

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Hearing on the COVID-19 Response

Witness appearing before the
House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies

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June 4, 2020

The COVID-19 pandemic has radically changed the way we live and work but the resolve of the Centers for Disease Control and Prevention (CDC) to protect the American people remains unchanged. Since I last appeared before you in early March, we, together as a nation, have taken aggressive measures to slow the spread of this novel virus. Today there are 1,827,425 cases and tragically there have been 106,202 deaths in the United States. This is the greatest public health challenge we have faced in more than 100 years. As America's health protection agency, CDC has been working 24/7 to save lives and protect America from this virus.

CDC has provided technical assistance to support state, tribal, local, and territorial public health partners in rapidly expanding existing public health preparedness and response core capabilities – particularly helping jurisdictions establish a skilled workforce, laboratory capacity and technical assistance, contact tracing, and the capacity to collect and effectively use data and predictive analytics. To date CDC has awarded nearly \$11.9 billion in emergency funding directly to states, tribes, local entities, and territories to support the implementation of their response and recovery plans. CDC has moved swiftly to get resources to jurisdictions. The first supplemental appropriation – the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 required CDC to award \$475 million to state and local entities within 30 days. CDC exceeded this goal - getting \$600 million out to jurisdictions in under two weeks after enactment. In the third supplemental – the Coronavirus Aid, Relief, and Economic Security (CARES) Act – CDC rapidly awarded more than \$630 million to states, tribes, local entities, and territories to battle COVID-19 and expand their capacity for testing, contact tracing, and containment. CDC epidemiologists are conducting surveillance to monitor changes in detected cases over time and investigations aimed at addressing key questions regarding SARS-COV-2 disease burden, transmission, clinical risk factors and disease outcomes. Community mitigation teams are providing guidance on infection control and contact tracing. Our laboratory experts are performing Real-Time Reverse Transcriptase (RT)-PCR and antibody testing, viral culturing, viral genetic

sequencing and other studies to better define the extent of virus exposure across the United States, including those who may be asymptomatic. And, like many Americans across the nation, we are working in new ways as we coordinate and respond.

On March 17, 2020, CDC joined the Federal Emergency Management Agency (FEMA) along with other federal government agencies in coordinating response and recovery activities. CDC is working as part of this whole-of-government effort to provide technical assistance to all 50 states, Puerto Rico, the District of Columbia, tribes and territories. The CDC participated in calls along with the White House and Federal partners to understand state capacities and needs. As a result of those calls, CDC is assisting jurisdictions where needed, emphasizing 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 also leveraging long-term investments in global health security, pandemic preparedness, and public health infrastructures and capacities built through programs like the President's Emergency Plan for AIDS Relief and the Global Health Security Agenda to support countries in containing COVID-19 and mitigating the effects of the pandemic on health systems and programs to protect health security.

Congress has addressed the urgent need to respond to this pandemic at home and abroad and has allocated substantial resources to support a federally-supported, state-managed, and locally-implemented response to COVID-19 in the United States. With resources provided by Congress for global disease detection and emergency response, CDC is also supporting prevention, preparedness, and response efforts in partnership with public health agencies, health ministry counterparts, and multilateral and non-governmental agencies worldwide. Specifically, CDC is working with health ministries to provide technical assistance and other support to help mitigate COVID-19 transmission in the community, across borders, and in healthcare facilities; support rapid identification, triage, and diagnosis of potential cases

to improve patient care and minimize disruptions to essential health services; and ensure readiness to implement vaccine and therapeutics when available.

Here in the United States, CDC is working closely with state, tribal, local, and territorial partners to focus use of these resources on establishing and enhancing case identification; conducting contact tracing; implementing appropriate containment and community mitigation measures; improving public health surveillance and reporting; enhancing testing capacity; controlling COVID-19 in high-risk settings; protecting populations that have experienced persistent health disparities; and working with healthcare systems to manage and monitor capacity. As of May 21, 2020, CDC has awarded nearly \$11.9 billion to support jurisdictions across America in their preparedness and response activities. This includes \$10.25 billion to 64 state, territorial, and local jurisdictions to be used, as directed by Congress, to develop, purchase, administer, process, and analyze COVID-19 tests; conduct surveillance; trace contacts; and perform other important response and recovery related activities. The \$10.25 billion is linked to submission of state testing plans, which are required to meet multiple criteria, including numbers and types of tests; plans to reach the elderly, vulnerable, and underserved; surge plans in response to outbreaks; utilization of novel community-based collection sites; and approach to serologic testing. Reviews will be conducted by a multidisciplinary, multiagency team, which will provide ratings to the individual states and work with them to ensure that the approach accurately reflects the unique needs of each jurisdiction.

CDC is also providing direct technical assistance and support to state, tribal, local, and territorial partners as they consider approaches to mitigate and contain COVID-19. As of May 27, there are 620 CDC staff working in state, tribal, local, and territorial health agencies. This includes 121 staff deployed to 33 field teams to provide multi-disciplinary technical assistance at the request of health departments. Teams continue to provide support for outbreak response, epidemiologic, surveillance and data analysis, community mitigation, infection prevention and control, laboratory support, and technical assistance.

CDC has deployed agency experts and is also offering remote assistance in epidemiology, water access, sanitation, infection prevention and control, community mitigation, community messaging and education, and other areas, to assist tribes and tribal-serving organizations and health departments on the frontlines against COVID-19. CDC teams are on the ground supporting tribal nations in standing up an incident command structure. A CDC field team analyzed water access in a tribal community and developed an implementation plan, which will lead to more homes in that community having safe water – a critical component of infection prevention and control. Through a Tribal Support Unit in the Emergency Operations Center, CDC also has two additional teams supporting tribal nations: a technical assistance team to provide support for training, protocol review, and implementation guidance; and a tribal support team, which offers additional support to tribes by linking them with CDC resources. CDC is also using available and flexible funding mechanisms to support tribal communities and allocate resources to our tribal partners quickly. CDC anticipates exceeding the minimum amount of financial support directed by Congress to our tribal partners by allocating more than \$205 million in COVID-19 funding to Indian Country. In addition, CDC has launched a multifaceted approach to enhance and complement state, tribal, local, and territorial efforts and expand on CDC’s current deployments, including testing, infection prevention and control, public health surveillance, and contact tracing.

Overall, CDC is drawing on its emergency response capacity and its long-standing relationships with state, tribal, local, territorial, global, and private sector public health partners to galvanize an evidence-based national response. CDC has produced more than 1,500 guidance documents and numerous other resources and tools for healthcare professionals, health departments, laboratories, businesses, community organizations, and the public to encourage safer practices, improve health outcomes, and save lives; these resources have been viewed more than 160 million times. Through 11 Clinician Outreach and Communication Activity (COCA) calls – which provide guidance and information to healthcare providers – CDC has reached more than 150,000 clinicians live and more than

400,000 participants through Facebook livestreams. A recent COCA call accessed by 14,000 locations covered the clinical characteristics of multisystem inflammatory syndrome in children (MIS-C), how cases have been diagnosed and treated, and how clinicians are responding to recently reported cases associated with COVID-19.

On May 13, 2020, CDC released interim guidance to help state, local, territorial, and tribal health departments develop plans for the implementation and enhancement of COVID-19 case investigation and contact tracing efforts in their jurisdictions. Contact tracing is a core infectious disease control strategy that involves case and contact investigation followed by the implementation of an intervention (for example, isolation and quarantine) that interrupts disease transmission. Case investigation and contact tracer staff have been employed by local and state health department personnel for decades to address other infectious diseases, and contact tracing is a key strategy for preventing further spread of COVID-19 as well as a key component of state plans to reopen. This guidance provides example staffing plans, key considerations, and strategies for health departments to facilitate case investigation and contact tracing, and CDC will continue to update guidance as new information becomes available.

CDC's outreach beyond healthcare sectors is also extensive and includes decision trees and consideration documents as well as sector-specific calls around rural health stakeholders, public and private partners, schools, camps, youth sports, workplaces, and mass transit, which have reached over 1.1 million participants. In partnership with the White House, CDC is working with the major media networks, public health partners, and digital platforms on a campaign that provides a series of national public service announcements and multi-channel content. This campaign is providing critical and urgent messages to the American public, with a specific focus on reaching higher-risk populations. Every day nearly 3.5 million Americans visit CDC's website for information on how to keep their loved ones, their communities, and themselves safe. CDC's detailed guidance, easy-to-use decision tools, and

consideration documents have given states and local entities resources to help them make decisions as people seek to safely return to school, work, and other gathering places.

First responder and healthcare guidance documents cover a range of topics - from addressing potential work-related exposures, implementing infection prevention and control measures in health facilities, and optimizing the supply of personal protective equipment to clinical evaluation, testing, and clinical care. CDC is providing these recommendations to support communities' efforts, while recognizing that each sector and community is unique and will need to consider these in the context of their community-level data and circumstances. For example, CDC has updated its guidance to help nursing homes add testing to other infection prevention and control practices to keep COVID-19 out, detect cases quickly, and stop transmission. When these practices are used together, nursing homes have a more robust strategy to protect residents and staff. CDC teams will continue working with state and local officials to integrate these recommendations into COVID-19 plans. We are strengthening COVID-19 data collection and surveillance in nursing homes as CDC works closely with the Centers for Medicare & Medicaid Services (CMS), which announced new regulatory requirements that will require nursing homes to inform residents, their families, and representatives of COVID-19 cases in their facilities; report cases of COVID-19 directly to CDC's National Healthcare Safety Network (NHSN); and cooperate with CDC surveillance efforts around COVID-19 spread. This information will be used to support surveillance of COVID-19 locally and nationally, monitor trends in infection rates, take action to detect, prevent, and respond to cases in facilities, and inform public health policies and actions. These requirements, coupled with ongoing CDC technical assistance – both on the ground deployments and remote assistance to nursing homes – along with research and surveillance, will further our aggressive efforts to protect vulnerable older adults.

The American people, communities, public health professionals, medical providers, businesses, and schools look to CDC for trusted guidance on responding to COVID-19. CDC develops and

disseminates guidance for individuals and communities. These recommendations include actions that every American should take, such as following good personal hygiene practices, staying at home when sick, and practicing social distancing to lower the risk of disease spread. CDC posts all our guidance on our COVID-19 response website: [cdc.gov/coronavirus](https://www.cdc.gov/coronavirus). CDC's communication teams work diligently to ensure that guidance and resources are accessible to persons with disabilities, are written in plain language, and are frequently translated into Spanish and other languages.

The nation's public health response to COVID-19 depends on effective public health surveillance. To fight this threat, CDC has adapted its existing public health surveillance systems, mortality surveillance, hospitalization data, and syndromic surveillance – to name just a few - to identify where the virus is and where it may be going. We run these systems in partnership with our nation's state and local public health agencies, which have been working heroically to protect the American public.

This crisis has highlighted the challenges presented by the nation's fragmented and outdated public health data infrastructure—a condition that predates the pandemic by decades—but it has also helped illuminate the way forward. CDC is working closely with the White House Coronavirus Task Force in leading an initiative to modernize and integrate the nation's public health data surveillance and analytical infrastructure for COVID-19 and into the future. In addition to an initial investment from Congress in Fiscal Year 2020, the CARES Act included a critical \$500 million appropriation to accelerate this initiative. Now, CDC and its public health partners across the nation have increased resources to develop and deploy world-class data and analytics to meet the unprecedented challenges presented by COVID-19. With these investments, CDC and its domestic public health partners are able to move forward with the implementation of plans to modernize the capabilities of state and local health departments so they can marshal fast, targeted responses to COVID-19 clusters; automate the provision of COVID-19 information from health care to public health to provide timely, complete, and accurate

data without burdening providers; and improve laboratory data quality, integration, and electronic reporting.

Timely and complete data are essential as CDC and the nation work to understand the impact of COVID-19 on all Americans, particularly for those at greater risk for severe illness, such as older Americans, those with chronic medical conditions, and some racial and ethnic groups. CDC is also working to understand the impact of COVID-19 on healthcare workers, first responders, and other essential workers. On May 26, CDC began daily reporting of U.S. data on total COVID-19 cases and deaths among healthcare personnel. Accurate data are critical as we continue to assess the burden placed on the American healthcare system to inform reopening. CDC is using data to monitor hospitalizations by race, ethnicity, underlying condition, age, and gender, and includes this information in CDC's weekly COVIDView summary (<https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>). CDC's population-based COVID-NET system monitors COVID-19-associated hospitalizations that have a confirmed positive test in more than 250 acute care hospitals in 99 counties in 14 states. Data gathered are used to estimate age-specific hospitalization rates on a weekly basis and describe characteristics of patients hospitalized with COVID-19 illness. CDC is now receiving and reporting more granular data on deaths by state and locality, allowing us to identify and address potential racial and ethnic disparities in morbidity and mortality. CDC also is augmenting the existing NHSN to monitor and analyze the capacity of the healthcare system daily—including any surges at our hospitals and nursing homes—so that federal, state, and local officials can adjust their response and mitigation efforts as needed. Understanding how COVID-19 impacts the capacity of the U.S. healthcare system is essential for the response to the pandemic. All levels of government, and the nation's healthcare system, need detailed and timely information about the availability and shortages of key resources – including hospital beds, ICU beds, ventilators, personal protective equipment, and healthcare personnel – as well as outbreaks in nursing homes.

From the outset, CDC laboratories have applied technologies to sequence isolates of SARS-CoV-2 - the virus that causes COVID-19 and have made the data available through domestic and global databases. CDC is leading a SARS-CoV-2 Sequencing for Public Health Emergency Response, Epidemiology and Surveillance (SPHERES) project, a new national genomics consortium that includes 37 state and local public health laboratories, several large clinical diagnostic corporations, and academic and non-profit leaders from across the country. The consortium aims to coordinate SARS-CoV-2 sequencing across the United States to complete large-scale, rapid genomic sequencing of the virus. These advanced molecular detection and sequencing activities are being ramped up at the state and local levels to give us a clearer picture of how the virus pandemic is evolving and how cases are connected.

CDC has developed and is using a serology test to assist with efforts to determine how much of the U.S. population has been infected with SARS-CoV-2. The test looks for the presence of antibodies, which are specific proteins made in response to infections. Antibodies to some infections can remain in the body, for in some cases, years or may only remain for a few months or weeks. It typically takes one to three weeks after someone becomes sick with COVID-19 for their body to make antibodies; some people may take longer to develop antibodies. The antibodies detected by this test indicate that a person has had an immune response to SARS-CoV-2, regardless of whether symptoms developed from infection or the infection was asymptomatic. However, it is important to highlight, that at this point, we do not know whether the presence of antibodies provides immunity to reinfection with the virus or how long these antibodies may remain in an individual – weeks, months, or years. Currently, CDC's serologic test is designed and validated exclusively for broad-based surveillance and research that is giving us information needed to guide the response to the pandemic and protect the public's health. CDC has developed guidelines for antibody testing and is also engaged with the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and the Biomedical Advanced Research and Development Authority (BARDA) to evaluate other new serology tests.

CDC and public health partners are actively investigating community transmission of the virus that causes COVID-19. The first stage of these studies used residual serum samples from commercial laboratories in Washington State and New York City. In our second phase, we expanded to include serologic testing in additional states covering all 10 HHS regions. CDC is also partnering with NIH, FDA, Vitalant Research Institute, and large blood collection organizations to conduct the largest nationwide seroprevalence survey to date to assess, through blood serum draws, how many people in the United States may have been infected with and developed antibodies to SARS-CoV-2. This seroprevalence survey will test nearly 325,000 samples over the next 18 months.

By using seroprevalence surveys, CDC can learn about people who have been infected, including those infections that might have been missed because some people did not have symptoms of COVID-19 or were never tested. These surveys can also track how infections progress through the population over time. This is done by taking “snap shots” of the percentage of people from the same area who have antibodies against SARS-CoV-2 at different time points. To complement this large-scale seroprevalence work, this month CDC will initiate ongoing community-level surveillance that follows cohorts of community members and households on a weekly basis across the United States. This system will help us understand the frequency of infections with and without symptoms and the risk of re-infection in different age, health, and occupation groups over the next year. On May 18, 2020, CDC worked with other HHS agencies to begin seroprevalence surveys of health care workers and first responders in New York City and Detroit metro areas. Additionally, corrections staff will be tested in New York City. The survey will assess what types of workers are most at risk, availability and efficacy of personal protective equipment, and previous illness compatible with COVID-19. Together, the seroprevalence and community cohort surveillance network will give us a better understanding of infections across the country.

On April 27, 2020, CDC updated its recommendations for testing prioritization of viral (PCR) tests and focused testing guidelines on those who may have or who are at risk for active infection. Clinicians considering testing people with possible COVID-19 should continue to work with their local and state health departments to coordinate testing through public health laboratories or use clinical laboratory viral tests for COVID-19. Increasing testing capacity will allow clinicians to consider the medical necessity of COVID-19 testing for a wider group of symptomatic patients and, in certain situations, people without symptoms. CDC recommends that clinicians use their judgment to determine if a patient has signs and symptoms of COVID-19 and whether the patient should be tested. The updated testing guidelines are designed to give the clinicians maximum flexibility. Many patients with confirmed COVID-19 have developed fever and symptoms of acute respiratory illness (e.g., cough, difficulty breathing), but some people may present with other symptoms. CDC has developed testing strategies and recommendations for critical infrastructure and vulnerable populations. Other considerations that may guide testing are epidemiologic factors such as the occurrence of local community transmission of COVID-19 infections in a jurisdiction.

While it's unclear how long the pandemic will last, COVID-19 activity will continue for some time. It's also unclear what impact the ongoing COVID-19 pandemic will have on the upcoming influenza season. If there is substantial COVID-19 and seasonal influenza activity at the same time, this could place a tremendous burden on the health care system and result in many illnesses, hospitalizations, and deaths. CDC is actively working on gaining Emergency Use Authorization for a newly designed assay that can simultaneously detect and differentiate infection with SARS-CoV-2 and influenza. In the context of likely ongoing COVID-19 activity, getting an influenza vaccine when it is available will be more important now than ever. Getting an influenza vaccine will help keep people out of a medical setting and help conserve scarce medical resources to care for COVID-19 patients. Determining if

influenza or SARS-CoV-2 is causing the infection is also important to clinical treatment, infection control and community mitigation efforts .

CDC works each year to increase the number of people who get the influenza vaccine and to eliminate barriers to vaccination. Ongoing COVID-19 activity may affect when, where, and how flu vaccines are given. CDC is working with manufacturers to maximize influenza vaccine availability and with health care providers to develop contingency plans so that people can be vaccinated in a safe environment. While surveillance, testing, contact tracing, and community mitigation interventions are the best tools we have right now, CDC is already hard at work to prepare our nation's public and private health systems to effectively deliver a COVID-19 vaccine once it is available. This includes working with Federal, state, and local partners along with CDC's 64 immunization awardees to help ensure that the U.S. immunization system can mount an effective vaccine delivery program, including vaccine distribution and tracking.

Right now, mitigation and containment of COVID-19 are the best public health strategies available and CDC is leveraging all our expertise and resources to advance this work. The COVID-19 pandemic has brought to light the need to transform the U.S. public health system to be on the leading edge of detection, prevention, and response. Investment in core capabilities at all levels to ensure leading edge data and analytics, deep laboratory capacity, a robust public health workforce, global health security, and national preparedness is critical as we continue to respond to the COVID-19 pandemic and prepare a strengthened national public health infrastructure for decades to come. While much remains unknown about this pandemic, one thing remains certain: the public health professionals at CDC remain committed to saving lives and protecting Americans from the coronavirus.