U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Witnesses appearing before the
U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Hearing Titled
Review of Coronavirus Response Efforts

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Introduction

Chairman Blunt, Ranking Member Murray and distinguished members of this subcommittee. It is an honor to appear before you today to discuss the Department of Health and Human Services' ongoing response to the COVID-19 pandemic. We are grateful for this opportunity to address how each of our agencies and offices are harnessing innovation to prevent, diagnose, and treat the novel coronavirus SARs-CoV-2.

COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. This new disease, officially named Coronavirus Disease 2019 (COVID-19), is caused by the SARS-CoV-2 virus. There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. Coronaviruses are a large family of viruses. Some cause illness in people, and others, such as canine and feline coronaviruses, only infect animals. Rarely, coronaviruses that infect animals have emerged to infect people and can spread between people. This is suspected to have occurred for the virus that causes COVID-19. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are two other examples of coronaviruses that originated in animals and then spread to people.

The Department of Health and Human Services (HHS) is working closely with all of our government partners in this response. Congress passed the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and the Paycheck Protection Program and Health Care Enhancement Act. These laws have provided additional resources, authorities, and flexibility. Within HHS, the Centers for Disease Control and Prevention (CDC), the Assistant Secretary for Health, and the Assistant Secretary for Preparedness and Response along with additional components not represented today, play critical roles in the response to this public health emergency as discussed below.

Centers for Disease Control and Prevention

CDC is America's health protection agency, and works 24/7 to prevent illness, save lives and protect America from health, safety and security threats. CDC has a key role in preparedness and response in the U.S. and abroad. Addressing infectious diseases like COVID-19 is central to our mission and CDC has decades of leadership in infectious disease response.

When there is an emerging pathogen like the SARS-COV2 virus, CDC expertise lies in our ability to study the new pathogen to understand how it is transmitted, and translate that knowledge into public health action. Since first learning of the cluster of cases in Wuhan, CDC has rapidly advanced the science around this new human pathogen, SARS-CoV-2. CDC has both been on the forefront of understanding this new disease and led the nation's efforts to protect Americans from infection. Currently, over 6,700 CDC employees have been engaged in the agency's COVID-19 response, and over 1,200 of these staff have been deployed to nearly 200 different locations in the U.S. and abroad. CDC staff have conducted rapid investigations of outbreaks that identified highest-risk priority populations and settings. Understanding specific population-level vulnerabilities and how infections spread in various types of settings has been instrumental in the development of guidance that will help keep the American people healthy and allow critical infrastructure services to be provided safely.

The Morbidity and Mortality Weekly Report (MMWR), sometimes called the "voice of CDC," has published more than 100 COVID-19 reports since the beginning of the pandemic, providing cutting-edge scientific articles that have been viewed by tens of millions of readers. These reports have provided the public, scientists, healthcare workers, and policymakers critical information about the virus, how it spreads, and the communities it has impacted. MMWR reports yielded the earliest descriptions of asymptomatic and pre-symptomatic transmission of the virus and elucidated the substantial risk of transmission at large gatherings, choir practices, and congregate living situations including nursing homes, prisons and jails, homeless shelters, and camps for children. They have described the disparate impact of COVID-19 in racial and ethnic minorities and identified the elevated risk of severe outcomes for older adults and people with underlying conditions. Finally, MMWR reports have indicated what successful control of the virus looks like, through careful mitigation efforts in everyday high-risk settings such as hair

salons and childcare centers. In short, MMWR's rapid publication of the highest quality science has laid the foundation of what we know about COVID-19 and illuminated the way forward.

In addition to publishing our own scientific information, CDC scientists are monitoring in real time the rapidly expanding scientific literature and have reviewed over 100,000 scientific papers thus far. This approach ensures that CDC responders are armed with the best information available. This comprehensive understanding of the emerging science base helps direct CDC's scientific agenda and informs CDC guidance, and helps guide CDC's direct support of clinicians and the public. CDC's Clinical Response Line has fielded over 32,000 individual inquiries from frontline healthcare providers, and the agency's hotline for public inquiries has responded to nearly 500,000 calls and e-mails.

CDC is drawing on its emergency response capacity and its relationships with state, tribal, local, and territorial (STLT), global, and private sector partners; and is leveraging our workforce's strengths in public health surveillance, prevention, and laboratory capacity to carry out research and share new knowledge related to this novel pathogen and its consequences. CDC provides guidance for healthcare professionals, essential workers, businesses, schools, and the public to encourage safer practices, improve health outcomes, and save lives. CDC works with partners to develop decision tools to assist STLT officials and other stakeholders with mitigation strategies. Importantly, CDC is preparing the nation's public health system and the private sector to disseminate a vaccine when one is available. CDC is leveraging investments in global health security and pandemic influenza preparedness infrastructures in over 60 countries to mitigate the effects of COVID-19 and stop the disease from spreading.

As of September 9, 2020, there have been 6,310,633 COVID-19 cases reported and 189,147 deaths attributed to the virus in the U.S. The latest data can be found on CDC's website: https://www.cdc.gov/covid-data-tracker/index.html. The U.S. Government has taken unprecedented action to address the public health threat posed by this new coronavirus. CDC has substantial supplemental funding to help respond to this pandemic at home and abroad. This funding supports a federally guided, state managed, and locally implemented response to COVID-19 in the United States.

With funds provided by the Coronavirus Preparedness and Response Supplemental Appropriations Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act,

CDC is providing states with needed resources needed to detect, respond, and prevent the spread of COVID-19 and to inform community mitigation strategies.

CDC's highest priority is to ensure that STLT public health programs have the resources they need to address the COVID-19 pandemic. These jurisdictions are best positioned to understand the unique situation of each community, including the status of their public health infrastructure and workforce and its needs for enhancement. CDC is supporting STLT partners who are working to identify cases; conduct contact tracing; implement containment measures and mitigate spread in the community. CDC is working alongside these health departments to improve surveillance and reporting and enhance testing capacity. Together, STLT and CDC teams are responding to COVID-19 outbreaks in high-risk settings and implementing best practices to control the spread.

As a public health agency and the nation's primary resource for STLT health departments on managing disease outbreaks, CDC provides guidance and support on the development and implementation of effective containment and community mitigation strategies. The goal is for all jurisdictions to have robust public health systems which include a contact tracing infrastructure that meets their unique needs. As of September 2020, CDC has posted over 30 contact tracing guidance documents, including case investigation guidelines, checklists for developing a case investigation and contact tracing plan, digital contact tracing tools, and a Contact Tracing Communications Toolkit for Health Departments. To support these activities, described in further detail below, CDC has awarded $12.1 billion to these entities in FY 2020, including $10.25 billion in funds executed on behalf of HHS to be used primarily to support each jurisdiction's testing goals (as outlined in state testing plans).

Testing Strategy

Beginning in April, the White House, and Federal partners including CDC, convened calls with all 50 states, Puerto Rico, and the District of Columbia to identify testing capacities and needs. Through these calls and other outreach efforts, CDC has worked with individual jurisdictions to identify needs, develop plans, and offer technical assistance to enhance testing capacity. CDC, under the leadership of the Office of Assistant Secretary for Health and in collaboration with the Association of Public Health Laboratories, reviewed individual state testing plans with a focus on achieving increased monthly testing targets. These discussions and

plans for action emphasized the need to serve vulnerable populations and include focused efforts for long-term care facilities, federally qualified health centers, and Tribal Nations, among others.

CDC is working with STLT health departments to support forward-looking testing strategies that ensure that vulnerable or high-risk populations, such as some racial and ethnic minorities, have adequate access to testing. For example, CDC worked with the Health Resources and Services Administration and health centers to survey health centers and better understand the populations they are serving. Approximately 60 percent of responding FQHCs are in urban areas, where persons of Hispanic or Latinx ethnicity were the largest proportion of individuals testing positive. This information allows STLT health departments to implement strategies to increase testing in FQHCs and provide them with the tools and resources to diagnose, treat, and monitor COVID-19 illness in the populations they serve.

CDC has developed a new multiplex laboratory test that checks for three viruses at the same time, two types of influenza viruses (A and B) and SARS-CoV-2, the virus that causes COVID-19, using a single sample collected from an individual. Testing for all three viruses will allow public health laboratories to continue surveillance for influenza while testing for COVID-19. This will save public health laboratories both time and resources, including testing materials that are in short supply. Another benefit of the new test is that laboratories will be better able to find co-infections of influenza and SARS-COV-2. The FDA issued an Emergency Use Authorization (EUA) for this combined laboratory test on July 2, 2020 and CDC released these reagents for distribution to states' public health laboratories on August 5, 2020. As of August 17, 2020, 135 multiplex kits were shipped to more than 100 laboratories. Each of these kits provides approximately 500 tests. Adjusting for the controls, these 135 kits provide approximately 67,000 tests. CDC has provided these kits to each state's or territory's main public health laboratory, as well as any regional or local laboratories that is approved to provide SARS-CoV-2 surge testing support. Importantly, multiplex assay technical information is publicly available on CDC's website so that commercial developers can use this information in developing proprietary tests. CDC also granted assay manufacturers right of reference to its EUA, allowing developers to use the data CDC submitted to FDA to streamline their efforts when applying for an EUA. CDC took these steps to catalyze the development and validation of these assays by the commercial sector which is better equipped to scale up testing capacity.

In March 2020, CDC and public health partners began seroprevalence surveys of community transmission of SARS-CoV-2. Seroprevalence surveys help identify infections that might be missed due to lack of symptoms or testing not being performed. Serology studies can also help determine risk factors associated with SARS-CoV-2 infection, including transmission in health care settings and communities, and inform guidance and mitigation strategies. For example, CDC has published the results from one of the seroprevalence studies that used remnants of samples collected during routine clinical care. This was done in conjunction with two commercial companies and results suggested that greater than 10 times more SARS-CoV-2 infections occurred than the number of reported COVID-19 cases. Another study on healthcare personnel who routinely cared for COVID-19 patients found that 6 percent had evidence of previous SARS-CoV-2 infection. This study identified two factors potentially associated with SARS-CoV-2 infection among HCP: personal protective equipment (PPE) shortages and not wearing a mask while interacting with patients.

Data Collection, Analysis and Understanding of the Pandemic

Accurate data are critical as we continue to assess the burden placed on the American healthcare system to inform reopening. CDC is leveraging all available surveillance systems, including influenza and viral respiratory disease systems, to monitor COVID-19 and protect vulnerable communities. These data collected by CDC help target critical COVID-19 interventions. In collaboration with STLT public health partners, CDC is committed to making data available to the public, while protecting individual privacy.

This crisis has highlighted the need to continue efforts to modernize the public health data systems that CDC and states rely on for accurate data. Public health data surveillance and analytical infrastructure modernization efforts started in FY 2020. Timely and accurate data are essential as CDC and the nation work to understand the impact of COVID-19 on all Americans, particularly for populations at greater risk for severe illness, such as older Americans, those with chronic medical conditions, and some racial and ethnic minorities. Modernization efforts include support for surveillance and data workforce, a key asset of the public health system. For example, CDC is working closely with our partners to help STLT health departments implement the Sara Alert system. Sara Alert is a standards-based, open source tool that increases interoperability among laboratory and clinical systems and automates the process of public

health monitoring and reporting individuals exposed to or infected with COVID-19. To date, eleven states and territories, along with nine jurisdictions including one Tribal Nation, have adopted the Sara Alert system. Twenty additional jurisdictions including two territories are in progress of or considering joining. At the current level of participation during an average 10-14 day timeframe, approximately 80,000 individuals areeither entering, being monitored by or exiting the system .

CDC's population-based COVID-NET system monitors COVID-19 associated hospitalizations that have a confirmed positive test in greater than 250 acute care hospitals in 99 counties in 14 states. Data gathered provide weekly estimates for age-specific hospitalization rates and describe characteristics of persons hospitalized with COVID-19 illness as well as predictors of those with more severe outcomes. CDC's existing National Healthcare Safety Network (NHSN) continues to collect COVID-19 data from nursing homes and other long-term care facilities. NHSN also continues to collect data from hospitals across the U.S. to address healthcare-associated infections and fight against antibiotic resistance.

The COVID-19 Case Report Form includes variables such as race and ethnicity to enable identification of populations that may be at higher risk for severe illness and risk factors. Though states are not required to report demographic information in the Case Report Form, they have improved the completeness of their reporting. In particular, the percentage of reports that include race data has increased from 21 percent in April to 61 percent in mid-August, while the percentage of reports that include ethnicity data increased from 18 percent to 50 percent during the same time period. While progress has been made, CDC will continue to work with states and other health system partners to improve completeness of the data.

Health Disparities

COVID-19 has disproportionately impacted many racial and ethnic groups. CDC continuously looks to enhance our COVID-19 outreach and mitigation efforts for communities identified as most at risk. For example, CDC is supporting local activities in African American, Hispanic/Latino, American Indian and Alaska Native, and Asian American, Pacific Islander, and Native Hawaiian communities to deliver COVID-19 prevention messages and community mitigation strategies. CDC recently released a COVID-19 Health Equity Strategy (www.cdc.gov/coronavirus/2019-ncov/community/health-equity/cdc-strategy.html) that provides

an evidence-based, comprehensive and coordinated framework for reducing COVID-19 disparities. The Strategy includes expanded plans for collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes among populations at highest risk. Additionally, CDC is working with existing program grantees, such as Racial and Ethnic Approaches to Community Health (REACH), to enhance outreach to populations at increased risk of complications from COVID-19. These broad-based community engagements and strategies are working with the aim of ensuring equitable access to testing, health care, and future COVID-19 vaccines.

American Indian and Alaska Native communities are some of the most affected by COVID-19. As of August 2020, CDC has provided $206.4 million to tribal nations, consortia, and organizations for responding to COVID-19 across tribal communities. This amount exceeds the minimum of $165 million directed by Congress through the Coronavirus Preparedness and Response Supplemental Appropriations Act and the CARES Act. CDC is using a multifaceted approach, guided by data, to allocate COVID-19 funding to tribal communities, enabling broad access to COVID-19 resources through a variety of direct and indirect supports.

Children

We are learning more about how COVID-19 impacts children every day. Although children are less likely than adults to develop severe illness when infected with SARS-CoV-2, household studies and outbreak investigations confirm that children can transmit the virus and often have the same or higher viral loads in their nasopharynx compared with adults. Though the mortality rate is low for children aged 18 years and younger, COVID-19–associated hospitalization rates increased among this age group during the summer months and are continuing to rise. From March 1, 2020 to July 25, 2020, one in three hospitalized children was admitted to an intensive care unit.

CDC is committed to providing schools, teachers, staff, parents, and caregivers with information and guidance to help keep our children as safe and healthy as possible as schools reopen. CDC has developed enhanced guidance based on the most recent science, including considerations for operating schools during COVID-19, considerations for Institutions of Higher Education regarding the appropriate use of testing, and a school decision-making tool for

parents, guardians, and caregivers. These resources provide students, school administrators, and parents the information they need to guide decision-making and how to adapt to local conditions.

Community Mitigation and Workplace Safety

The American people, communities, public health professionals, medical providers, businesses, and schools look to CDC for trusted guidance on responding to COVID-19. CDC is building and using a growing, data-driven evidence base to develop and disseminate guidance for a range of audiences, including business, schools, and healthcare professionals. These recommendations include actions that every American should take, such as wearing a mask, following good personal hygiene practices, staying at home when sick, and practicing social distancing to lower the risk of disease spread. CDC recently released Interim Guidance for Businesses and Employers Responding to COVID-19 to help prevent the spread of COVID-19 in the workplace and protect critical infrastructure workers. CDC guidance specifies that business operation decisions should be based on both the level of disease transmission in the community and their readiness to protect the safety and health of their employees and customers. CDC guidance for businesses is available here: http://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html.

Vaccine Planning

While surveillance, testing, contact tracing, and community mitigation interventions are the best tools we have right now, looking to the future, CDC continues to work to prepare our nation's public and private health systems to deliver a COVID-19 vaccine once it is available. CDC is using its expertise in public health preparedness and response, along with its immunization infrastructure, to support Operation Warp Speed in vaccine promotion, distribution, administration, and monitoring. CDC is working closely with the Advisory Committee on Immunization Practices (ACIP), a group of medical and public health experts who develop recommendations on the use of vaccines to control disease in the United States. ACIP members have expertise in areas such as vaccinology, immunology, internal medicine, family medicine, virology, public health, infectious diseases, and/or preventive medicine, and one member is a consumer representative who provides perspectives on the social and community aspects of vaccination. An August ACIP meeting focused on post-marketing vaccine safety surveillance, epidemiology of individuals at increased risk of COVID-19, and modelling

allocation strategies of the initial COVID-19 vaccine supply. Any recommendations ACIP makes for who should get COVID-19 vaccine and in what order will be grounded in guidance from the country's foremost experts on immunization science.

CDC is working closely with state and local health departments and community organizations to prepare a detailed yet flexible plan for vaccine distribution that will be informed by a prioritization framework recommended by ACIP.

These efforts include working with CDC's 64 immunization grant recipients to help ensure that the U.S. immunization system can mount an effective vaccine delivery program, including vaccine distribution and tracking. State and local health departments have conducted pandemic vaccination planning with immunization and preparedness funding from CDC for over a decade. Updating these vaccination response plans for implementation of a COVID-19 vaccine will build readiness for timely administration when a vaccine becomes available. During August 2020, CDC completed in-person and virtual site visits to assess needs as vaccine planning intensifies. Lessons learned during these site visits will inform CDC's provision of technical assistance to all jurisdictions to aid in the development of state-specific COVID-19 vaccination plans.

In addition, some state and local health department's utilized supplemental resources to build infrastructure that would address current COVID-19 response needs and incorporated planning for future phases. One example is in Chicago, where the health department has developed the Chi COVID Coach app to communicate directly with Chicago's residents who may be COVID-19 positive. The forward-thinking app, built by private sector companies, can be adapted throughout the course of the pandemic. It now allows users to register to receive the vaccine once it becomes available.

While it remains unclear how long the pandemic will last, COVID-19 activity will likely continue for some time. It is also unclear what impact the ongoing COVID-19 pandemic will have on health care and public health systems during the upcoming influenza season and beyond. Circulation of COVID-19 and influenza virus at the same time could place a tremendous burden on the health care system. Therefore, getting a flu vaccine is especially important. It is important that Americans have confidence in all vaccines. CDC will leverage its immunization program to help maintain high coverage in routine childhood immunizations, promote

immunization for adult vaccine-preventable diseases, and increase coverage for flu vaccinations, and prepare for a potential COVID-19 vaccine.

CDC works with public health and clinical partners each year to increase the number of people who get a flu vaccine and eliminate barriers to vaccination. Ongoing COVID-19 activity may affect where and how flu vaccines are given. On June 4, CDC awarded $140 million to 64 jurisdictions through CDC's existing immunization cooperative agreement to launch a scale up for influenza season, given the increased risk of COVID-19. Funds are supporting staffing and preparedness with a focus on ensuring flu vaccine coverage for populations most at risk.

Conclusion

COVID-19 is the most significant public health challenge to face our nation in more than a century. CDC is providing the American public with the information and assistance it needs to defeat COVID-19. As we work together to fight COVID-19 and end this pandemic, CDC is committed to its mission to protect all Americans from disease threats and to save lives, now and in the future.

Office of the Assistant Secretary for Health

Diagnostics and Testing

Testing is an essential component of the public health response to SARS-CoV-2 (the virus that causes COVID-19). It enables clinical decision making, informs resource allocation and disease prevalence monitoring, and is necessary to minimize community and economic disruption through targeted infection prevention and control measures. The indications for viral testing depend on the stage of the pandemic and the extent of community spread. In general, testing is indicated for diagnosis of those who are symptomatic or asymptomatic, tracing of those in contact with those who are infected, screening of specific employees (for example nursing home staff), and surveillance testing of those who are asymptomatic to achieve infection control and/or other public health objectives.

Repeated testing of a majority of the U.S. population is not feasible at this time, nor necessary to assure safe return to work, school, and other activities. Rather, a targeted testing strategy that rapidly diagnoses those who are ill, protects the vulnerable, and identifies emerging outbreak areas – when combined with public health mitigation measures like mask wearing, is proven to reduce the spread and flatten the curve.

To date, the U.S. has accomplished over 95 million tests, at an average current rate of between 700,000 – 800,000 tests per day, with enough tests in the market to perform three to four times that amount. Since early March, we have increased our daily testing by over 30,000 percent. In June, July, and August, states far surpassed their goals for testing. Specifically, state goals for June were 12.9 million tests, and nearly 16 million were actually performed. The goals for July were 13.7 million tests; again, states far exceeded their goals by conducting over 25 million tests. In August the nation completed over 25.2 million tests, far exceeding the August goal of 21.1 million tests. Over the next several months, the nation's testing capacity will continue to increase. We anticipate that supplies and reagents will be sufficient to conduct approximately 90 million tests in September. If pooling occurs even for a fraction of these tests, there is capacity to perform much greater than 100 million tests per month today. Turnaround time is improving and continuing to improve. Currently, 97 percent of ACLA tests ordered in the previous week received results within 3 days, and 99 percent received results within 5 days.

The role of the Federal Government is to set the overall testing strategy and requirements, provide technical guidance, secure the supply chain, scale scarce resources, enable innovation, and support state plans to achieve the overall national objectives as well as any specific state objectives. States, territories, and tribes are responsible for formulating and implementing testing plans that meet national objectives and additional goals for their state. The academic, commercial, and private sectors will continue to develop and produce technologies, supplies, and services to meet the needs of the states and the nation at large.

The national strategy for testing was formally outlined in the *Testing Blueprint: Opening Up America Again*, and the *Addendum to the Testing Blueprint*. The immediate objectives of the strategy are to:

- Identify newly emergent outbreaks

- Support public health isolation and contract tracing
- Diagnose COVID-19 rapidly in hospitalized patients
- Protect the vulnerable
- Support safe reopening of schools and businesses
- Enable state testing plans

The national strategy for testing was further enumerated in the COVID-19 Strategic Testing Plan Report to Congress initially submitted to Congress on May 24th. On August 22nd, HHS submitted the first update to the Strategic Testing Plan. The report outlines how HHS increased domestic testing capacity across the United States and provides additional guidance and information about diagnostic technologies, platforms and inventory that states, territories and tribes can utilize to develop flexible, adaptable, and robust COVID-19 testing plans.

Identifying Newly Emergent Outbreaks

In addition to public health surveillance systems monitored by the CDC, the nation is currently maintaining sufficient baseline testing for SARS-CoV2 in order to detect early changes in percent positivity. At present, a minimum target of testing 2% of a state's population per month has been sufficient to detect early changes in percent positivity, and thus enable state and local officials – with the technical assistance of the federal team – to implement mitigation steps rapidly to curb the emerging outbreak.

In order to assure that states meet this 2% threshold to detect any threat of emergence in that state, the federal government will continue to:

- Assist states with the procurement of collection supplies to achieve minimum of 2% population testing per month; and if possible, provide more supplies if needed to meet the approved state plan targets. To date, the Federal Government has procured and delivered 95 million swabs and 77 million tubes of media
- Assure sufficient supply of reagents to achieve testing goals in the context of point of care utilization and use of commercial referral labs;
- Prioritize states with outbreaks or potential outbreaks, if needed, and;
- Continue to expand the availability and use of point of care tests.

Support Public Health Isolation and Contact Tracing

A key function of testing is to support identification of infected individuals, many of whom may be asymptomatic, in communities identified with outbreaks or emerging outbreaks. In response to "hotspot areas", the Federal Government has set up surge testing to increase baseline testing 2X-5X for short periods of time. Surge testing sites have been implemented in Miami, FL; Jacksonville, FL; Edinburg, TX; Uma County, AZ; Pima County, AZ; Coconino, AZ; Phoenix, AZ; Atlanta, GA; Birmingham, AL; Cochise County, AZ; Mohave County, AZ; Yavapai County, AZ; Baton Rouge, LA; New Orleans, LA; Bakersfield, CA; Houston, TX; Harris County, TX; Clark County, NV; and Honolulu, HI. These 19 sites have conducted approximately 290,000 tests. Surge testing is a supportive adjunctive activity; it cannot substitute for disciplined adherence to mitigation measures including masking, hygiene, avoidance of indoor crowded areas and crowds, and protection of the vulnerable. These mitigation techniques, when combined with selective surge testing – have proven highly effective to reverse recent community outbreaks.

In order to support public health isolation and contact tracing, and to reduce turnaround time, the federal government has:

- Provided massive surge testing to localities prioritized by the White House Coronavirus Taskforce, and agreed to by state and local officials;
- Augmented testing, both baseline and surge, for Federally Qualified Health Centers (FQHCs) and retail sites, both fully federally sponsored and federally enabled;
- Supported local testing efforts with surge of collection supplies and reagents;
- Worked collaboratively to validate and promote EUAs for pooling across all laboratory platforms;
- Worked collaboratively to validate and promote EUAs for new extraction methods to increase productivity;
- Invested in new testing technologies that improve sensitivity, specificity, and/or turnaround time, including new point-of-care tests, and;
- Providing point-of-care testing to all nursing homes in America.

Diagnose COVID-19 Rapidly in Hospitalized Patients

Because there are now treatments authorized for hospitalized patients with COVID-19, including Remdesivir, convalescent plasma, and steroids, it is critical to diagnose patients as soon as possible. Currently, large commercial labs are prioritizing inpatient samples to ensure diagnosis within 24-36 hours. Our best information also suggests that the great majority of individual hospitals are able to meet this time frame for patients within their hospital systems.

Protect the Vulnerable

Older Americans, particularly those in nursing homes, are much more likely to suffer serious consequences including death, from COVID-19. In addition to older Americans, racial and ethnic minorities are also disproportionately affected.

To ensure that specimens are collected without overburdening the traditional health care system, and to ensure testing in the most vulnerable communities, in mid-March, the Federal Government established Community-Based Testing Sites (CBTS) in CDC-prioritized locations across the country. The CBTS model was developed for States, local public health agencies, healthcare systems, and commercial partners as they work together to stop the spread of COVID-19 in their communities, focusing initially on healthcare facility workers and first responders. The CBTS federally supported, state managed, locally executed model has been a profound success, testing approximately 400,000 individuals. For the initial 41 sites, CBTS 1.0, the federal government provided a federal physician who ordered all of the COVID-19 tests, the federal contracts for shipping the specimens, laboratory processing, patient notification, and logistics (to include supplies, personal protective equipment, language translation services). The federal government also utilized U.S. Public Health Service personnel to provide data management, safety and quality control checks at each site.

Building on the initial success of the CBTS model, the Federal Government next leveraged public-private partnerships with pharmacy and retail companies (CVS, Health Mart, Kroger, Rite Aid, Walgreens, and Walmart), also known as CBTS 2.0, to accelerate testing for more Americans in more communities across the country. The public-private partnership model operates on the federally supported, state managed model.

As the transition of CBTS federally run sites to state-run sites has been completed, the federal government has broadened its community testing support to a more sustainable model -- specifically by continued support of retail and pharmacy partnerships in more than 800 locations in all 50 states and the District of Columbia, which collectively have conducted over 2 million tests to date. The Federal Government focused on communities with high social vulnerability using the CDC's Social Vulnerability Index (SVI) as one of the main factors to select site locations. Approximately 65 percent are located in communities with moderate to high social vulnerability. The SVI measures the resilience of communities when confronted by external stressors along four main themes: socioeconomic status, household composition and disability, minority status, and housing type.

This pharmacy and retail partnership provides convenient access to COVID-19 testing, but it is also a bridge for retailers to implement new regulatory flexibilities and expanded reimbursement options HHS has provided through private insurance, Medicare, and Medicaid. This partnership also leverages the newly expanded authority given to pharmacists to order and administer COVID-19 testing, this effort is also known as CBTS 3.0. Now, CVS and Walmart have over 1900 sites utilizing these new regulatory and reimbursement options with over 2 million tests performed.

Health Resources & Services Administration (HRSA) supported health centers are community-based and patient-directed organizations that deliver affordable, accessible, quality, and cost-effective primary health care to medically underserved communities and vulnerable populations across the United States. Nationwide, nearly 1,400 HRSA-funded health center grantees operate approximately 13,000 sites, providing primary and preventive care to more than 28 million patients each year. Over 91 percent of health center patients are individuals or families living at or below 200 percent of the Federal Poverty Guidelines and nearly 63 percent are racial/ethnic minorities. Health centers are uniquely situated in communities to serve those that are most vulnerable and 97 percent of these centers offer COVID-19 testing. As of September 4, 2020, health centers have administered 3,690,098 COVID-19 tests (including 215,231 antibody detection tests), with over 49 percent of tests provided to racial and/or ethnic minority patients. Of these tests, 444,186 returned positive, with 59 percent of racial and/or ethnic minority patients testing positive.

To prevent further spread and deaths in nursing homes, CDC and CMS recommended that nursing homes perform baseline testing of all residents and staff, followed by routine testing of staff to reduce outbreaks, morbidity, and mortality. CMS requires a regimen of staff testing based on the degree of community spread. To protect the vulnerable and to assist states in meeting these recommendations and requirements, on July 14, 2020, the Trump Administration announced that HHS would embark on a one-time procurement of rapid point-of-care testing instruments and tests to be distributed to nursing homes using the Defense Production Act. Through this aggressive action, nursing homes will be able to augment their current capacity for coronavirus testing, bolstering their response and helping to prevent the spread of SARS-CoV-2. This will facilitate baseline testing among nursing home residents and staff, and enable a pathway to conduct ongoing testing according to public health guidelines.

I am pleased to announce that all 13,850 initially eligible nursing homes have received one or more point of care instruments, and nearly 5 million tests. Following this initial distribution, we will facilitate nursing homes being able to reorder supplies via their normal commercial distribution channels.

Vulnerable populations in many underserved communities are suffering disproportionate health impacts resulting from COVID-19, including number of infections, hospitalizations, and deaths. As part of the HHS response to this crisis, on June 23, the HHS Office of Minority Health (OMH) announced the selection of the Morehouse School of Medicine as the awardee for a new $40 million initiative to fight COVID-19 in racial and ethnic minority, rural and socially vulnerable communities.

Morehouse School of Medicine has entered into a cooperative agreement with OMH to lead the initiative to coordinate a strategic network of national, state, territorial, tribal and local organizations to deliver COVID-19-related information to communities hardest hit by the pandemic. The three-year initiative will include the development and coordination of a strategic and structured network of national, state, territorial, and local public and community based organizations that will help mitigate the impact of COVID-19 on racial and ethnic minorities as well as rural and socially vulnerable communities across the nation. The initiative also includes a national multi-media outreach and education effort. One of the primary goals of these

information dissemination efforts is to provide additional education and community-level information on resources to help fight the pandemic to those who need it most.

Support Safe Reopening of Schools and Businesses

While we must be prudent to protect those most vulnerable, we must also be mindful of the prolonged effects that school and business closures have on millions of children and parents. The efforts of the Federal Government to galvanize the testing infrastructure in the United States, and the efforts to reduce turnaround times, have provided communities with the resources they need to safely reopen schools and businesses.

Enable State Plans

To enable states to achieve the testing goals developed in coordination with the Federal government, the Federal government has worked with manufacturers to gain insight into diagnostic instrument install bases; procured and shipped collection supplies; and determined reagent inventory. The Federal Government then provided all information to states so they could better determine how to optimize their testing strategy. The Federal Government also purchased and allocated POC devices and over 2.3 million tests; developed, implemented, and facilitated community-based testing sites across the country; and provided significant guidance and technical assistance for state plans. The increase in the numbers of tests performed since early March is a direct reflection of these efforts.

States and territories have now submitted two iterations of their testing plans. These plans were developed in collaboration with federal multidisciplinary experts through teleconferences and other meetings. Plans were reviewed by a multidisciplinary federal team that included leadership from CDC, the Immediate Office of the Secretary, and the Office of the Assistant Secretary for Health.

The first iteration of the jurisdictional testing plans for May and June were released to the public on July 10, 2020, and are available for viewing here. The Federal team provided feedback to each state, and each state incorporated this feedback into detailed plans covering July through December. The state plans for July-December have been reviewed and scored and were released to the public on August 10, and are available for viewing here.

To ensure states meet their testing goals, the federal government procured FDA authorized swabs and transport media, and is distributing these supplies to a single location in each state determined by the Governor's office. Starting in May and through September 11, the federal government has distributed over 95 million swabs and more than 77 million tubes of transport media.

Moving forward, jurisdictions should use the $10.25 billion provided to states, territories, and localities by the Federal government to support the purchase of tests and related supplies, personnel for contact tracing, and reporting infrastructure, etc., for their jurisdictions, as needed to fulfill their approved testing plans.

Other Initiatives

In order to capture feedback and foster communication between Federal officials and the private sector, HHS created the National Testing Implementation Forum. The Forum brings together representatives from key stakeholder groups to share information and provide input to federal leaders about SARS-CoV-2 testing. Members of the Forum provide their perspectives on how HHS can best identify and address end-to-end testing supply chain issues across commercial, public health, academic, and other sectors and define optimal testing in various settings (diagnostic, screening, surveillance, others). Members also provide input to improve technical assistance across the nation to target testing among the vulnerable and underserved and create a sustainable diagnostics ecosystem that is sustainable and fully capable for future public health challenges. The first Forum meeting was held on July 30th and the principle topic of discussion was testing supply chain. On August 13th the second meeting was held and surveillance and reopening strategies were discussed. The third forum, with the topic of engaging minority and underserved communities, was held on September 3rd.

On August 27th, the Administration announced that a $760 million contract was awarded to Abbott for the delivery of 150 million rapid BinaxNOW COVID-19 point of care tests. This initiative will expand strategic testing in the United States. The Abbott BinaxNOW COVID-19 Ag Card, which recently received an EUA from the FDA, does not require instrumentation and will deliver COVID-19 test results in 15 minutes or less. This test uses nasal swabs and can be easily deployed in many settings across the country.

United States Public Health Service Commissioned Corps

Since the early stages of the COVID-19 outbreak, the Corps has been an indispensable asset leveraged to address the public health needs of the nation in response to this crisis. The Corps is one of the eight uniformed services of the United States and the only uniformed service committed to protecting, promoting, and advancing the health and safety of the nation. Corps officers serve throughout the nation in communities that are most in need by providing essential healthcare services to underserved and vulnerable populations.

In January, the Corps deployed officers to provide expert outbreak response in direct support of CDC. Deployment expanded rapidly from 53 officers on January 24, 2020 to 4,170 officers deployed as of September 8th, with many officers being deployed numerous times. Corps officers provided critical assistance to community-based testing sites throughout the nation and their contributions to this effort are immeasurable. In response to the escalating crisis, the Corps established COVID-19 Clinical Strike Teams, which include officers from the variety of disciplines needed on the frontlines. This kind of ready-made unit allows the Corps to deploy a "cavalry" to support healthcare systems under stress in states across the country. COVID-19 Clinical Strike Teams have deployed to a long-term care facility in Kirkland, Washington, to the Javits Center in New York City, and to the TCF Center in Detroit. At the end of March, the Navajo Nation requested CDC assistance to provide care amidst a surge of COVID-19 cases. Since that time, the Corps has deployed teams to support the response.

The United States Public Health Service Commissioned Corps stands ready and willing to respond to the public health needs of our country and to provide essential healthcare services.

Assistant Secretary for Preparedness Response

The Assistant Secretary for Preparedness and Response's (ASPR) mission is to save lives and protect Americans from 21st century health security threats. During previous public health emergencies, ASPR has led, on behalf of HHS, Emergency Support Function #8: Public Health and Medical Services, under the National Response Framework. This means ASPR serves as the

primary coordinator for public health information and deployment of assets to support the domestic health components of a response.

For the current COVID-19 domestic response, ASPR funding has been used to accelerate development of medical countermeasures, enter into contracts to resupply personal protective equipment and other critical components deployed from the Strategic National Stockpile (SNS) to aid in the treatment of persons with or suspected of having COVID-19, provide grants to hospital associations and healthcare centers to aid in the ongoing response, and provide support via the National Disaster Medical System (NDMS) to augment care in communities significantly impact by COVID-19.

It is important to note that while the COVID-19 response remains the primary mission and duty at ASPR today, there are other existing requirements the organization has supported throughout 2020. Throughout 2020, ASPR has assisted in the repatriation of Americans from China and Japan at the start of the COVID-19 outbreak. We deployed personnel to Lebanon in August to assist with response and recovery efforts following the explosion in the Port of Beirut. ASPR provided temporary medical surge support in Louisiana, Texas and Mississippi after Hurricane Laura, and we still have National Disaster Medical System (NDMS) teams deployed to Louisiana to assist with recovery efforts following Tropical Storm Sally. In addition, ASPR deployed personnel to California and Oregon to support search and rescue efforts for the wildfires. We supported these calls for action and support while simultaneously responding to domestic requests for assistance to aid in the COVID-19 response. . ASPR is a unique and nimble organization and has been able to respond to emerging needs throughout the COVID-19 response.

Medical Countermeasure Development Efforts

Since late January, the Biomedical Advanced Research and Development Authority (BARDA) within ASPR has collaborated with counterparts across the government to identify potential COVID-19 medical countermeasure candidates and accelerate their development. BARDA has a track record of success in delivering effective countermeasures in response to public health emergencies. Past successes include the 2009 H1N1 influenza pandemic, Ebola outbreaks in

2014-2016 in West Africa and in 2018 in the Democratic Republic of the Congo, as well as the Zika outbreak in 2015.

At the onset of the pandemic, BARDA reviewed investments, modified contracts, and began working with Regeneron, Janssen, and Sanofi Pasteur to initiate the development of vaccines and therapeutics for COVID-19. All three have successfully developed both prophylactic and therapeutic medical countermeasures for emerging infectious diseases in the recent past.

To date, utilizing the supplemental funding provided by this Committee, ASPR/BARDA is supporting over 50 medical countermeasure projects for COVID-19 response. All of these contract awards are listed on medicalcountermeasures.gov in detail and include: nine therapeutics, 29 diagnostics, and seven vaccine candidates. Six vaccine candidates are operating under Operation Warp Speed (OWS). In support of securing a safe and effective vaccine as quickly as possible to protect the American people and return to normal operations, we are making significant progress in advancing these vaccines. In fact, three – AstraZeneca, Moderna, and Pfizer – are in Phase 3 meaning that we are closer than ever before in having a safe and effective COVID-19 vaccine available to the public. The remaining three – Novavax, Sanofi Pasteur/GSK, and Janssen are in Phase 1/2.

It is important to note that we are strictly adhering to and following all regulatory and safety requirements to support vaccine development. We are not sacrificing the safety of the vaccine in order to expedite its development. We are instead supporting two steps at the same time: vaccine development and vaccine manufacturing. Supporting these efforts simultaneously ensures we are positioned to produce and manufacture the vaccine quickly and effectively. Specifically, we are making investments in the necessary manufacturing capacity at Federal risk, giving companies confidence that they can invest aggressively in development and allowing faster manufacturing and potential distribution of an eventual vaccine. Specifically, the recent awards to Pfizer, Novavax, AstraZeneca, Moderna, and Sanofi Pasteur/GSK all include product development and investments in large-scale manufacturing capabilities in the contract award.

BARDA is also working with and reviewing the capabilities and capacity of our Centers for Innovation in Advanced Development and Manufacturing (CIADMs). The CIADMs are government-sponsored facilities that were created as public-private partnerships to establish domestic manufacturing capacity and response capabilities in order to ensure the nation has adequate surge capacity for rapid medical countermeasure production to address pandemics or other biological threats. The two HHS CIADMs are Emergent BioSolutions in Baltimore, MD, and Texas A&M University System in College Station, TX. Currently, AstraZeneca and Janssen have reserved space at the Emergent facility to manufacture vaccines at scale. In addition, in June, BARDA reserved existing vaccine manufacturing capacity as well as expanded manufacturing capacity at the Texas A&M CIADMThrough OWS, manufacturing capacity at the Department of Defense's (DoD) Advanced Development and Manufacturing facility, Ology Bioservices Inc. could also be utilized if necessary. I would be happy to keep the Committee updated on the progress of utilizing CIADMs as we move forward in this space.

Lastly, ASPR/BARDA is supporting efforts to expand capacity for fill-finish to ensure that, once we have an approved vaccine, we can begin manufacturing without having to wait for ancillary products (e.g. (vials, needles, and syringes). Contracts include: capacity expansion for needles and syringes (contracts with Smiths Medical, Inc., Retractable Technologies, Inc., and Becton, Dickinson, and Company); capacity expansion for glass tubing and vials/cartridges (Corning Pharmaceutical Technologies); expansion of sterile injectable capacity (Thermo Fisher Scientific); establishment of manufacturing systems for durable, high-performance glass/plastic vials (Si02); and, general capacity expansion and reservations for fill/finish (Grand River Aseptic Manufacturing, Inc.).

Resupply of the Strategic National Stockpile

ASPR, through the Strategic National Stockpile (SNS) maintains a national repository of large quantities of medical countermeasures for a variety of threats (chemical, biological, radiological, and nuclear (CBRN) threats as well as general public health responses) stored in strategic locations around the nation. While SNS assets can be deployed for CBRN incidents, the SNS is also poised to provide assets to support response operations to large-scale public health emergencies, such as those caused by hurricanes, disease outbreaks, or other natural disasters..

Specific to the current COVID-19 response, as of August 18, 2020, and in coordination with interagency partners including the Department of Defense and the Department of Homeland Security, the SNS has provided more than 18.5 thousand tons of personal protective equipment (PPE) and other medical material to support States to aid in medical response as well as the federal repatriation effort to bring American citizens back from abroad. This deployment of PPE encompassed approximately 90 percent of the total SNS PPE inventory available at the beginning of the COVID-19 pandemic. In addition to PPE, the SNS deployed ventilators and Federal Medical Stations (FMS) to support the response.

To respond and prepare for COVID-19, as well as prepare for any new and emerging public health threat, ASPR/SNS is working to implement SNS 2.0. This initiative has three main objectives:

- Ensure the SNS has the breadth and depth to meet any future pandemic or public health emergency;
- Bolster the U.S. industrial base for critical pharmaceuticals and medical supplies; and,
- Reduce America's vulnerabilities and reliance on foreign suppliers and manufacturers.

Under the first initiative, current planning is underway to achieve a capacity to meet 90 days of need by this fall, which will require a combination of actions to increase the supply of PPE and other critical items in the SNS, in the commercial supply chain, and at the point of use (such as hospitals). Since the start of the pandemic, orders have been placed for approximately 800 million N95 respirators and face masks for delivery to the SNS. The SNS currently holds approximately 80 million N95 respirators and face masks within the overall stockpile. The SNS is currently on track to have 10 times more masks on hand by the fall of 2020 than were available prior to the start of the COVID-19 pandemic. Additionally, the SNS has received more than 125,000 new ventilators from COVID-19-related contracts awarded in the spring. The SNS currently has more than 130,000 ventilators on hand for deployment, which is more than seven times the quantity held in pre-COVID-19 pandemic inventory. The SNS has also began procuring necessary testing supplies, including test kits, swabs, and viral transport media, to ensure that Americans have access to the most advanced and robust COVID-19 tests in the

world. The SNS inventory is projected to include 44 million swabs and 65.5 million viral transport media by the end of 2020.

To support a number of these contracts, HHS has leveraged and utilized actions under the Defense Production Act (DPA). Title I of the DPA allows the President, among other authorities, to require businesses and corporations to prioritize and accept government contracts for materials and services. HHS has exercised Title I DPA authorities using the Health Resource Priority and Allocations System (HRPAS) in order to prioritize contract action to compel a direct response to the place of greatest need. A number of health resource materials have been identified that are essential to respond to the COVID-19 pandemic; however, these items, like PPE and ventilators, are in high demand. A priority rating has at times proved necessary to provide the requested quantities and qualities of these health resources within a specified time period or delivery date. These rated orders are filled first when there are both commercial demands and government demands for the same product, or component(s) of a product. Utilizing this authority has enhanced national preparedness and is helping ensure there is product available if and when it is needed.

Under the second initiative, ASPR/SNS is working with DoD to expand domestic manufacturing capacity. The partnership between DoD and HHS, which allowed SNS to tap into DoD's contracting resources and experience with industrial based expansion projects, was critical for the success of the U.S. Government's efforts to expand domestic production capacity of medical supplies during the COVID-19 pandemic. Using CARES Act funding, the SNS has funded a number of projects including:

- Melt blown fiber (MBF) – to date the SNS has expanded the domestic manufacturing capacity to produce MBF, a critical component in N95 and surgical mask production.
- Increased domestic production capacity for surgical masks – to date the SNS has supported contracts to allow manufacturers to stand up additional production lines and production centers to produce surgical masks.
- Increased domestic production capacity for nitrile gloves – to date the supported contracts to increase annual domestic production capacity of nitrile gloves by 450 million starting July 2020, to be completed by July 2021.

- Increased domestic production capacity for testing swabs – to date the SNS has supported an increase domestic production capacity for swabs
- Increased domestic production capacity for rapid point-of-care test kits – to date the SNS has supported an increase in annual domestic production capacity of COVID-19 test kits by 8 million a month by February 2021.

Lastly, to support efforts under the third initiative, ASPR is working in partnership with the HHS Food and Drug Administration (FDA) to understand and identify, as early as possible, supply chain issues. Much of our supplies and medical materiel come from international partners. We must, and will, continually evaluate and understand these dependencies to best inform acquisitions and planned procurements.

Preparing the Nation's Healthcare System

ASPR's Hospital Preparedness Program (HPP) strengthens health care sector readiness to provide coordinated, life-saving care in the face of emergencies and disasters. As the only source of federal funding for health care system preparedness and response, HPP promotes a consistent national focus to improve patient outcomes during emergencies and disasters and enables rapid recovery.

HPP was established after the September 11, 2001, terrorist attacks, with the goal of improving the capacity of local hospitals across the country to deal with disasters and a large influx of patients in an emergency. Prior to COVID-19, HPP's annual appropriation supported: the annual cooperative agreement program to 62 state, local, and territorial health department recipients to support health care coalitions; the Regional Disaster Health Response System (RDHRS); the National Emerging Special Pathogens Training and Education Center (NETEC); and ten Regional Ebola and Other Special Pathogen Treatment Centers (RESPTCs).

In response to COVID-19, HPP has awarded additional funds COVID-19 supplemental funding to support National Special Pathogen System (NSPS), building upon many of HPP's core programs and activities. Funds were distributed to support the traditional HPP recipients, the 10 RESPTC recipients, the NETEC, and a new funding mechanism to directly support hospitals and

other health care facilities through 53 hospital associations. The NSPS supports a coordinated national approach to preparing for public health and medical emergencies so that the U.S. has a tiered, capable system that coordinates national expertise, regional capabilities, and state and sub-state health care capacity across the public and private sectors in order to drive an effective and safe pandemic response. The NSPS will continue to deploy and enhance capabilities to address continued surge events during the current pandemic – as well as prepare to address potential future special pathogens.

Additional supplemental funding was awarded by HPP to support efforts to secure the nation's blood supply through a partnership with the American Red Cross. Through this effort, we will be better able to maintain blood operations, enabling hospitals and other health care entities to meet demand for blood and avoid shortages of this lifesaving medical resource. Lastly, HPP is also supporting a collaborative effort with DoD to establish a National Emergency Tele-Critical Care Network (NETCCN) to support expanded telehealth capabilities nationally. The NETCCN is comprised of a cloud-based, low-resource, stand-alone health information management system for the creation and coordination of flexible and extendable "virtual critical care wards." These wards bring high-quality critical care capability to nearly every bedside, whether in a health care facility, or in an alternate care site such as a field hospital, or in a gymnasium – enabling critical care anywhere.

ASPR's Support for COVID-19 Response

While we await a vaccine, ASPR has supported other efforts to help mitigate the transmission of the virus when and where possible. Beginning in March 2020, ASPR initiated the production and distribution of more than 500 million cloth face masks across the country. Many of these face masks were provided to long term care and dialysis facilities to help protect some of the most vulnerable in our communities. And, more recently, we are sending 125 million cloth face masks to states and territories for distribution to schools.

ASPR also works to enhance medical surge capacity by organizing, training, equipping, and deploying Federal public health and medical personnel, such as National Disaster Medical System (NDMS) teams, and providing logistical support for federal responses to public health emergencies. NDMS was originally created during the Cold War to take care of military casualties from overseas in U.S. civilian hospitals.

At the start of the COVID-19 outbreak in January and February, 2020, NDMS teams were deployed to strategic locations across the country to care for U.S. citizens evacuated from Japan who may have been exposed to SARS-CoV-2, effectively providing medical care and limiting the potential spread of the disease. Overall, HHS deployed over 600 Public Health Service Commission Corps Officers and NDMS personnel to support this repatriation effort. In addition, HHS provided cache equipment, (e.g., medical supplies and resources) to the repatriation sites to aid in the medical needs and care of returning Americans.

As the response shifted and cases increased domestically, NDMS teams have been deployed, when requested by a state, to provide augmented care. Specifically, NDMS has supported hospital augmentation (such duties include: emergency room support, hospital decompression, setting up medical overflow centers for patients, and mortuary support). As of September 10, 2020, ASPR has supported approximately 3200 NDMS deployments of medical, mortuary, and veterinarian specialists to various missions across the country to 18 different states. With the aid of NDMS personnel and resources, communities have been able to continue to provide care to those in need of medical assistance and treatment. NDMS will continue to support such requests, and we appreciate the funding this Committee has provided to date to support these efforts.

Conclusion

On behalf of all the witnesses, we thank you again for your support. Whether supporting hurricanes, floods, influenza outbreaks, and other infectious disease outbreaks such as Pandemic Influenza, Ebola, Zika, or the current COVID-19 pandemic, we have utilized the authorities and resources provided by Congress to best support the nation in responding to the threat and mitigating the lasting impact.

Your partnership and support enable our mission accomplishment. We would be happy to answer any additional questions you may have.