chair again for holding this important hearing at this critical time, and I yield back the balance of my time.

DELAURO: I want to thank my colleague, and just take a moment to say that the never that gets the award for traveling the farthest once again is our colleague, Congresswoman Herrera Beutler. Thank you so much for being here.

And with that, I would like to recognize for an opening statement the chair of the full Appropriations Committee, Congresswoman Nita Lowey.

LOWEY: Thank you, Chair DeLauro. I'm assuming this is working and you can all hear my voice. Is that correct, Madam Chair?

DELAURO: We can, loud and clear.

LOWEY: Okay. Okay. Well, I do want to really thank you, my friend, Chair DeLauro, and my friend, Ranking Member Tom Cole, for bringing us together. It's a pleasure for me to join you remotely. And Dr. Redfield, welcome back before the subcommittee.

As a nation faces the greatest public health crisis of the past century, Americans have never needed the CDC more than we do right now, and that's why I'm so troubled. The president has pushed away a science when it did not suit him time and time again. The president pushed aside medical experts, including the CDC's expert on respiratory diseases, Dr. Nancy Messonnier, because her legitimate warning rattled the stock market.

The president encouraged the use of hydroxychloroquine even though studies have shown that cologne--coronavirus patients receiving this drug were more likely to die. He even raised ingesting disinfectants like Lysol and Clorox, causing manufacturers to warn of the danger and leading to a spike in calls to poison control centers throughout the country. This is not normal, my friends. This is dangerous.

We have lost more than 100,000 souls, nowhere more than in my own home state of New York. And in the absence of a strong federal role, New York has been a leader in testing to contain COVID-19. But this virus does not recognize state boundaries. To succeed against the coronavirus, our federal public health officials must take charge, combat disinformation, and get this right.

With many states beginning to reopen, the CDC must remain vigilant to combat the continued increase in cases as well as the expected second wave this fall. The president's preference of a patchwork for 50 different states fighting COVID-19 on their own will not stop these levels of destruction and will lead to more suffering and death. We need a national strategy on testing and tracing and, my friends, we need it now. We don't need the Democratic plan. We don't need a Republican plan. We need a United States plan and we need it now.

And we stand ready to support the CDC. In recent months, this committee has provided $7.5 billion in emergency supplemental funding to CDC to respond to this public health crisis, and the House passed HEROES Act would provide an additional $2.1 billion. And we will do everything we can, working together, Democrat and Republican. We have a responsibility to protect the public. I only wish the president would do the same. Thank you, Madam Chair.

DELAURO: I think the gentlelady. And now, Dr. Redfield, again, thank you for being here, and thank you again for your public service and for--that's not only the United States, but all over the globe as well. You understand that your full testimony will be entered into the record, and you're now recognized for five minutes.

REDFIELD: Thank you very much, Chairwoman DeLauro, Ranking Member Cole, the distinguished members of the committee. Thank you also for the opportunity to testify before you, and again thank you for your long-term support of CDC.

The COVID-19 pandemic is the most significant public health challenge to face our nation and more than a century. And as we sit here today, this novel val--virus is weaving its way through our social consciousness, our outward expression, and our grief. I am deeply saddened personally by the many thousands of lives that have been lost to COVID-19 in the United States and around the world, and I fully recognize the anguish that our nation is experiencing now.

Today, I call on the American people to remain vigilant in our collective obligation to protect the vulnerable, to protect your community, your grandparents, your loved ones who may be a risk for severe COVID complications. And we must lessen the impact of COVID on--on Ameri--African-Americans, Hispanics, Latino, American Indian, and Alaska natives who are being disproportionately affected by this disease.

This nation is not only hearing a wake-up call, rather, we're hearing a clamoring for equity and healing, for a positive and permanent change to health and social disparities that persist in our nation. As communities make plans to cautiously reopen, this means that we need to continue to embrace the now familiar social distancing, handwashing, and face coverings. These actions will allow us to move forward and contain the outbreak along with readily available testing, comprehensive contact tracing, timely isolation of known cases, and self quarantine, to break the chains of transmission.

CDC is providing communities with public health tools and information to confront this novel virus. Personally, I can't tell you how proud I am of the men and women and the dedicated public health professionals at CDC, and how grateful I am for their service and their families' sacrifice.

CDC has deployed over 5000 personnel to the COVID-19 response. Field teams are on the ground providing local health officials with expertise in epidemiology, surveillance, infection prevention and control, lab science and community mitigation. We've published more than 1500 specialized information and guidance documents so far, and the COVID website has been consulted more than 1.3 billion times.

CDC has responded to more than 20,000 inquiries for doctors and clinicians, and we've hosted calls that have reached over half a million more. With your support, CDC has been able to award nearly $12 billion to states, territories, tribes and localities. These funds are being used to enhance diagnostics, healthcare worker safety and the other important public health measures that I previously mentioned. Through our partnerships with CMS and the Indian Health Service and HRSA, we're deploying teams to the needs of population at the highest risk, specifically those living in nursing homes, shelters and correctional facilities.

This outbreak has shown a bright light on the true heroes of the response. They are the public health and the healthcare professionals, the first responders and the critical infrastructure workers. But unfortunately, this pandemic has also highlighted the shortcomings of our public health system that has been under resourced for decades. Never has it been more clear that our nation's public health IT infrastructure requires modernization to support and collect reportable, reliable, comprehensive and timely data.

When we confront any disease threat, CDC and public health departments must make real-time decisions based on real-time data. Data forms the roadmap, and it informs policy. Data is the backbone of any disease threat response. As a virologist and a physician, I know the importance of strong clinical laboratories. We must equip our public health laboratories with advanced technology and the ability to adopt new platforms required in emergency response. We must exponentially grow the necessary workforce to address COVID and future public health threats.

Sustained investment in our public health system of this nation is an investment not only in health and prosperity for today, but for the future generations tomorrow. Preparedness will be critical when influenza and COVID hits the doorsteps of our hospitals and healthcare providers this winter. I want to encourage all Americans to be prepared to embrace flu vaccination with confidence for the families themselves and communities. This single act will save lives.

As a person of faith and good conscience, I ask all of you to see the possible. We must resolve. We can, and we must lessen the health disparities in this nation. I leave you with a reminder from our mutual friend, the dear--the late dear Congressman Cummings when he used to say the cost of doing nothing isn't nothing. As CDC director and a grandfather, I ask you to continue to work with me to build a public health system our nation not only needs, but that it deserves. Now is the time, and I want to thank you for this opportunity, and I look forward to your questions.

DELAURO: Thank you very much, Dr. Redfield. Let me begin. Many Americans today are worried that politics and not public health facts or the CDC are driving our nation's coronavirus decision. March 13, President Trump

declared a national emergency. Our nation had 556 new cases and seven deaths. Four days later, he urged the American people to follow stay-at-home guidance. He said we are asking everyone to work at home if possible, postpone unnecessary travel, limit social gatherings to no more than 10 people.

Let me show you this chart. On June 2, as this chart shows, there were over 20,000 new cases, and we've had more than 1000 new deaths. And President Trump is telling the American people that we are reopening the economy and everything is okay. Our policies don't seem to make any sense. When we had fewer than 1000 cases, we went into a national emergency. Now we have 20,000 or more new cases a day. Yet we are opening up. Based on those inconsistent responses, I've come to a conclusion. In March we made decisions based on public health expertise. But now we are basing decisions or making these decisions based on the interests of politicians in the White House.

My question--these facts, and I have several questions so I'm going to try to move quickly. This chart show the crisis isn't over. Instead, it appears the White House is trying to convince the Americans to just accept more risk and death. You run what has been the world's preeminent global disease detection and control center. How does this make sense from a public health perspective? I'm going to ask you to be succinct, Dr. Redfield, because there are a few more questions, and there are a whole lot of folks who want to ask questions.

REDFIELD: (OFF MIC) we've experienced this coronavirus pandemic, we're learning every day. I think probably the most critical thing that we've learned is to understand who is most vulnerable to this infection. Clearly we've seen that with the nursing homes, the elderly. We've seen it, obviously, in African-Americans, Hispanics and American Indians and native Alaskans, and really design our policies to protect those vulnerable individuals. I think that's one of the fundamental lessons that we have learned in the last several months. And I think that's really central to the policies that we have going forward is to continue to protect the vulnerable.

DELAURO: So yes or no? Does it make sense for us to be doing what we're doing when we are looking at a 20,000-plus cases on June 2 and over 1000 deaths? So it leads me to believe that we are not following what is based on public health expertise, but rather then making decisions based on what are more political interests. Let me ask you these questions, and this is a yes or no, Dr. Redfield. Do we have a vaccine yet?

REDFIELD: We have candidate vaccines under development.

DELAURO: But we don't have one yet?

REDFIELD: We don't have one for deployment at this point.

DELAURO: Are we close to achieving herd immunity across the United States, yes or no?

REDFIELD: No.

DELAURO: Is there any evidence the virus has become less contagious or is becoming tired of infecting us, yes or no?

REDFIELD: No.

DELAURO: Okay. Are all the states meeting the basic tests that the White House guidance laid out for reopening, downward trajectory, documented cases within a 14-day period, downward trajectory of positive tests within the 14-day period?

REDFIELD: Chairwoman, of course these were guidances that we put out, and to answer your question directly, not all the states have met those criteria.

DELAURO: Okay. My understanding is that we've had--well a number of states. Let me just ask you one concrete example. Let me show you this photograph. This is the Lake of Ozarks. Yeah, I had the same visceral response, Dr. Redfield. Look at this. Look at these folks. This is unbelievable. And you've got--this happened in the state of

Missouri. The White House guidance says that states need to have the ability to trace the contacts of COVID and results. The state of Missouri where this has happened does not have the capacity to do contact tracing. Is the CDC tracing everyone who was there? Yes or no, Dr. Redfield?

REDFIELD: It would be the state, and we would assist them, and the answer is that we haven't been asked to assist them for that--that--

DELAURO: So we are not contact tracing, even though we have the person--we've identified the person?

REDFIELD: We are--I can't answer for the state what they're doing, but I will say because of Congress's support we are building enhanced capacity across this country to do contact tracing and get that capacity fully operationalized by the fall this year when we're going to need it to maintain containment as we get into the fall and winter of 2020.

DELAURO: Let me take--let me have you look at this photograph. This is--I saw the Ozark photo. This is the photo from last week's SpaceX launch, people gathered on the bridge. Would you put yourself in these types of situations?

REDFIELD: I think the really important thing of all of this, as you pointed out, is not just to the individuals, but to the risk that they're putting the individuals they go home to (PH).

DELAURO: And that's what's happening. That is what's happening. Let me just--I will try to close with this. Two and a half months ago president started the process of shutting down the economy, fewer than 1000 new cases a day. Since then, administration's failure to respond competently squandered the opportunity to bring the virus under control, protect the health of the American families. We're being told it's safe to reopen. Over 20,000 new cases, over 1000 deaths. We do not have testing, tracing resources that we need to prevent more deaths. It is no wonder the world's leading medical journals, The Lancet just this past week calls the federal response inconsistent and incoherent, but the president wants us to get used to this and to pretend it's business as--is as usual. Let me just say this to you, Dr. Redfield, with all of the--I have such admiration for the work that you and CDC do but if you and the CDC are driving this bus you are taking us in a dangerous stir action. From everything I can tell these CDC isn't in the role you have had in the past. Not only aren't you driving the bus but the President seems to have left you at the curb. That is wrong for CDC but it is deadly for our country. Recognize my colleague Congressman Cole.

COLE: Thank you very much. I have got a different question but let me start with this, are other countries in the world based on mortality rates doing less well than the United States?

REDFIELD: There are--there are countries as you pointed out in your opening statement that our--are not doing as well as the United States.

COLE: And are those countries reopening for business?

REDFIELD: There are--there are companies that are reopening.

COLE: At some point we have put 40 million Americans out of work literally in a matter of the last few weeks and we have done what we can as a Congress in a bipartisan basis we supported the administration to help those people. We think we are making a lot of progress on both therapeutics and vaccine but people do have to go to work, you do have to have a functional economy at some point and you know again we did the shut down a lot of this was to try to make sure we didn't overwhelm our own health care system. Could you give us some view as to whether or not we were anywhere close to that or how has that worked out in retrospect?

REDFIELD: Thank you--thank you, Congressman. I think that was fundamental. I think there was enormous concern that I and others have that this pandemic could have overwhelmed our healthcare system particularly in some of our major metropolitan areas such as New York and Connecticut area and the Northeast area, Northern New Jersey and so there was--and we saw that actually happen in Italy it overwhelmed (INAUDIBLE). We saw that in Wuhan, China that they overwhelmed the health system and so when it did overwhelm the health system not only

the mortality rate for the COVID was up but the mortality rate in general for being in the hospital was up so that was the greatest concern. That is where you saw the--the attempt to expand health care capacity.

It is--we were able to get through that and in the sense with some augmentation but in general in most jurisdictions we were able to get through--through that and I think that is the scene you have changed and it isn't just health versus the economy and I think you know it really is health versus health. I mean I mentioned that 85 percent of the children have now missed their immunizations, around the world 120 million kids have missed the immunization to measles. There are going to be more deaths from measles in children then there is going to be from flu so it is trying to find that balance as we come back and being able to make sure that we can begin to operationalize not only our employment but our health system. When you think of all of the cancer screenings that have been missed that are going to have consequences. So I do think it is important to get back you know not only our economy back but our health system back but to do it strategically and prudently.

As I said we have learned a lot. The key to us right now is to protect the vulnerable and to focus our energies on that. This pathogen doesn't in general cause a lot of disease in young individuals but boy, it can be deadly in those with chronic medical conditions and the elderly.

COLE: Let me ask you this and then I want to go to a topic that we have discussed many times before and I sort of want to pat this committee on the back because the last five years we have increased funding for NIH by 39 percent, for CDC by 24 percent, strategic stockpile by 34 percent, set up the infectious disease rapid response fund as my good friend the chair noted. In other words we have done quite a bit and yet we were still overwhelmed by what happened. And we are responding right now in a crisis mode with supplementals. I am really concerned about what we do going forward and the administration original budget obviously was put together with no idea that this was going to occur so that budget no longer is really applicable in my view.

I want to ask you looking forward and you reference this in your remarks what kind of budget do we need in terms of sustained commitment, what areas do we need to focus on? Because they again I know we are going to keep passing supplementals, I don't think that's the real answer here. I think we need this really focused deal. Dr. Friedman(PH) your predecessor came here and talk to about a--equivalent of a what we call an (INAUDIBLE) account, it is an off budget account for the military that allows them in extraordinary circumstances to finance military activity and not be limited by the budget. My friend the chair and I have talk together about we have a budget agreement of maybe CDC, NIH, FDA, food inspection, strategic stockpile may be a few accounts ought to be selected to get outside of that agreement and just do what we need to do because we are going to be dealing with it.

So I would really welcome your thoughts as to what kind of investments we need to make going forward and how do you sustain those investments because I don't like one and done supplementals here I don't think that is going to ultimately it is going to help us in a crisis but it is not going to get us where we need to go.

REDFIELD: Yeah, first I just want to thank the chair and yourself and the committee for the consistent enhancement of our capacity. You know from the very beginning within the first month of me being CDC director my assessment was that they public health core capabilities, the core capabilities of public health that we need both at CDC and throughout this country in states, local, tribal, territorial is--is an adequate and that we really need to be over prepared, not underprepared and when you asked me what kept me up at night I would say pandemic flu because we are just not prepared. I think this is highlighted even with all of the improvements which I treasure the data modernization that the chair put forward, fundamental.

You know the reason we are having trouble with the issue in healthcare disparity and understanding how this irises affecting the African-American (INAUDIBLE) because we don't have the data and getting that data modernization is fundamental. You know I feel the same way about laboratory free civilians in multiple platforms. The workforce that we just talked about, we are going to need 30,000 to 100,000 new contact tracers and we are going to need them before September.

The rapid response fund that you all have put into place which is critical and continues to support and of course the global health security which I think is the big elephant in the room. You think we weren't prepared for this well, wait until we have a real global threat for our health security and I echo your concern. I think it is a much greater probability than we have a--a real defense thread and so I think we do have to build that into this--the long-term base budget and figure out you all and to work to figure out how to get that done and I think that the public health infrastructure of this nation which you all know a significant portion of it goes to state, local, tribal, territorial. We find 50 percent, 70 percent of all of the public health infrastructure in your own state and communities. That needs to be augmented and truthfully what I said at the end with my friend Congressman Cummings(SP) the cost of nothing isn't nothing. The time is now to do it and

COLE: Thank you. Thank you Madam Chair. It is difficult without the clock but I--I apologize for that. Thank you.

DELAURO: (INAUDIBLE) everyone is here today.

COLE: Absolutely. I--I have got it. Thank you.

DELAURO: Recognize the chair of the full committee Congresswoman Lowey.

LOWEY: Thank you very much Madam Chair and Dr. Redfield it is good to hear from you today.

New York's ability to scale up testing has been extraordinary and we are now testing about 50,000 residents each day with more to come. We need every state however to take these steps to have a true picture of where infection rates are rising and mitigate the damage. Most states are not even close to New York's capabilities. Can you tell me why hasn't the CDC established testing benchmarks for each state to meet and maybe I will have you answer that and then with all due respect the virus doesn't recognize state lines. We cannot fully protect the population of one state if other states aren't holding up their end of the bargain. So a federal response is needed to truly protect the public.

I don't understand why CDC isn't taking a leadership role in establishing testing benchmarks for each state to meet.

REDFIELD: Thank you very much chairwoman for your question and also thank you for the recent resources that you provided to HHS of which $10,250,000,000 came to CDC and has already been distributed to the states to be able to do just that. We have worked with each of the states to develop their independent plan and benchmarks and those plans are now under review. They were due on 31 May

[*]REDFIELD: for--for--through June, and then from June 15 they're due for the rest of the year for July to December. It's really going to be important--I will say that you're blessed with the Wadsworth Lab and one of the best state labs in the nation. As I talked about core capabilities, the number two was laboratory resilience. I am personally saddened that there is a handful of state labs that have the capability to do what needs to be done. Again, as part of this core capability investment, I want all state labs to be able to do that. I got to work with Harold Zucker very early as New York state labs stepped up to develop their own test, as you know. And they were the first to develop the test not on what I call the slow platform that we have for flu, but they put it on a rapid throughput platform and really led the way.

So I agree with you. We're in the process of doing those plans with each of the states because of the resources from you all and Congress. But I would add that I think it's a critical time for us now to invest heavily in state labs so that they have the resilience to do exactly what your colleagues in New York have been able to do. We could do that in each of the 50 states of this nation.

LOWEY: Well, thank you very much. And I just have a little time left. And I want to say that this committee had the benefit of being briefed early on by Dr. Nancy Messonnier, the director of the National Center for Immunization and Respiratory Disease at CDC. And on February 26 she said ultimately we expect we will see community spread in this country. It's not so much a question of this will happen anymore, but rather more a question of exactly when

this will happen and how many people in this country will have severe illness. Was Dr. Messonnier's explanation correct?

REDFIELD: Yes. I mean, I just also would add that Dr. Messonnier is one of the outstanding lead scientists at CDC. She continues to run our Center for Immunization and Respiratory Diseases. And as you know, she was the first leader of our (INAUDIBLE) response to this outbreak when it was grounded in her center.

LOWEY: Now I just want to comment in the limited time I have left. Was she sidelined for telling the truth? It's been widely reported that President Trump wanted to fire Dr. Messonnier after her comments, fire her for telling the truth because of the impact on the stock market. Instead, he removed her from any public-facing role. What does this say to the public health professionals at CDC who may be fearful of retribution for doing their jobs?

REDFIELD: I just want to stress that Dr. Messonnier remains one of our outstanding leaders. She continues to run our Center for Immunization and Respiratory Disease. She's a great scientific ally of mine and other leaders. In addition, I just want to point out she's our lead on the Project Warp Speed in developing the vaccine and taking the leadership for CDC on that task force. So she has not been sidelined, and she continues to use her expertise to lead one of the most important agencies that we have at CDC.

LOWEY: (INAUDIBLE) time. I want to thank you, Dr. Redfield. We've known each other a long time, and I'm glad that you're there, and I'm glad that Dr. Messonnier continues to be a key parts of this project. Thank you very much, Madam Chair.

DELAURO: Thank you.

REDFIELD: Thank you, Chairwoman.

DELAURO: Congressman Harris.

HARRIS: Thank you very much, and thank you, Dr. Redfield, for being here. First off, I want to draw the distinction between March and June. In March because the chairman brought up, well it doesn't make any sense; we had very few cases in March. We have a lot of cases now, but in fact China had a lot of cases by then, and we really didn't know a lot about the disease by then. We know much more about it now, and I would suggest that if we really want scientifically-based actions, we should actually use data, and we have a lot more data now. For instance, I remember sitting at a hearing in this committee where the death rate was speculated to be 3 percent to 4 percent. And last month the death rate, I think the CDC quote best estimate is 0.26 percent. So a lot has changed in the past time, and to say that this is politics is ridiculous. This is actually science. It's actually looking at data and dealing with science.

Now, Dr. Redfield, I don't have a lot of time, but you are well aware of the effect of unemployment on health, I hope. The landmark study in 2009 Quarterly Journal of Economics looking at the unemployment rate following the oil crisis in Pennsylvania in the 1980s showed that the death rate among men unemployed doubled in the year following their unemployment, and when they tracked it for 20 years, there was an effect that lasted 20 years with an average loss of longevity of 1 to 1.5 years for unemployed people. That's a pretty serious health effect.

So I'm going to ask because we're in the midst of reopening in Maryland, and one of the things that in my district is very important is the tourism industry and restaurant industry. And our governor has decided, in accordance with CDC guidelines because I mean we have the phasing document--our governor's decided we are ready for phase 2. I look at the--at the document that CDC has about scaling up operations for restaurants and bars. It is a step 2 where you have indoor dining, and our governor has decided for some reason you can do outdoor dining and you can't do indoor dining in restaurants. So I'm going to ask you a very simple question.

In fact, since our government decided phase 2 gating has already--criteria has already been satisfied, is there anything in CDC guidance that would say indoor seating is not appropriate, maintaining social distancing? I mean, would--could the governor say well CDC guidance is holding me back, once phase 2 gating has been exceeded?

REDFIELD: No, you wouldn't find that in there. Again, as you pointed out, the critical thing is to have these things--CDC, we're not an opinion organization. It's got to be science-based, and I think the principle of the science that we have right now in social distancing is that 6 feet, two-meter distancing, and that's the key.

HARRIS: Should be adequate. Thank you very much. That's--that's what I thought. And again, you know you want to talk about things based on politics, some of these delayed reopenings are based purely on politics because there, as you suggest, there really isn't a whole lot of scientific evidence that at this point would delay some of these reopenings, consistent with CDC guidelines of social distancing.

Now I do have a question about masks because you know, there is now a cult of masks. That's what I'll refer to it as because you know, we get criticized, oh my gosh I'm afraid to get a picture taken and be without a mask somewhere because someone will say well how can you possibly--you're a doctor; how can you not wear a mask? But in fact, we don't know a whole lot about whether a mask is better or worse than a cloth face covering or is better or worse than a face shield. But I'm going to ask you something very specific about restaurant opening guidance because the CDC document says that restaurant workers should wear cloth masks and not surgical masks. I mean it specifically says wear cloth masks, not surgical masks. But my understanding is a surgical mask is probably a little bit more protective of the other person in the room than a cloth mask.

So is there evidence behind that? I mean, is it just that we want to reserve surgical masks for other situations? Is there science behind that saying a cloth mask is better than a facemask? And face shields aren't even mentioned in the guidance.

REDFIELD: Yeah, not in terms of better. Clearly there is science behind the potential benefit, if I am infected, of wearing a face covering, in changing the amount of infectious virus that can go across a 6-foot space or 3-foot space. And we have good data to show that. But I think you hit the answer yourself is the real issue is to preserve the medical surgical masks for the medical surgical first responder community. That's the intent there, not that there's any evidence that there's one better than the other.

HARRIS: Yeah, that's what--that's what I imagined. And again, you know, getting back to science because there's a lot of critique when, you know, first people were told don't wear a facemask, then they're told wear a facemask. We had a big discussion, you know, is it surgical masks, facemasks, face shields? What is--the bottom line is you should protect the other person that you're coming near--

REDFIELD: That's right.

HARRIS: --in case you are an asymptomatic or presymptomatic carrier.

REDFIELD: That's right. That's the purpose.

HARRIS: Thank you very much. I yield back, Madam Chair.

DELAURO: Congresswoman Roybal-Allard.

ROYBAL-ALLARD: Thank you, Madam Chair. And Dr. Redfield, thank you for being with us today. I'd like to follow up on the issue of masks. In early April the CDC reversed its initial guidance from masks being optional to advising the public to wear cloth masks in public spaces at all times. In spite of this advisory, U.S. culture has continued to be a barrier to a universal acceptance of these recommendations. Mask wearing, unfortunately, has become very politicized, and those who oppose their use argue that mandating masks is interfering with individual freedoms.

A recent study by a group of Cornell University scientists showed that when quarantines are lifted, if 80 percent of the population wears masks with social distancing, the virus could be eliminated. Unfortunately, to date, only 15 states require the wearing of masks in communal places, and the president continues to flaunt his opposition to this public health recommendation. Based on the science, why did you initially recommend the mask as optional? And

what fears do you now have regarding the spread of the virus if states and individuals can't be incentivized to wear masks in public, including during these massive protests that we have recently witnessed throughout our country?

REDFIELD: Thank you very much. I think fundamental to this was the recognition of the importance of asymptomatic infection or pre-symptomatic infection. When this outbreak originally happened, CDC had the original 12 cases. In the first--the January, February we did about 800 contacts through our contract follow-up. Two of those individuals were confirmed to be positive, both systematic and both spouses. So we had the view from our Chinese colleagues in their experience and our earlier experience that this was a symptomatic disease like most respiratory viral diseases were. But what we rapidly started to learn is there is significant asymptomatic infection, and what we would call pre-symptomatic infection. And we've learned that the amount of virus that's shed in individuals that are asymptomatic is just as high as that in symptomatic. And when knowledge base came, we realized that we had an important public health tool that we need to take advantage of. And that's if people were asymptomatic or pre-symptomatically infected, if they were wearing a face covering, that they would have less ability to transmit others. And that's why we embraced this important public health tool.

And I will say that I--we continue to see this is a critical public health tool, as I said in my opening statement, that we ask the American public to be vigilant about utilizing particularly as a major mechanism that we have to protect the vulnerable.

ROYBAL-ALLARD: And--and can you also elaborate on what your concerns are then when you see these mass protests, when you see--as things are opening, when you see people on the beaches and in public places who are not wearing masks? What--what is your concern of what the possible outcome of that will be in terms of the spread of the disease?

REDFIELD: Yeah. Obviously, we're--we're very concerned that our public health message isn't resonating. We continue to try to figure out how to penetrate the message with different groups. And the pictures that the chairwoman showed me are great examples of serious problems. You know, and I can say that we will continue to try to message as well we can. We're going to encourage people too, that have the ability to request or require masks when they're in their environment, to continue to do that.

We do think this is an important public health tool, and it--we're going to try to continue to figure out how to get more and more people to embrace it. I was just remarking, when I will go home in the Baltimore area, I don't see anybody without a mask. But a lot of times when I walk through Washington, DC I see a lot of people without a mask.

So, there is a different cultural approach to it, but we think it's an important public health message and we're going to continue to stress it. And I think it's going to be key. These social distancing strategies that we learned our something we need to perfect because we're going to need them to be our major defense again in October, November, and December.

ROYBAL-ALLARD: Well, I--I hope that you can start with convincing our president to be a champion of advocating for masks to prevent the further spread of the virus. I yield back.

DELAURO: Thank you. Congressman Moolenaar?

MOOLENAAR: I--

DELAURO: --Can you--can you unmute and then start from the outset here.

MOOLENAAR: Okay. Thank you, Madam Chair. I appreciate the opportunity. And Dr. Redfield, we appreciate your presence with us today, and want to thank you, the 5,000 members of your team that are helping during this health crisis, and also just for the sacrifice that they and their families are making to help protect the vulnerable.

And I wanted to talk with you, one of the areas that you brought up as a concern was the IT infrastructure. One of my priorities on this committee has been to provide funding for the CDC's public health data modernization

initiative, and I think this pandemic has really demonstrated the importance of that. In fact, some of the early reporting said that the CDC's response was hampered by an antiquated data system and a fractured public health recording system across the United States. And I wondered if you could speak to the early response as well as what you've done since that time and, as we go forward, what do we need to do to really invest in this data modernization.

REDFIELD: Thank you. And again, I--I want to thank the chair and--and this committee. You I think her those discussions that I had I think in the first weeks of my directorship, and we talked about the core capabilities. And the one that I said was the most, most, most important was data. We need data. We need it in real time. We need it actionable.

And I mentioned that I had had a briefing the first month that I was on with the opioid deaths, and when they finished--this was in April 2018. When they finished, I asked my CDC experts what the data was through, and they said March 2015. And I said is that the most recent data we have? And they said yes. And I said I didn't know I was becoming a medical historian. And I shared that comment with the chair and the co-chair and others, and we're appreciative.

We have a long way to go though. It's not just the data system is CDC, it's the data system throughout this nation. And in some states, they have decentralized public health data collection. I have states that are still collecting data on pen and pencil. And so, this data modernization that you all started, I--I do believe to get us over the goal line, it's going to require a substantial enhancement of that investment. We're talking about building a comprehensive data system for the public health system in this nation.

But when that is accomplished, it's going to be a gold mine. You know, we're able to do syndromic surveillance now. And--and that--that two year lag that I had, three year lag I had for opioid deaths we now can solve in 48 hours. We saw with the Evalle syndrome that we had with--with the e-cigarettes, how rapidly we were able to detect that because we could use syndromic surveillance.

So, I--I want to just encourage you to continue to accelerate the ability for us to modernize this nation's system and get it done once and for all. It's going to have enormous health benefits for us across the nation, to be able to respond to that which we don't know we're going to need to respond to. Even in my short time, we've had Evalle, we've had unexplained hemorrhagic deaths from contaminated marijuana, we've--we've now obviously had this. All of these thing--we have the acute flaccid paralysis in children. All of these things would be enhanced so much if we had a real-time actionable data system across this nation.

MOOLENAAR: Thank you, Doctor. You know, it's--I want also follow up with you along the line of the data collection and talk with you about the skilled nursing facilities. It's no secret that nursing homes and long-term care facilities have been among the hardest hit during this pandemic, and data from CMS suggests that 26,000 nursing home residents have died from COVID-19 and more than 60,000 have fallen ill. However, only 80% of nursing homes have reported data to the CDC, so these numbers are only going to increase.

Two questions; how has the CDC been working with CMS to ensure greater compliance on reporting of infections and deaths in nursing homes? And then also, when do you expect that we could get this data reporting as close as possible to 100%?

REDFIELD: Thank you, Congressman. This is a major priority. CMS, Seema Verma and ourselves, our group, are working very closely together. This is really one of the key priorities, to successfully combat the impact of this pandemic on nursing homes.

And as you mentioned, we have the ability now to have these nursing homes required to report all their infections to us, and deaths, and for us to get those into CMS, and for CMS to face them forward so the American public knows what nursing homes are doing well in one nursing homes aren't doing well, and we know which ones we need to go in and help them even more with infection control.

I'm hopeful that will have this completed over--over the weeks ahead. This is a priority. It's a requirement now by CMS that these nursing homes do report. You know, was just a couple weeks ago we were--we were under 20%, and then recently 60% and now 80%, and I think actually I heard numbers today that might be 90%. So, I think we're going to get this done hopefully before the--the beginning of July. This is a priority, get it done this month.

MOOLENAAR: Thank you. And I yield back.

DELAURO: Congresswoman Lee?

LEE: (OFF-MIC) It's very, very timely. First, let me just say you know what I think everyone recognizes we have a pandemic upon a pandemic in the African-American community. And so, today I just want to take a moment to offer our--my condolences to the Floyd family as we mourn and grieve his loss, and hope that justice is served in his memory. And that goes right into the disproportionate rates of African-Americans and people of color who are dying from COVID-19.

Now, Dr. Redfield, the PPP and Healthcare Enhancement Act, which became law April 25th, mandated that the CDC provide us with a report on COVID-19 data based on race and ethnicity, socioeconomic data within 15 days. Now, we've--within 21 days, excuse me. We received this report on May 15th, and of course you signed this report. It was 2.5 pages long and contained no new insights, and what it did was just link to websites of data that was outdated and it was very limited on testing and demographics. In short, the CDC and the Trump administration did not complete the assignment at all.

And so Doctor Friedman(PH) first of all what is your plan for how you are going to target resources and federal response to black and brown communities which are disproportionately being hit and as you said the impact is greater disproportionately with people of color. How are you going to target a federal response if you don't have the data? You said you would provide this. I actually called on May 18 two some of your deputies and ask for some of this data as it relates to where African-Americans are being disproportionately hit and I was told the CDC did not have the data to illustrate these disparities and must make assumptions.

So I want to know how are we going to get the actual data and the report quickly so we can target the federal response? And then secondly I cochair the Asia-Pacific un-American caucus health task force and I am concerned about the fact that the data as it relates to the API community is not disaggregated which makes it challenging to properly allocate resources and to ensure positive health outcomes. Actually in one of your reports you have the a API community designated as other and so what is--what are you going to do in terms of collecting data as it relates to the a API community, as it relates to cases and mortality and how are you going to make sure we get the report, your next report which I think is due on June 14 that tells us where we need to target these resources based on race, ethnicity and socioeconomic status?

REDFIELD: Congressman Lee I want to thank you for your question and first I personally want to apologize for the inadequacy of our response. It wasn't intentional. Unfortunately, it is just reflective of what I tried to say is that we didn't have the data that we needed to be able to answer that in a--in a responsive way. That--that data comes into was obviously from the state and local tribal health departments but that response was not adequate and I apologize and--and unfortunately, it was under my signature so I take responsibility but we are correcting it.

I think there is going to be an announcement today that because of what you all have done with the CARES Act it is now going to be a requirement for all laboratory test to be reported to CDC to include the type of test, the ZIP Code of the test, the ethnic, racial demographics, the age and the sex and it is as I said before in my opening speech the data is the roadmap, it is fundamentally the key first step that we need to do to address the health disparities that you have so correctly have highlighted.

And I--I think many of you know I spent 22 years practicing medicine in urban Baltimore. I understand firsthand the disparities of healthcare in this nation. This is why Congressman Cummings(SP) and I became close friends. I have every intent to get that data so that we can begin to understand. Clearly increasing the access to knowledge of infection in vulnerable communities is critical, getting testing more available in there. I do think with the--

LEE: So Dr. Redfield so what report are you going to release today so that we can have--so that we know in advance what we can expect?

REDFIELD: Yeah, it's not a report Congressman. It's--it's going to be--it's a requirement that the reporting to CDC now is going to include ethnic, race, age and demographics and ZIP Code so we are going to be able to generate exactly what you have been requesting very specifically so we will know exactly where this virus is occurring--

LEE: Dr. Redfield okay, so the next report to Congress is June 15. Will we have that data based on the CARES Act requirement?

REDFIELD: All I know is that whatever data I have and I am pushing to get it in the way that meets yours and my goal I am not going to be able to promise that it's going to be perfect on the 14th but it is going to be a lot further along than it was in the last one and I think we are going to get this solved if not five the 14th by the next one so you are going to--

LEE: And I know my time is up but just let me ask you will the API data be disaggregated? We need that because otherwise we won't have a true picture of where to target resources.

REDFIELD: Yeah, we are going to--we are going to try to make sure this data is forward facing down to the ZIP Code level Congresswoman.

LEE: By--know, I am asking you the disaggregation of data based on the a API, the Asian American Pacific Islander community. For example are you going to say that in the Chinese-American community this is the data, and the Filipino community this is the data, in the Japanese American community this is the data. You know disaggregate the Asian-Pacific--

REDFIELD: Okay. That--that--that I will have to look into but I will take your concern and recommendation that we work to see how to accomplish that.

LEE: Thank you very much. Thank you Madam Chair.

DELAURO: Congresswoman Herrera Beutler.

HERRA BEUTLER: Thank you, Madam Chair. Thank you Dr. Redfield for being here. I have a difficult question for you but I think it's really important to really understand what we can do to not be in this place it again and I value so much your work and your many sleepless nights and the work of your agency because I know they have been on the front lines.

I was reading an article--there's--I saw an article from the Wall Street Journal I think in April and I saw one from the times today about CDC and testing. One of the things that was quoted said former officials in the CDC said the CDC's culture locks some of the agencies and plays into a fixed way of thinking helping (INAUDIBLE) it's first and most consequential failure in the crisis it's inability early on to provide state laboratories around the country with effective diagnostic test. And then if I kind of fast-forward over to where and I am not trying to say who--I'm not trying to take a big error down despite what everybody is probably thinking I want to understand this. I understand that one, the public health emergency was declared on January 31 it meant that state labs had to--in the lab had to get permission to get approval to do our own testing. Basically it was about a month later before test started really flowing.

We know early on the kind of the control of the situation was aggregated. They wanted whoever made the decision that it was aggregated and CDC was going to produce the first test and send them out to the states. What we now know is those test didn't work, they were sent to Washington state. Washington state had to send them back and ultimately what I feel like happened was you know we have to have diagnostic testing ability and we had to ramp that up quickly in order to stop infection. Now we are at the place of limiting new infections for reopening and we have broken through some of the barriers. Thank goodness the private companies were able to step up. We broke

down some of that bureaucracy and they were able to step in and fill in holes. I know in my community in Southwest Washington my local health--I mean I spent--I have spent months trying to get testing capability for private labs. I know that because of relationships for example within the Vancouver clinic in Southwest Washington they were able to use their relationships to get their testing capability going. Everybody was--it was kind of like everybody was doing their own thing to make it move forward and we were trying to break down the bureaucracy.

The Wall Street Journal says and this was back in April that an FDA official flew to the CDC headquarters in Atlanta, visited the lab that had prepared the test and the lab was quote a mess and it became clear that the test had likely been contaminated (INAUDIBLE) said one person familiar with the matter. The CDC then distributed and disputed that the lab was a mess and pulled back its test and there's been an investigation and we haven't--I haven't seen the investigation results yet.

I know that your heart and your soul is to protect and to promote the public health of the people in this country. There is no question about it. You have a long and distinguished career which we are grateful for. In recognizing these problems my question is and I keep hearing we just need to put more money into public health we just need and I--I agree. I want a real time active data system but this committee in a bipartisan fashion has increased funding for CDC, strategic national stockpile, we have instituted a rapid response team. We say yes to public health request, we really have and yet here when it all counted some people in some places made decisions that all of this was going to be kind of constricted by the federal government, the federal government was going to be the one that innovated and then distributed it and I don't know if all of the money on the world can fix what some have called a culture where quote again this is the New York Times the culture at the CDC is risk-averse, perfectionist and ill-suited to improve--improvising in a quickly evolving crisis. That's--so when I read that I don't think I(PH) love the CDC I think you guys are doing what you are doing in your lane but what in this better be--wouldn't we all better be served if the doors of collaboration opened at the very beginning and

[*]HERRA BEUTLER: wasn't public health or private, you know, or private labs because we've got my challenges with how private labs have done things with regard to Quest and LabCorp. But if we'd have thrown open the doors and said together we're going to move forward--and I would ask you, would you consider--I know you want your legacy to be building a robust public health system, but could your legacy also include fixing some of what seems like a siloed approach within the CDC? And that's going to require you to fight upwards, I realize, not just downwards. But is that something you'd be open to consider in terms of righting this ship so that the next time we're in this place--and I pray to God it's not in the fall, but it could be--but is that something you'd consider and perhaps speak to that?

REDFIELD: Appreciate your comments. A couple quick things. First, I do believe just to level the field here, is that the CDC developed within 10 days a test from the time the sequence was published, and that test is not a flawed test. It works perfectly. It was available that--in mid-January. They diagnosed the original cases in Washington, as you know. And its only limitation was in order to get that test you had to send the blood to the CDC. And there was never a moment in this nation when any health department couldn't get the test. They just had that limitation. There's no question there were shortcomings at CDC when we--

HERRERA BEUTLER: I have to push back on that one. My public health departments could not get that test.

REDFIELD: Well, I'm saying if they chose to send it to CDC they could get the test. That's what I would say, Congresswoman. We always had that capacity. The shortcoming is with then we tried to manufacture the test so that each health department would have their own. All right? I don't think you're going to see CDC in the manufacturing position anymore. We contract it out to (INAUDIBLE). And in that time there was a shortcoming. There was a contamination. It's being--there's an inquiry to figure out you know what was there and why it happened. But I will say within five weeks it was corrected, and so for me within five weeks of the sequence we had the testing now available in the public health labs, which some people may think is a delay. As a virologist from the time of the new pathogen to having the test in public health labs around the country, I think that's still an accomplishment. But I--

HERRERA BEUTLER: Let me add in there, though, that six weeks--Madam Chair, I beg your indulgence--that six weeks was the six weeks that we had to get ahead of this virus. That six weeks--you said five weeks--on January 29 to February 29, that's when we shut down, and now we are doing--we are digging our small businesses--we're digging everybody out. That I know as a virologist that's good, but we have to get into the 21st cen--we have to change the culture of the organization because that was--that was the five weeks we had. That was our lead time.

REDFIELD: If I could just make one last comment on this--I know my--

HERRERA BEUTLER: Please, Madam Chair. I thank you. I beg your indulgence.

REDFIELD: I know the time's--can I make one comment?

DELAURO: Yeah.

REDFIELD: I know the time is up. I won't go through the other comments because we can talk off-line on that. But the issue that really has to happen and that one thing we have to correct is the day CDC got in the lane to make a public health test, the private sector had to be in the lane to make a test for the rest of rest of America. It wasn't CDC. CDC makes the public health lane. It took, unfortunately, you know, weeks and weeks and weeks before the private sector stepped up, all right, and developed what we now have. As you know, we've now done over 17 million tests. The private sector's in the game. The public health is a small part of it, but I think that has to change, too.

HERRERA BEUTLER: Thank you. Thank you, Madam Chair.

DELAURO: Congressman Pocan.

POCAN: Thank you very much, Madam Chair. Thank you, Dr. Redfield for being with us. Dr. Redfield, I have a lot of questions, so if you can be as concise as possible, I would certainly appreciate that. It was inferred earlier by our ranking member that--I think you answered the question--but that we don't have the worst amount of cases, the highest amount per capita on the planet. Is that correct?

REDFIELD: Yeah, that's correct.

POCAN: However, according to your data, CDC data, we've had over 1.8 million cases of coronavirus. That's nearly a third of all the cases on the planet, and by far the most of any country. Is that also correct?

REDFIELD: Of those that have been reported, yes.

POCAN: And also we've had 106,000 deaths, by far the most in the world. Is that correct?

REDFIELD: Again, of those that have been reported, yes.

POCAN: And our death rate is like 320 per 1 million, which is six times the reported global average. Is that correct?

REDFIELD: I would have to double check that. I don't have that figure in my head, but I have confidence that you have data there that--but I'd be glad to check that and get back with you.

POCAN: Sure. Thank you. In fact, there's only eight countries out of 195 or so countries that exist on the planet that have a worse ratio per capita, Qatar, San Marino, Andorra, Bahrain, Kuwait, Luxembourg, Singapore and Chile. Altogether, their populations are 33.5 million people, about a tenth of the United States. So it's not exactly impressive to say that we don't have the worst, but for almost every country we have the worst amount of cases that are out there. You have to agree, Dr. Redfield, that countries like Germany with a rate of 220 out of 100,000, New Zealand 31 out of 100,000 and South Korea 22 out of 100,000 have been more successful than the U.S. in controlling the spread of the coronavirus?

REDFIELD: Based on the reported cases that we have, that would be correct.

POCAN: All right. So I think one of the problems that we have in the United States unfortunately, Dr. Redfield, is back in mid-April your agency was putting together detailed step-by-step recommendations for businesses, childcare facilities, restaurants and others to reopen and that got sidelined for a month. In fact, I think it finally was on May 20 you released those guidelines, and on May 14 you put out decision trees. Who made the decision to delay the release of the reopening guidelines?

REDFIELD: Again, all of these guidelines that we have developed, and as I mentioned--

POCAN: Well, the question specifically is who made the decision to delay?

REDFIELD: Right, and I was just trying to don't answer, sir, that these guidelines, forming them was a reiterative process, so it wasn't a question of delaying the guidelines. It was a question of completing the process to make sure the guidelines had the input of the different groups.

POCAN: Who made the decision specifically that they would be released on May 20 rather than anytime sooner?

REDFIELD: It would have been me, sir.

POCAN: Okay, and were you at all in consultation with anyone at the White House, and if so, who?

REDFIELD: No, we were working again through the interagency group, so again that has multiple agencies that have input when these guidelines cross over. As I mentioned, it's a collaborative inter--

POCAN: I--I--I can tell you that release, though, Dr. Redfield, you know, states like Wisconsin where our state Supreme Court forced us open and other states were opening came after all that happened, and it created a lot of chaos, and we had a spike in cases after that. Let me ask you another question. So we know that chemical agents that are similar to teargas and teargas itself can cause people to cough, which can spread COVID-19. Is that correct?

REDFIELD: Definitely coughing can spread respiratory viruses, including COVID-19.

POCAN: And that you agree that teargas and chemical agents like teargas can cause people to cough?

REDFIELD: That's been my experience.

POCAN: Have you made any advice to the president or to any police agencies or the military to not use teargas or chemical agents with the recent protesters because obviously that could cause an increase in COVID-19 due to the coughing?

REDFIELD: I think you raise an important point. We have advocated strongly the ability to have face coverings and masks available to protesters so that they can at least have those coverings, but you do raise an important question.

POCAN: Yeah, would you make that recommendation to the president and to law enforcement?

REDFIELD: I'll pass on--I'll pass on this comment to the next task force meeting, yes.

POCAN: Okay, I appreciate that. And with six seconds left, I will yield back.

DELAURO: I thank the gentleman. Congresswoman Clark.

CLARK: Thank you, Madam Chairwoman, and thank you, Dr. Redfield. As you acknowledged in your opening comments, you come before us today in a time of national anguish and turmoil. This pandemic did not create inequities, disparities or racism, but it has magnified the lethal effects of all of those.

REDFIELD: So true.

CLARK: We will only emerge through this public health crisis, this economic crisis and this moral crisis if we demand that our American ideal of equity truly applies to each and every one of us. Dr. Redfield, the CDC website contains pages of information on disparate health outcomes for people of color, higher rates of asthma, heart disease, diabetes, to name a few. I understand from your answers to Congresswoman Lee's questions that tomorrow you will have an announcement, or today, later today, about mandatory demographic reporting. But wasn't it eminently predictable that COVID-19 would disproportionately impact black, Latinx, and indigenous communities?

REDFIELD: You know, Congresswoman, I don't know. But it's clear once we understood that individuals with certain medical conditions were greater at risk, once we, you know, stepped back and understood certain social factors in--in--in living conditions would be critical, I think it became rapidly self-evident.

CLARK: Well, I can tell you it--it played out very, very quickly, and evidently in--in my district.

REDFIELD: Yeah. I know.

CLARK: And I think that is true across--across this country. And we have to do better. This plan that you're putting forth, is it a written plan that you will be sharing us with specific benchmarks on how you are going to collect this data?

REDFIELD: Again, the announcement that it's coming, it's actually coming from the Secretary of Health. It's not CDC, but it's CDC that's going to be getting this.

But you highlight just such an important area. And those of you who have been able to visit CDC, the whole area of health disparity, the whole area of social determinants of health, the whole area of making purposeful, meaningful progress in this not just for COVID but for--you know, for all of the health outcomes that we have, I do--I didn't mean what I said when I said that the time is now to--to get a purposeful program to address--

CLARK: --We would--

REDFIELD: --These inequities.

CLARK: I would--and I have visited CDC, and I--and I appreciate your commitment to that. But in this particular case with this pandemic reaction, there were public outcry and outcry from members of Congress and pressure to have this information. I'm interested in who--who wrote this plan that is going to be released today? Was that the CDC or someone within HHS?

REDFIELD: It's in responsiveness, I--as I understand it, to the CARE Act and HHS will be announcing it. I think the--

CLARK: --Do you know who wrote it?

REDFIELD: It's really just meeting the criteria. It's not a plan in how to respond.

CLARK: Okay.

REDFIELD: It--

CLARK: --Well, what I would request is that we get a plan--

REDFIELD: --I agree with you--

CLARK: --So we can make sure that we actually collect this data.

Going back to the other point, we see native Hawaiians and Pacific Islanders have the highest COVID-19 rates of any race group in California. And in many states, Asian Americans have a case fatality rate significantly higher than

the overall population. I hope you will do more than look into the disaggregating of AAPI information, but that you will make it happen. I also hope that you will add the LGBTQ community. June is Pride Month. This is a great time to add them to your forms, your surveillance forms, in particular the person under investigation form.

Your website also states that a lack of health insurance is one of the reasons that communities of color face systemic health disparities, and in particular have been hard hit by COVID-19. Is it your professional opinion than that dismantling the ACA and the administration's proposed budget cuts of $1.6 trillion to Medicare and Medicaid could actually harm people and, in particularly, people of color in this country?

REDFIELD: You know, Congresswoman, I--the--the way I can answer this is that, you know, I share with you the deep commitment that all Americans get access to high-quality healthcare, and there should--and that we effectively address access issues. I do know--

CLARK: --Do you think there is a way to address the disparities of healthcare in this country without expanding rather than reducing access to quality affordable health insurance?

REDFIELD: I think we clearly have to make sure that all Americans and expand the ability to get access to high-quality healthcare. The man--manner in which we do that, you know, the--I'm--I'm not really here to comment on it, but I--

CLARK: --I'm not asking you to comment on the manner. I'm just saying is there any way, in your professional opinion, to address these disparities if we do not expand rather than contract access to healthcare in this country?

REDFIELD: And as I said, I--I'm firm--firmly with you, that we need to continue to expand access to high-quality healthcare in this country for everybody.

CLARK: Thank you. I yield back.

DELAURO: Congresswoman Frankel?

FRANKEL: Yes. Thank--thank you, Madam Chair. Thank you. I want to thank your staff, Gloria Inludim (PH). I soap--I hope I said her name right, but she really set us up well for this. And I'm finding this meeting actually very enjoyable, even though I'm sitting--and I'm sitting at home. That makes it even better. I didn't have to get on one of those planes.

So, thank--thank you, Dr. Redfield, for your service to our country. I want to--I have a few questions. First of all, Dr. Redfield, do you--would--do you agree that the CDC might have learned more about the virus and--and the necessary response had we had a greater global presence in the days and months leading up to the COVID outbreak?

REDFIELD: You know, Congressman, I think we would have benefited enormously from having a greater presence, particularly in our CDC office in Beijing.

FRANKEL: Thank you for that. And in your written testimony, you say that contact tracing is a core infectious disease control strategy, and--and involves case and contact investigation, followed by implementation of intervention. You've also--I know you testified at the Senate that contact tracing is going to be the difference from succeeding in containing this outbreak.

So, first of all, I--I just--a few questions in regards to contact tracing. You--one of your former predecessors, Tom Frieden, as suggested a workforce of at least 300,000 people in the country to effectively contact trace. I'd like you to comment on that and then a--a few other things. How should a community determine the right number of contact tracers they need to respond to the pandemic?

REDFIELD: Thank you very much. I--you know, I've spoken to Tom about this. I know his number. He estimated 300,000. I--I mentioned that I have estimated between 30,000 and 100,000. It is sizable. I think we won't really

know until we work state-by-state. We have met with all 50 states and jurisdictions, and some of this is in metropolitan areas that--or cites that we have also, and to work with them to figure that out.

I'm--I'm happy that many of the states have started to really expand. A number of them have already added 1,000, 1,500 contact tracers. We're working with them. CDC has made available through our foundation the ability for states--we--we will allow them to hire people to help augment the--the epidemiologists and the leadership group that they need, and then we're looking at them with the resources we gave them. We're hopeful that AmeriCorps will be another source.

But we--we really have to get this built, and we have to get it built between now and September and get these public health workforces up. And in some states it may be 500. In other states, it may be 5,000. We're in the process of doing that state by state by state to help them understand what is that workforce they need.

FRANKEL: What exactly are you doing to build the contact tracing, the--the workforce?

REDFIELD: So, what we're doing is really a couple. We--we have over 600 CDC people now embedded throughout the country, but we've--through our foundation, our found--CDC Foundation is--is there to hire for the states additional personnel. And we can augment--augment that substantially. That process is ongoing.

In addition, obviously we dispersed the--the resources that you all have given us to the states to encourage them. And some states have already, I know, hired on their own over 1,000 individuals that are being trained as contact tracers to work under the supervision of the people that they hired through our foundation. And we're going to continue to do that.

Lastly, I'm hopeful that AmeriCorps will also in each of the states be having a public health workforce that will provide more long-term augmentation of this public health workforce. So, we're working state by state by state to see them augment. And as I mentioned, some states have already augmented over 1,000.

You know, finding that magic number, I don't--it's--I don't know. I do think in some states is going to be over 5,000 people, maybe 10,000. In other states, it's going to be, you know, 300 to 500 people, what they need. But it is fundamental that we have a fully operational contact tracing workforce that can--every single case, every single cluster can do comprehensive contact tracing within 24 to 36 hours, 48 hours of the latest, get it completed, get it isolated so that we can stay in containment mode as we get into the fall and winter of--of 2020.

FRANKEL: Thank you. And--and Madam Chair, if I may just--just follow up with one--one more thought on this, on contact tracing, is, you know, we're watching all these peaceful demonstrations.

And I know a lot of people are very close together so I just would like your--what--what are you advising the states if we--if the number of cases overwhelm contact tracing abilities?

REDFIELD: Yeah, I think the first thing I would like to see is those individuals that have partaken in these peaceful protest or have been out protesting particularly if they are in metropolitan areas that really having control the outbreak to the extent we want. Minneapolis happens to be one it was still having significant transmission. DC is another one. We really want those individuals to highly consider being evaluated and get tested and obviously go from there because I do think there is a potential unfortunately for this to be a seething event and the way to minimize that is to have each individual to recognize it is to the advantage of them to protect their loved ones to hey, I was out I need--I need to go get tested in you know three, five, seven days go get tested, make sure you are not infected.

FRANKEL: All right. Well, I don't think you answered back question but you know the question was what are you advising the states if they are overwhelmed and they don't have the contact tracers.

REDFIELD: Yeah I--I want to work with the state so they don't get to that pace. I agree with Thom Friedman we need to build that workforce and they need to work with us now to make sure they have--they are over prepared.

This is not an area that you'd need to skimp and be underprepared. This is a time to be over prepared and if you hire extra contact tracers then you can use them to help with their HIV elimination program or vaccination program or maternal Child health program but this is not a time to be under--understaffed.

FRANKEL: Thank you Madam Chair. I yield back.

DELAURO: Congresswoman Bustos.

BUSTOS: Hello, everybody. Thank you very much Dr. Redfield. Appreciate your time today and thank you Madam Chair for putting this together. Back to Congresswoman Frankel's point just a second to go my entire screen disappeared right when I went to go on mute so I think this is you know we are all learning this together but Dr. Redfield like many of my colleagues and I know Congresswoman Clark brought this up just a little bit ago, Congresswoman Lee did also I am very, very concerned by how COVID-19 is impacting our communities of color and so I would like--I would like to start there with my line of questioning with you.

So I am from the state of Illinois and African Americans represent roughly about 15 percent of the population but nearly 30 percent of the COVID-19 depths. Hispanics represent about 17 percent of the population in Illinois and 31 percent of the people diagnosed with COVID-19. All right so that puts it in perspective. I am going to drill down to my own congressional district which I live in downstate Illinois and when--when I look specific to my congressional district Winnebago County which is the farthest northeast county and my congressional district African-Americans make up 13 percent of the population there and 25 percent of the COVID-19 cases. In Peoria County which is the furthest southeast part of my congressional district African-Americans make up 18 percent of the population and 36 percent of the COVID-19 cases. (INAUDIBLE) County which is where I live, where I'm sitting right now, the Mississippi River is to my left ear the (INAUDIBLE) make up 13 percent of the population and 22 percent of the COVID-19 cases.

So Dr. Redfield given these facts I want to ask you about how social determinants of health can feel such statistics. In just further in the southern part of the city of Peoria African-Americans face serious food desert issues. I heard a story of a resident there who literally would have to stop at 16 stops while riding the bus to be able to get to a grocery store and that is the only way that that person had access to fresh produce. So my question is this Dr. Redfield can limited access to healthy food increase poor health outcomes and lead to issues like diabetes and obesity? Do such conditions put people at higher risk if they contract COVID-19?

REDFIELD: Thank you very much Congresswoman. You have hit on a critical issue, something I would love to work with Congress. The social determinants of health you know as a laboratory scientist you know I kind of shrugged my shoulders saying I don't know if that's really going to be relevant but obviously data is the key and I happen to be data driven and I have seen overwhelming compelling data to show the social determinants of health in childhood actually do determine long-term health outcomes. I would like to work with Congress to develop the mechanism for this nation to understand long-term which ones are the most important. I have talked about trying to set up a Framingham(SP) like study over the next 20 years that really allow us to nail down firmly is it--is at the grocery store, is that the fresh area? Is it violence in the home? What are the critical social determinants of health but to answer your question directly there is no question. There is no question that the social determinants of health as pertain to access to quality food have enormous public health outcomes.

BUSTOS: So--so let's drill down a little bit and part of this my line of questioning Dr. Redfield is I want to make a point and I think we are on the same page here and I hope my--my colleagues are as well but further in there is a 2018 Rockford regional health Council report that says two out of five black residents are below the 100 percent federal poverty level in--in the Rockford(SP) region. Again that is the farthest northeast region of my district. Dr. Redfield can you also talk about how poverty can lead to negative health outcomes and can poverty levels put a person at greater risk of contracting COVID-19?

REDFIELD: Again I--I don't think there's any question. What I would like us to be able to or not me but hopefully my grandchildren or maybe in the next five years, 10 years, 15 I would like us to really understand exactly which social determinants of health are the most influential and--and get these things corrected. We don't have to wait for an

answer to start correcting them because some of them are just obviously intuitive but I do think this is one of the critical public health issues of our time, the social determinants of health.

BUSTOS: Thank you, Dr. Redfield. In my five remaining seconds what I would like to point out is I have a bill called the social determinants of health Accelerator act. Just want to draw that to the attention of my colleagues and also Dr. Redfield to your attention. I am really hoping that this is something that not only will have a debate around it but also pass it this Congressional session. Thank you very much and I yield back.

REDFIELD: Thank you.

DELAURO: Congresswoman Watson Coleman.

WATSON COLEMAN: Thank you, Madam Chair. Thank you very much for this hearing and thank you Dr. Redfield for all of your testimony thus far.

Want to follow up on a couple of questions that have already been posed to you. With regard to the report that is going to come out that is supposed to break down (INAUDIBLE) the demographics of where the disease is, (INAUDIBLE) it and how it has affected certain populations will that information that come--that is coming out and the report on the 15th include the number of positive cases by race, ethnicity, etc., the number of hospitalizations by race, ethnicity, etc.? The number and the percentage of depths under those categories? Will it be broken down that--to that finite degree?

REDFIELD: Yes, just to clarify again Congresswoman this is the beginning of finally getting the data that we really need to do all that you just ask so there is now--

WATSON COLEMAN: So that's a no?

REDFIELD: No--

WATSON COLEMAN: That's a no?

REDFIELD: No, it's not a no--

WATSON COLEMAN: so--

REDFIELD: I--I am just I am saying this is the beginning of having the data to get the report in the manner that you ask and the first step is to get the data, that is really what the announcement is later today that that data is coming to us and that gives us, enables us to give those reports in that granular detail that you are requesting.

WATSON COLEMAN: So will that granular detail be in the report that is coming out on the 15th or are we going to wait for a later report? Just want to know.

REDFIELD: Yeah, I'm going to--

WATSON COLEMAN: (INAUDIBLE)

REDFIELD: I'm going to give you all of the data that I have at that time.

WATSON COLEMAN: You're not answering the question.

REDFIELD: Well, I'm going to give you the data that I have and--and that's really all I can do. I will continue--

WATSON COLEMAN: Thank you. Reclaiming my time doctor. When will testing be unavailable to anybody who wants it and thinks they need it? Do you have any idea?

REDFIELD: I think the key on this testing is for it to be a decision between the individual and their--and their health provider to get the testing.

WATSON COLEMAN: Yeah, I--I'm simply asking is there any impediment to anybody getting tested who wants to be tested if--if they have a doctor and the doctor says yeah. Is there any impediment? Is there--is there testing capacity that they exist to meet that need?

REDFIELD: There should not be an impediment Congresswoman.

WATSON COLEMAN: If you're not--if you don't have a relationship with a doctor and you are just an uninsured individual how do you get tested?

REDFIELD: So there's a variety of different testing sites that have been setting up and I know I think over two thirds, 70 percent have been set up in areas that are considered socially disadvantaged. Those

[*]REDFIELD: wasn't public testing sites are there and available for the American public.

WATSON COLEMAN: So if we're going to consider reopening up our economy, is there any science that informs us has to what percentage of a population needs to be tested and their information traced, if necessary before we know that we're really in a healthy mode as opposed to a leveling off of a curve simply because of the few numbers that were testing? Is there a percentage of the population? I know each state would be different in terms of the number, but is there a percentage of the population?

REDFIELD: It's an excellent question. What we have is estimates from the WHO and others that the threshold of being adequate in your testing is when one out of every 10 tests that you do is positive. So when we were at one--

WATSON COLEMAN: Okay, but that's--that's how many based upon how many are testing. I'm asking you, what is the percentage of the population that should be tested?

REDFIELD: I don't know the answer to that question at this moment in time.

WATSON COLEMAN: Okay, does--are there people in the science field who think they've got a handle on that?

REDFIELD: I will--

WATSON COLEMAN: And if so, would you - met would you find out for us and share that information with us?

REDFIELD: Yes, Congresswoman.

WATSON COLEMAN: Okay, thank you. Earlier on in response to representative DeLauro's question you made some comment that if this were a global health threat--is there's not a global health threat, this pandemic?

REDFIELD: Yes, it's a global health threat. You must have misunderstood my comment.

WATSON COLEMAN: Okay, thank you. Then should we not be connected to the World Health Organization? Have you any position on that, and have you given the president your wisdom, your advice on that?

REDFIELD: The WHO continues to be a close a colleague of ours in the public health efforts. We're currently working on a number of outbreaks, as you know, around the world, polio, Ebola--

WATSON COLEMAN: It's not--yeah. It's not (INAUDIBLE)

REDFIELD: So we continue to--we continue to have a close collaboration with the WHO.

WATSON COLEMAN: Thank you. It doesn't seem to be a priority of the presidents. I'm going to ask you a question about the Ozarks, the wonderful time they had on memorial day and the launching of the space shuttle. Even

though those states may not have asked for your help because of the possibilities of additional infection or a higher rate of infection because those people were sowed densely integrated into whatever they were doing, is there a role for the CDC to be proactive in reaching out to them to see if we can get a handle on what possibly could be a problem before it becomes a big problem? And if so, what would that be?

REDFIELD: Yeah, I agree with you, Congresswoman. We do routinely reach out to the different state health officials and offer our assistance. And in those circumstances I have 38 teams now out assisting different states, territories with the different outbreaks, particularly in the area that you mentioned, contact tracing. And we will continue to emphasize that obviously to our colleagues in Missouri and Florida that we are prepared to provide the assistance if they would request us to come in and help.

WATSON COLEMAN: Thank you. Chairman, just one last thought. Given your vast experience and your interest in this area, was it not obvious to the CDC that the African-American community would be disproportionately negatively impacted by this Covid from the very beginning?

REDFIELD: Again, Congresswoman, I think we have worked and will continue to work to try to identify and help respond to develop interventions that could minimize the impact of this in the African-American community, and we have. The challenge that we had that we've acknowledged is we haven't gotten the data that we needed so that we could give the American public the analysis. And again, we're going to continue to commit to get that data so that we can do that.

WATSON COLEMAN: Thank you, Dr.--thank you, Dr. Redfield. I guess you have to go where the action is. Thank you. I yield back.

DELAURO: Thank you. We're going to begin a second round, but it can be only two minutes. After Redfield has a hard stop at 130. I want to accommodate people, but we can only go to minutes. Try to be as lenient as I can because this is a critical, critical hearing and people have excellent questions that they need to get answered. So with that, let me start, and what I want to do is talk about vaccinations. And influenza vaccine campaign. After Redfield, you said that in April the need for an enhanced vaccination effort this fall for seasonal flu. As you noted, we were going to have--we're going to have a flu epidemic, and the coronavirus epidemic at the same time, which will put tremendous strain on the hospital system. Yes or no, do you still stand by your April 21 questions? Your answer.

REDFIELD: Yeah, I think were going to have a difficult time.

DELAURO: Okay. Given that we have to be prepared to deal with that effort, we're also going to be having companies around the world bracing for a vaccine. There's funding that means for infrastructure, medical supplies, workforce and a bunch of unknowns which have to do with storage requirements, cold chain supply, etc. Explain that aspect of massive vaccination campaign. What's already in the works? What activities, what is the funding capabilities question mark you can deal with all the funding now, I want a budget because it will impact our--our negotiations when we're dealing with the Senate on the heroes bill.

REDFIELD: Chairwoman, is that in reference of influenza or in Covid?

DELAURO: I want to know about vaccine, but I also wanted you to answer the question on influenza and what we need to do with regard to that.

REDFIELD: So the Covid vaccine effort, operation warp speed, which is run by the secretary of defense and the secretary of health, that is moving very rapidly. I can just leave it at that. It's moving quickly. It's my expectation that we will have one or more vaccine available before the end of the year for Covid. Which will be a great--

DELAURO: The infrastructure, the infrastructure for putting this together.

REDFIELD: That's right.

DELAURO: And a budget for putting this together. We need it now.

REDFIELD: Okay, well we'll be able to work with HHS and get that back to you, okay?

DELAURO: Okay.

REDFIELD: And I do want to emphasize the importance of flu vaccine. And Nancy Messonnier's leading that effort. We mentioned it to really get our nation accelerated. As you know, only about 47% of the American public take advantage of flu vaccine. We're really hoping that the American public will see that the flu vaccine is one major way they can help the station get through this fall.

DELAURO: And that's going to be a further strain on the system with this virus. Congressman Cole. Call my thank you very much, Madam Chair. Since my friend from Wisconsin had some questions about my numbers, let me just add some. Death rate in the United States, 333.9 per million. United Kingdom, 597.5. Italy, 556. France, 433. Spain 580. Belgium 835.9. Netherlands 347.6. Sweden 446. Ireland 341.8. Those are all advanced countries with first rate healthcare, and frankly, likely to produce numbers that we can trust. Personally, for the record, I don't trust the numbers coming out of Russia, China or Iraq, and I think a lot of the rest of the world, frankly, just doesn't have the infrastructure to give us they don't have the tasting capability or anything else. I will say there are some real stars that I do trust. Japan, 7.1 New Zealand, 4.5; Taiwan, 0.3; Hong Kong, 0.5. I just say that to say there are places clearly have done this better than us and we have lessons to learn from but I want to be clear that we're not the worst in the world. And this data is very interesting to compare because it's not the same data from the same source. So there's a lot of apples and oranges comparison. Let me move to something near and dear to my heart as this committee because I just have a few seconds left, recent data from the University of California said that tribal nations where states the five states with the highest infection rates in the country would all be tribal nations. I'm going to repeat that. On a per capita basis five tribes have more coronavirus cases than the state of New York. Try with the highest rate Mississippi band of Choctaw Indians and infection rate more than double. Given that challenge in that community, can you tell us just quickly some of the things - (INAUDIBLE) you working on this hard but you're doing to help tribal nations deal with this.

REDFIELD: Yeah, it's really important, Congressman. I mean clearly the Native American community has been disproportionately hit. We have been able to award, as you know from what you've granted CDC almost $60 million of the tribes with a total hopefully soon to be 205 million to Indian country to help give them the financial support. I think more importantly, we've also provided a number of rapid response teams in the Indian country to basically provide technical assistance, because they have had some of the more significant outbreaks, as you know, help them with contact tracing and--and--and community mitigation as well as some of the unique challenges they've had in dealing with--particularly with water security.

And we will continue to augment the ability of the Indian Health Service to support these tribal nations at a--in terms of providing both technical assistance and resources, because they are disproportionately affected.

DELAURO: (OFF-MIC) Congresswoman, can you unmute?

ROYBAL-ALLARD: Yes.

DELAURO: Fine.

ROYBAL-ALLARD: Can you hear me?

DELAURO: We can hear you now, yeah.

ROYBAL-ALLARD: Okay. Dr. Redford, first of all, let me acknowledge that under the leadership of both con--Congresswoman Rosa DeLauro and Congressman Cole it has been mentioned that efforts have been made to address the serious or fallen CDC funding. But nevertheless, there still remains chronic deficits in local and state health department resources, as well as CDC still has an antiquated infrastructure.

There--there has been discussion during the subcommittee that you have received billions of dollars to address the COVID-19, and also are--it's anticipated that you'll be seeing more money under the--the HEROES Act. Can you explain to this committee what is the difference between what the supplemental funding pays for in the base funding that you actually need to address the shortcomings in CDC's infrastructure and core capabilities?

And then quickly after you answer that, if you could just please give your opinion with regards to what your predecessor, Tom Friedman (SP), said about the need to create a health defense operations budget designation that would exempt certain health security budget lines from the Budget Control Act spending caps so that we don't have the same situation where CDC gets money through a supplemental during a public health crisis and then we go back to the erosion of--of funding CDC.

REDFIELD: Thank you very much, Congresswoman. The majority of the funds that we've received from the supplemental we've really pushed out to the state, local, tribal, and territory health departments to really give them the immediate response capability and--and--and, at CDC, to support the more than 5,000 people that we've now moved out to help support this response.

So, it's really been directed at immediate response activities, as well as building that capacity in the states that we mentioned for rapid ready testing, contact tracing, and isolation and quarantine. I mean, the issue is many states don't have the capability to effectively isolate people that don't have adequate housing. This stuff has to be built.

The--the--the real challenge, as has been alluded to by the chair and--and--and--and Congressman Cole as well as yourself, is how do we get this into the long-term base funding so that we can make sustainable progress in these core capabilities. And I will just say that I don't know the best way to accomplish that, but it's going to be very, very important. I think the--the comment also that you've worked with the Emergency Response Fund, the ability to have emergency funding when things happen around the world is important.

DELAURO: Thank you.

HARRIS: So, if I'm correct, despite reopening and greatly increasing the number of tests so you can actually confirm or cases, we're down about 40% from our peak. Is that right, the peak numbers? We're at--it was about 32,000. Now it's down to about 20,000?

REDFIELD: Yeah, we--

HARRIS: --Yeah, okay--

REDFIELD: --Average about 20,000 new cases a day.

HARRIS: Right. So, we're down about 40%, again, despite reopening and despite more testing. So, that's evidence that--I guess that we really are in a decline and now is the time to think about reopening because we can't really say shut down forever.

Now, you brought up a point in--in response to a previous question. That is, you know, if CDC is expected to be the foremost public health authority in the world, that actually needs cooperation from other health authorities in the world. Could you describe the cooperation between Chinese authorities and the CDC in January when--when--when we really needed information about this epidemic that was going to become a pandemic?

REDFIELD: Well, as you know, Congressman, we have a CDC office in Beijing. It's limited in its staffing, although I had augmented it by another technical expert. I had been in regular discussions with my counterpart, George Gao (SP), who's the Chinese CDC director in--over the New Year. And we do have discussions about what was then an unidentified pulmonary illness. We did request the invitation to come in and assist them directly. And then particularly, after the coronavirus, we reiterated that, formally requested that I--at the levels above him to grant that request. Unfortunately, we--we haven't been able to have that scientific interaction that we have requested.

HARRIS: And is that because you think they also consider--consider CDC the world's leading expert in public health, or was it may be for political reasons? You can't--I know you can't--it was a rhetorical question. And I assume that the release, for instance, of the genetic information on the virus was held back until it was actually recorded outside of public channels.

Look, the bottom line is you can do your job if we don't get cooperation. We didn't get cooperation from the Chinese. I yield back, Madam Chair.

DELAURO: I thank the gentleman very much. Let me just--okay. No, Congresswoman--Congresswoman Lee?

LEE: Thank you for meeting next week with the Black, Hispanic, Asian Pacific American, and Native American members of Congress next week. It's going to be a very important meeting, we thank you so much for that.

Secondly, let me just say one thing as it relates to what Congresswoman Bustos talked about as it relates to social determinants. I'm really surprised to hear your response, Dr. Redfield, because we have a roadmap, the National Medical Association. I know all of the African-American doctors, the Asian Pacific American, the Hispanic community in terms of the medical profession. We have the roadmap on how to deal with social determinants of health care.

Actually, Surgeon General David Thatcher, way back in the day, came forward with that, so I was really surprised and also disappointed at your response. It takes the political will of this administration to address it, and so we need to discuss that with you further because we can't wait. We know what the social determinants are and we have a roadmap that's been completed for many years on exactly how to address that.

Let me ask you about contact tracers. Because of the sensitive nature of this work, we want to make sure that contact tracers are from the community, trained, and provide this very sensitive type of work. Can you comment on a protocol or--or the importance of having not people coming into our communities doing this in minority communities, but--but the trusted messengers being trained, how they would be trained, to provide this type of work?

REDFIELD: Yeah. Thank you for both. I'll be very quick. First, I'm very familiar with the Thatcher report, and I have high regard for it. And I think it was a critical turning point. I was just trying to raise the idea of getting scientific proof for which ones influence, but not waiting. And I look forward to working with you on that.

Secondly, on the contact tracing, I can't--I couldn't agree with you more. It's the same thing you and I discussed about the Indian HIV in America. We need to build trusted members of the community to be the community workers to get this work done. We don't need outsiders coming into communities to do this work. So, we do have significant training programs, and I do think these need to be--you know, we have to expand the community base of trusted individuals in the community to do this work. I couldn't agree with you more.

LEE: Thank--thank you very much. Thank you, Madam Chair.

DELAURO: Congressman Pocan?

POCAN: Thank you very much, Madam Chair. So, let me ask you, Dr. Redfield, a little question about the supplies. We've had a problem Wisconsin getting supplies from the federal government. FEMA originally months ago said they would get us reagents. Then I think around April 8th the policy changed and said we would get them from CDC, from the IRR. In April, we got less than 1% of the reagents that we requested as a state. Last month, of all the information we requested, we got less than 18%.

I--I find it confusing that, of all the PPE and other supplies that we're supposed to be getting, FEMA gets us some of it, although as I just said one out of every five items that we actually need, but that we have to go to another agency to get reagents. And from CDC, we could only get reagents for public labs, which is a couple labs in the state, we have 60 labs that are actually doing COVID tests. Can you just address that real quickly? Because we need more

reagents, and we need them for our hospitals and clinics in the state, and we're not able to get them right now from FEMA and we're not able to get them from the CDC.

REDFIELD: Well, clearly the CDC IRR, which is longstanding that we support our public health labs, is that--that mechanism for the public health labs. Congressman, I need to look to see. I know we've been transitioning to the private sector to be providing for the nonpublic health enterprises. But let me look directly into your request and see if I can get better clarity and get back to you and your staff.

POCAN: No, I appreciate that and then in the 30 seconds I have left Mr. Harris(SP) said that cases are going down however Scott Gottlieb(SP) this morning in the last hour tweeted out that we are slowly expanding the number of cases according to a Morgan Stanley report and that is part of because there is still this know consistent standards for people reopening. Can you address what did we do wrong that we are eighth or ninth worst in the country only behind Bahrain(PH) and Qatar?

REDFIELD: Well, you know I do believe we have enhanced our response you know as I mentioned I think we have now tested almost 17 million people. I don't want to get into the numbers of test because I don't think that's the real issue, it is how testing is used and what is the consequence but we have after the slow start that we had in getting the private sector engaged we continue to build and that's not to say we are at the end of the day. We still need to expand (INAUDIBLE) access of testing across the this nation. You know it's not where it ultimately needs to be but I will say that each day, each week we continue to make progress with that expansion and we will continue to do that. I will look into the specifics of your question though related to where additional laboratory reagents are coming from for your state.

UNKNOWN: Thank you. I yield.

DELAURO: I yield to Congressman Graves and since Congressman Graves did not get his five minutes in in the first round he is recognized for five minutes. Congressman Graves.

GRAVES: Thank you Madam Chair and thank you Dr. Redfield. I--I come to you from Georgia (INAUDIBLE) and thank you for your service over these (INAUDIBLE) last several months. I know it has been difficult but we are grateful for your work. I wanted to just change just a little bit to antibody and antibody testing and if you could maybe share with us a little bit of about (INAUDIBLE) FDA approvals if there are any FDA approvals (INAUDIBLE) and if you could just give us a little feedback, a little insight into that what we can expect there.

REDFIELD: Thank you very much for your question Congressman. There are a series of antibody test that initially the FDA allowed the EU a(SP) to come out and a lot of test got on the market and then they had to show that they really were valid. A number of them have been pulled back but there are a series of antibody test and I can get you the names of them that are really quality test approved by the F--or EUA by the FDA. The real issue is what does antibody mean and right now we don't really know exactly what antibody means. If--if you have a valid antibody it means that you have been infected at one point in time by the virus. We don't know how long Matt antibody will last but we don't know the critical question is when does the antibody test mean you are immune to the virus and that is what we are still trying to find. It does help us as CDC to understand the full extent of the infection in our nation. You know our current estimates is about 5% of the American public got infected during this initial experience. That does mean that about 95% are still susceptible just for us to understand what might be coming. Some cities it's much different like New York obviously in the New York metropolitan area but that is the key. Right now it is a surveillance tool that we have. Whether it has clinical implications or not we still don't know.

GRAVES: (INAUDIBLE) that list of you might recommend would be approved vendors that seems like there is a lot of potential for fraud, a lot of vendors out there.

REDFIELD: I'm sorry--

GRAVES: Maybe you could share with us also how do you think or what about the accuracy and the reliability of the testing as well?

REDFIELD: I think your point is critical and I can have my staff get you the actual list of the testing that we know we do not recommend and that the FDA is asking get off the market and then there's another group that have really performed well and I can make sure you get that. (INAUDIBLE) is one of the main ones that we have been using for antibody testing and so I can get you that and make sure your office has it.

GRAVES: Okay, great. Thank you. And as we talking about testing in the COVID-19 testing and the testing sites is there in the value to at the same time testing for antibodies? I know a lot of individuals go to get tested because they are concerned they may currently have the virus but is there any value in in testing for both simultaneously? And then on top of that do you believe that antibody testing is something that should be paid for by the government as we have had previously as the COVID-19 testing is?

REDFIELD: Yes, the challenge that I have there is just trying to understand what the clinical utility of antibody testing is an CMS and they will all pay for it if it's for a specific clinical indication and my understanding is they currently pay for it with the clinical indication being that you have been previously infected by this virus so that is the one part I was going to say something else but I'm having an adult moment with the first part of your question.

GRAVES: Was about should--should the test be conducted simultaneously along with the COVID-19 test when an individual goes to be tested is there (INAUDIBLE) -

REDFIELD: I think the one area that it has a major clinical relevance is in the children. You have seen about this hyper inflammatory syndrome that we are seeing in children. Luckily it is very rare but it really occurs post a COVID-19 infection and it does help understand that that is really the causation so we do use antibody testing in trying to define the case definition of children that have this new rare inflammatory system but I think--I think the answer to your question just to be honest and transparent is I don't know.

GRAVES: Well thank you and so to just sort of some up on antibody testing we really don't know what it means right now if somebody test positive it sounds like we don't know is it a (INAUDIBLE) if not or how long it might last and those results have yet to be determined is that (INAUDIBLE)--

REDFIELD: That's--that's correct and it is one of the critical things I think we are going to learn between now and January.

GRAVES: Thank you again and thank you Madam Chair for letting me jump in a little late here today.

DELAURO: Ms. Clark

CLARK: Thank you so much. I want to go back for one minute to the disparities and outcomes and ask you if the CDC has made any effort to ensure that public test sites are installed in communities of color? Is that going to be a focus?

REDFIELD: Yeah, and that really was orchestrated by the Assistant Secretary of health and I don't have the exact number but I can tell you that 60% to 70% of them were put into areas that had were basically in areas that had social disadvantaged sites but I can get you the exact number because there was a direct intent to open the sites when the federal government opened these testing sites that you know and the testing sites that are being developed with CVS and but I can get that exact information to you but it is substantial and the answer is yes.

CLARK: Okay. Because there have been some recent investigations saying that these are showing up in more--in wealthier and wider communities and we want to make sure that we are putting our scarce resources where they are most needed and that we also remember that not everybody has a car for a drive up site.

REDFIELD: I agree. I agree. Very important.

CLARK: I want to go back to what my colleague mentioned briefly which is the World Health Organization. Back on April 15 you said that we have a long history of working together and multiple outbreaks throughout the world and I

am heartened to hear you say today that you are continuing that relationship. Do use stand by your comments in April? Do you feel this is an important partner for us at this time of a global pandemic?

REDFIELD: Yes, and actually in the last couple of days I was telling the chairwoman before this hearing start unfortunately we have a new Ebola outbreak in now in the Western in Congo when we have--we jumped in right in with WHO and the Ministry of health to begin to confront that Ebola outbreak.

CLARK: If this administration completely severed our ties and remanded that you do as well are you worried about our impact to develop our access of vaccination?

REDFIELD: You know I--I--I don't want to get hypothetical. I feel there is--I feel confident that the public health partnership that we have although it may be modified in some way at a political level I don't think it's going to be modified in terms of our public health efforts.

CLARK: Thank you.

DELAURO: Congresswoman Frankel?

FRANKEL: Thank--thank you Madam Chair. Dr. Redfield I--I am going to--I have a softball question for you. Older adults represent a high risk group for COVID-19 as higher hospitalization mortality rates and CDC correctly is telling them to stay home but we also now

[*]FRANKEL: see that this isolation is exacerbating loneliness, stress, mental health challenges, making it more difficult to obtain food, fill prescriptions, be physically active. So my question to you is would CDC benefit from an increased collaboration across agencies during the pandemic, as well as the pandemic--after the--beyond the pandemic to meet the public health needs of older Americans?

REDFIELD: I think you raise really critical, critical, critical questions. As you said, many older Americans who have stayed at home have been also have had negative consequences of isolation, lack of human connectedness, obviously other issues into maintaining critical activities of life. They've also necessarily maybe not gotten the preventive medical care for their chronic illnesses that they need. You know, we're committed to continue to work and figure out how to maximize the health and well-being of these Americans, and any way that we can assist, I know this is an important issue for you, and we're prepared to learn and assist to help improve that. This is a critical target group, unfortunately, for this particularly virus is--is those of us--and I'm in the group, you know I'm over--I'm 68--older Americans.

FRANKEL: Thank you. Madam Chair, just to remind you, I know we've talked about this, that I have filed--actually we filed a bipartisan legislation that would establish a national COVID-19 resource center for older Americans within HHS and establish a healthy aging grant program at the CDC.

REDFIELD: Good.

FRANKEL: I thank you, and I yield back.

REDFIELD: All right. Thank you.

DELAURO: Congresswoman Bustos.

BUSTOS: Thank you, Madam Chair. Dr. Redfield, prisons across the country have seen large outbreaks of COVID-19. Unfortunately, our communities, our prison staff, our inmates are being put an additional risk because the Bureau of Prisons continues to transfer inmates without first testing them for COVID-19. This is in part because the CDC guidelines do not recommend testing inmates before they are transferred even from facilities with COVID-19 cases. So your guidance notes, and this is a quote, if a transfer is absolutely necessary, perform verbal screening and a temperature check, end quote. So as a result of this, a few weeks ago the Bureau of Prisons transferred 19 inmates from the Chicago prison where there are cases of COVID-19 to the Thomson (PH) prison in my

congressional district where there were zero cases, and they did this without first testing all inmates. So now two of those inmates have tested positive for COVID-19 at our prison in Thomson, Illinois, which by the way, there are no hospitals in the county where that is located, and so for those inmates that have tested positive for COVID-19, we've got that, and then for weeks because of all of this going around I have been pushing the Bureau of Prisons to test all inmates before they are transferred.

So what they've told my office is that they cannot test inmates before transfers because they don't have adequate testing supplies. So a couple questions. What is the CDC doing to increase testing capacity at the Bureau of Prisons? And should inmates be tested for COVID-19 before they are transferred, especially from facilities with cases of COVID-19? And I'm hoping you will end this by saying you will update your guidance. Those are my two questions.

REDFIELD: Thank you, Congresswoman. You raise a very, very important critical issue. Obviously I think we all know that we are learning as we go along. One of the areas that we've prioritized for surveillance--and when we talked about the $10 billion to go out for each of the states to come out with their testing strategy, the priorities that we have given them--one of the priorities we've given them is a comprehensive surveillance strategy, all nursing home residents to be tested and then weekly testing for the workers in the nursing home, to develop their prison guidelines. And again, that's being debated back and forth right now, but I think there is a strong sense of again getting everybody tested in the prison and obviously new people coming in.

I can't tell you where that's going to land, but we are highly discussing that now, and obviously encouraging states to use these new testing resources to accomplish that. And obviously the same goes for homeless shelters and homeless settings. These are critical areas that--and in certain industries like meatpacking plants and where we have congregant (PH) living. So we're on board with you that we need expanded testing in these circumstances, particularly highlight--

DELAURO: We have to wrap up.

BUSTOS: Okay. All right, I yield back. I'd love to know a little bit more, but we can talk off-line. Thank you.

DELAURO: You may need to talk off-line.

BUSTOS: I yield back, Madam Chair.

DELAURO: Congresswoman Watson Coleman.

WATSON COLEMAN: Thank you, Chairman. Dr. Redfield, I want to explain something to you, what my concern is about our opening of our various states. And I asked you that question about what's the safe percentage of people that need to be tested as a function of the population because some states may be testing more than other states, and some states may have more relevant data as to what the situation really is because they're testing more, whereas the state next to you may be testing only a fraction of the people that it needs to test. Is there not any kind of guidance on what percentage of the population needs to be tested to make sure that we're at optimum opportunity to open up?

REDFIELD: I think you raise an important point. I know the first threshold was at least 2 percent. I know we have some states that are over 10 percent. I think you've raised this earlier and you raise it again. I think this is an area that we're going to go back and have our subject matter experts really discussed because it's clear that you benefit from this guidance.

WATSON COLEMAN: Thank you. And lastly, I just want to point out that when the ACA was passed about 10 years ago there was a section under 4302 where you - where the CDC had a responsibility to develop a form to collect information and then add the demographic data requirements that both Congresswoman Lee and my other colleagues have asked for. And I've asked for. So it's not really creating something brand-new. It is something that

really already been in operation, and so is that does that mean that you your form is out of compliance with the requirements of the ACA in a law that was passed 10 years ago?

REDFIELD: Know, our forum that we do for case reporting is has that information. Where the challenge has been is the reporting of the actual laboratory test results. You know, historically that's not something that was necessarily independently reported to CDC. We would get case report forms, and that data we do have good racial ethics and sex distribution. We know where it's coming from. But we're also now getting reporting of all the test results. It's just a test result. And they come in non-name linked without that information and the difference is now every test result every positive test result every negative test result is going to have those fields of that we discussed. And I think it's going to be very helpful for us to get even additional sets of information based on testing.

WATSON COLEMAN: Thank you, Dr. I yield back.

DELAURO: Thank you. Let me yield now to Congressman Cole for closing remarks.

COLE: Thank you very much, Madam Chair. First I want to thank you for holding this hearing. It's a very informative and I want to thank all the members on both sides. At that the participation in the questions were extremely good. After Redfield, gob I also obviously want to thank you for being here. You have one of the most important jobs in the United States but probably one of the toughest, too. And I appreciate you giving our committee this much time and I want to publicly also think the president Chief of Staff who helped make that possible Mr. Meadows I know our chair talked with him directly and he couldn't have been more helpful in making it possible for you to be here. So we're grateful for that. We covered a lot of ground today, and I thought again it was very good, and I think appropriately so a lot of the focus is clearly driven by coronavirus, clearly on the massive supplementals where we've devoted much more money to this than your normal entire budget. We've entrusted a lot of money there. I think you've done a tremendous job honestly moving this through the chain at CDC and getting it out into the country and to your state and local and tribal partners to deploy these resources really well. And I want to thank you for that, acknowledge the hard work of your staff. And I also want to close by saying while I'm really confident that the Congress will continue to work on the supplementals like I suspect the chairman I'm worried about the long-term funding here and capacity, and you've certainly talked about that in your opening remarks and in your testimony, and I don't want to lose sight of that. This committee and, frankly, the Congress are dealing with a budget agreement that, again, was done in good faith, nothing malign. I'm not critical of anybody for it, but it doesn't apply now. I mean, just as I--I told somebody the other day, look, the defense budget was one thing on December 1st, 1941. It was something very different in January 1st, 1942. There was an intervening event called Pearl Harbor.

This is a biomedical Pearl Harbor, and we need to recognize that and we need to not just deal with this thing, but build the capacity. The phrase I've used, it's not popular with some of my friends, is--but I think it's right, it's--it's a smart thing to spend billions to save trillions. We know what the cost of this event has been to our economy and our country.

We need--and I hope our leadership on both sides--I know I'll be working with my friend, the chairman, on this. We need to have the adequate permanent investments. What we--Ebola and some of the other instances have taught us, the supplementals, again, can be helpful, but then the capacity starts to erode when the supplemental money runs out. We need that long-term thinking, because we not--we know we will be dealing with this in the fall and for the foreseeable future. We also have just gotten one heck of a lesson from the biosphere about how dangerous it is and how, even when we think we've done pretty well, it wasn't nearly good enough.

So, I--I just pledge to my friend the chair, we'll be working with you to try and make sure that you have the resources and that this committee has the resources to invest to give the American people the protection that they deserve and they require, and to work with our friends around the world, because what we do this for ourselves, frankly, we also work with others, and appropriately so. This is a global pandemic. There are no isolated countries. We're--we're going to need to work together.

And I just thank you for your leadership in that area, Dr. Redfield. You've been a visionary on this for a long time. We've talked about this many times before we were dealing with this crisis. So, thanks for being ahead of the curve on that. Again, Madam Chair, thank you very much for the hearing.

DELAURO: Well, I thank the gentleman, and a gentleman and my friend. And it's good to partner with you on--on these efforts. And thank you, Dr. Redfield, for being here today.

Let me just make one comment. I know that Representative Harris said that we've been successful in reducing our cases by 40 percent from a peak of 32,000 a day to 20,000 per day, so we are ready to reopen. And I just reiterate that it wasn't that--what we talked about in March, and--and we declared a national emergency when we had 556 cases.

Virtually all other developed countries have other cases by about 90 percent or more before they reopened. The federal position seems to be--the federal--our government's position seems to be that we can't do what other countries do so we just have to live with 20,000 new cases per day. That puts us all in danger, in--in--in--in my view.

I agree with my colleague, Congressman Cole, that we need to have long-term funding and capacity. But I will just say this to you, Dr. Redfield, because you made a comment that--that it was Dr. Messonnier who had some lead role when the response to this pandemic was grounded in your center at the CDC. That is no longer the case. You are no longer at the center, the point of the spear on this issue. It really has gone to FEMA. It's gone to the White House. I will be very honest with you. I want to build your capacity. I want to get you the data. I want you to be science driven. But by God, I do not want your science and your health experts challenged by people who do not know and understand either science or public health.

And I might just add that we have talked about at this hearing your guidance, changes, delays, the duplication. We didn't get to that. The National Healthcare Safety Network by HHS shows a--a message from this administration, in my view, that CDC is being undermined. The administration violates every rule in your 450 page manual all of the time. Talk about Lysol; talk about Lysol. We need credible messages. We need credible guidance. We need to hear more directly from CDC's experts.

And the CDC media briefings, I want to--I hope you will--just one more comment from you and I have one more thing to say. But your briefings stopped. You had daily briefings and they stopped. And those briefings need to continue. And I hope--let me just say this to you. Will you continue those daily briefings? It's a yes or no answer, Dr. Redfield.

REDFIELD: We had them weekly. Just so you know, we did our weekly briefings. And we--we do have our briefings back. You know, I did one last Friday. Right now they were going to be every other week. I'm--I'm working to get them every week.

DELAURO: We need to have those briefings back online.

I just want to comment on yesterday in the publication The Nature. They published a study that analyzed the economic impacts of lockdown and reopenings. The conclusion was that to protect our economy we need to focus on public health, and we are not doing that. I make a reference to these photographs that I showed earlier on. We are not doing it.

Reopening before the virus is under control will put our economic recovery at risk. And until we get that and it's loud and clear from the science community, from the public health community we're not going to succeed economically, in my view. You talked about testing. The number of tests every day and knowing that and the public knowing that is important because we need to know who is testing, where they're being tested, and where they are not.

I'd just say I am in awe of science, Dr. Redfield. I don't have scientific knowledge. Dr. Harris does and there are others, but most of us do not. What we do here is to provide the resources that allow you and your colleagues at CDC to do what you do, so we are reliant on that science. Let me just say to you don't be afraid. Stand up. Talk

about what your scientists do and give us that direction. And I will tell you that we will provide the resources that you need to do your job. Without that and without driven, there will be a great reluctance, I'll speak for myself, on my part to go further if it's not a partnership and going forward.

Thank you for your service. Thank you for what you do, as I said, domestically and internationally. I know that is where your heart and soul lies, in the science. Let us hear from all of you on that. Thank you. And this hearing is over, closed, whatever the proper word is for it.

UNKNOWN: We're adjourned.

DELAURO: It's adjourned. It's adjourned.

(LAUGHTER)

Thank you.

Load-Date: June 10, 2020
