EXAMINING THE NATIONAL RESPONSE TO THE WORSENING CORONAVIRUS PANDEMIC

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

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EXAMINING THE NATIONAL RESPONSE TO THE WORSENING CORONAVIRUS PANDEMIC

Wednesday, July 8, 2020

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC.

The committee met, pursuant to notice, at 12:02 p.m., via Webex, Hon. Bennie G. Thompson (Chairman of the committee) presiding.

Present: Representatives Thompson, Jackson Lee, Langevin, Richmond, Payne, Rice, Correa, Torres Small, Rose, Underwood, Slotkin, Cleaver, Green of Texas, Clarke, Titus, Watson Coleman, Barragán, Demings, Rogers, Katko, Higgins, Lesko, Joyce, Crenshaw, Guest, Bishop, and Van Drew.

Chairman THOMPSON. The Committee on Homeland Security will come to order.

The committee is meeting today to receive testimony on examining the National response to the worsening of the coronavirus pandemic.

Without objection, the Chair is authorized to declare the committee in recess at any point.

Today the Committee on Homeland Security is meeting to examine our National response to the worsening coronavirus pandemic. This hearing comes at a critical moment. The number of coronavirus cases is surging, topping 50,000 per day for the first time on July 1, and setting alarming records for new cases over the past week.

Dr. Anthony Fauci recently warned that U.S. cases could double to 100,000 per day, if current outbreaks in the South and West are not contained, putting the entire country at risk.

As infections threaten to spiral out of control, President Trump has tried to downplay the impact of COVID–19, calling 99 percent of cases totally harmless, even as more than 130,000 Americans have died and many more have become seriously ill. Just this week, he falsely claimed the U.S. coronavirus death rate is the lowest in the world when, in fact, it is among the highest. Unfortunately, the President's comments come as no surprise.

His administration's response to the coronavirus has been an abject failure by any reasonable measure. He ignored early intelligence on the virus, continues to disregard the opinions of doctors and scientists, including those in his own administration, and perpetuates misinformation about COVID–19 rather than allowing the experts to speak directly to the American people about the disease.

Just yesterday, Congress received notification that the President has begun the process of withdrawing the United States from the

World Health Organization in the midst of a pandemic, endangering global health against our own interests. The President has shirked his administration's responsibility to prepare and respond to the pandemic and his own obligation to the Nation in a time of crisis, shifting the burden to State and local governments and the people—and the American people. The effect of American lives lost and damage to our economy have been devastating.

The United States currently has 20 percent of the world's coronavirus cases, despite having only 4 percent of the world's population. As the countries are bringing their outbreaks under control, U.S. cases are headed in the opposite direction. Meanwhile, President Trump continues to deny the severity of the problem and is instead focused on his own reelection campaign.

Many State and local governments, public health officials, hospitals, and medical workers are doing the best they can under the circumstances, but we need real leadership at the Federal level if our country is to overcome the COVID–19 pandemic.

Today we will hear from those who have taken action where the administration has failed to do so: A Governor, a mayor, a public health official, and an emergency manager. They are in many ways on the front line of this worsening pandemic, obtaining PPEs and testing supplies, requiring masks and social distancing, and sounding the alarm about the devastating effects of this disease on minority and economically-disadvantaged communities.

I hope to hear that testimony about what needs to be done to reverse the current trend of cases to protect our health and our economy. The American people are counting on us.

I thank the witnesses and my colleagues for participating today.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

JULY 8, 2020

This hearing comes at a critical moment. The number of U.S. coronavirus cases is surging, topping 50,000 per day for the first time on July 1 and setting alarming records for new cases over the past week. Dr. Anthony Fauci recently warned that U.S. cases could double to 100,000 per day if current outbreaks in the South and West are not contained, putting the entire country at risk.

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I hope to hear their testimony about what needs to be done to reverse the current trend of cases to protect our health and our economy. The American people are counting on us.

Chairman THOMPSON. The Chair now recognizes the Ranking Member of the full committee, the gentleman from Alabama, Mr. Rogers, for an opening statement.

Mr. ROGERS. Thank you, Mr. Chairman. I appreciate you granting my request to allow Members to use the hearing room today. As you know, I strongly disagree with the unilateral decision to shut down the House of Representatives. We should be conducting our important oversight and legislative business here in Washington. We are much more productive when Members are here in person doing our work together. We have always proven we can do it safely. I hope we will return to regular work as soon as possible.

As I said before, our hearts go out to those who have lost their loved ones to COVID–19 and those who are currently undergoing treatment. COVID–19 is an unprecedented global pandemic that requires unprecedented response.

Unfortunately, we lost time early in the response when China hid the disease from the world. For weeks, the Chinese Communist Party refused entry of outside medical experts. The Chinese suppressed journalists reporting. Worst of all, China deliberately withheld evidence of the virus, the virus' structure, and deadly spread. During this, the Chinese hoarded life-saving medical supplies and encouraged foreign travel, seeding the virus across the globe.

I want to commend Ranking Member McCaul's work on the Foreign Affairs Committee to extensively document this deadly cover-up in a recent report.

It is clear that China has pulled out all the stops to manipulate everyone, from media outlets to the World Health Organization. The WHO maintained for months that China had promptly self-reported COVID–19. They did not. After months of lying, the WHO has come clean. The WHO now says it found out about COVID from media reports and whistleblowers from within China.

The Chinese Communist Party, once again, has been caught with blood on its hand.

Facing an extraordinary public health crisis, China's deadly cover-up, the Trump administration has responded with a whole-of-Government response. To date, the administration has prohibited the entry of travelers from global hotspots; invoked the Defense Production Act to increase supplies of critically-needed medical equipment, such as ventilators; coordinated the delivery of 176 million respirators, 682 million surgical masks, and 17 billion gloves; sent over $125 billion to the States to support medical response to COVID–19; distributed over $500 billion in PPP loans to

small businesses; helped facilitate the testing of over 36 million tests. In fact, we are now capable of conducting over 700,000 tests per day. That is good news.

The bad news is the number of positive tests are rising in many States. That is why it is important for all Americans to continue to heed the advice of our Federal Government, State, and local public health officials.

I am pleased to see a couple of public health emergency response officials on the panel today. Colonel Hastings currently serves as the director of Alabama's Emergency Management Agency. He has a very distinguished career, 30-year career in the Air Force. For the last 3 years, he has done a tremendous job leading the EMA's response to several natural disasters and now the COVID–19.

Colonel, thank you for joining us today.

I appreciate all the witnesses for appearing. I look forward to hearing you all, hearing how you are using emergency funding and support resources provided by Congress and the administration to respond to this crisis. I am also interested in knowing what more Congress can do effectively to help you respond.

Our country has faced outbreaks of serious disease in the past. In each case, we have marshalled our collective resources and ingenuity to overcome the crisis. I am confident that will be the case with COVID–19.

Thank you, Mr. Chairman. I yield back.

[The statement of Ranking Member Rogers follows:]

STATEMENT OF RANKING MEMBER MIKE ROGERS

JULY 8, 2020

Thank you, Mr. Chairman.

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During this, the Chinese hoarded life-saving medical supplies and encouraged foreign travel, seeding the virus across the globe. I want to commend Ranking Member McCaul's work on the Foreign Affairs Committee to extensively document this deadly cover-up in a recent report.

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I'm confident that will be the case with COVID–19.

Thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. [Inaudible]

Mr. ROGERS. Can you all hear the Chairman? I can't either.

Chairman THOMPSON. Can you hear me now?

Mr. ROGERS. Yes, yes.

Chairman THOMPSON. All right. Other Members of the committee are reminded that under the committee rules, opening statements may be submitted for the record.

[The statement of Hon. Jackson Lee follows:]

STATEMENT OF HONORABLE SHEILA JACKSON LEE

JULY 8, 2020

Chairman Thompson and Ranking Member Rogers, thank you for holding today's hearing on "Confronting the Coronavirus: The Federal Response."

I thank today's witnesses and look forward to their testimony:

- Jay Robert "J.B." Pritzker, Governor of Illinois
- Jason Shelton, Mayor, City of Tupelo, Mississippi
- Umair A. Shah, MD, MPH, Executive Director and Local Health Authority, Harris County (TX) Public Health
- Col. Brian Hastings, USAF (ret.), Director, Alabama Emergency Management Agency.

This hearing will allow Members to question State and local leaders about the impact of the novel coronavirus (COVID–19) and the failures of the Trump administration's response to the pandemic in their communities.

Members will also have an opportunity to discuss how to improve pandemic response and better support communities across the country currently seeing sharp increases in COVID–19 cases.

We owe a special debt to First Responders who will be the lifeline for many who will need medical care to overcome this coronavirus.

I introduced the "FIRST COVID–19 Care Delivery Act" to provide a path to citizenship for doctors and nurses working in the United States under the J or H visa designations or may be in the country under TPS or DACA status.

My focus from the earliest news reports in early January on the novel Coronavirus's rapid spread in China was what needed to be done to minimize infections in the United States and find a cure.

I knew COVID–19 was not something to be taken lightly and that time was not on our side to mount an effective defense based on my years of service under several administrations.

There was a body of Federal work on the topic of a global flu-like pandemic and what the United States needed to do to protect its people, but I had concerns that the current administration would not fully appreciate the gravity of the situation or be positioned to take the right steps and push into action the key offices and programs needed.

HISTORY OF U.S. PLANNING TO COMBAT A FLU-LIKE PANDEMIC

Starting in 2005, the Bush administration released the "National Strategy for Pandemic Influenza," which called for greater coordination of domestic production and stockpiling of medical supplies in anticipation of a potential influenza outbreak.

Additionally, the Strategy included the following warning:

"A pandemic, or world-wide outbreak of a new influenza virus, could dwarf this impact by overwhelming our health and medical capabilities, potentially resulting in hundreds of thousands of deaths, millions of hospitalizations, and hundreds of billions of dollars in direct and indirect costs."

In 2016, the Obama administration developed a strategic playbook on pandemic preparedness.

The 69-page Pandemic guide, entitled, "Playbook for Early Response to High-Consequence Emerging Infectious Disease Threats and Biological Incidents," includes, "hundreds of tactics and key policy decisions laid out by the National Security Council what should be done to fight pandemics."

Also in 2016, the Obama administration established the National Security Council Directorate for Global Health Security and Biodefense, also known as the White House's Pandemic Response Office, with the mission of doing "everything possible within the vast powers and resources of the U.S. Government to prepare for the next disease outbreak and prevent it from becoming an epidemic or pandemic."

The Trump administration disbanded the office in 2018.

In January 2017, the U.S. Department of Defense finalized a report on pandemic influenza and infectious disease response.

The report warned:

"A catastrophic biological incident could threaten the Nation's human, animal, plant, environmental, and economic health, as well as America's national security. Such an event would demand a rapid and effective response in order to minimize loss of life and other adverse consequences associated with the incident and to thwart ongoing threats and follow-on attacks in the case of suspected criminal activity or terrorism. The potential for a large biological incident to impact the United States is real."

Months before the spread of COVID–19, "the Trump administration eliminated a key American public health position in Beijing intended to help detect disease outbreaks in China . . . [an] American disease expert, a medical epidemiologist embedded in China's disease control agency, left her post in July [2019]." The expert, Dr. Linda Quick, worked for the U.S. Centers for Disease Control and Prevention (CDC), and according to one report, "was in an ideal position to be the eyes and ears on the ground for the United States and other countries on the coronavirus outbreak, and might have alerted them to the growing threat weeks earlier."

A September 2019 report, published by the White House's Council of Economic Advisers, "warned a pandemic disease could kill a half million Americans and devastate the economy."

In November 2019, according to multiple public reports, "U.S. intelligence officials were warning that a contagion was sweeping through China's Wuhan region, changing the patterns of life and business and posing a threat to the population."

The American people needed the Federal Government at its best to protect them from a previously unknown, deadly, and highly infectious respiratory threat as it developed into a global pandemic.

On February 10, 2020, I held the first press conference on the issue of the novel coronavirus at Houston Intercontinental Airport.

I was joined by public health officials, local unions, and advocates to raise awareness regarding the virus and the implications it might have for travel to the United States from China and to combat early signs of discrimination targeting Asian businesses in the United States.

On February 24, 2020, I held a second press conference on the International Health Regulations Emergency Committee of the World Health Organization declaration of a "public health emergency from the outbreak of the Coronavirus."

At that time, I sent a letter to the President of the United States requesting the immediate suspension of any health-related cuts that impact efforts to contain and

treat the coronavirus, including the $3.3 billion in cuts to the National Institutes of Health (NIH) and the discretionary budget cuts for the Centers for Disease Control and Prevention (CDC) of nearly 19 percent at $678 million, severely threatening the CDC's ability to respond to this and other epidemics in the future.

Additionally, I requested the President to suspend cuts in both the Medicare and Medicaid programs.

On February 26, 2020, I sent a letter to the Chair and Ranking Member of the Committee on Homeland Security seeking a meeting with Acting Secretary of Homeland Security Chad Wolf to gain insight into the Preparedness of the Agency to address a possible pandemic.

On February 28, 2020, I spoke on the floor of the House and announced plans to form a Congressional Coronavirus Task Force.

On Monday, March 9, 2020, we sent the Dear Colleague invitation to other Members of the House, which was signed by me and the 2 co-chairs: Congressmen Brian Fitzpatrick, and Dr. Raul Ruiz, as an invitation to other Members to join the Congressional Coronavirus Task Force.

As you recall Chairman Thompson, on March 11, 2020, the World Health Organization declared that COVID–19 was a pandemic, which had by that date reached at least 114 countries, sickening over 100,000 people, and killing more than 4,000.

On January 29, 2020, the administration established a Federal Coronavirus Task Force and began to close international travel, eventually closing border crossings almost entirely.

After holding Task Force Briefings daily and first taking the lead on the U.S. response, the administration then began shifting the responsibility to Governors who have been left to shoulder the burden of figuring out how to chart a path through a global pandemic.

The Task Force has resumed public activity and working with State Governors to meet local and State needs.

The Nation has not left the first wave and we are predicted to have a second more deadly wave in the fall.

The number of infections is on the rise and Governors and local governments are the last line of defense for a COVID–19-exhausted Nation.

On July 6, the CDC reported 2,932,596 cases of COVID–19 in the United States, and 130,133 deaths.

JULY 2020

On July 7, 2020, the World Health Organization (WHO) reported 11,500,302 confirmed cases of COVID–19 globally.

On July 7, 2020, the Texas Department of State Health Services (DSHS) reported 200,557 cases of COVID–19 in the State of Texas, which included an estimated 94,120 active cases, 103,782 individuals who have recovered from the virus and 2,655 confirmed COVID–19-related fatalities.

On July 7, 2020, DSHS also reported that Texas had its deadliest day from the coronavirus with 75 deaths and 10,400 new infections State-wide, according to a data analysis and reporting by Hearst Newspapers.

Across Texas, a total of 2,431,861 COVID–19 tests have been completed, of which 2,163,729 were viral tests and 207,980 were antibody tests.

On June 26, Harris County Judge Lina Hidalgo raised the Current Level of Risk for Harris County from Level 2 to Level 1 or Code Red.

Level 1 signifies a severe and uncontrolled level of COVID–19 in Harris County, meaning outbreaks are present and worsening and that testing and contact tracing capacity is strained or exceeded.

As of July 7, 2020, Houston and Harris County Combined: cases 39,311, and deaths 407; Harris County: cases 13,915, deaths 163; and Houston: cases 25,396, deaths 244.

At this level, residents must take action to minimize contacts with others wherever possible and avoid leaving home except for the most essential needs like going to the grocery store for food and medicine.

GOVERNOR ABBOTT

The Governor of Texas is taking action to pause or roll-back measures intended to open the economy given the dire rise in COVID–19 infections in his State.

On July 2, Governor Abbott issued an Executive Order requiring all Texans to wear a face covering over the nose and mouth in public spaces in counties with 20 or more positive COVID–19 cases, with few exceptions.

On June 3, 2020, the Governor issued an executive order stopping local jurisdictions like Harris County and the city of Houston from taking steps to mandate that

all persons in public spaces must wear face coverings or masks to reduce the spread of COVID–19.

On June 17, 2020, Governor Abbott issued a new executive order that placed responsibility for all customers and employees wearing of face mask or coverings on the business owner and in effect rescinded the June 3 order.

The Governor also issued a proclamation giving mayors and county judges the ability to impose restrictions on some outdoor gatherings of over 10 people, and making it mandatory that, with certain exceptions, people cannot be in groups larger than 10 and must maintain 6 feet of social distancing from others.

On July 2, Governor Abbott announced that the Texas Health and Human Services Commission (HHSC) will provide approximately $182 million in emergency Supplemental Nutrition Assistance Program (SNAP) food benefits for the month of July.

On July 2, Governor Abbott and the Texas Health and Human Services Commission (HHSC) announced that $2.67 billion in Federal funding has been approved to support Texas hospitals that provide care for people receiving Medicaid.

The glaring omission is the State of Texas refused to expand Medicaid under the Affordable Care Act, which means millions of Texans in need of health care due to COVID–19 may delay in seeking urgent medical care unless steps are taken to inform them of their status given the conditions created by the Pandemic.

JUNE 2020

On June 30, Governor Abbott and the Texas Health and Human Services Commission (HHSC) announced $9 million in Federal funding for nursing facilities to implement infection control.

On June 30, Governor Abbott issued a proclamation suspending elective surgeries at hospitals in Cameron, Hidalgo, Nueces, and Webb counties to help ensure hospital bed availability for COVID–19 patients in these communities.

This proclamation amends the Governor's previous Executive Order to include these 4 counties in addition to Bexar, Dallas, Harris, and Travis counties.

We are witnessing the State of Texas and community on what might be the brink of its worst nightmare: Hospitals overrun with extremely ill patients—not enough beds, doctors, nurses, equipment, or medicine.

It is my concern that Harris County and the city of Houston may be on a glide path into what New York City experienced when the virus spiked killing over 27,000 New Yorkers.

In March, estimates had COVID–19's infectiousness ratio as 2.3, much higher than the flu, which is 1.5.

From the earliest arrival of the virus that causes COVID–19 we have been struggling with the idea of asymptomatic and symptomatic persons and the messaging around the two has not been clear.

TESTING FOR COVID–19

Testing across the Nation and in my State of Texas has greatly improved, but it is still short of where we need to be in order to reopen safely.

I am troubled by plans to end the Federally-managed community-based sites in the Harris County and the city of Houston without concrete assurances that the sites will be maintained and fully staffed.

It is also troubling that contracts for testing and contact tracing were left without consideration of cultural competence, diversity, and inclusion to assure that the planning and execution of these essential components for checking the spread of COVID–19 would be effective in all communities and areas of the State.

According to the CDC 39,011,749 (over 39 million) tests have been given resulting in 3,604,689 positive cases of COVID–19 being identified, which is 9 percent of the total number of people tested.

The State of Texas has 29 million residents and only 2.4 million test have been done.

There should and must be more robust and expansive community-based testing.

Our Nation can win this battle against COVID–19 because we have knowledgeable and trained virologists, public health experts, and physicians who are available to help people get the information they need and provide care should they need it.

To win we must have the leadership, appropriate levels of funding, and the guidance of State, Tribal, territorial, and local public health officials.

I look forward to witness testimony on this important homeland security threat.

Thank you.

Chairman THOMPSON. I will yield to the Ranking Member for the purposes of a colloquy.

Mr. ROGERS. Thank you, Mr. Chairman. Could you please explain our agreement on the committee procedures during these remote proceedings?

Chairman THOMPSON. Thank you, Ranking Member. Let me begin by saying that standing House and committee rules and practice will continue to apply during this remote proceeding. Members will be expected to continue to adhere to the rules of the committee and the House. During the COVID period, as designated by the Speaker, the committee will operate in accordance with House Resolution 965 and the subsequent guidance from the Rules Committee in a manner that respects the right of all Members to participate.

The technology we are utilizing today requires us to make some small modifications to ensure that the Members can fully participate in these proceedings.

Mr. ROGERS. Thank you, Mr. Chairman. Could you elaborate on how Members may expect to be recognized during the remote proceeding?

Chairman THOMPSON. Thank you. First, to simplify the order of questioning, I will recognize Members for their 5 minutes questioning based on a strict seniority basis as determined by our committee roster, a departure from previous procedure. Members must be visible to the Chair in order to be considered as present for purposes of establishing a quorum or for voting. Members should make every effort to remain visible on screen throughout the proceedings. If a Member experiences issues with their video stream, they may proceed with solely audio to ensure connection, provided they have been identified previously.

At the beginning of this hearing, Members are muted. Members may unmute themselves in order to be recognized for purposes of their 5 minutes of questioning of the witnesses. At the conclusion of speaking, Members will be expected to then mute themselves to prevent excess background noise. If a Member does not mute themselves after speaking, the clerk has been directed to mute Members to avoid inadvertent background noise.

Should a Member wish to be recognized to make a motion, they must unmute themselves and seek recognition at the appropriate time.

Mr. ROGERS. Thank you, Mr. Chairman. What could a Member expect should they encounter technical issues during this remote event?

Chairman THOMPSON. In the event a Member encounters technical issues that prevent them from being recognized for their questioning, I will move to the next available Member of the same party, and I will recognize that Member at the next appropriate time slot, provided they have returned to the proceeding. Should a Member's time be interrupted by a technical issue, I will recognize that Member at the next appropriate spot for the remainder of their time once their issue has been resolved.

If I should encounter technical issues myself, the Vice Chair of the committee, if available, or the next most senior Member of the Majority shall assume the duties of the Chair until I am able to return to the proceeding.

Mr. ROGERS. Thank you, Mr. Chairman. What should Members expect regarding decorum during the remote event?

Chairman THOMPSON. Thank you again. Members are reminded that they are only allowed to attend one virtual event at a time. Should they need to attend another committee proceeding, please fully exit the hearing before entering another proceeding.

Finally, all Members are reminded that they are expected to observe standing rules of committee decorum for appropriate attire and should have a professional and apolitical background when they are participating in any remote event.

Mr. ROGERS. Thank you, Mr. Chairman. What should Members expect if a witness loses connectivity?

Chairman THOMPSON. In the event a witness loses connectivity during testimony or questioning, I will preserve that time as staff address the technical issue. I may need to recess the proceeding to provide time for the witness to reconnect.

Mr. ROGERS. Thank you, Mr. Chairman. Finally, what should Members expect if a vote is called during a remote event?

Chairman THOMPSON. H. Res. 965 requires Members to be visibly present to have their vote recorded during a remote event. Members who join the proceeding after a vote is called and who are not called upon for their vote should seek recognition from the Chair to ensure their vote is recorded. Should a Member lose connectivity during a roll call vote, I will hold the vote open for a period of time to address the technical issue and provide Members with an opportunity to have their vote recorded.

Mr. ROGERS. Thank you, Mr. Chairman.

I yield back.

Chairman THOMPSON. With that, I ask unanimous consent to waive committee rule VIII(A)(2) during committee remote proceedings under the covered period designated by the Speaker under House Resolution 965.

Without objection, so ordered.

I welcome our panel of witnesses.

I yield to the Vice Chair of the committee, Ms. Underwood of Illinois, to introduce our first witness.

Ms. UNDERWOOD. Thank you, Mr. Chairman.

Our first witness is the Honorable J.B. Pritzker, the Governor of the great State of Illinois. Before becoming Governor, Mr. Pritzker was a National leader in early childhood education for over 20 years and earned his law degree from Northwestern University. We are so glad to have him on the panel today to discuss his experience leading a State of nearly 13 million people through this challenging time, including one of the largest cities in the country, as well as extensive suburban and rural areas with very different needs.

Back in March, we heard testimony from Dr. Ngozi Ezike, the director of Illinois Department of Public Health, and I am looking forward to getting an update today from Governor Pritzker.

Welcome, Governor.

I yield back.

Chairman THOMPSON. Thank you very much.

Our second witness is The Honorable Jason Shelton, the mayor of Tupelo, Mississippi.

For those who are on here who might not know, Elvis Presley was born in Tupelo, Mississippi.

After practicing law in Tupelo for more than a decade, Mr. Shelton was first elected mayor in 2013. Under his leadership, the city of Tupelo received a 2015 All-American City Award.

Welcome, Mr. Mayor.

Since we have two members of the panel who are from Houston, Texas, I yield first to the gentlewoman from Houston, Ms. Jackson Lee, to introduce our third witness, and after that, I will yield to the gentleman from Houston, Texas, also to finish that introduction.

Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, thank you very much. To the committee Members and the Ranking Member, to all of the witnesses, thank you for your presence at this very important hearing.

Dr. Shah, my pleasure.

My good friend, Dr. Umair Shah, is the executive director and local health authority of Harris County Public Health since 2013. Under Dr. Shah's leadership, Harris County Public Health is a Nationally-recognized, $100 million agency of 700 public health professionals serving the Nation's third-largest county with 4.5 million. He has been a strong, important, and interesting but provocative messenger on the importance of the health challenges throughout the Nation and really around the world.

We worked together on the issues dealing with the Zika virus, environmental health threats, creosote contamination, and he has been a strong voice in the needs of the county as it relates to the COVID–19 pandemic.

Today in Houston, the most important titles a person can have is doctor or nurse, and he is that as he deals with COVID–19 patients. He has been involved with the care of patients as relates to the Harris County health. He previously worked as an emergency department physician at Houston's VA Medical Center and as chief medical officer of Galveston County Health District. He earned his M.D. from the University of Toledo Health Science Center.

We are very delighted to have Dr. Umair Shah, who is a voice of leadership but also guidance during Houston's very, very difficult time fighting COVID–19.

Thank you, Mr. Chairman. Delighted to be able to have the privilege of introducing Dr. Shah.

Chairman THOMPSON. Thank you very much.

Now I yield to the gentleman from Houston, Texas, to complete the introduction.

Mr. GREEN of Texas. [Inaudible]

Chairman THOMPSON. Unmute yourself. Will the gentleman from Houston unmute himself?

Mr. GREEN of Texas. The gentleman believes he has done so, Mr. Chairman. Thank you for the reminder. Greatly appreciate it. Thank you to the staff for the outstanding job they have done with this transmission, saving Al Green. I think we have done an exceptionally fine job.

Mr. Chairman, one of the hallmarks of Dr. Shah's luminously illustrious career is that he gets involved. He responds. He responded to Tropical Storm Allison, Hurricanes Katrina [inaudible]

and Haiti. He responded to Ebola and Zika. He has served as the medical branch co-director, and he did so at a time when in my district we had some 27,000 persons to move from Louisiana, my home State, to Houston, Texas, into my Congressional district. He was there for the evacuees when they were housed over at the Astrodome.

I am honored to have him as a dear friend, and we are pleased to know that he serves our constituents not only in the Ninth Congressional District, but across the length and breadth of the State of Texas and indirectly across the country.

Thank you for being here, Mr. Shah—Dr. Shah, if you will—and thank you for your involvement.

Chairman THOMPSON. Our final witness, as acknowledged by the Ranking Member, is Colonel Brian Hastings, the director of Alabama Emergency Management Agency since August 2017. Colonel Hastings previously served in the United States Air Force over 30 years. During his military service, Colonel Hastings earned 2 Legion of Merit medals, the Bronze Star, and 3 Meritorious Service Medals.

Welcome to the panel, Colonel.

Mr. HASTINGS. Thank you.

Chairman THOMPSON. Without objection, the witnesses' full statements will be inserted in the record.

I now ask each witness to summarize his statement for 5 minutes, beginning with Governor Pritzker.

STATEMENT OF THE HONORABLE JAY ROBERT "J.B." PRITZKER, GOVERNOR, STATE OF ILLINOIS

Governor PRITZKER. Thank you very much, Mr. Chairman.

Chairman Thompson, Ranking Member Rogers, and Members of the committee, thank you for the invitation to testify about our National response to the on-going COVID–19 pandemic.

Illinois is the sixth-most populous State with the fifth-largest economy. We have some of the world's best hospitals, like Northwestern Memorial and Rush, and we have renowned researchers, modelers, and public health experts at world-class institutions, like the University of Illinois and the University of Chicago.

When it became clear that COVID–19 was not a phenomenon limited to Asia or to Europe, we fully expected the Federal Government, home of the Centers for Disease Control and the U.S. Department of Health and Human Services, would arm the States with information and equipment and testing capability and personnel. After all, the Federal Government had the experience fighting H1N1, SARS, and Ebola. A global pandemic requires a National response, but that is not what happened.

First, though, I want to talk about what did happen. We took action here early with Illinois' hospital leaders, epidemiologists, modelers, public health officials, and emergency management leaders quickly helping to put plans together. We were among the first States to close nursing homes to visitors and do wellness checks on the staff. In consultation with local officials, I shut down St. Patrick's Day celebrations and then closed bars and restaurants, and then schools. We were the second State in the Nation to issue a stay-at-home order.

The Federal Government wasn't leading. We were.

Illinois is home to the country's third-largest metropolitan area and to major international transit and tourism sectors. We had all the potential to become a major early hotspot like New York, and like Florida and Texas have now become. Early March projections showed that without intervention, our health care system would be overrun, leading to tens of thousands more deaths. Our curve peaked approximately 6 weeks later.

Today, our COVID-related deaths per day are down 85 percent from a high 8 weeks ago. Even as our testing continues to grow to over 30,000 tests per day now, our COVID cases are down 71 percent from a high 9 weeks ago. The number of COVID-positive hospitalizations, including in the ICU, has dropped by over 70 percent since early May. Our case positivity rate was over 23 percent at one point, and it is now at around 2.5 percent.

That isn't to say that the cascade of decisions that got Illinois to this point were easy. In fact, every one of them has been a choice between bad and worse, muddled further by the White House's broken promises on testing supplies and PPE deliveries.

I spoke with many of my fellow Governors, Democrats and Republicans. They had the same problems. Because the Defense Production Act was not broadly invoked early enough, we were in a bidding war for life-saving supplies against each other and against our international allies. We were paying $5 for masks that should have cost 85 cents. There were States calling other States to try and figure out if some international businessman offering a warehouse of 2 million N95 masks was a scammer. Many were.

In the midst of a global pandemic, States were forced to play some sort of sick Hunger Games game show to save the lives of our people. Let me be clear. This is not a reality TV show. These are real things that are happening in the United States of America in the year 2020.

If there is one job Government has, it is to respond to a life-threatening emergency. But when the same emergency is crashing down on every State at once, that is a National emergency, and it requires a National response.

When medical professionals across the Nation are crying out for supplies, it is the Federal Government's job to make sure that a nurse being properly equipped in Peoria, Illinois, doesn't come at the cost of a doctor being ready for work in San Antonio, Texas.

There was no National plan to acquire PPE or testing supplies, and as a result, people died.

I am so grateful to the incredible, experienced public servants inside of FEMA, the CDC, HHS, VA, and the Army Corps who worked so hard along the way to give us their expertise and assistance. We will need more of that before we will have vanquished COVID–19.

I want to offer my thoughts on what the Federal Government can still do to step up and help us get through this pandemic.

First, we need to see a coordinated National strategy for containment. That means more testing and more contact tracing, and it may even mean National restrictions that will be followed in every State.

Second, every State has suffered revenue loss because of COVID–19, and without help, there will be massive layoffs of public servants, teachers, and firefighters. A bipartisan coalition of Governors thanks the House of Representatives for taking swift action on State and local support in the HEROES Act.

Third, the Federal administration also needs to provide clarity on insurance coverage for COVID–19 testing. Testing is not a one-off tactic. We need regular testing across our population, and that means people need to know that their insurance will cover their testing every time.

Fourth, we need to continue COVID response funding for the National Guard through next year in the face of a possible, maybe even likely, second wave.

Finally—and this might be the most important thing that we can do to save lives—we need a National masking mandate. We instituted ours in Illinois on May 1, one of the first in the Nation, and it aligns with our most significant downward shifts in our infection rate.

It is not too late for the Federal Government to make an impact. In fact, it is more important than ever.

So I want to thank all of you, and I look forward to your questions later on in this hearing.

[The prepared statement of Governor Pritzker follows:]

PREPARED STATEMENT OF HON. J.B. PRITZKER

JULY 8, 2020

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First, though, I want to talk about what did happen. We took action early, with Illinois' hospital leaders, epidemiologists, modelers, public health officials and emergency management leaders quickly helping to put plans together. We were among the first States to close nursing homes to visitors and do wellness checks on the staff. In consultation with local officials, I shut down St. Patrick's Day celebrations, and then closed bars and restaurants, and then schools. And we were the second State in the Nation to issue a stay-at-home order.

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That isn't to say that the cascade of decisions that got Illinois to this point were easy—in fact, every one of them has been a choice between bad and worse, muddled

further by the White House's broken promises on testing supplies and PPE deliveries. I spoke with many of my fellow Governors, Democrats and Republicans—they had the same problems. Because the Defense Production Act was not broadly invoked, we were in a bidding war for life-saving supplies against each other and against international allies. We were paying $5 for masks that should cost 85 cents. There were States calling other States to try and figure out if some international businessman offering a warehouse of 2 million N95 masks was a scammer. Many were.

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It's not too late for the Federal Government to make an impact—in fact, it's more important than ever. Thank you and I look forward to your questions.

Chairman THOMPSON. Thank you, Governor. We look forward to your responses to the questions.

I now recognize Mayor Shelton to summarize his statement for 5 minutes.

STATEMENT OF JASON L. SHELTON, MAYOR, CITY OF TUPELO, STATE OF MISSISSIPPI

Mr. SHELTON. Thank you, Chairman Thompson, Ranking Member Rogers, and distinguished Members of the Committee on Homeland Security. Thank you for the honor and opportunity to be here with you today to discuss the on-going devastating impact of COVID–19 on our great Nation, and more specifically for me, to discuss the impact on our local governments.

I did hear the Chairman mention that you can't have political things in the background. I think I have complied with that, but I also do have a not-so-subtle reminder that I am from Tupelo behind me, and I hope that that is OK.

The adverse impact of the public health crisis and corresponding economic crisis caused by COVID–19 has had a direct negative impact on the ability of local governments all across our Nation to provide the basic services that every single American depends on in carrying out their normal day-to-day activities, such as getting to work, providing for their family, and having safety and security in their community.

As the Members of this committee are aware, nearly 3 million Americans have already been diagnosed with COVID–19, and the number of deaths of Americans is in excess of 130,000 individuals.

While some loss of life from the pandemic is likely unavoidable, in my opinion, many of these deaths could have been prevented by a quicker and more uniform response from our Nation's Commander-in-Chief and his administration. Rational, stable, and consistent leadership, based upon medical and scientific data, is desperately needed from our Nation's highest office during this very real pandemic. Unfortunately, that is missing at this moment.

In the last 6 months, we have seen leaders of nations all over the globe respond to this deadly pandemic with rational, science-based decision making and genuine concern for their citizens and their economies. We have seen leaders from all over the world step up and rise to the occasion. It is past time to see that leadership here in the greatest country on Earth.

As was mentioned in the Chairman's opening statements, our Nation has 4 percent of the world's population but over 20 percent of the world's COVID cases. Similarly, we have over 20 percent of the world's deaths right here in the United States.

My purpose here to speak today is about the hardships facing the local governments which are on the front line responding to our Nation's health and economic crisis. Mayors, county officials, parish officials, and others are on the front lines and doing all that they can do to enact local policies that are based on science and the recommendations of our Nation's top agencies and experts. Their efforts, however, are being hamstrung by the lack of rational, stable, and science-based leadership in the White House.

Due to the continued political climate surrounding COVID–19, our cities continue to have difficulty in getting individuals and businesses to comply with the safety measures to prevent COVID–19-related sickness and death in our city. This will prolong both the health and economic crisis in our community.

The city of Tupelo has been very proactive. We initiated our emergency response February 24 of this year. Since that time, I have issued 17 different executive orders, all ratified by our bipartisan city council, to combat COVID–19. COVID–19 does not recognize city limits or even a county or State border. That is why National mandatory policies are needed if we are going to truly combat the health care and economic crisis facing our Nation.

I want to take this opportunity as mayor of the city of Tupelo, as a member of the small towns council of the National League of Cities to thank the Members of this committee and this collective body for passing the CARES Act legislation. This is a great thing for our country. I also want to thank the Members who have supported the HEROES Act and the SMART Act, those legislations—

pieces of legislation to get need—get resources to local governments that are desperately needed.

That is the gist of my testimony today, to advocate that direct Federal funding be delivered to local governments so that we can offset the loss of revenue.

The National League of Cities anticipates about a $360 billion loss of revenue for local governments over the next 3 years. We need funding to be able to provide the very basics that every American depends on to get to work every day; garbage, trash collection, litter, you know, fixing potholes, fixing a red light that is not working, fire protection, public safety, EMTs, the things that every American depends on each and every day. Those things, those functions of government happen here at the local level.

The loss of revenue due to the economic crisis of COVID–19 is going to severely diminish our ability to provide those basic services, and that is why direct funding from the Federal Government to local governments is desperately needed.

Former Speaker Tip O'Neill famously said that "all politics is local." While the solutions will likely be debated in Washington and our State capitols, they will be implemented where literally the rubber meets the road, right here in our local governments.

Thank you again for allowing me, Chairman Thompson, Ranking Member Rogers, Members of this committee, thank you for allowing me the opportunity to be here to advocate for local governments. I appreciate the opportunity to speak to you, and look forward to answering any questions that you may have for me.

Thank you.

[The prepared statement of Mr. Shelton follows:]

PREPARED STATEMENT OF JASON L. SHELTON

JULY 8, 2020

Chairman Thompson, Ranking Member Rogers, and distinguished Members of the Committee on Homeland Security, I would like to begin by thanking you for the opportunity to be with you today remotely to discuss the on-going devastating impact of COVID–19 to our great Nation, and, more specifically, to our local governments. The adverse impact of the public health crisis and the corresponding economic crisis caused by COVID–19 has had a direct negative impact on the ability of local governments all across our Nation to provide the basic Government services that every American depends on in carrying out their normal day-to-day activities such as getting to work, providing for their family, and having safety and security in their own community.

As you are aware, nearly 3 million Americans have already been diagnosed with COVID–19 and the number of deaths from COVID–19 is in excess of 130,000. While some loss of life due to the deadly global pandemic is likely unavoidable, in my opinion many of these deaths could have been prevented by a quicker and more uniform response by our Nation's Commander-in-Chief and his administration. Rational, stable, and consistent leadership, based upon medical and scientific data, is desperately needed from our Nation's highest office during this very real viral pandemic. Unfortunately, that is missing at the moment.

In the last 6 months, we have seen leaders of nations all over the globe respond to this deadly pandemic with rational science-based decision making and genuine concern for their citizens and their economies. We have seen leaders from all over the world step up and rise to the occasion. It is past time to see that type of leadership here in the greatest country on earth.

We must, as a Nation, listen to our scientists and our health care providers in responding to a medical crisis. If other nations have the ability to flatten the curve and reduce the number of deaths, then we also have that ability in the United States of America. Our Nation has 4.25 percent of the world's population, but over 20 percent of the world's COVID–19 cases. Our Nation has 4.25 percent of the

world's population, but over 20 percent of the world's COVID–19 deaths. That is a failure of leadership. This failure, in addition to the exacerbated public health crisis, has caused a tremendous amount of harm to our Nation's economy. The medical crisis and the economic crisis are interrelated and one cannot be fixed without fixing the other, and these two simultaneous crises are directly contributing to the hardships being faced by American families, American businesses, and local governments all across our Nation.

My purpose here today is to speak to the hardships facing local governments which are on the front line of responding to our Nation's health and economic crises. Mayors, municipal board members, county and parish leaders, and countless other local officials are doing all that they can to flatten the curve in their communities. Local officials are making local policies based upon the recommendations of Dr. Anthony Fauci and the National Institute of Allergy and Infectious Disease, the Surgeon General, the Center for Disease Control, State agencies, and their local medical communities. Their efforts, however, are being hamstrung by the lack of rational, stable, and science-based leadership from the White House.

In Tupelo, for example, by executive order, we recently instituted a mandate to wear masks or face coverings at indoor businesses. The request for our city to mandate this policy was made by the North Mississippi Medical Center, our Nation's largest rural hospital, which is based in Tupelo, Mississippi, and the Tupelo Economic Recovery Task Force—a bi-partisan group of approximately 40 business and community leaders in our city. While it appears that the majority of our citizens support and are in voluntary compliance with the executive order, a sizable number of people in our area are adamantly opposed to masks or face coverings for a number of reasons, none of which are science-based. The opposition is largely based upon conspiracy theories and what appears to be unofficial right-wing political propaganda. Many people appear to be of the belief that COVID–19 is simply a hoax designed to hurt the President politically. The President has an obligation as the leader of our Nation in both words and deeds to dispel these rumors and encourage our citizens to take every precaution to prevent the spread of COVID–19.

Because of these unchecked conspiracy theories and rumors, local leaders have an increasingly difficult time enacting common-sense measures to protect both the health of their citizens and their local economies. That compounds the needs of local governments which I am here to speak of today.

I have attached hereto as "Exhibit A" to my opening statement a narrative of the efforts of Tupelo, Mississippi to combat COVID–19, help our citizens, and re-boot our local economy.

A summary of those efforts are as follows: We instituted our emergency protocol on February 24, 2020 and formed our administrative team to respond to COVID–19 at that time; between February 24, 2020 and April 30, 2020 I executed 17 separate Executive Orders to do my best to combat the deadly virus and each of these orders were ratified and adopted by our City Council.

Among the measures enacted by executive order and adopted by our City Council was a mandate for our citizens and businesses to follow "The President's Coronavirus Guidelines for America." The Tupelo Economic Recovery Task Force also proposed and our city adopted the "Tupelo Economic Recovery Guidelines" which were formulated based upon the President's "Reopening of America" guidelines.

Both the President's Coronavirus Guidelines and the President's Reopening of America Guidelines were well-written and helpful in combating COVID–19 and would likely have had a tremendously positive impact had they been mandated nationally. Unfortunately, the President issued no such mandates and was highly critical of Governors and other leaders who actually mandated the very guidelines issued by the White House in their respective State or community. While the written documents called for a slow and measured approach based upon science and data, the public mandate from the President and many Governors was contrary to what was contained in those written documents. This has greatly hampered the ability of local leaders to respond due to the President's large and passionate following. This has had a direct adverse impact on the economy and financial ability of local governments all across the Nation to provide basic city services.

Due to the continued political climate surrounding COVID–19 our city continues to have difficulty in getting individuals and businesses to comply with safety measures to prevent COVID–19-related sickness and death in our city. This will prolong both the health and economic crises in our community.

Until we can slow the sickness and death in our community and across the Nation, it is impossible to truly stop the adverse economic impact to our local governments. That is why direct financial assistance to local governments for revenue loss is desperately needed.

On behalf of the citizens of Tupelo, Mississippi and as a member of the National League of Cities Small Towns Council, I would like to thank the Members of this committee and the Congress for acting swiftly to respond to the economic and medical crises caused by the deadly global viral pandemic of COVID–19. I applaud this body's swift bi-partisan effort to pass the various CARES ACT bills which provided much-needed relief to individuals, hospitals, businesses, and State governments across the country. In today's highly-politized climate it is increasingly rare to see the leaders of both parties come together so quickly to pass such historic legislation. The legislation helped virtually every level of our society.

The purpose of me being here today, however, requires that I speak candidly regarding to this issue to the honorable Members of this committee as to what I believe to be a significant oversight in the historic legislation.

Local governments under the acts were eligible for reimbursement for actual unbudgeted expenses incurred as a result of COVID–19. For many cities and local governments, however, the actual expenses incurred paled in comparison to the most significant harm incurred by local governments—the loss of revenue from the economic crisis caused by COVID–19. While the CARES ACT bills did many great things, the legislation unfortunately did not provide any means for local governments to recover lost revenue and went further to directly prohibit CARES ACT funds from being used to replace lost revenue by local governments due to COVID–19. I have attached a summary of the adverse financial impact to the city of Tupelo, Mississippi as "Exhibit B" to this statement.

By way of example, the State of Mississippi received over $1.2 billion of CARES ACT funds and not a single dollar of those funds could be allocated to a local government to directly help the local governments of our State recover from the substantial loss of revenue due to COVID–19. Like in other States, municipal governments in Mississippi receive a substantial portion of their revenue from local sales tax. Tupelo, Mississippi receives approximately 50 percent of our annual budget revenue from sales tax collections. Due to the economic shut-downs and societal shift to even more on-line shopping, that revenue, as indicated in Exhibit B, was greatly reduced for our city. The same is likely true for every local government in the country that depends on local sales tax revenue as a source of funding for their annual budget.

As Americans, we rightfully are often passionate about the larger issues that get debated in Washington, DC and in our respective State capitols, but it is at the local level where the rubber literally meets the road in American society.

The revenue loss in our city and in cities like us all across the Nation may mean that streets do not get paved or repaired, that litter pick-up and debris removal does not occur, that first responders and other public safety workers are laid off or furloughed due to the economic hardships faced by local governments, and that the opening of new businesses are delayed because of backlogs in the permitting offices or for a lack of building inspectors in the city. Virtually every business in America has to interact with a local government and the city services need to be available and timely available to keep our local and our National economy moving forward.

While the Federal and State governments have a large-scale impact on our Nation as a whole, the ability of every worker in America to actually get to work on time by way of a decent road or local transportation system depends on a capable and functioning local government. Every mom-and-pop business in our Nation has to depend on a local municipal or county (parish) government to make sure that the infrastructure is sound and that the community is safe to operate their business.

Fire fighters, first responders, police officers, code enforcement workers, sanitary water and waste removal, garbage and debris pickup, youth sports and adult recreation leagues, local parks, public works departments, and a host of other functions that have a very real and daily impact on the lives of every American are performed by the local municipal or county government where that person and their family lives. Those are the services being threatened by the loss of revenue to local governments due to the economic crisis caused by the health care crisis resulting from the global COVID–19 pandemic.

Former Speaker Tip O'Neill famously said that "all politics is local" and it is certainly true at this moment that while our Nation's response to COVID–19 may be debated in Washington, DC and in our respective State capitols, it is being felt the hardest in our local communities all across our great Nation.

As this honorable committee and this collective body continues to debate and deliberate upon our Nation's response to COVID–19, on behalf of all mayors and local officials and governments across our Nation, I would respectfully request that you consider direct payments for local governments to city and county (parish) governments for lost revenue. Unlike our Federal Government and even our State governments, our cities and counties (parishes), particularly in our small rural commu-

nities, do not have the ability to absorb significant revenue losses and also continue to provide the high level of services that our citizens and businesses expect and deserve.

Thank you again Chairman Thompson, Ranking Member Rogers, and distinguished Members of this honorable committee for allowing me the honor and privilege of being here today under this unique remote format to speak on behalf of our Nation's local governments.

ATTACHMENT A.—CITY OF TUPELO COVID–19 RESPONSE

Closely watching the COVID–19 pandemic unfold, the city of Tupelo responded early to be prepared with what was feared to be the largest public health crisis for the United States and our city since the Influenza Pandemic of 1917. On February 24, 2020, Mayor Jason Shelton issued an executive order which appointed Tupelo Fire Chief Thomas Walker to serve and administer the response to the Coronavirus threat for the city of Tupelo. At that time, an internal COVID–19 Response Team was formed. In the days following and with careful monitoring of the statistics in Mississippi and Lee County, many difficult decisions were made to prevent the spread of the virus. In total, there were 17 city of Tupelo executive orders through April 30, 2020 which addressed the evolving nature of the pandemic. Each executive order outlined restrictions based on COVID–19 local and State statistical data from Mississippi State Department of Health, CDC, Johns Hopkins University, and daily communication with health officials of North Mississippi Medical Center. Due to the rampant spreading of the virus, the city of Tupelo acted without waiting for the State of Mississippi's response, and issued a shelter-in-place executive order on March 21, 2020. Once the Governor's executive order was issued days later, the city ratified its orders to comply. Various issues were addressed in executive orders, including the discontinuing of water and light cutoffs as well as evictions during the pandemic.

Government is essential and city services must continue to be provided. Balancing the city government workforce to provide these services balanced with their health was crucial. After Mayor Shelton issued a declaration that Tupelo was in a State of Emergency, Tupelo City Hall and all departments were scaled back as much as possible. Those who could telework did so, and those jobs which required physically being on-site were accomplished with smaller groups. Tupelo City Hall remained open every day. Signage was placed on City Hall doors and other department doors with CDC guidelines regarding health symptoms, whether those entering had traveled, and other specifics. Appointments were encouraged to the public for all city of Tupelo business rather than in-person. Safety guidelines were put into place for all departments, and city workers were provided masks and hand sanitizer. Weekly department head meetings were conducted by teleconference with Zoom. In addition, Zoom teleconferencing was used for all Tupelo City Council meetings which were televised on Comcast and Facebook Live. As another way to stay connected to the community, the city of Tupelo produced a video "We Will Be Back" created to inspire and give hope during this difficult time. The video premiered on Facebook on April 24 and had almost 50,000 views.

Communication during the pandemic was and continues to be imperative. Because it affected literally all aspects of our community, there were many questions from our citizens. The first priority was establishing an effective form of communication. The city of Tupelo COVID–19 Team established an email where all questions and concerns could be sent. Inquiries were answered swiftly by the team. This was not only efficient, but also provided transparency and built trust with our citizens. In keeping with the importance of communication, Mayor Shelton was Facebook Live each day to update viewers with developments. All social media was utilized to the fullest as well as the city of Tupelo website, which had a complete section dedicated to COVID–19. This section was easily visible and accessible on the home page, and contained all Tupelo executive orders, State of Mississippi executive orders, and a Q & A list. Communication with other entities was key in staying informed. Administration participated in briefs from the White House, Governor's office, and had frequent calls with Community Development Foundation, Lee County Council of Governments, North Mississippi Medical Center, various industry and business leaders, and Tupelo Public School District. Staying in touch with all entities provided valuable information to respond to the changing needs in the community.

The huge economic impact was felt as most businesses and restaurants closed. Options were explored to help them overcome the challenges. Special accommodations were made to allow businesses to use public parking spaces for curbside and take out service. Accommodations were also made to allow for banners and signage without permits for businesses. Also helpful was the extension of the downtown

Tupelo leisure and entertainment district to include the entire city limits of Tupelo, which allowed restaurants to sell takeout alcohol with food sales.

With businesses facing unprecedented challenges, Mayor Shelton formed the Tupelo Economic Recovery Task Force, a cross-section of business and community leaders who themselves were dealing with the negative impacts of COVID–19, to advise him in creating meaningful strategies for restarting the local economy and for pursuing State and Federal assistance in supporting those efforts. The task force went to work immediately to communicate with leaders at all levels of government, working to ensure that the city of Tupelo comes out of this crisis as successfully and safely as possible. The Tupelo Economic Recovery Task Force has reviewed and approved plans laid out by Mayor Shelton and his administration to safely reopen Tupelo's economy while mitigating risk and protecting the most vulnerable. These plans, called the "Tupelo Economic Recovery Guidelines" are formulated from President Trump's "Reopening of America" as a foundational document with input from the citizen-driven task force. The guidelines will continue to comply with State and Federal orders.

The city of Tupelo has endured 2 devasting tornadoes in this century, the first in 1936 which cost hundreds of lives and massive infrastructure damage. In 2014 another tornado struck Tupelo, forcing the city to again rebuild businesses and homes. Geographically, Tupelo is located in "Tornado Alley", so being prepared is second nature to the city. With the forecasting of modern meteorology, the city prepares accordingly. On Sunday, April 12, tornadic weather was predicted for Tupelo. With the COVID–19 pandemic, every precaution had to be made in regard to public health. It was decided that all Tupelo storm shelters would be open. City employees manned each shelter, and hand sanitizer and face masks were given to everyone upon entering. There were cities which did not open their shelters due to the pandemic. But with Tupelo's unfortunate history of tornadoes, administration sided with the welfare of its citizens to provide shelter to keep families safe.

Although the physical illness of COVID–19 has been first and foremost in everyone's thoughts, the pandemic has also affected people both emotionally and mentally. From health concerns to financial burdens, everyone is dealing with some anxiety. Mayor Shelton recognized that a fun diversion would help to take minds off the pandemic for a while. He organized the "Mayors Music Series", which lasted 30 days. Each day at 5:30 p.m., viewers could watch Facebook Live for a free concert. Music was provided by local artists of various genres, and even included the lively entertainment of Elvis Tribute Artists from around the globe. The "Mayors Music Series" was a huge success, and actually had 2 goals. The first was to provide something fun to watch, especially to those sheltering at home. Second, it provided income to musical artists who had no work during the pandemic. Each artist was paid $500 each for their 30-minute show.

The collaboration of the city of Tupelo's outreach committee with many community partners served a number of needs in the community in response to the COVID–19 pandemic:

- The Tupelo-Lee Hunger Coalition provided thousands of lunches for students who receive free or reduced lunches. The packing of food boxes continues today, as many families depend on these weekly meals.
- Tupelo City Schools also provided grab-and-go services and meal delivery to homes with food insecurities. Mayor Shelton signed a "School Lunch Hero Day" proclamation recognizing the "men and women who prepare and serve school meals" to help nurture local children with their daily interaction and support.
- Project Search Students was organized to find job placement for Tupelo High School graduates with special needs. The students started their training with a rotation of job positions at North Mississippi Medical Center. Students are transported to and from their jobs by Tupelo Transit.
- The Mayor's Homeless Task Force and MUTEH continued their work during the pandemic. Welfare checks continued, homeless encampments were cleaned up, and housing was arranged through various organizations.
- Queen's Reward Meadery switched from making mead brandy to producing hand sanitizer. The city of Tupelo partnered with the local company for a drive-through free hand sanitizer giveaway on April 17 and April 24 at Tupelo City Hall. Each car received 2 bottles of the hand sanitizer.
- Toyota Mississippi and Mid-South Food Bank set up a mobile food pantry at the city of Tupelo's BancorpSouth Arena on April 20. Thirty thousand pounds of food was given away, with 500 slots available. This incredible donation served as many as 6,000 people.
- Money left in the city of Tupelo Tornado Fund (2014) established at the CREATE Foundation was used to assist needy families with basic necessities including diapers, formula, and toiletries.

- Downtown Tupelo Main Street Association provided masks and gloves for all merchants. They also provided on-line business seminars, virtual shopping platforms, created a website dedicated to relevant information for downtown restaurants and merchants, and other creative ways to support the Main Street Community during the economic challenges of the pandemic.
- MEMA conducted a drive-thru COVID–19 testing facility at the city of Tupelo's BancorpSouth Arena.
- Steve Tabor and 8 Days of Hope, along with American Family Radio delivered 20,000 meals for needy Tupelo families.
- Blue Delta Jean Company switched from making their custom blue jeans to making face masks for the community.
- United Way of Northeast Mississippi established a fund at the CREATE Foundation to assist families with needs and financial hardship of the COVID–19 pandemic.
- Saints Brew provided a grab and go take out breakfast for the homeless.
- Tupelo-Lee Humane Society offered drive-thru for those who volunteered for short-term foster care for dogs and cats.

The COVID–19 pandemic has been a challenging time for the city of Tupelo, as well as all municipalities. Using the information received from medical professionals, the city's administration and Tupelo City Council acted swiftly and thoughtfully to make decisions with public safety the priority. Reaching beyond the city's scope of services and collaborating with community partners, the city of Tupelo assisted thousands of its citizens affected in various ways by the pandemic.

ATTACHMENT B.—COVID–19-RELATED FINANCIAL IMPACT ON TUPELO, MISSISSIPPI

- BancorpSouth Arena is closed due to COVID–19, which is anticipated to cost tax payers almost 1 million due to the loss of revenue; part-time employees have been eliminated.
- Tupelo Convention and Visitors Bureau revenues were trending up prior to COVID–19. Tupelo anticipates a drop of 20 percent of the tourism tax revenue compared to last year's collections without considering the growth we experienced prior to COVID–19. The projected loss amount as of June 30 is $830,000. This could change for better or worse as we approach the July 15.
- Tupelo Parks & Recreation loss of revenue has cost the city approximately $200,000. Indirect revenue from Parks & Recreation events is much higher.
- Tupelo Municipal Court revenue has dropped $100,000.
- Tupelo Aquatic Center indirect revenue has dropped as facility was closed (economic loss due to canceled events).
- The General Fund has been slashed with a cut of more than $500,000 to City Departments.
- The city has incurred $250,000 in overtime pay pursuant to the city of Tupelo's Emergency Policy.
- PPE and protective measures cost the city over $35,000.
- The city of Tupelo sales tax dropped $557,000 for March and April combined. The true loss is $630,000 since our pre-COVID–19 numbers were up 2 percent. Collections for the remaining fiscal year are unknown at this point. Prior to COVID–19, Tupelo had experienced 6 consecutive years of record-breaking economic growth.
- The city of Tupelo's Capital Plan decreased $1,000,000 for the revitalization efforts due to budget cuts.
- Total budget cuts of 2.5 million for the city of Tupelo.
- The true impact of COVID–19 remains to be seen. The provided numbers reflect the financial impact that can be determined at this point.

Chairman THOMPSON. Thank you for your testimony.

I now recognize Dr. Shah to summarize his statement for 5 minutes.

STATEMENT OF UMAIR A. SHAH, EXECUTIVE DIRECTOR AND LOCAL HEALTH AUTHORITY OF HARRIS COUNTY PUBLIC HEALTH, TEXAS

Dr. SHAH. Thank you, Chairman Thompson, Ranking Member Rogers, and Members of the committee and subcommittee. Members of the Texas delegation, Representatives Sheila Jackson Lee,

Al Green, Dan Crenshaw, and Michael McCaul, I want to thank all of you in particular.

My name is Dr. Umair Shah. I am the executive director and local health authority for Harris County Public Health. I am past president of NACCHO, that represents the nearly 3,000 local health departments across the country.

Harris County is the third most populous county in the United States with 4.7 million people, including the city of Houston as one of the most diverse and fastest-growing metropolitan areas. The population in our community is larger than 25 States.

We are no stranger, unfortunately, to emergencies such as storms, hurricanes, fires, and infectious disease responses. From a public health standpoint, there truly is never a dull moment in our community.

Unfortunately, the present COVID–19 pandemic has had an unprecedented impact on our community and our Nation well beyond health, and has undoubtedly tested the resolve of the American people.

Harris County Public Health has responded to H1N1 for 18 months back in 2009, 2010, but tomorrow marks only the 6-month mark for COVID–19. It is truly a marathon not a sprint.

Today I am here to make 3 main points. One, we as a Nation still have the opportunity to fight this pandemic but only by working together. No. 2, all eyes are on Harris County in Texas right now, and despite being successful previously, the situation has now changed. No. 3, public health is key, and we must support and invest in it.

Let me start by saying that the local response to COVID–19 led by Harris County Judge Lina Hidalgo has been strong, decisive, and proactive, and has worked closely with other area officials, including Houston Mayor Sylvester Turner.

Case in point, Harris County released its Four T's approach for addressing COVID–19—test, trace, treat, and teamwork—from March to May. This approach saw the Houston Harris County community working together successfully to flatten the curve.

More recently, the story has changed. Our community has seen an increase in cases, the percentage of tests that are coming back positive and hospitalizations, including in our county's safety net hospital system. Our threat level for COVID–19 has been raised to red, its highest level. We now have over 39,000 cases and 400 deaths in Harris County.

The changing picture in Harris County demonstrates what I have called the layering effect of reopening in Texas on top of events and holidays, such as Mother's Day, Memorial Day, protests and marches, further layering exposure and risk to our community.

Inconsistent messaging at the Federal, State, and local levels have led to further confusion and complacency at the individual community level. Case in point, CDC has not been consistently visible as the Nation's voice of public health.

In Texas, while many local officials, elected and health authorities alike, stated clearly that our State was reopening too quickly, the process of reopening continued. Powers of authority previously available at the local level were removed. Fortunately, the State has now begun to dial back reopening. Reopening responsibly

means that decisions should be driven primarily by health and medical, while balancing other interests.

Public health often gets the short end of the stick. It has been chronically underinvested in. I call this the #InvisibilityCrisis.

While I have come to this committee before to share similar points, enough is enough. We need to take this seriously if we are ever to correct the course in time to protect our communities. Yet when we need it the most, public health is still largely invisible, underappreciated, and underfunded.

The COVID–19 public health work force has been working well beyond 40 hours a week, available 24/7, months on end. The public health front line is committed, but it is facing burnout and stretched to its limit. In the span of 4 months, our department has doubled its own work force. Our epidemiology team has gone from 25 to 500. This massive scaling for COVID–19 has proven necessary, but without reliable and secure funding outside reactionary and supplemental funds, it is simply not sustainable.

Daily, our leadership juggles needs between the central public health services and the COVID–19 response, and we are not alone across the country. This is where the Federal Government comes in, the primary financing mechanism to expand capacities through CDC's ELC grant. For example, our department is ineligible for direct funding, yet the same mechanism has been used for the COVID–19 response.

The pandemic must be fought together. It is felt like every health department has been left on its own trying to create new systems response in real time. While Federal support is appreciated, Federal testing sites were planning to cease operations at the very time we were seeing increasing need. Similar issues are likely to play out again when vaccinations become available, meaning proactive planning for vaccine distribution is needed soon.

Although scaling of testing has increased, results take too long to reach health departments, especially at government-supported sites. The data exchange is moving slower than the disease. With this delay, public health measures become less effective. This is especially true for those most vulnerable, such as disproportionately-impacted communities and those in congregate settings. We are equally concerned with the health inequities seen in Hispanic and African American communities in this response.

If the Federal Government expects there to be robust systems of surveillance, better data informatics capacity is needed at the local level. This includes CDC's support for innovative study of disease patterns in Harris County, utilizing state-of-the-art technologies, and genetic sequencing.

As a workaround, our department has had to develop new data systems, public-facing data dashboards, and on-line screening tools for testing on its own. Those local efforts are necessary to get the job done, but they are reactive as National efforts to modernize such systems have failed.

Let me close by saying the pandemic is an unprecedented time for our country. We are being tested like never before. Smart, strategic, scalable, and sustainable investments are needed now. All eyes are on Texas and Harris County. We should be able to look to the Federal Government for leadership and support.

On behalf of Harris County Public Health and our public health colleagues across the Nation, the offensive line of the football team, I appreciate again the opportunity to testify today. Along with our local leadership, we join you in working together in fighting COVID–19 to protect our National security, our economic vitality, and the very health of our people.

Thank you.

[The prepared statement of Dr. Shah follows:]

PREPARED STATEMENT OF UMAIR A. SHAH

JULY 8, 2020

My name is Dr. Umair A. Shah, and I am the executive director for Harris County Public Health (HCPH) and the Local Health Authority for Harris County, Texas. I am a past president and former board member of the National Association of County and City Health Officials (NACCHO). NACCHO is the voice of the nearly 3,000 local health departments (LHDs) across the country. I am also a past president and current board member of the Texas Association of City and County Health Officials (TACCHO) which represents approximately 45 LHDs across Texas.

Today, I particularly want to acknowledge Michael "Mac" McClendon and Jennifer Kiger, 2 Nationally-recognized leaders in emergency planning and response, who serve as our Department's deputy incident commanders for COVID–19. They oversee an incredibly strong response team who have all dedicated countless time and effort in protecting the Harris County community.

NEVER A DULL MOMENT

Harris County is the third most populous county in the United States with 4.7 million people, including the city of Houston, and is one of the most culturally diverse and fastest-growing metropolitan areas in the United States. We are home to the world's largest medical complex, the Texas Medical Center (TMC), one of the Nation's busiest ports, the Port of Houston, and 2 of the Nation's busiest international airports.

Harris County is no stranger to significant events, disasters, and large-scale emergencies. These range from natural to infectious disease in nature: Tropical Storm Alison (2001); Hurricane Katrina sheltering (2005); Hurricane Ike (2008); Hurricane Harvey (2017); Tropical Storm Imelda (2019); nH1N1 influenza pandemic response (2008); West Nile virus (WNv) response (2012); Ebola readiness & "response" activities (2014–2015); human rabies death and canine rabies, respectively (2008 and 2015); Zika virus (2016–2017); measles "resurgence" (2019); and 3 large-scale chemical fires (2019). From a public health response standpoint, there truly is never a dull moment in Harris County.

Unfortunately, 2020 adds more to this list, with COVID–19 being the summation of all of these emergencies both due to length of response and more importantly its impact. As our department sent out its first official health alert to regional health care partners on January 9, tomorrow marks fully 6 months into the HCPH COVID–19 response and we are nowhere near the end. It is truly a marathon and not a sprint when it comes to our response activities and the toll it has taken on our community.

The first cases of COVID–19 in Harris County were tied to an Egypt cruise tour in late February and a number of milestone events and phases have occurred since that time. Our department has been responding continuously since then; yet we are reminded that during nH1N1, HCPH was activated for 18 months and that was a mild pandemic in comparison. Although we are months into the pandemic, responding to the immediate and long-term impacts of COVID–19 will take years. The pandemic will likely ebb and flow, and does not have the distinct start and end of an emergency such as a hurricane. Preparedness, response, and recovery phases will blur and need to be addressed in tandem.

COVID–19 RESPONSE

As you know, local health departments are the chief health strategists for their communities. In January, HCPH in coordination with the Houston Health Authority, Dr. David Persse, began hosting coordination meetings and planning with partners well before the first case of COVID–19 ever reached Harris County. We dis-

cussed then that it was not a matter of "if" but rather "when" COVID–19 would impact our community directly.

These partnerships have continued dynamically throughout the response. Important twice-weekly calls are held with regional local health authorities as well as separately with the health care community through TMC. Key and timely communications and response efforts directed by Harris County Judge Lina Hidalgo have been coordinated through the Harris County Office of Emergency Management & Homeland Security and with other county partners. These have been crucial to real-time coordination and the elimination of barriers to response. Earlier in March, HCPH partnered with Judge Hidalgo to release the foundational "Four T's" approach for addressing COVID–19 (Test, Trace, Treat, and Teamwork). More recently, the COVID–19 Threat Level System was unveiled in June to help the community understand the continued importance of COVID–19 prevention efforts for Harris County.

In addition to coordination with a multitude of partners, LHDs such as HCPH play primary roles in disease surveillance and providing guidance to the community that are unique from most of its partners. Preventing spread without available medical countermeasures has been a real issue in the COVID–19 response since there are no vaccines or pharmaceuticals by and large that can address the myriad of issues that COVID–19 presents. This means focus by LHDs on tried and true public health measures such as communications coupled with specific activities such as contact tracing, congregate setting assessments and testing, and community testing are keys to a successful response. These further the main goal of interrupting disease transmission and put a stop to the pandemic.

HARRIS COUNTY, TEXAS . . . AN INCREASING HOTSPOT FOR COVID–19

Harris County, led by County Judge Lina Hidalgo, and Houston, led by Mayor Sylvester Turner, were rightfully proactive in recognizing the pandemic's threat and proactively engaging the community. On March 11, the Houston Rodeo, a pillar event for the community (it generated $300 million for the local economy in 2019), was canceled as soon as there was evidence of the first case of community transmission in the Harris County area. Shortly after, Harris County was one of the first in Texas to issue a "Stay Home, Work Safe" Order to protect Harris County residents.

While not easy, fortunately, the Harris County community listened, and our community was successful in flattening the curve. In fact, Harris County's case and death rate trailed far behind other major communities such as LA, Chicago, and New York City through the earlier stages of the response.

However, to the detriment of public health, those orders quickly became political and the State took away all local authority to issue any orders more restrictive than its own, including the requiring of masks. Of note, the State's stance on masks, just last week, has now changed which is a welcome step but time will tell if it is too late in the response to have the necessary effect. Regardless of whatever level of government it involves, decisions driving the response to the COVID–19 pandemic should be driven by public health and medical experts without the fear of retribution or political interference.

The spike in Harris County today demonstrates what I have called the "layering effect" of reopening. Starting May 1, 2020, Texas began reopening its businesses such as dine-in restaurants, retail, salons, gyms, bars, and more. The layering effect occurred with these reopening alongside holidays and milestone events such as Mother's Day, Memorial Day, protests and marches, Father's Day, etc. that then "layered" exposure and risk to the community. The effects were even more pronounced as inconsistent messaging at the Federal, State, and local level meant that there was simply confusion and complacency at the individual community member level. While local officials—elected officials and health authorities alike—stated clearly that Texas was reopening too quickly, the process of reopening continued and slowly one began noting an increase in numbers of persons testing positive for COVID–19 alongside hospitalizations in Harris County and in other parts of Texas.

Much of the success during the prior phases of response has been wiped out as these numbers have begun to climb. As of July 6, Harris County has over 36,000 cases and 400 deaths with a steady increase of late, necessitating the community's threat level being moved to its highest level (red). Harris County now has the highest cumulative case count in Texas, surpassing Dallas County. While Texas has now taken steps to "dial back" reopening and require the wearing of masks, the damage may already have been done as our local health care system is very busy now and implementing necessary surge plans. It is not just the cumulative numbers that are concerning but the fact that previously 1 in 8 tests in the community were coming back positive for COVID–19. In the last few weeks, this positivity rate has now in-

creased to 1 in 4 tests being positive, or about 25 percent of tests being conducted in Harris County.

The impacts of COVID–19 are beyond just case counts unfortunately. HCPH evaluated the health of Harris County in a milestone report Harris Cares: A 2020 Vision for Health in Harris County released in late 2019 (prior to the COVID–19 pandemic) and found major health disparities. More recently, the Harris County Commissioners Court Analyst's Office released a report, Disproportionate Impact of COVID–19 on Low-Income and Minority Households, stating that "the fallout of the COVID–19 outbreak is exacerbating existing financial, health, food, and economic challenges of low-income persons and communities of color." The impact to the economy, the community's physical and mental health, and effects of delayed care (e.g., addressing heart disease or diabetes, children's immunizations, etc.) are on-going and will be felt well after the pandemic stabilizes. Several recommendations from Harris Cares, especially its focus on health equity and community voice, data sharing capacity before emergencies, local governance, and sustainable financing would have greatly enhanced HCPH's response to COVID–19.

#INVISIBILITYCRISIS

I spoke previously in Congress about the fact that public health is often times invisible when it does its work. This so-called "Invisibility Crisis" (or #InvisibilityCrisis) means that we have a real problem in our Nation when it comes to recognizing the importance of the often behind-the-scenes work that public health is engaged in each day. However, the invisibility crisis that has kept public health an under-recognized workforce has put Local Health Departments (LHDs) like HCPH undervalued and under-invested in over the decades. This is the recipe for disaster when one is faced with a public health crisis like COVID–19 where public health is expected to be front and center leading the response.

The public often recognizes the vital role of other first responders, such as EMS, Fire, or Police, but the substantial role of public health and the public health workforce before, during, and after a crisis often goes unacknowledged.

WE'VE BEEN HERE BEFORE

As Judge Hidalgo raised the threat assessment level to red, I stated "enough is enough" to our community in addressing the seriousness of the situation here in Harris County. To this committee, today I stand before you to say also "enough is enough"—we have let the COVID–19 pandemic get out of hand in this Nation and must do everything we can to correct the course before more people get infected and more people die.

We need to take my recommendations given to the 2017 House Budget Committee seriously:

- Public health is underfunded and undervalued, yet is absolutely critical to protecting our communities even when its work is largely invisible.
- Public health is like the "offensive line" of a football team—rarely recognized for the success of the football team but absolutely critical, nonetheless.
- Public health and its capacity must be invested in a sustainable and proactive way.

This #InvisibilityCrisis has unfortunately led to funding cuts for public health and even more so, public health emergency preparedness at every level of government over time. Despite the significant impact on the community's overall health and well-being, public health is largely invisible, under-appreciated, and as a result underfunded.

These issues are further exacerbated when public health agencies are confused for health care. Yet even now it has been forgotten that COVID–19 is a public health crisis with secondary impacts in health care. Taking the offensive line metaphor further, the health care system is perceived as the all-important "quarterback" and thus receives the attention (and the funding) which makes our communities less safe. It is important to note rising COVID–19 hospitalizations and deaths are an indicator of failure to contain the pandemic through prevention measures that should have happened at the community level. Coming together to support the community while respecting the crucial role that both public health and health care play in fighting the virus is imperative to keeping communities and the Nation safe.

In 2019, I testified before this committee that strong public health agencies at all levels of government are important because (just as in medicine) there is a science and an "art" to public health decision making. All levels of government, Federal, State, local, must coordinate better with each other (and globally) in response activities and planning for the next phases of the COVID–19 pandemic.

SMART, STRATEGIC, SCALABLE, AND SUSTAINABLE SOLUTIONS

The best way forward is a path that allows all of us to work smarter not harder. Solutions should be strategic and scalable actions to ensure the COVID–19 response is meeting the needs of the community.

Solutions jump-started now must be sustainable beyond COVID–19 to fix long-standing issues that have plagued public health and ensure we are prepared for future threats. HCPH supports recommendations offered by NACCHO, the Council of State and Territorial Epidemiologists (CSTE), as well as recommendations offered to the Senate Health, Education, Labor, & Pensions Committee on June 23, 2020, regarding "COVID–19: Lessons Learned to Prepare for the Next Pandemic." Further, HCPH offers the following additional recommendations:

Public Health Workforce Crisis

1.1 LHDs needs sustainable and consistent financing to secure the workforce and scale our response appropriately. LHDs depend on mixed sources of funding that are either declining or unreliable.

1.2 LHDs need investment in workforce development to ensure adequate recruiting, retention, and succession planning is available throughout the response both for continuity of essential public health services and dynamic COVID–19 response.

Inadequate Public Health Financing

2.1 Congress should require CDC to report on how much Federal funding, especially for COVID–19 such as Epidemiology Laboratory Capacity (ELC) funding, actually reaches LHDs via State health departments. Congress should explore per capita funding formulas direct to local health departments. Although existing ELC mechanisms may be the fastest way to distribute to many local health departments today, it is not equitable and leaves many populations (such as in the non-Houston portion of Harris County) untouched.

2.2 Congress should increase funding for Public Health Emergency Preparedness and review funding directed to LHDs as part of other health care finance reform initiatives such as through Medicaid reform as a sustainable mechanism for local health departments. Supplemental and reactionary appropriations are necessary now, but do not allow for planned scaling of response or preparation for future crises such as pandemics.

2.3 Congress and States (in partnership with local authorities) should coordinate to explore the services provided by LHDs and clarification of jurisdictional lines by the Nation's web of LHDs and authorities to inform public health system reform.

Federal Communications and Coordination

3.1 CDC should be made front and center as a leader in the current pandemic and communicate clear honest, and consistent guidance with the public on prevention messaging. Inconsistent policies and/or messaging at the Federal, State, or local level creates undue confusion and complacency at the individual community member level.

3.2 Scaling of testing (including through Federal sources such as Federal Emergency Management Agency [FEMA]) should also include coordination with LHDs and public health to expedite case investigation and contact tracing. Testing support should be available when demand and positivity rates have increased.

3.3 Proactive planning is needed now with Federal, State, and local governments on vaccine distribution plans and communications. This is especially important as many LHDs will continue to handle other important response responsibilities at the time that vaccines become available further exacerbating the issue. Operational roles and responsibilities should be delineated before a vaccine is developed.

Disparate Disease Surveillance

4.1 Health and Human Services (HHS) and CDC should support standardizing data platforms across State and Federal level for intake of lab data before sharing back to locals. While there is funding to support States in modernizing platforms, locals are not funded to develop or maintain surveillance and reporting systems as they have been forced to do for COVID–19.

4.2 If Congress expects efficient surveillance, the Federal Government needs to encourage States to bolster local surveillance capabilities for contact tracing and case investigation that are interoperable across jurisdictions.

4.3 CDC and other Federal partners should coordinate through coalitions such NACCHO, Council of State and Territorial Epidemiologists (CSTE), etc. to provide technical assistance to local health departments on policy and planning, data, epidemiology, and other LHD needs. In fact, HCPH has had to reach out directly to many

local health departments across the county to share best practices and feedback due to a lack of such sharing mechanisms in comparison to previous emergencies.

4.4 Congress should invest in modern and responsive data systems, such as the National notifiable disease surveillance system (NNDSS), electronic case reporting (eCR), syndromic surveillance, electronical vital records systems, and laboratory information systems. Technology alone is not the solution, and data informatics workforce also needs support at the local level.

LOCAL HEALTH DEPARTMENT PAIN POINTS DURING COVID–19

PUBLIC HEALTH WORKFORCE CRISIS

Local Health Department Perspective

Findings from NACCHO indicate State health departments and LHDs have lost nearly a quarter of their workforce since 2008, shedding over 50,000 jobs across the country. The deficiency is compounded by the age of the public health workforce—nearly 55 percent of public health professionals are over the age of 45 and almost a quarter of health department staff are eligible for retirement. Between those who plan to retire and those who plan to pursue opportunities in the private sector (often due to low wages), nearly half of the local/State health department workforce might leave over the next several years. Further worsening matters, several public health leaders across the country have been threatened, fired, or pushed out of their job role leaving it necessary to find qualified persons available to take over during a pandemic.

Epidemiologists are the disease investigators and backbone of the COVID–19 response. In order to support epidemiologists in investigating cases and offering control measures, the workforce must also include communications staff to push prevention messaging, data analysts to explore trends and visualize outbreaks and case data, logistics and clinical support for testing and operations, social services and wraparound support for assisting with quarantine and isolation, administrative and business support for massive scaling, policy analysts, and more. Unfortunately, staff in public health across the Nation—the invisible workforce—are mission-driven but unduly stretched. The LHD workforce is diverse, facing burnout, and stretched to its limit.

HCPH COVID–19 Response

By March 2020, the workload and strain on the HCPH staff to respond to COVID–19 was so great, one of the first internal wellness initiatives was to bring puppies and kittens from the HCPH Veterinary Public Health Division to help our epidemiology staff destress. We began instituting regular mental health sessions, which we have since expanded. Eventually, it was not about mental health breaks, it was having more work than the current workforce had the capacity to handle. In the span of just 3–4 months (March–June), we have doubled the size of HCPH.

Before COVID–19, HCPH was staffed with a workforce of approximately 650. Today, we have doubled to almost 1,300 employees and contractors. The HCPH COVID–19 response has grown from 30 staff members under the Incident Command System (ICS) to just under 900 while the HCPH epidemiology group grew from about 25 to 500 staff with 300 contact tracers alone on-boarded by May 22. COVID–19 has proved this scaling is necessary, but without reliable and secure funding outside of reactionary and supplemental funds, LHDs are not prepared for the next pandemic or long-term planning.

Rapid scaling of HCPH has placed immense strain on our system, and it has required an intense focus on quality control and continuous re-alignment of skill sets. The response has pulled staff from across the health department leaving many critical roles for continuity of operations vacant. Dentists were needed to collect specimens at testing sites. Food safety staff continue to provide data and administrative support for our epidemiologists. Mosquito control staff coordinate teams for mobile operations and contact tracing. Every week, our command staff review workforce needs for public health essential services and the COVID–19 response in order to shuffle staff, accommodate conflicting needs, and "right size" the response. Continuity of operations for non-COVID–19 public health services is near impossible for a response that has no clear end in sight.

INADEQUATE PUBLIC HEALTH FINANCING

A Local Health Department Perspective

LHDs work hard each day to meet the needs of the community and often operate on a tight budget. To this immense work and tight budget, public health added the COVID–19 response. Infrastructure investments must be made now to further

strengthen, enhance, and scale up the ability of public health agencies and others to meet demands for future COVID–19 vaccinations and for mitigating the long-term health impact of COVID–19.

Health care finance reform has been the topic of discussion for decades. Sweeping health care financing reform, although necessary, does not translate to sustainable public and population health capacity. Public health prevention infrastructure has never been funded robustly enough to limit health care costs.

However, over the last decade public health has faced steep declines and threats to financing. Public Health Emergency Preparedness funding streams have steadily declined since initial allocation after 9/11. In Texas, instead of expanding Medicaid, the State submitted an 1115 Waiver that is set to expire in 2022. The direct participation of LHDs accounted for 15 percent of the total DSRIP pool, or about $1.7 billion in Texas. 1115's were an unprecedented and novel pipeline to LHDs for Medicaid dollars. No other mechanisms exist for LHDs in Texas to secure Medicaid funding, despite being a critical component of the safety net.

Public health financing reform is inhibited by the lack of formalization and designation of LHDs in State and Federal regulation. Not all LHDs are created the same and offer vastly different services locality to locality. Without a massive effort to inventory provided services, better understanding of jurisdictional lines and amount of population served, and coded designations across State and Federal Governments for LHDs it is difficult to jumpstart system reform and revise funding formulas.

The primary financing mechanism for State and local governments to expand their epidemiological capacity is through CDC's Epidemiology and Laboratory Capacity (ELC) Cooperative Agreements. These dollars are directed toward 50 States and 6 major cities. However, allocation from States down to local governments has fluctuated and many LHDs are unsure if the funding provided will be able to last throughout the pandemic.

The ELC funding formula for cooperative agreements to the true "boots on the ground" LHDs is flawed and outdated. After distribution to States, locals often do not receive a significant portion of these dollars to expand their surveillance capacity even though they are expected by their residents to provide surveillance, maintain personalized dashboards, and conduct case investigations themselves. This disparity for LHDs is compounded as CDC continues to use this funding formula for supplementary funding throughout COVID–19 response, continuing to leave many LHDs expected to perform out of the direct funding loop. Accountability and oversight to States and CDC are needed to ensure the Congressional intent of allocating funding to LHDs is fulfilled.

HCPH COVID–19 Response

To scale the COVID–19 response and sync with closing of businesses, several essential public health services have been impacted such as restaurant inspections, mosquito abatement, clinic-based services, Grant funded projects have been slowed, sometimes to a complete halt, with requests for extensions being made across the board. For COVID–19 response, HCPH has had to divert limited resources from elsewhere in order to scale some of the most important tools available to fight COVID–19. HCPH's financial and grant portfolios are at risk alongside many other LHDs across Texas and the Nation.

For fiscal year 2020–2021, HCPH had an operating budget of $121 million, comprised of 53 percent grant funding, 32 percent local funding, and 15 percent special revenue funding. Making matters worse, HCPH has spent approximately $25 million for COVID–19 over the course of 6 months and has only received $4.4 million through discretionary and supplementary Federal support to date (as pass-through dollars from the State). The majority of costs for COVID–19 response will likely have to leverage county disaster funds. These local disaster funds are not a sustainable solution for public health response and planning. When activating grant funded staff and resources for COVID–19 response, LHDs face the threat of not being able to charge back grants for staff time though the individual remains an LHD staff member. Had there been more robust infrastructure and regular funding for public health before COVID–19, LHDs would have been better poised to respond in more cost-effective and timely manner.

CARES Act funding was passed to support counties and cities alike, but without direct designation for LHDs, allocation is likely to be limited for public health since funding constraints mean there is competition for these precious dollars across local governmental systems. However, one promising step related to the CARES Act funding formulas is that it has clear guidelines on shared city and county allocations based on population size. This is not the case for example with ELC funding. For ELC and other Federal funding intended for local health departments, funding for-

mulas should be reviewed to ensure LHDs such as HCPH receive their appropriate share (whether based on per capita or another reasonable basis) in a manner similar to the CARES Act funding for local governments as a whole.

FEDERAL COMMUNICATIONS AND COORDINATION

Local Health Department Perspective

From the outset of the COVID–19 crisis and continuing today, the public has received mixed and contradictory messages on the severity of the outbreak, the differing roles of Federal, State, and local government, the availability of tests, potential treatments, the appropriateness of masks, and time lines and approaches for shutting down non-essential businesses and reopening. CDC has not been publicly visible as the Nation's apolitical voice of public health. LHDs are less effective to respond to early outbreaks when Federal, State, and local health messaging and communications are not in sync.

HHS agencies (especially ASPR and CDC) have not coordinated with States and LHDs on how best to access strategic National stockpiles at the Federal, State, and local level. As a result, unnecessary confusion has existed on Federal, State, and hospital-level responsibilities in procuring PPE and testing supplies. Due to shortages, hoarding, increased market prices, and competition between locals, States, and even hospitals the supply chain was unduly compromised.

Inconsistent or unavailable guidance from the Food and Drug Administration (FDA) on Emergency Use Authorizations (EUA), especially for the reliability and availability of emerging testing technology, has pushed LHDs to have to internally track unreliable vendors for testing kits. This has been problematic throughout the response because vendors have reached out directly to local health departments and local elected officials.

Proactive planning is needed now with the Federal Government on coordination for mass vaccinations.—The Federal Government should seek input from local governments on how to best operationalize a COVID–19 mass vaccination. As was done during 2009 H1N1 response, Federal and State governments should work with private partners to distribute the vaccine while having a set priority criteria to ensure the vaccine is available to those at most need first. Local public health departments cannot be expected to run the mass vaccination operation while also continuing other key response activities. Delineated roles and responsibilities should be in place before a vaccine is developed so wide-spread distribution plans among private and public partners is clearly laid out.

HCPH COVID–19 Response

Since March, HCPH has been supported by 2 FEMA fixed-site testing locations in Harris County (2 additional FEMA sites are within the city of Houston jurisdiction). These sites were set to cease Federal support by June 30—at the very time that Harris County was seeing increasing demand for testing, increase in cases, and increase in positivity rates for tests performed. To maintain Federal support for testing, HCPH requested that FEMA remain for 2 months. After much advocacy at the local, State, and Federal level, FEMA fortunately agreed to continue its testing support for longer. However, it is still scheduled to cease this support by July 14 even while testing remains more important than ever.

In addition to the Federal testing support, in order to meet additional testing demand throughout Harris County, HCPH has partnered with private labs to provide testing at home, in mobile locations noted as "testing deserts" (utilizing county-owned mobile units), and through testing strike teams for congregate settings. In fact, HCPH has spent $16 million (of its total $25 million expenditure) on testing efforts in Harris County. Overall, to date, HCPH has tested 100,000 residents.

While things have become more coordinated now, earlier in the pandemic, lack of coordination resulted in disjointed contracting and securing of supplies and resources, many of which were largely unavailable because they were also held by the Federal Government. Local partnerships were needed to create local supply chains for PPE and testing supplies. Without consistent or reliable testing options, HCPH had to secure its own stockpile and build systems for local supply chains and donations. When faced with shortages in viral transport media that threatened operations, HCPH had to consider even retrofitting its mosquito control lab to have capacity to produce 5,000 vials per week. At times, it felt every LHD was left on its own trying to create a system for response in real-time due to these limitations at hand.

Scaling of Government-supported testing sites has not resulted in expedited contact tracing or scaled prevention because results are not readily available to LHDs. In Harris County, FEMA community-based testing centers instructed people being

tested to contact their local health department for their results when HCPH was not part of the system and had no way to access the test results. Because Federal testing sites utilized labs outside of the State, results were delayed weeks before the LHD was ever able to access the result. This resulted in wide-spread frustration with LHDs such as ours and the residents we serve. Scaling of congregate and mobile testing through the State of Texas done without full public health engagement has resulted in similar issues for Texas.

In fact, HCPH has faced strong pushback from congregate settings to investigate and test within facilities, in part due to overlapping State and Federal jurisdictions of facilities. The Federal Government should partner with States publicly to empower local health departments to assess and test congregate facilities such as nursing homes, assisted living, homeless shelters, detention centers, etc. due to the concern about increased risk in these settings.

DISPARATE DISEASE SURVEILLANCE

Local Health Department Perspective

Efforts to modernize public health surveillance and data systems have been made over the years, but the categorical, disease-specific approach to funding and implementing improvements has resulted in uneven progress.

The Nation's public health infrastructure is so fragmented and antiquated that health care providers who already have the data collected and stored in electronic health records cannot rapidly share these health data because LHDs cannot receive them electronically. The data is moving slower than the disease. LHDs are responsible for investigating cases and notifying potential contacts to break chains of transmission, but that job becomes impossible when data shared to LHDs is inconsistent, missing key information, or delayed. This issue area is not new and has plagued public health response regularly.

Data Gaps for Timely Investigations

1. Labs have consistently reported incomplete results to State health departments (which are in turn later shared to LHDs) through multiple data pipelines, including facsimile (i.e., fax). LHDs must perform background checks for basic contact information of known cases when data is incomplete. Although HHS released guidance on data fields that must be reported to States starting August 1, it is far too late and limited mechanisms exist for enforcement.

2. Across the Nation, there are unclear jurisdictional lines of LHDs and authorities. As mentioned above, without formal designations and definitions of LHDs, States and the Federal Government often send results outside of the LHD jurisdiction hoping that LHDs will work together to share across the system. However, there is limited interoperability, if any, to share efficiently case and contact information across LHDs and no way to ensure cases are not falling through cracks.

3. Disparate disease-specific surveillance systems exist for many LHDs. Data collection requirements from the State and CDC during the case investigation and monitoring of cases have consistently been modified throughout the response. No system has proven robust enough to meet local needs for reporting data requested in multiple formats, including fillable PDFs and spreadsheets. Additionally, surveillance systems lack the ability to measure key performance indicators which are often needed to justify funding. Locally-created solutions to track disease and performance of contact tracing have required real-time development alongside an ongoing pandemic.

4. LHD epidemiologists must manually call infection control practitioners to track the status of hospitalized patients because consistent access to electronic health records is not consistently available to LHDs. Hospitals are required to send data directly to Federal and State governments, but no interoperability exists for LHDs to access and analyze health care data directly for surveillance, decision making, or planning.

5. Technology solutions for disease surveillance are not feasible without stronger investment into dedicated informatics workforce support at the local level as well as hardware availability.

Disease Modeling and Planning for Local Officials

Additionally, LHDs are expected to provide disease trend analysis and modeling projections to inform local decision making on non-pharmaceutical interventions and planning. Although many Federal modeling and projections are available at the State level, no sufficient options exist for LHDs to maintain situational awareness. Local models and dashboards from academic partners and others have been ad-hoc and inconsistently maintained. Without accessible health care data, aggregate data must be manually scraped from reporting health care coalitions to inform health

care utilization projections. LHDs need disease modeling support, especially when the population of some LHD jurisdictions is comparable to the size of small States (of note, Harris County itself has a population larger than 25 States).

Data analysis support is also needed to determine local outbreak trends and prevalence for granular, place-based decision making that can inform local operations such as congregate setting outbreaks or super-spreading events. Index case and social network analysis is impossible without shared contact trace and case information across jurisdictions. If Federal Governments expect efficient disease surveillance, they need to encourage States to bolster local surveillance capabilities. Knowing simply that a county or State has increasing disease rates does not inform proactive prevention measures, testing, or outbreak containment for LHDs. CDC should assist LHDs to track genetic trends and seroprevalence.

HCPH COVID–19 Response

HCPH, for example, was forced to invest in ad-hoc and internally-housed disease surveillance symptoms to catch up with the reporting needs at the local, State, and Federal levels. While this may have been true across other LHDs, HCPH created its own data reporting platform as "off the shelf" systems were simply not robust enough to capture the data elements and needs of the local context.

Because lab results are often delayed when sent by the State through multiple platforms, HCPH has had to secure direct partnerships with labs to share data, in addition to their already-required State reporting. To ease communications with infection control physicians, HCPH has been able to request direct access to one hospital's Epic electronic medical record system. These "one off" solutions are not practical system-wide for data exchange and are an indicator of failed public health and health care interoperability for LHDs to access needed data for case investigations and data analysis.

HCPH was one of the first LHDs in Texas to develop a public-facing dashboard using its own internally created surveillance platform that it then incorporated public health data from its Houston Health Department partner. When reporting cases out to the public, changing guidance on CDC's probable case definitions led to delay and confusion on how to classify cases using newer testing technologies and unknown labs. This unclear guidance has resulted in complicated historical data integrity and has limited any possibility of efficient data sharing across jurisdictions. Additionally, third-party contact tracing apps and surveillance solutions have continued to reach out to LHDs. HCPH has spent much time in reaching out and following up on contact tracing app solicitations without consistency from the State (or Federal) government. Potential solutions from the public or private sector for technology must be regional or State-wide to account for the mobility of residents, especially in a community such as Harris County.

CONCLUSION

On behalf of Harris County Public Health, and the nearly 3,000 local health departments across the country and those in Texas, I appreciate again the opportunity to testify today. This behind-the-scenes dedicated public health workforce, under continues to work around the clock to protect our communities even as it is stretched to its limits. Our work would be impossible without the leadership and support of Judge Hidalgo and county leadership.

The pandemic is an unprecedented time for our country and our Nation's public health preparedness is being tested like it never has before. Smart, strategic, scalable, and sustainable investments are needed now to prevent continually subjecting public health to trial by fire.

We join you in working toward strengthening a public health system that protects our economic vitality, National security, and the very health of our people. Thank you for your support in building safe, healthy, and protected communities across this great Nation of ours.

Chairman THOMPSON. Thank you very much, Doctor.

I now recognize Colonel Hastings to summarize his statement for 5 minutes.

STATEMENT OF COLONEL BRIAN HASTINGS (RET.), DIRECTOR, ALABAMA EMERGENCY MANAGEMENT AGENCY

Mr. HASTINGS. Good afternoon, Chairman Thompson, Ranking Member Rogers, and Members of the committee. On behalf of Ala-

bama Governor Kay Ivey, thank you for inviting the Alabama Emergency Management Agency to participate in today's hearing.

I am here before you as the director of the Alabama Emergency Management Agency, and we are the State's lead agency for the coordination of Alabama's all-hazards mitigation, preparedness, response, and recovery activities. Thank you for the opportunity to share with you Alabama's perspectives and our experience in preparing for and responding to COVID–19.

Over the last 4 months, Alabama has transitioned from a stay-at-home order issued on 20 March to a safer-at-home order issued on 30 April. The latest order from Governor Ivey has recently been amended and extended through 31 July.

When this pandemic began, Alabama was fortunate that ADPH, our Department of Public Health, had on hand an existing stockpile of PPE left over from the H1N1 response over a decade ago. This stockpile of PPE was mostly expired but was able to be distributed early in our response to COVID–19 with the help of a waiver granted by the U.S. Food and Drug Administration.

The initial push of ADPH's existing PPE stockpile, combined with the slow rise in COVID–19 cases and the release of Federal Strategic National Stockpile, helped reduce the initial shock of the global PPE supply-and-demand crisis. Today, the health care supply chain is still struggling to provide medical-grade respirators, some disinfectants, and other specific personal protective equipment. This supply-and-demand mismatch continues to plague Alabama, just as in many other States, as we continue to provide PPE to the health care system, while simultaneously working to replenish our State stockpile in preparation for the fall surge of COVID–19.

As a State EMA director, I appreciated the more active role FEMA played as the U.S. coronavirus response evolved. Even though the dual reporting change of HHS and FEMA were sometimes cumbersome, it was better than not receiving critical coronavirus response information, and the relationship provided much-needed visibility into the U.S. public health response at a National level that we lacked, to some extent, during the early days of the Federal Government's response.

The combination and collocation of FEMA and HHS leadership was mirrored in Alabama's own Unified Command set up on 30 March. We found that this helped our communication information flow across and within our State agencies. This combined construct and the close coordination it enables between emergency management and public health officials should be purposefully encouraged in Federally-supported preparedness programs. This would reduce duplication and streamline coordination of preparedness outcomes driven by the separate HHS and DHS/FEMA emergency preparedness funding programs, of which FEMA's Emergency Management Performance Grants and HSS' Public Health Emergency Preparedness programs are 2 prominent examples.

As the United States develops future strategies and policies for pandemics, all-hazards emergency management activities and threats to National security, I offer a few items for consideration to our Federal partners.

Assess public health vulnerabilities to National security based on comprehensive supply chain analysis to include the location of raw materials, availability of production resources, transportation vulnerabilities, and location of manufacturing.

No. 2, with regard to the CARES Act and the crucial financial support it provides to State and local government, there are lingering questions about eligibility that at this time are causing some level of confusion at the State and local levels. For example, it is unclear whether CARES funding may be lawfully used to accommodate the extraordinary expenses of emergency management agencies like AEMA that have been incurred in responding to COVID–19, even though the vast majority of our personnel expenses have been dedicated to that end, to date. Increased clarity on the intended and allowable uses of CARES funding would enable State and local officials to make better decisions about the most effective and responsible uses of this essential emergency funding mechanism as we work to maintain Government operations during this crisis.

Requirements that are too restrictive or specific in our emergency preparedness funding programs, whether in authorizing legislation or implementing guidance passed down from Federal agencies, often create very distinct functional cylinders of excellence and siloed functional expertise in a way that is inwardly focused, instead of enabling cooperation and sharing of resources in a fully integrated National emergency management and preparedness enterprise. Our focus should be on fostering an outward sharing of resources and information that is incentivized by Federal grants aimed toward developing capabilities with commonality, interconnectedness, and partnerships instead of driving duplication, competition, or stovepipes. This is especially pertinent in terms of overlap between sometimes competing objectives of the FEMA and HHS emergency preparedness funding programs.

Last, in accordance with FEMA's framework of Federally-supported, State-managed, and locally-executed disaster activities, please give consideration to the role that subdivisions of Government and private partners should play in stockpiling resources for future pandemics or building local capability. If the Federal Government focuses too much only on Federal responsibilities, the United States may miss an opportunity to create a whole-of-Government and whole-of-society approach to preparing for future pandemics and complex disasters. We all play a role in emergency preparedness, so the Strategic National Stockpile should be a multi-tiered National system comprised of integrated whole-of-Government, whole-of-business, and whole-of-society partnerships to strengthen the resiliency of the United States at all levels: State, local, Tribal, territorial, and Federal.

In conclusion, I am proud to say that Alabama remains committed to fighting the coronavirus, reducing loss of life, and minimizing the suffering of our citizens. As our Nation continues to respond to this public health crisis, we ask that you remain attentive to the evolving needs of each State, in particular, Alabama, and mobilize the information, resources, and funding capabilities of the Federal Government that are needed to protect our Nation's public health and safety.

Again, thank you for this opportunity to testify. Thank you for your support of the CARES Act and to our Federal partners who have partnered with us in the response, and I welcome your questions.

Thank you.

[The prepared statement of Mr. Hastings follows:]

PREPARED STATEMENT OF BRIAN HASTINGS

JULY 8, 2020

Good afternoon Chairman Thompson, Ranking Member Rogers, and Members of the committee. On behalf of Alabama Governor Kay Ivey, thank you for inviting the Alabama Emergency Management Agency (AEMA) to participate in today's hearing.

I am here before you as the director of the Alabama Emergency Management Agency, and we are the State's lead agency for the coordination of Alabama's all-hazards mitigation, preparedness, response, and recovery activities. My goal today is to share with you Alabama's perspectives and our experiences preparing for and responding to the novel coronavirus public health crisis. More so, I will share with you our experience working with our State partners and our Federal partners at the U.S. Public Health Service, U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Small Business Administration (SBA) and the Federal Emergency Management Agency (FEMA). I am hopeful that by sharing with you how Alabama has responded to the novel coronavirus public heath National emergency, you will be able to strengthen and enhance the coordination between critical Federal agencies and all States, including Alabama. I will first give a little background on our operations tempo this year and then give an update on Alabama's Unified Command activities and the status of the phases of our State strategy and conclude with a few observations.

Beginning in January, AEMA, along with the Alabama Department of Public Health (ADPH), actively monitored the public health situation arising from Wuhan City, China. Throughout the Winter and Spring, Alabama was also managing the impacts from our record-breaking winter rainfall and flooding, the fifth-worst tornado outbreak in Alabama history on Easter Sunday, and the effects of a straight-line wind event the following Sunday, all while responding to the coronavirus public health crisis and complying with CDC guidelines and public health orders. The significant impacts of these weather events resulted in Governor Ivey requesting 3 of our 4 Presidential Major Disaster Declarations in 2020, of which the declarations for flooding and coronavirus have been approved, the 2 other weather-related requests are currently pending approval. Already, 2020 has been another busy disaster year in Alabama and COVID19 has added a level of complexity we have not seen in our lifetimes.

Commensurate with President Trump declaring a National Emergency on 13 March in response to the global pandemic, Governor Ivey declared a State of Emergency, Alabama received a Federal Emergency Declaration, AEMA activated a hybrid virtual State emergency operations center and deployed personnel for operations embedded with ADPH, and we started State-level coordination group calls with our internal State emergency management partners. Alabama began the groundwork for submitting a Presidential Major Disaster Declaration request for Public Assistance and the Crisis Counseling Program and worked with the Department of Commerce to submit a Small Business Administration (SBA) Disaster Declaration. Thanks to our close relationship with our Federal partners, we promptly received approval of our SBA Declaration on 20 March easing the impacts on the small business community that makes up 70 percent of the Alabama economy. Our Major Disaster Declaration was approved on 29 March for FEMA Public Assistance as well as the crucial Crisis Counselling Program administered by the Alabama Department of Mental Health in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) of HHS to ease the suffering of our citizens most affected by the impacts of the coronavirus.

On 16 March, Governor Ivey stood up a Coronavirus Task Force to leverage a whole-of-government approach in addressing the multitude of complex and cascading effects of the coronavirus pandemic. Soon after, Governor Ivey approved a coordinated State response under a unified command with ADPH and AEMA as co-leads. Under this National Incident Management System (NIMS)-compliant construct, ADPH provided the lead and expertise on public health activities while AEMA provided wrap-around services and support in the form of additional manning and disaster funding mechanisms to bolster Alabama's whole-of-government re-

sponse. On 25 March, we held our first video conference call with key leaders of State agencies in the unified command and then established a fully integrated unified operations structure on 30 March along with members of the Alabama Department of Public Health (ADPH), Alabama Forestry Commission (AFC), Alabama National Guard (ANG), U.S. Public Health Service (USPHS) and the Federal Emergency Management Agency (FEMA). Recently, on 1 July, Alabama's Unified Command transitioned to an ADPH-led incident command system postured for longer-term operations with AEMA continuing to provide wrap-around services and coordinate support from State partners and FEMA.

As we stood up the Unified Command in March, Governor Ivey approved a grand strategy, strategy, and 4 phases of operations——

Grand Strategy.—Alabama demonstrates the capacity and resolve to defeat Coronavirus, emerging more unified and capable. Alabama's mobilization and community resilience are a model for America and help lead the fight against the coronavirus.

Strategy.—Mobilize Alabama for a whole-of-society response to slow the transmission of coronavirus to a level commensurate with our medical system's capacity to care for our citizens in order to buy time to find a vaccination or treatment to eliminate the health, economic, and social impacts of the coronavirus on our people and economy.

Phases of our State Operations:

- Reduce transmission of COVID19 (on-going)
- Sustain & Expand health care capacity and capability (on-going)
- Inform and reassure the public (on-going)
- Transition to a better Alabama (on-going).

Alabama has used a whole-of-government approach to reduce the transmission of COVID19 and bolster the health care system by working with subdivisions of government, associations, and organizations to slow the spread of the coronavirus. At the height of our Unified Command activities and leveraging crucial Federal support for National Guard operations under Title 32 authorization, Governor Ivey had activated 789 members of the Alabama National Guard to support logistics and medical operations planning, commodity and PPE transportation, warehouse management, nursing home decontamination, and nursing home infectious disease training. The Unified Command, leveraging the incredible support of the soldiers of the Alabama National Guard (ALNG), assistance of the logistical experts from the Alabama Forestry Commission (AFC), resources and staff of Alabama Attorney General Steve Marshall, and many other State agencies, has delivered 16,264,959 articles of personal protective equipment (PPE); 86,285 coronavirus test kits; and 10,974 vials of lifesaving Remdesivir. The soldiers of ALNG Task Force 31 completed 185 nursing home decontamination missions and provided 26 training missions to 821 civilians and nursing home staff to reduce the spread of COVID19. As Alabama right-sizes our coronavirus response, there are currently 246 members of the National Guard activated. Additionally, at the request of the Alabama Unified Command, the CDC deployed a team to Alabama to help nursing homes obtain additional support with infectious disease control.

Through Direct Federal Assistance (DFA) coordinated through FEMA, the United States Army Corps of Engineers (USACE) deployed personnel to Alabama who embedded in our Unified Command and completed more alternate care site (ACS) assessments than any other State in FEMA Region IV. These assessments provide Alabama's health care system with a multitude of options to expand health care capacity in response to COVID19 surges, if required. Our Alabama goal continues to be slow the spread of COVID19 while supporting hospital surge capacity to keep traditional hospital patients in traditional hospitals receiving traditional hospital care, rather than to resort to ACS solutions whenever possible.

Throughout the evolution of the COVID19 response, Alabama's Unified Command has worked hard to message our activities, share the Alabama story with our citizens, motivate Alabamians to adopt the beneficial habits of non-pharmaceutical interventions, and align all our communities toward a common goal of slowing the spread of the coronavirus. Under the Unified Command construct, we created a Joint Information Center (JIC) led by Governor Ivey's communications director with support from ADPH and AEMA to support consistent and timely messaging that has been aligned with CDC and other Federal COVID19 policy and guidance recommendations. Alabama has smoothly transitioned from a "Stay at Home" order issued on 20 March to a "Safer at Home" order issued on 30 April; the latest order has recently been amended and extended by Governor Ivey through 31 July.

Last, as we transition to a better Alabama, the Unified Command and State partners continue to leverage FEMA Public Assistance and CARES Act funds to mitigate short- and long-term negative effects of the coronavirus on our communities,

economy, and citizens. One example of the incredible partnership between our Federal, State, and local partners is the effort led by University of Alabama Birmingham (UAB) Medicine with CARES Act funding allocated by Governor Ivey to develop a State-wide coronavirus testing, tracing, and informatics program for institutions of higher education to safely bring students back onto campus this fall for in-residence education. The potential exists to scale and scope this testing effort beyond 2- and 4-year colleges and universities to mitigate the spread of the coronavirus throughout Alabama.

Before I close my written statement, I would like to share a few observations and recommendations. When this pandemic began, Alabama was fortunate that ADPH had on-hand an existing stockpile of PPE leftover from the H1N1 response over a decade ago. This stockpile of PPE was mostly expired but was able to be distributed early in our response to COVID19 with the help of a waiver granted by the U.S. Food and Drug Administration (FDA). The initial push of ADPH's existing PPE stockpile—combined with a slow rise in COVID19 cases and the rapid release of the Federal Strategic National Stockpile (SNS)—helped reduce the initial shock of the global PPE supply and demand crisis. Today, the health care supply chain is still struggling to provide medical-grade respirators, some disinfectants and other specific personal protective equipment. This supply-and-demand mismatch continues to plague Alabama, just as in many other States, as we continue to provide PPE to the health care system while simultaneously working to replenish our State stockpile in preparation for a possible fall surge of COVID19 cases.

As a State EMA director, I appreciated the more active role FEMA played as the U.S. coronavirus response evolved. Even though the dual reporting chains of HHS and FEMA were sometimes cumbersome, it was better than not receiving critical coronavirus response information and the relationship provided much-needed visibility into the U.S. public health response at a National level that we lacked, to some extent, during the early days of the Federal Government's response. The combination and co-location of FEMA and HHS leadership was mirrored in Alabama's own Unified Command. We found that this helped with our communication and information flow across and within State agencies. This combined construct and the close coordination it enables between emergency management and public health officials should be purposefully encouraged in future Federally-supported preparedness programs. This would reduce duplication and streamline coordination of preparedness outcomes driven by the separate HHS and DHS/FEMA emergency preparedness funding programs—FEMA's Emergency Management Performance Grant (EMPG) and HHS's Public Health Emergency Preparedness (PHEP) programs being two prominent examples.

As the United States develops future strategies and policies for pandemics, all-hazards emergency management activities and threats to National security, I offer a few items for consideration to our Federal partners:

(1) Assess public health vulnerabilities to National security based on comprehensive supply chain analysis to include the location of raw materials, availability of production resources, transportation vulnerabilities, and location of manufacturing.

(2) With regard to the CARES Act and the crucial financial support it provides to State and local government, there are lingering questions about eligibility that, at this time, are causing some level of confusion at the State and local levels. For example, it is unclear whether CARES funding may be lawfully used to accommodate the extraordinary expenses of emergency management agencies like AEMA that have been incurred in responding to COVID19, even though the vast majority of our personnel expenses have been dedicated to that end. Increased clarity on the intended and allowable uses of CARES funding would enable State and local officials to make better decisions about the most effective and responsible uses of this essential emergency funding mechanism as we work to maintain Government operations during this crisis.

(3) Requirements that are too restrictive or specific—whether in authorizing legislation or in the implementing guidance passed down from Federal agencies—in our emergency preparedness funding programs often create very distinct functional cylinders of excellence and siloed functional expertise in a way that is inwardly-focused, instead of enabling cooperation and sharing of resources in a fully integrated National emergency management and preparedness enterprise. Our focus should be on fostering an outward sharing of resources and information that is incentivized by Federal grants aimed toward developing capabilities with commonality, interconnectedness, and partnerships instead of driving duplication, competition or stovepipes. This is especially pertinent in terms of the overlap between—and sometimes competing objectives of—the FEMA and HHS emergency preparedness funding programs.

(4) In accordance with FEMA's framework of Federally-supported, State-managed, and locally-executed disaster activities, please give consideration of the role that sub-divisions of Government and private partners should play in "stockpiling" resources for future pandemics. Emergency management and risk management are everyone's responsibility. If the Federal Government focuses too much only on Federal responsibilities, the United States may miss an opportunity to create a whole-of-government and whole-of-society approach to preparing for future pandemics and complex disasters. We all play a role in emergency preparedness, so the "strategic National stockpile" should be a multi-tiered National system comprised of integrated whole-of-Government, whole-of-business, and whole-of-society partnerships to strengthen the resiliency of the United States at all levels—State, local, Tribal, territorial, and Federal.

In conclusion, and I am proud to say that Alabama remains committed to fighting the coronavirus, reducing loss of life, and minimizing the suffering of our citizens. As our Nation continues to respond to this public health crisis, we ask that you remain attentive to the evolving needs of each State—and, in particular, Alabama—and mobilize the information, resources, and funding capabilities of the Federal Government that are needed to protect our Nation's public health and safety.

Again, thank you for this opportunity to testify, and I welcome your questions.

Chairman THOMPSON. I thank the witnesses for their testimony.

I remind each Member that he or she will have 5 minutes to question the panel.

I will now recognize myself for questions.

Governor, Johns Hopkins University has documented the disproportionate number of deaths in the United States, the disproportionate number of testing. How do you think we got to this point in the United States that our people are dying more disproportionately than others? After you say that, can you give us what you think we ought to be doing that we didn't do?

Governor PRITZKER. Well, you are talking about communities of color, right? I just want to make sure. Because, from my perspective, this is something that was so overlooked in the very first weeks of the pandemic in the United States. Then as the data was coming out, I think all of us, you know, that care about this jumped on it and tried to figure out, you know, what are the things that we can do to make up for, to try to, you know, diminish the negative impact of coronavirus, particularly on the African American community, the Latino community, the Asian community.

Here, look, this is the conclusion that you have to reach, which is this is a result of, frankly, hundreds of years of failure to invest in basic health care, basic needs, you know, investment in communities that has been lacking for so long. The result is that, you know, you hear a lot about the comorbidities that exist in the African American community. Well, those don't just exist by accident. They exist because we haven't invested in those communities. So people suffer from the comorbidities more, guess what, in communities where there is more poverty.

So, you know, from my perspective, to counter this, we put a lot of testing capability into, at least here in Illinois, into communities of color, particularly Black communities. We have seen, of course, a disproportionate number of Black people who get coronavirus dying from coronavirus. We also see a disproportionate number of Latinos getting coronavirus relative to their population size. So in both of those circumstances, you know, we had to react. There are different challenges in each of those communities that we had to react to.

But when you asked me what are the causes, I mean, the causes are things that have existed for many, many years that only now, I think, not just with coronavirus highlighting the failures, but now on top of that, the recognition as a result of the, you know, outpouring of protests and peaceful protests in the wake of the murder of George Floyd that, you know, we need to do so much more. We are not prepared in this pandemic to deal with it. We need to make sure that we are doing everything we can now, but we also need to make sure we put the resources in so that, God forbid, if we have another pandemic, this isn't [inaudible]——

Chairman THOMPSON. Thank you.

Dr. Shah, you talked about a few things that we could do right now to try to minimize the increase in the numbers. Can you kind-of repeat that for the Members again?

Dr. SHAH. Sure. Thank you. Thank you, Mr. Chairman. To say it very bluntly is that we have to make sure that we are consistent in our policies and our messaging. I think that is the No. 1 thing.

The second thing is that we also have to make sure that health and medical and science and evidence, the best we can—we know it is not always there because this is a new and novel disease—that that is also driving those decisions. We are particularly concerned about the CDC and the fact that the visibility and the leadership that we have seen previously with CDC that has not been noted, at least at the local levels, in public health, and that is a significant concern.

Then I do think that there are some preventive measures that are very much about the masks and really ensuring that we have the policies in place from a prevention standpoint that really can be very much a part of the solution forward.

We have to be smart about it, but we also have to be thinking about how we can continue to move this process forward. Because this phase, the phased approach that we are having in our community is very different than the Governor is having in Illinois right now or you are having in Mississippi. Everybody is going through this at different times, and so we all have to be working together.

Chairman THOMPSON. Thank you very much.

Mayor Shelton, you were one of the first municipalities in Mississippi to require masks of your citizens, and your council supported you. How did you reach that conclusion?

Mr. SHELTON. [Inaudible]

Chairman THOMPSON. Unmute yourself.

Mr. SHELTON. I apologize for that. Thank you, Chairman.

We began our emergency protocol February 24. You know, we saw the pandemic coming toward us, so we made the decision then that this is an emergency, so we have to treat it like an emergency. So the 17 different executive orders we have done since then have all been based on the recommendations of either Dr. Fauci or the CDC, the Mississippi Department of Health. We have tried to follow the science. We have the Nation's largest rural hospital here in Tupelo, the North Mississippi Medical Center. A lot of the requirements that we have mandated have come from requests from the North Mississippi Medical Center.

I do want to—I appreciate getting credit for that, though I want to make up for my friend, Mayor Robyn Tannehill in Oxford, and

some of the others. Tupelo is not the first on the masks. We have been first on shelter-in-place and some of the other things, but I want to give credit to my fellow mayors where credit is due.

But we based those decisions on the science, the recommendations, and, in our case, the requests of our medical professionals here. You know, this is a health care crisis. We have to listen to our health care professionals. We have to make sound decisions based on the science.

Chairman THOMPSON. Thank you very much.

At the request of the Ranking Member, we are going to recognize Mr. Higgins, who has a flight to catch. The gentleman from Louisiana is recognized for 5 minutes.

Mr. HIGGINS. I thank the Chairman and the Ranking Member. I thank the Chairman for holding this hearing.

As the Chairman and my colleagues are aware, I respectfully object to House proxy voting and remote committee attendance. The Senate is open and working in person, the White House is open and working in person, yet the House is not. Walmart, Home Depot, Lowe's, grocery stores, police departments, fire departments, maritime ports, airports, all open and working in person, but not the people's House. That is my position on that. I respect that of my colleagues, but it is important that we clarify our stance during this era of challenge.

I have a question for the Governor. If you would, good sir, could you briefly summarize, what formula have you used to deliver CARES Act relief funding into your local government entities? This is a challenge across the country, and I am interested to hear how you have handled that.

Governor PRITZKER. Yes. Well, thank you very much, Congressman, for the question. Let me start with, we began in Illinois with a challenge. We didn't have a method, an entity through which we could distribute those funds, so we had to go to our legislature to have them pass a law to allow us to do that. They did that. The legislature hadn't met during the spring until mid-late May, and at that point, the legislature created the opportunity for us to distribute those funds.

There is a direct amount of money that goes directly to the counties and cities across the State, the ones that are outside of the northeast metropolitan areas, which, you know, get those funds through their counties that got funding directly.

Mr. HIGGINS. So, generally speaking, Governor, in the interest of time, have you——

Governor PRITZKER. Yes, sir.

Mr. HIGGINS. Would it be fair to say that as the executive of your State, you have responded to a challenge that has never been faced before, and you have navigated your way through it within the parameters of the law, and you have done your best to respond to the local and municipal governments within your State? Is that a fair summary of your endeavor?

Governor PRITZKER. Yes, sir.

Mr. HIGGINS. For the subsequent Governor—and I am sure you are a fine gentleman and supported obviously by the majority of the citizens of your State, but would it be fair to say that for the subsequent Governor, you have now determined a path forward for

this particular type of challenge that was not known until you navigated through it?

Governor PRITZKER. Well, I wouldn't say that we have got everything figured out, Congressman.

Mr. HIGGINS. But you are working on it?

Governor PRITZKER. But we certainly have—there is an awful lot of learning that has taken place from March until now. Yes, I believe that we have created a path for someone in the future to follow.

Mr. HIGGINS. Thank you.

May I respectfully state that that is exactly what our President has done in response to this incredible challenge that we have never faced before as a Nation.

Now, I would like to ask the mayor, Mr. Mayor, what is your perspective, sir, for your municipality? Very briefly, have you had problems receiving funds, CARES Act relief funding from your executive, yes or no?

Mr. SHELTON. Well, Congressman, as you know, the CARES Act specifically prohibits loss of revenue funds——

Mr. HIGGINS. I understand, and yet every State executive had received massive amounts of the people's treasure, intended to be distributed by the State executive, into local and municipal governments. So as a mayor, you sound like a smart and compassionate man. We thank you for that. Have you had problems receiving that funding?

Mr. SHELTON. Congressman, again, the lost-revenue funding is not available. My understanding is that the State is going to send for the PPE funds——

Mr. HIGGINS. So you haven't received funding yet from your executive?

Mr. SHELTON. I would have to double-check that but not that I have been made aware.

Mr. HIGGINS. All right. Thank you, sir. I don't know how much time we have remaining. We are absent a clock from what I can see, but—17 seconds?

Mr. Hastings, I will leave you with this question: Do you believe that a public health crisis is best addressed at the local and State level or by Federal mandate? I yield.

Mr. HASTINGS. I think it depends on your perspective. Growing up in the emergency management community, our strategy for handling all hazards is Federally-supported, State-managed, locally-executed. So we try to adhere to that as we partner with the Federal Government, with our State agencies, and our counties and municipalities, which are the pointy edge of the spear.

A caveat to that might be, is that as the sixth-poorest State in the union, and heavily rural populated State, there are some counties and municipalities that need extra support. So we are sensitive to that in identifying gaps and then trying to plug in both Federal and State capabilities and resources in those areas as we can.

Mr. HIGGINS. Given that response, I thank the Chairman and the Ranking Member, my colleagues across the country right now, and here in the District of Columbia. Mr. Chairman, I yield.

Chairman THOMPSON. Thank you very much. We now yield 5 minutes to the gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman, and I appreciate it very much to have the opportunity. Thank you to the witnesses. In 2016, the Obama administration developed a strategic playbook on pandemic preparedness, the playbook entitled "Playbook for Early Response to High-Consequence Emerging Infectious Disease Threats and Biological Incidences."

I am reminded of the Ebola pandemic or episode, and it started, or it was certainly focused in Dallas, Texas. Had it not been for the focus of the Obama administration on infectious disease and cooperating relationships with the Federal Government, there is no way of knowing how disastrous Ebola would have been in the United States.

The playbook was in the Trump administration, left behind, and it reportedly did not heed its guidance. The mortality rate was cited by the administration as the lowest in the world as it relates to COVID–19. Johns Hopkins indicated that it is the sixth worst in the world. We also heard the words that COVID–19 would go away like magic.

Governor Pritzker, thank you for your leadership. Would you focus in on the disaster that is created on top of the disaster when there is no National effort, there is no National strategic plan to be able to deal with COVID–19?

Governor PRITZKER. Well, thank you very much, Congresswoman. Let me just begin by saying that we had—immediately, you know, we knew we needed supplies. So, PPE was something, you know, certainly a term that I don't think I had ever used before in my life. All of a sudden, we were out in the marketplace competing for the most basic things, like N95 masks, gowns and such, to make sure that our hospitals were supplied, and then our first responders and so on.

We are competing against every other State in the United States, States that have more resources than we do, countries that have more resources than we do, with no help from the Federal Government, no invocation of the Defense Production Act to help us out.

So that was just the very first manifestation of the problem that, you know, people were going to work—our HEROES, our nurses, our doctors—going to work unable to use PPE that was so necessary to keep them healthy, so they could keep other people healthy.

Ms. JACKSON LEE. Well, Governor, we thank you for yielding.

Governor PRITZKER. So, that was just one example, but I will just add, the testing supplies, you know, were impossible to get, and the Federal Government was, you know, nowhere to be found for too long on that topic.

Ms. JACKSON LEE. For those of us who have interacted with the military, we know the saddest terminology is MIA, missing in action, very sad terminology. We mourn and continue to look for our soldiers, but when you are MIA, lives can be lost. Do you think lives have been lost throughout the United States because of that ineffective National strategy?

Governor PRITZKER. There is no doubt about it. Thousands and thousands of lives have been lost, tens of thousands, across the Nation, as a result of the inaction, the late action taken by the administration.

Ms. JACKSON LEE. Thank you.

Dr. Shah, thank you for your leadership. Let me just cite right now into the record, Harris County has confirmed cases today, 39,311. There have been 395 deaths. This is as of 7 a.m., July 8, this morning. Houston, 55,000 cases confirmed, 581 deaths, this is in fatality. I have a document in my hand that I ask unanimous consent to put in the record, Texas Coronavirus Timeline* that was done by a number of individuals reported in the *Houston Chronicle,* that indicates May 1 was when our orders—our stay-at-home lift—orders were lifted rather, and then we proceeded to open everything up and we are now where we are today.

Would you please respond to the idea of the ineffectiveness of saving lives when there is no National strategy, or when there is the early and too-early opening up of States in particular. Then, finally, when there is no cooperation, is it important to have cooperation between county and city governments? I want to thank Judge Hidalgo and thank Mayor Turner for their leadership. Also, if you would comment on what happens when 5,000 persons are coming to a community that has asked them not to come to, and all of the resources will have to be used as these people congregate for a convention?

Dr. SHAH. Thank you, Congresswoman, and thank you again for your support. Let me unpack that as quickly as I can in the interest of time. First and foremost, that in any time you have inconsistencies that are occurring across that chain of Federal, State, local, I don't really care where it is at, that is where you have the problems in the community, and that is where my biggest concern is.

When it comes to what we have really looked at from why people are coming together, it does not matter, from a public health standpoint, whether it is a red or blue issue, whether it is a left or right issue. When people are coming together, that layers risk on top of each other, and that is the biggest concern, especially if it is an indoor—there is some difference between indoor and outdoor—but definitely an indoor.

The other aspect of this that is I think is absolutely critical is that as we have played this out, the State and local dynamics are absolutely critical. But when you have the Federal Government not having a National strategy, what that does is that everybody is fending for themselves, everybody is doing things differently. While we believe in really State and local nuances, we also believe there should be a path forward that the Federal Government provides as we have seen in previous emergencies.

Ms. JACKSON LEE. You know, I have worked on testing sites. I would just like to have you emphasize how important it is to have testing sites, how important it is to continue to have the Federal Government maintain its testing sites, and how eager Harris Countyians and Houstonians are desperately in need of tests.

Dr. SHAH. That is absolutely right. Testing is the foundation of this response. Folks have focused on contact tracing and all these other, you know, terms in public health as if these are new terms. These are things that we have been doing for decades, but the foundation remains testing. Testing gives you then the cases. Cases

*The information is provided at the conclusion of this document.

then allow you to determine, after investigating who are the contacts, and that is when contact tracers come into mind, come into play, and then they turn around and reach out to individuals to get them tested, and you start that whole cycle over again. That is why testing is absolutely critical.

Congresswoman, I have said, you cannot trace without a case, and, so, testing is the foundation, and we do need to have that testing support from the Federal Government.

Chairman THOMPSON. The gentlelady's time has expired. I would now recognize the Ranking Member from Alabama for 5 minutes.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. Hastings, unfortunately, Alabama has had several natural disasters over the last 3 years that we have had to manage. How are you and your fellow EMA directors adjusting your plans to this health crisis created by COVID–19, and are you getting adequate support from FEMA in this planning process?

Mr. HASTINGS. Ranking Member Rogers, thanks for that question. In my written testimony, it talks about, this has been a banner disaster year again for Alabama as the seventh-worst major-disaster-declaration State in the Union. We have been complying with all the CDC and public health guidelines through the transition of stay-at-home and safer-at-home. Since we have been essential personnel, we haven't stopped a beat since the beginning.

So at the beginning of March, we went into remote and dispersed operations. We deployed our people away from the EOC, and stayed connected via IT, and we did not accept—since we are—I declared everyone essential personnel, no one received unemployment and we kept working.

So what we did is we just made sure that we wore masks when we were close to people. We socially distanced as we went out into the communities and working with our counties, because the locals is where the disasters happen, just like politics. So, we have changed the way we have done business.

Now, there are some people who did not like that we went so early into remote and dispersed operations. But we were just executing the pandemic annex of our emergency operation plan, and we are fortunate to have our own IT division and a separate network that allows us to do those things.

In preparation for the hurricane, which has had a lot of attention recently, we are working with the CDC guideline, public health guidelines, FEMA preparedness plans, the Red Cross, and local communities, both Baldwin and Mobile County, to reexamine the preferred method of non-congregate sheltering.

But it is very challenging, because as well as you know, between the coast and middle Alabama, there is not a whole lot. It is the rural south. So, to find opportunities for non-congregate sheltering to house people in a disaster is very challenging. So we are going to have to find a blend of congregate sheltering, complying with public health orders, and then also, soon as we can, get our survivors, our evacuees, the folks looking for a shelter, back into some type of non-congregate shelter in a hotel, a larger amphitheater, or some of those larger coliseums that we have in Montgomery, Alabama, and a few places in the coastal counties.

But it has entirely changed everything that we do, and it has made us question whether we can even go to the State Emergency Operation Center, because you only have 2 feet, 3 feet, between 125 people, 100 feet below ground.

So we have also looked at other opportunities, like the RSA Towers in Montgomery, of where maybe we, on a floor or Joint Forces Headquarters of the National Guard, we would stand up a Joint Force office and administer and partner with our Federal, State, and local communities, to manage and navigate a disaster in the upcoming season. Hope that answers your question, sir.

Mr. ROGERS. Well, both the Chairman and I care very much about hurricane preparedness, so I appreciate that. But back to COVID–19, you heard Governor Pritzker talk about the demand for PPE. How has Alabama managed demand for PPE outside the health care sector?

Mr. HASTINGS. It has been challenging. As it has evolved, there are portions of the PPE that are now available to us. So we just got 2½ million cloth masks. We helped the Alabama Superintendent of Education procure 2½ million masks, partly youth masks and adult masks, for the upcoming education season.

But where we are having problems, and it is hard to get visibility of the health of the supply chain, and also to actually get our hands on these medical-grade masks, are the N95s. So we still have a shortage. As soon as we get any of those in, whether it is from the Federal Government or a stockpile, it goes right out to the hospitals. The hospitals are receiving those, both from the task force of the White House, through normal supply chains, but it is not "normal" yet. It is not to the levels that it was pre-COVID–19.

Then we are working through the Big Six supply chain, and we have a call with the Federal Government, the Supply Chain Task Force, on Friday, to see how Alabama, a small State, can maybe partner with the Federal Government, other regions, to get higher prioritization for these critical, medical masks, both for our hospitals now and to build a stockpile for the upcoming fall COVID surge.

Mr. ROGERS. OK.

Mr. Chairman, my time is expired. I yield back.

Chairman THOMPSON. Thank you very much. The Chair recognizes the gentleman from Rhode Island, Mr. Langevin, for 5 minutes.

Mr. LANGEVIN. Thank you, Mr. Chairman. I want to thank all of our witnesses for their testimony today.

Governor Pritzker, if I could start with you, thank you for being here today. I just want to go back to the discussion about PPE, and really, the dire challenges you had in acquiring PPE for your State to begin with. You described it as a Hunger Games competition, so to speak.

So I think you, and I would clearly agree that it would have been much more effective for the President to truly invoke and use the Defense Production Act, where it could have been both used for acquisition and distribution of PPE. We would have gotten a bulk price, the taxpayer would have got a lower price, and we would have been distributing more effectively.

It was the position of the administration—and I have had the opportunity to speak directly with the director of FEMA—that they would acquire the equipment and then they put it into the pipeline, so to speak, but not using the Defense Production Act. Can you tell us where we are today? Did that strategy ever work in terms of putting into the commercial pipeline? How are you and other States doing today in terms of being able to access PPE now?

Governor PRITZKER. Two different answers. First of all, the air bridge, as you are, you know, talking about, the air bridge was designed to bring supplies, you know, and give them to distributors in the United States who already had a list of customers, not based upon where the need was for dealing with COVID–19, but simply customers that were preexisting, that they needed to provide supplies to, because that is what you do for your customer list, and prioritize them based upon your business dealings.

Those supplies, sure, they worked their way through the United States but not prioritized for COVID–19. So I think the air bridge was an utter and complete failure in the sense that most of the supplies need to go to areas where there is a great need, and not necessarily to where some private, for-profit distributor thinks they need to feed a preexisting customer. So that is one thing.

Where do we stand now? We have been constantly, I mean, from Day 1, we have been out in the marketplace, competing to get PPE, and you know, the State of Illinois, as a buyer, we—I had many conversations directly with manufacturers, and I can remember one in particular who basically said to me, Look, you know, I will allow you to acquire this amount of these PPE items, or this equipment, if you will up your order by X amount so that you are greater than this other customer who is promising to acquire, you know, a certain amount. So, essentially, pitting me against another customer.

In an environment in which we have a pandemic—people are dying, you know—I am having to make decisions, you know, based on some business person's desire for greater profit. So that was very troubling.

Today we have acquired a lot of PPE. We have made sure that we have got a constant supply, and we have orders that are ongoing on a regular basis. I would say prices have come down. The environment is a little bit better. It is not back to normal. Someone else on the panel said, you know, this is not pre-COVID pricing, but we are paying a lot less today than we were at the very beginning, and we are able to acquire PPE here in Illinois.

Mr. LANGEVIN. All right, thank you, and, hopefully, that is the case with other Governors in other States, but clearly, not the most efficient system. It would have been better to have the PPE be directed to where it is needed most based on need.

Let me ask this on preexisting conditions and health insurance. You know, on June 27, President Trump had tweeted the following statement, where he said, "I will always protect people with preexisting conditions, always, always, always." Now, *The Washington Post* fact checker has stated that this claim is untrue. So, the President's claim that he would protect preexisting conditions received this rating, in part, because—and I quote—in the middle of a pandemic, against the advice of many Republicans, the President is trying to ask the Supreme Court to strike down the entire Afford-

able Care Act, including coverage guaranteed for people with preexisting conditions.

So Governor, I want to ask, you know, how does the lack of health insurance, especially in vulnerable populations, exacerbate the current public health crisis? And Governor, as we approach the 30th anniversary of the Americans With Disabilities Act—and I am someone who lives with a disability—how important is the Affordable Care Act's guaranteed coverage of preexisting conditions particularly for people with disabilities?

Governor PRITZKER. Well, the guarantee of coverage for preexisting conditions is vital. It is probably the most important aspect of ObamaCare and the expansion of Medicaid. The idea that we would do away with this, particularly at this moment in history, seems just unimaginable to me.

Look, first we have got to make sure—and I mentioned it in my remarks—we have got to make sure that everybody knows they can get a test for free, that they shouldn't be dissuaded from getting a test thinking this is going to cost them, you know, a lot of money. Hopefully, you have got private coverage, but if you don't, let's make sure everybody can get a test, because that is the most important thing, along with contact tracing, that we can do going forward—masking being another one—so that we can identify—you know, testing allows us, and contact tracing allows us to identify where the outbreaks are and minimize them. So we want people to get tested.

Then, of course, when people get sick—I mean, this is a National emergency. People should be able to get health care. They should be able to get treated. We should be keeping everybody alive and not having people think about whether or not they should go to the hospital in the first place when they are contagious and when they are symptomatic.

So I am very concerned about where we are, and all I can say is that we have got to make sure that we maintain our Medicaid coverage and make sure that, particularly people who are having difficulty getting testing, know that it is absolutely free to them.

Mr. LANGEVIN. Very good. Governor, thank you very much. I know my time is expired.

Chairman, I yield back, but I thank all of our witnesses.

Chairman THOMPSON. Thank you very much. We now recognize the gentleman from New York for 5 minutes, Mr. Katko.

Mr. KATKO. Thank you, Mr. Chairman, and thank you all for being here.

Governor Pritzker, just a very quick, succinct question. Via the average, did the State of Illinois get stockpiles of PPE that were being brought in and then you decide where to disperse them throughout the State? Because I know that is what happened in New York.

Governor PRITZKER. Not through the air bridge. The air bridge was bringing in equipment, PPE, that was being given to distributors. To the extent there were Government entities that happened to be on the customer list of the distributors that received those supplies, they may have received them.

But in terms of what we got as a State, we were asked at the very beginning, Congressman, what do we need, which is a terrific

question for the Federal Government to ask. So we put forward a list of all the items—gowns and gloves and N95 masks and so on—that we needed. We have, in total, from the very beginning to now, we have received about 12 percent of everything that we asked for. So at some point, the Federal Government just gave up on delivering——

Mr. KATKO. I understand what you are saying, but I just want to question, did you receive anything from the air bridge, and the answer is no. Did you receive stockpiles from FEMA at all, then you decided where they would go?

Governor PRITZKER. We did receive—that is what I am talking about. The 12 percent of what we asked for, we received 12 percent, and we were able to direct that where we thought it should go.

Mr. KATKO. You were aware, were you not, that the biggest problem with the PPE shortage at the beginning of the crisis—and it got exacerbated as the crisis spread—was the fact that our National stockpile was not where it should have been, correct?

Governor PRITZKER. That is true, yes.

Mr. KATKO. That has been a systemic problem that spans several administrations, not just this one?

Governor PRITZKER. I am not sure. All I know is the Federal Government didn't have what it needed.

Mr. KATKO. Right. OK. That is what I thought. OK. Tell me, I got a quick one, switching gears basically, Governor, did you ever institute a policy in Illinois whereby individuals that came from nursing homes that had been infected with the coronavirus were sent back to the nursing homes after being diagnosed?

Governor PRITZKER. We did not institute a policy like that, no.

Mr. KATKO. Why not?

Governor PRITZKER. We wanted—well, No. 1, we were making sure that the hospitals were releasing, if they were releasing nursing home residents, that they were COVID-free.

Mr. KATKO. Right.

Governor PRITZKER. So when they went back to their nursing homes, they were COVID-free. That was something that we had. Also in our nursing homes, we had a policy of making sure that the nursing homes—or we provided for the nursing homes, a policy that they should separate, of course, COVID-positive from COVID-negative residents.

Many of them did. I will say some of them didn't do it right, and, you know, we are holding them accountable.

Mr. KATKO. OK. Thank you very much.

Mayor Shelton, I love Elvis, so I am going to ask you some questions. When I left as a Federal organized crime prosecutor in El Paso, my parting gift was a velvet Elvis picture, so—and I still have it in my office today. That was 20-some-odd years ago. I am curious, you are a city of less than 500,000, and homes in my area, in my district, I have the city of Syracuse, which is less than 500,000, and the county it is in, including the city, is less than 500,000. So under the CARES Act, they have received no direct funding, and I presume you have not either?

Mr. SHELTON. That is correct, Congressman.

Mr. KATKO. Have you received any funding from the State that was sent by the Federal Government?

Mr. SHELTON. No. My understanding is we have not. Now, we have been told that we have been approved for some funding for different things, but as far as actually receiving those funds, I just asked my communications director to double-check, and she said we have not. But my understanding is we have not actually received any of those funds of the $1.2 billion that was sent to the State of Mississippi.

Mr. KATKO. Yes. Here is the oddity with our—just to the right, Syracuse in the city—in the county of Onondaga received no money, similar to you. Just to the west of me is the city of Rochester in the county of Monroe, and because there were just over 500,000, they received over $120 million in the last package. So the disparity in support for the 2 cities is stunning.

So tell me, as a small city, what you would do if you got that money, and what it would help you prevent doing?

Mr. SHELTON. Well, thank you, Congressman, and that is the crux of the matter. So the things that we would do are basic city services. So every business in the city of Tupelo has to make sure that literally the lights are on on the streets, you have first responders, that you have firefighters, that you have police officers, that you have the ability of public works to respond if there is a water—you know, a water break, you know, some sort of, you know, the incidents that happen in cities every single day, fixing potholes, cleaning up, beautifying the city, those basics, that is what is in jeopardy. The city is collectively losing $360 billion.

So, you know, we have the big-picture issues in Washington and our State capitals, but the nuts and bolts of American society happens in our small cities and in our counties all across the country. Those basic city services of literally being able to drive down a decent street and have functioning red lights, have your garbage picked up at your curb, have litter, debris picked up, those basic services.

Then you get beyond that when you talk about economy—the permitting office, building inspections, code enforcement—all of those local offices that are necessary to make sure that businesses are open and running, that a new business can get an occupancy permit, that a new construction project can be inspected. All of those type things are jeopardized by the loss of revenue to cities and counties across the country, where we don't have the money, you know, we have to do cutbacks or furloughs, and those basic city services don't get performed. That directly—that has a direct adverse impact on mom-and-pop businesses and individual families all across the Nation.

Mr. KATKO. All right. Appreciate that. It is very helpful. Last, I want to thank you, Governor Pritzker, for acknowledging that. You have done an awful lot of learning during this crisis. I think we all have, and I think that starts at the top of government, all the way down to the States and locals as well.

We all have a lot to learn from this, and I have submitted a bill to Congress along, with my colleague and good friend, Stephanie Murphy, from the Democratic side of the aisle, to form a 9/11-type

commission after this is all over to look back and see what we can do better next time.

It is easy to criticize, but now, I think as you acknowledge, the lot of learning that you did on the job and I think everyone has from the top down.

With that, I yield back. Thank you.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from Louisiana, Mr. Richmond, for 5 minutes.

Mr. RICHMOND. Thank you, Mr. Chairman, and I guess following the gentleman from New York, I will, in a minute, call BS when I think I hear BS. Let me start with thanking you for your holding this hearing and your patience.

I mean, my colleague from Louisiana, Mr. Higgins, talked about how important it was for people to actually be in the room and be there so that we could have this hearing as he asked to skip the order so that he could go catch a flight and leave the hearing.

So I just want to make sure that, while we are having this call, that we are honest. This issue is far too important to the American people to simply politicize it or play defense.

Mr. Katko mentioned that learning is important in this role, and I agree with him 100 percent, but I also would say that accurate information to the American people is very important. With that, let me just ask one basic question to all of the witnesses: Do you all agree that wearing a mask is a basic tool to containing and beating the coronavirus? Could you answer with a yes or no, please?

Governor PRITZKER. Yes.

Mr. SHELTON. Yes.

Dr. SHAH. Yes.

Mr. HASTINGS. Yes.

Mr. RICHMOND. Hearing that we are in unanimous agreement, I think that it is, unfortunately—if we are going to talk about learning, I want to make sure that all my colleagues understand how important it is. My colleague who left the hearing early, in his area, said, what you are wearing is a bacteria trap. It is not helping your health or anybody else's. That is not learning. That is not accurate information. That is Mr. Higgins' quote.

His next quote was, wearing a mask was dehumanization of God's children. I just want to say that the biggest rise right now in Louisiana, in terms of coronavirus spreading, is in Mr. Higgins' district. I use that not to pick on Mr. Higgins, but to highlight that accurate information to people in this country, and leading by example, is one of the ways that we are going to defeat COVID–19 and save lives, not Republican lives, not Democratic lives, not Black lives, not White lives, but that is how we are going to save the lives of people, and I think that that is very important.

Mr. Shelton, let me ask you a question. You mentioned the essential workers, and I want to talk about that. Let's take your public transit bus drivers, or any of your essential workers, are any of them getting hazard pay?

Mr. SHELTON. Well, we have a—Congressman, thank you. We have an emergency plan here for workers that we get time-and-a-half, everybody that was with the city. Our State enacted a policy

to allow us to put people on administrative leave. So in Tupelo, we utilized those policies so that every city worker in the city of Tupelo received their salary, and then those that worked during the emergency got time-and-a-half.

More specific toward transportation, though, that is actually something that is in very real danger of getting cut altogether from the budget cuts. We have already cut over $2.5 million from our budget.

We have got budget time coming up. Our municipal budgets have to be finished by September 15, and our municipal transportation system very well could not survive this year's round of budgets due to lack of funding.

Mr. RICHMOND. What about those city services that you may contract out? I mean, in some places they contract out their labor or staffing, their bus drivers or their sanitation or their hoppers. How are you providing hazard pay for bus drivers or others that may be privatized?

Mr. SHELTON. Well, our transportation system is contracted out, so that is private. Our waste collection is private through waste management. So those, you know, other than city of Tupelo maintaining our payments, those companies are responsible for making sure the employees get paid.

Now, some of them, my understanding, have taken advantage of some of the unemployment benefits through the CARES Act. There are a lot of great benefits that have helped a lot of people, and I, again, want to thank this body for passing that. But it has been a challenge.

Mr. RICHMOND. Since I am about to be out of time, but the HEROES Act would allow us to send you a substantial sum so that you could provide hazard pay for your city employees, but also make sure that those who are providing city services would have the ability to receive some sort of hazard pay also and protect them?

Mr. SHELTON. That is absolutely correct, Congressman. Thank you. The HEROES Act would be a huge help to local governments all across the United States of America.

Mr. RICHMOND. Thank you, and with that, Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The Chair recognizes the gentlelady from Arizona, Mrs. Lesko, for 5 minutes.

Mrs. LESKO. Thank you, Mr. Chairman, and it is good to see the other Members, if not in person, virtually.

Governor Pritzker, I have a question for you. You had said somewhere along this testimony that you wanted to thank all of the Congress Members that voted for the HEROES Act. In the HEROES Act, there is a provision that released Federal prisoners 50 years old and older, no matter what type of crime they had committed, and it also financially incentivized States to do the same.

In a letter that our office received against a bill that was included in the HEROES Act, it says, we are incredibly concerned—and this came from an organization called Rights for Girls, which is an organization that protects girls and women from sexual trafficking—sex trafficking and violence, and it says, "We have been contacted by survivors from several States that are extremely dis-

tressed about the wide-spread release of people from prisons, including those with histories of sexual violence, sex trafficking, and child-sex offenses." Do you support that provision of the HEROES Act as well?

Governor PRITZKER. Well, I haven't read that provision, but I can tell you that here in Illinois, you know, we have been very careful looking at our prisons to make sure that any releases that have been done—and there have been some—have been people who have committed nonviolent offenses, people that were near the end of their term, their sentence, and, indeed, making sure that we are doing the best that we can to keep COVID–19 away from the staff, you know, the officials that work at our prisons, as well as the prisoners themselves.

You know as well as I do that the congregate settings, in every circumstance—and it is certainly true in prisons—are, you know, are just, you know, petri dishes, potentially, for COVID–19. So we have done as much as we could, but——

Mrs. LESKO. Thank you, Mr. Governor. I have to ask the next question, just because I have a limited period of time if I didn't. But at least it sounds like you are making some common-sense decisions about not releasing just anybody and everybody.

The next question I have is in the HEROES Act, it actually would allow—or have the IRS pay illegal aliens $1,200 in those relief payments. Do you support that provision of the HEROES Act as well?

Governor PRITZKER. Well, look, we have undocumented residents in the State of Illinois, and it is important for us to make sure that they are supported in some fashion, that they are not starving, that they are people who can survive. So, you know, we are supporting them at the State level, and we certainly would appreciate support from the Federal level.

Mrs. LESKO. All right. Thank you, Mr. Governor. Also, Mr. Governor, you had said in your testimony today that we need a National masking mandate. I don't know about Illinois—and I am going to ask you about Illinois—but in Arizona, there are some portions of the State of Arizona, some rural areas, that don't have any cases. So in Illinois, I assume it is the same. Do you think that even if a—like an area that has no cases at all, that you should mandate people wearing masks if there is nothing happening in that area?

Governor PRITZKER. I do, and here is why. This disease, this infection, knows no boundaries. The fact is that people in our rural areas, in southern Illinois, for example, we have an infection rate, a positivity rate, that is now roughly the same as the positivity rate in the city of Chicago——

Mrs. LESKO. All right. Thank you.

Governor PRITZKER [continuing]. So this can go anywhere.

Mrs. LESKO. Thank you, Mr. Governor. So then, since you want this top-down mandate on masks, would you also agree that we should have a top-down National mandate on the violence that is—gun violence, the shootings of residents against residents in Chicago, should the National government come in and do something about that as well, instead of the local and the State?

Governor PRITZKER. Actually, the Federal Government does provide some funding to help us fight violence, and we use that appropriately.

Mrs. LESKO. But should it be a mandate, as with the masks, from the National level down?

Governor PRITZKER. Well, I do think the Federal Government should provide violence prevention funding and helping us to deal with the violence that exists in cities all across the Nation, yes.

Mrs. LESKO. Thank you, Mr. Governor. I wasn't asking about funding. I was asking about a mandate, like the mandate that you want on mask-wearing.

So with that, I will yield back. Thank you.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from New York, Miss Rice, for 5 minutes.

Miss RICE. Thank you, Mr. Chairman. I would just like to throw out to all of the witnesses. We are—in my district, school districts work independently, and they are each coming up with a plan as to how they are going to reopen schools. The mayor of New York city just said that New York city school kids will be coming back very likely 2 or 3 days a week with a severely-reduced class size.

We have already seen how difficult it is for kids to get a quality education when they are learning from home, for a whole host of reasons. I would just start with the Governor, and then go through everyone else. How are you looking at reopening the schools? Has that decision been made yet in your State, and are you following the CDC? You know, the President came out today and basically said that, don't listen to the CDC, because their guidelines are ridiculously restrictive, whatever that means, and he has said now that we should all wait for guidance to come directly from the White House. I don't know what he has based that guidance on, but if it is not on the CDC, I really don't know what value it is going to have.

So, Governor, if I could start with you and then just go through everyone else, that would be great.

Governor PRITZKER. Sure. Well, I think if the President really wanted schools to be open, he wouldn't have just said it, he would have put forward a plan. But here in Illinois, we are—you know, our Board of Education, in fact, did put forward a plan. It is a plan that takes into account that there are differences between the more rural areas of our State, the suburban, and the urban areas, and allows the local school districts to adjust how they would reopen.

There are areas where it will be difficult to bus everybody in a rural area to the school, because there are only so many school buses. We can't have the school buses packed with kids in the morning going into school and packed with kids going home. So, you know, we have got to make sure that we have got shifts, let's say, or that kids are perhaps coming in on alternate days.

Remember, we are also trying to save the lives of and the health of the people who work at the schools—our teachers, our paraprofessionals. So, you know, this is a challenge, there is no doubt about it, and we are watching our metrics very closely, so that we can make adjustments, and we will be making decisions along the

way here. But as for now, we have provided at least guidance for school districts about how they should open.

Miss RICE. Anyone else have any thoughts on that?

Mr. SHELTON. Yes. Thank you, Congresswoman. You know, we have known since this pandemic started in March—you know, before March, got to the country in January—we have known that we have got—that we are going to have to open schools in the fall. The President, you know, contradicting CDC today is part of what I said—you know, what I was alluding to in my opening statement and my submitted documents, that that exacerbates the problems that local officials are having.

You know, when I issue an executive order here, and then the President—you know, my executive order is based on CDC recommendations—and then the President gets on Twitter and says, don't believe that, well, the President's passionate supporters are going to listen to the President and not the CDC. That complicates the ability of government at every single level to be able to respond to COVID–19.

As far as our school district here in Tupelo, it is, like you mentioned, a separate school district. They have a plan to reopen in August, but they are kind of going day-to-day, seeing how the situation [inaudible] if the cases continue to rise here.

Dr. SHAH. Congresswoman, here in Texas, from a public health perspective, Texas Education Association has, just yesterday, put out some guidelines related to how schools will reopen here in Texas. We have been working with some of our school districts prior to this, and I think the concerns that individuals have is what you have just heard from the Governor and the mayor, which is really about not just protecting the students, but also protecting the staff and any visitors that are coming in. It is the entire group of individuals that need to be protected. So, there are concerns that schools have related to that safety piece.

Obviously, we have an increase in cases, and we have increase in concern and worry in our community as well as [inaudible]. So I don't believe it has been worked out, but I will tell you that those guidelines are being looked at very closely, not just at the State level, but at the local level, not just in the education system, but also in the public health system.

The concern is to make sure that we have an approach that, again, is common-sense driven, that we want to make sure it is also based on evidence and science, but it also assures the safety and health of everyone involved, and that also may mean that a hybrid approach of in-person, in addition to obviously virtual, that some of those approaches need to be part of it.

Miss RICE. Colonel Hastings.

Mr. HASTINGS. Thank you, ma'am. In Alabama, I am not the superintendent of schools, but I know that Dr. Eric Mackie has been in close coordination with Dr. Scott Harris, our public health officer, and they put forth a road map to open schools that I thought was very reasonable, followed CDC guidelines and public health orders.

But ultimately, like in your State, ma'am, here in Alabama, it will be a local decision of how the schools open. Because we are a diverse tapestry of 67 counties and a tribe of a multitude of person-

alities, cultures, and a way of living. You can't mandate from a central point down and have it work.

So I feel like there is enough information out there for our local superintendents and principals to find that happy medium to make parents feel safe, children feel safe, faculty feel safe, and to make sure that children coming together in close quarters, you really need to be careful, because they may be the perfect vector of this disease, and then they bring it back to Alabama. In Alabama, especially in rural Alabama, we have multigenerational homes.

So that is all going into this, and how we use the CARES Act money, the CARES Act money given to the school districts, and then allowing the counties to partner to operate in a way that is good for them.

Miss RICE. Thank you all very much, and thank you, Mr. Chairman. I yield back.

Mr. ROGERS. Mr. Chairman, this is Mike, Mike Rogers. Can you hear me?

Chairman THOMPSON. Ranking Member, go ahead.

Mr. ROGERS. Yes, sir. I just wanted to make sure that you were aware that we are having a problem with the public feed. None of Mrs. Lesko's and most of Miss Rice's testimony was not seen. They were looping Cedric Richmond's questioning repeatedly, but it is back up now, but just wanted you to be aware there is a problem.

Chairman THOMPSON. Thank you. We were about to recess to create the ability to go on-line again. Our YouTube channel is down. So thank you, Mr. Ranking Member, and we will recess shortly and reconvene subject to the call of the Chair.

Mrs. LESKO. Mr. Chair, this is Congresswoman Lesko. I have a question. Mr. Chair? I just want to know if—because I have another appointment I need to go to, if I have to reask my questions, or are the questions recorded and the answers that the Governor gave, so you can rebroadcast them later?

Chairman THOMPSON. Well, I can't give you that question yet. I will talk to the technical people. If we can, we will do that. Other than that, if you can submit it in writing, I am sure we can get it. But the technicians are working on the problem right now. We will recess subject to the call of the Chair.

[Recess.]

Chairman THOMPSON. Well, we would like to reconvene our hearing, and, Mr. Bishop, we will go to you for questioning since Mr. Crenshaw is not available. If he comes, according to the rules, we will just go back. So the gentleman will be recognized for 5 minutes for questioning.

Mr. BISHOP. Thank you, Mr. Chairman. Can you hear me?

Chairman THOMPSON. Yes.

Mr. BISHOP. Thank you, sir.

Governor Pritzker, I was struck by the certitude of your criticism of the administration's efforts. I was just looking on the Worldometers website, and it appears to me that in terms of the experience measured by deaths per million during the pandemic, a number of nations have had worse experience than the United States. Of the larger ones, the United Kingdom, Spain, Italy, Sweden, and France have all suffered worse results. Do you believe

that those nations also have had a failed response—national response?

Governor PRITZKER. Look, what I can tell you is that we were—a lot of promises were made to the States, including to us, that were not delivered upon. That is what I was really referring to. I am not comparing us to other nations specifically. I am just saying the Federal Government, the White House in particular, had made promises about the delivery of PPE, about testing supplies, had the capability to allow the CDC to give us more guidance, and really, you know, very little of that was delivered.

Mr. BISHOP. One of the things that has gained a lot of currency, and the President refers to it a lot, is that his early decision to cut off entries from China other than U.S. nationals, do you concur—a lot of Democrats criticized that—do you concur that the President made the right decision in that regard?

Governor PRITZKER. Well, I think we all are seeing now that, you know, travel by people who may be infected is something that everybody's paying attention to, and that, you know, limiting that by people who, again, come from areas that are—have significant infection rates is important. So I—again, I have not been somebody who has talked about that.

What I have talked about, though, is the way in which that was done. You know, we had a problem on the days in which the President just decided and announced it, really nothing was done to help airports deal with the problems of all the incoming, international passengers from those places. Many people were desperate to get back to the United States who may have been U.S. citizens living in places like China or in Europe——

Mr. BISHOP. Thank you, Governor.

Governor PRITZKER. Yes. So—let me just say, we had an overrun of people—it was a real problem—packed into a——

Mr. BISHOP. Let me change subjects just a bit. You were particularly critical on the PPE thing, and you made reference to that again. I guess Illinois maintains a stockpile of PPE. Is that correct?

Governor PRITZKER. That's right. We had a stockpile to begin with.

Mr. BISHOP. Why didn't you have bigger stockpile?

Governor PRITZKER. Well, look, I can't answer that question, because those stockpiles were put in place before I became Governor, but what I can say is—and I think I heard one of the other panelists talk about—that there were leftovers stockpiles from H1N1 that had expired, that had to be, you know, reupped and allowed—yes.

Mr. BISHOP. Suffice to say that if you had larger stockpiles or any State had larger stockpiles of its own public health supplies, they might be less inclined to cast blame or find blame with the Federal Government for the amount of its stockpile. Fair to say?

Governor PRITZKER. Well, I would say this is certainly an unprecedented pandemic, but I would also say that the Defense Production Act, it wasn't really a criticism that we didn't have the stockpile at the Federal level. It was that we could immediately have invoked the Defense Production Act in order to help us rebuild those stockpiles.

Mr. BISHOP. Let me ask you about that. So, I mean, what that would assume is that by taking command, control, of the economy for producing PPE, we would produce more and faster and get them distributed to the right place and leave the existing economic actors in place. Is that what you believe? Do you have any evidence to support that that would have been better?

Governor PRITZKER. Well, the existing economic actors were not prioritizing PPE to the places that were needed in this pandemic. It was the States and local governments and emergency management personnel and health officials that——

Mr. BISHOP. And hospitals, right?

Governor PRITZKER. And hospitals too. My point is that we weren't getting that PPE from the Federal Government, and what we needed was to—yes, we needed the Federal Government to organize the market, to direct those resources so that we could use them to save lives.

Mr. BISHOP. What is to say that in the context of a 2-month period of time, or 3-month period of time, the Federal Government taking over that market with a command-and-control structure would have produced more, and in the right place, than allowing the market to function with augmentation of efforts from the Federal Government, such as FEMA directing resources, as it did? [Inaudible] confidence to that effect.

Governor PRITZKER. Right. Well, look at what happened with the air bridge. You know, the distributors who received the items through the air bridge distributed them, again, not based upon where the need was, but based upon where their customers were, you know, who they had as historic customers, not where the need was right at that moment. That is precisely what Defense Production Act invocation would have allowed the Federal Government to do, to direct the resources where they were needed.

Remember, New York, California, other States that had an immediate rise in cases, PPE could have gone directly to those places immediately, to Chicago and to Illinois, where we needed it. Of course, we knew where the hotspots were. So, again, having some direction from the Federal Government would really have helped.

Mr. BISHOP. Thank you, Mr. Chairman. My time is expired, and I yield.

Chairman THOMPSON. Thank you very much. The Chair recognizes the gentleman from New Jersey, Mr. Payne, for 5 minutes.

Mr. PAYNE. Thank you, Mr. Chairman, and I would like to thank the witnesses for being here.

Governor Pritzker, Illinois, like my home State of New Jersey, has made serious progress in combating the spread of coronavirus. Although, you know, we still both have a long way to go. At a time when much of the actual attention is focused on new hotspots, such as Florida, Texas, and Arizona, are you getting everything you need from FEMA to continue the fight against the COVID–19, and ensure that the recent gains are not short-lived?

Governor PRITZKER. Well, thank you, Congressman Payne, and let me first congratulate you on your victory yesterday. I happen to have spoken with your Governor last night to get his advice on a matter or two. Let me just say that, look, we need more help. There is no doubt about it. You know, we are trying to expand—

desperately trying to expand our testing in the State of Illinois. We think that is a hugely important thing.

We have done—we have made a lot of progress on it, but the Federal Government, once again, can be more help to us in that process. They were, by the way, along the way. Not at the beginning, but by May, the Federal Government was, in fact, sending us swabs, which was something that we needed desperately, I think were needed around the country.

There is so much more that is needed, though. Let me just, you know, go back to something I said in my remarks, which is, remember that our State and local governments, because there is a failure of revenues as a result of COVID–19, are going to be faced with massive layoffs for first responders, for the basic services that people need across our State and across our Nation.

Without those resources, I mean, what we have seen as a health care crisis, where we have had to put a lot of dollars into public health, is, of course, now also become a financial and economic crisis. We don't want it to be exacerbated by having State and local governments make massive cuts to the very services that, at this critical moment, people really need.

So I would just say that if I had to name, you know, among the things that I have talked about, one of the most important things is making sure that our State and local governments can do what they need to do during this terrible crisis, because it is not over, and it is not ending in the next couple of months. We need to see a very effective treatment or a vaccine before we can get beyond this.

Mr. PAYNE. Absolutely. You know, to the point about the Federal Government, you know, in the HEROES Act, we tried to address that with the aid to State and local governments, but it is sitting over there in the Senate with the other 600 bills that we have passed over this Congress.

So, you know, maybe one day they will decide to pick them up and take a look at them while the American people languish with this dreaded disease.

I tend to agree with you, this administration has been less than desirable in their attitude in reference to this. FEMA has done the best they can, but they are at the behest of the President and the Vice President. You know, it is unfortunate that they aren't allowed to do what they need—they know what to do. It is being allowed to do it, and going in and helping different locales fight this disease.

Now, we see what is happening in Florida and Texas and Arizona, but there was no problem, it was going away. You know, if we are not careful, we will see the same situation back in our States. So, you know, and the President of the Senate's attitude is, you know, well, pull yourself up by your bootstraps, you know, except in Kentucky where he is making sure they have everything. So it is just unfortunate that the administration has taken that attitude.

Dr. Shah, you know, I am pleased to see you here today. I appreciate you gave excellent testimony back in October last year at my subcommittee hearing on bioterrorism preparedness. I see the massive resurgence of COVID–19 this summer as a disturbing trend.

Dr. Shah, what do you think will happen in the winter when the flu season will return? What do we need to be doing to prepare?

Dr. SHAH. Thank you, Congressman, and good to see you again, and thank you for reminding of the pre-COVID hearing last year, which seems, you know, ages ago.

Mr. PAYNE. Yes.

Dr. SHAH. On your previous question, I did want to make a comment that public health has seen over 56,000 jobs that have been lost over the decade, and that is really concerning to me. From a public health standpoint, across the Nation, we have taxed the public health system so much that very well we are going to see markedly more diversions and folks leaving the public health work force, which is a real concern of ours.

In the fall, to your question, the real concern that we have is that we are still not through, as Dr. Fauci said, this first wave, and now in just a couple of months, we are going to very much be in the midst of flu season. While we are in the midst of a summer, if you will, a usual respite from flu, now flu is going to come back in the midst of fall season. We also have concerns about people not taking flu vaccine because of concerns, misguided though they are, around anti-vaccination, that there is really a concern that people are not going to be vaccinated and, No. 2, that you are going to have a vengeance when you have both flu and COVID that are intermixed together in the fall, and that is a concern of all of ours in public health.

Mr. PAYNE. Thank you.

I don't know if my time is——

Chairman THOMPSON. The gentleman's time has expired.

Mr. PAYNE. Thank you, Mr. Chair.

Chairman THOMPSON. I know you are celebrating yesterday, but we have some other Members.

Mr. PAYNE. I yield back. I am sorry.

Chairman THOMPSON. That is all right.

We now recognize the gentleman from Texas for 5 minutes, Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Mr. Chairman.

Thank you Dr. Shah. It is good to see you as always. You mentioned Harris County's history of responding to crisis and disasters. You have a lot of history being on the front lines doing so, and we appreciate that. How does this Federal response to COVID relate to the past disasters that you have seen?

Dr. SHAH. First of all, Congressman, great to see you, and thank you for your continued support, really appreciate it.

You know, I think there are a couple things I would say. One is about the disaster itself. This is not a hurricane in one spot. This is throughout the country, throughout the globe. All communities across the world are going through this differentially. So there is this massive nature of this. But the piece that is of concern to me is that, in the past when we have had these disasters, these emergencies, we have actually seen CDC oftentimes be that leading voice and actually convening behind the scenes, a lot of discussions with State and local health officials that allows us to learn from each other. That has not happened as much as I have seen in the past.

I have got a lot more to say, but I think let me pause there because I know you have more questions.

Mr. CRENSHAW. Yes, and I do. That is a reasonable concern to have, and I appreciate your candid and honest response. Because what I have heard from [inaudible] hearing, the tone of this hearing, you know, you would think we live in a totally different world than what actually happened. I won't dwell on the dishonesty that I have heard from others, but I appreciate your honesty on this. I think we are on the same page.

When we met in my office in early March, we focused on the fact that we had public health issues other than COVID and that COVID could negatively affect those on-going issues too. There are other public policy goals, as it turns out: Education, jobs, other health issues. What was the result of the lockdown on these other public health issues?

Dr. SHAH. Well, thank you again for that. As you know that it is not just health and medical impacts from COVID. It is this real socioeconomic, sociodemographic impact across the communities. So it has—obviously, it is too early for us to have specific numbers to say what was the impact on education or the economy all throughout.

I will say this: That we know that there have been secondary impacts, and while they have not been quantifiable, we also know that education, jobs, et cetera, also have secondary impact on health, and vice versa. They all work together. So, you know, I do want to make sure that we recognize that we have to really make sure this is not an either/or, that we are only looking at health. We should be looking at all of those aspects together. It is an "and" as we continue to fight this pandemic.

Mr. CRENSHAW. As you state, I mean, dealing with this, it is a science and an art. Some people say, well, let's listen to the science. Well, science disagrees on a lot of things, and there are judgments that have to occur, weighing costs and benefits and weighing other issues, like we just mentioned.

There has also been a lot of debate over reopening the economy. Now, Texas reopened in early May. Places like California, which is seeing spikes just as bad as Texas, even though nobody likes to mention that—I wonder why—they opened up a lot slower and they were locked down much more severely, but both saw spikes.

So can you expand on what you talked about with the layering effects that you mentioned that may have caused the spike that we are seeing across the country?

Dr. SHAH. Yes. You know, this virus is an equal opportunity virus. It does not respect seasons. It does not respect who you are, how you are, what you are trying to do in life. At the end of the day, if you are exposed, there is this real concern that the exposure can lead to infectivity, and I think that is the critical piece.

The layering effect, in my mind, is very important. It is not just reopening. I can't quantify exactly how much, because no one can. It is not just reopening restaurants at 25 percent, then 50, then 75, or bars or gyms, and back and forth. But what it is is that you have layering effect in addition to these milestone events like, as I mentioned, Mother's Day and holidays and protests, and now we

have had Father's Day, and now you have graduations in between. Now we have had 4th of July. All of that layers upon each other.

When you dial something up or you have an event, it generally takes a few weeks for you to see the impact. Just conversely, when you dial down, it takes a few weeks for you to see the impact. It is not immediate.

But the concern we have in our community, as you know, is that what is happening in our health care system is that we cannot wait for this runway, because there is limited runway in that health care system, and that is why we are concerned about making public policy decisions that can really interrupt this transmission now.

Mr. CRENSHAW. Thank you.

I am out of time. I have a lot more to say, but thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from Illinois, Ms. Underwood, for 5 minutes.

Ms. UNDERWOOD. Well, thank you, Mr. Chairman.

What a treat it is to have our Governor with us on the line today. He certainly has made us quite proud throughout this response, and I have a series of questions for him.

I would like to begin, Governor, your background is in education, and I am sure you would agree that returning to school is integral to the well-being and development of our children, as well as to working parents, and to the long-term health of our economy. But it is essential to make sure that reopening schools does not place students, teachers, and their families in danger. States and schools should be able to count on the Federal Government for guidance during a crisis of this scale.

So as you prepare to safely reopen Illinois schools, what information, expertise, and resources do you need from the Federal Government?

Governor PRITZKER. Well, thank you, Congresswoman. I want to just begin by saying thank you for your very strong advocacy for the State of Illinois in Washington, and especially for your advocacy in helping us get through this pandemic with everything that we may need. I know you are fighting for us there, and I really appreciate that.

In answer to your question, you know, this is a very complex challenge, getting our kids back to school and doing it safely. You know, we didn't do this starting out with the idea that we have to get everybody back to school. We started with the idea, you know, does the science and the data allow us to send kids back to school? If so, in what manner and how would that work? Especially when we know that we need to watch our distance, we need to make sure people are wearing masks or face coverings, and all the challenges of people with preconditions that the adults and the children who are going to be in that school, not to mention—and people don't really mention this much—the parents who interact with the school.

So, you know, that has been the challenge. What we did to begin with was we got our health professionals—and this is how we have done all of the facets of reopening and restoration that we have done. We got the public health officials together with the people

who know our schools best, all across the State. Again, we have very different school districts in rural Illinois than we do in suburban and, you know, in the city of Chicago, for example.

But we got them together and made sure that the ideas that were being put forward were, No. 1, going to keep our kids and everybody at the school healthy and safe and, No. 2, were feasible and, No. 3, what investments do we need to make——

Ms. UNDERWOOD. Yes.

Governor PRITZKER [continuing]. To make sure that we can get those accomplished. So long story short is the Federal Government's guidance is so vitally important, from the CDC. I hate to say that I have often found the CDC as being muzzled along the way here. I think the CDC is what we should be relying upon. There are a lot of terrific epidemiologists and expertise that exists at the CDC, but often, what we have found is either they put out guidance and then the White House tells them, no, we are pulling it back——

Ms. UNDERWOOD. That is right.

Governor PRITZKER [continuing]. Or they are beginning to put out guidance and someone says, you are not allowed to talk. So we are very concerned about that fact.

So I feel very fortunate that I come from a State where we have got some terrific, world-renowned scientists, epidemiologists, researchers, and so on. So we have been able to rely a lot on our local capability that really is world-class. But I wish that we could have a Federal Government that was our partner in this endeavor. That is why I was so frustrated to see the President just sort-of pronounce that, well, everybody should open their schools. Well, great. Please, please provide us the kind of guidance that will help us do that.

Ms. UNDERWOOD. Yes. I am certainly concerned about their announcements today from the Department of Education, for example.

We have a minute left, sir, so I know that the State budgets across the country have been devastated by the pandemic, and nearly 2 months ago, the House passed a bill, the HEROES Act, that would provide nearly—not nearly—$500 billion in relief funds to State government, including almost $18 billion for the State of Illinois. Unfortunately, the Senate hasn't acted on the bill.

So for the benefit of our colleagues in the Senate, what impact would this funding have on our State of Illinois?

Governor PRITZKER. Well, before I say that, I just want to say that I talk to Republican and Democratic Governors all the time, all across the Nation. So when I answer your question, I am partly answering what I think Republican and Democratic Governors across the country are saying, which is, without that funding, imagine how difficult it will be to reopen schools——

Ms. UNDERWOOD. Right.

Governor PRITZKER [continuing]. To provide, you know, the resources that we need for schools, not to mention our public health infrastructure, which is funded by State government. Our city, county governments provide our firefighters and our police officers and public safety. They are already making layoffs, significant lay-

offs. We can't afford to have that happen across the country in the middle of a pandemic.

If you can spend, you know, trillions of dollars helping large corporations survive, $500 million to support State and local governments, which provide such vital resources for our residents, you know, I would say is a small price to pay for what is absolutely necessary here.

Ms. UNDERWOOD. Well, Governor Pritzker, thank you for your leadership. Thank you for being with us today.

Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from Pennsylvania for 5 minutes, Mr. Joyce.

Mr. JOYCE. [Inaudible] Let's start again. Thank you.

Chairman, thank you for yielding and thank you for convening this hearing, although I am disappointed that we are not all here together to conduct this important committee business in person.

I would like to thank my colleague, Ranking Member Rogers, for his leadership in gathering us here today. I would also like to thank our panel of witnesses for appearing today.

The COVID–19 pandemic started a crisis unlike anything we have seen in our lifetimes and certainly unlike anything I have seen in practicing medicine for over 25 years. As we have seen this virus progress, it has disproportionately impacted elderly patients, especially those living in nursing homes or other long-term care facilities.

In my home State of Pennsylvania, this problem was tragically increased by a misguided order from our Governor to readmit COVID–19-positive residents back into nursing homes. This order flew in the face of common sense and guidance from the Center for Medicare and Medicaid Services issued just days before.

I would strongly urge this committee and the entire House of Representatives as a body to look into this order and similar orders given in New York, Michigan, California, to take full account of these deadly mistakes.

As we continue to face this virus, we cannot forget where it originated. Chinese obstruction and outright lies to the media and to international investigators are at the root cause of this virus and allowed it to spread onto a global scale. It remains critical that we are vigilant to the threat from China and act together as a committee to respond to any increased cyber attacks or other threats to our homeland while we continue to fight this coronavirus.

Director Hastings, thank you for appearing today. In your testimony, you mentioned how quickly you were able to receive major disaster declarations from the Trump administration. I am pleased to report we had similar success in my home State of Pennsylvania, and our delegation was able to support the request from our Governor in a bipartisan manner. It is also my understanding that the Trump administration was able to approve similar declarations very quickly for States all across the country.

Director Hastings, could you please elaborate on any additional resources that Congress might need to make available to help States like Alabama be successful in their continued fight against COVID–19?

Mr. HASTINGS. Thank you, Congressman. I think in my written testimony, I talked a little bit about the CARES Act. One of the things that we are concerned about—and I was going to get ready to poll the Region 4 State directors—is the interpretation of whether the CARES Act funding can be used for both the activities that any emergency management agency does, because we are not considered public safety agents. So that is one.

No. 2, we also got really quick approval through the Alabama Department of Commerce through the Small Business Administration to get an SBA disaster declaration. The blessing and the curse of being in Region 4 is that we are disaster-prone, so I enjoy a great relationship with our sister States and also with FEMA Region 4.

But I think the biggest thing is that the National emergency right now ends on 31 December, and I am not a public health officer, epidemiologist, or a pathologist, but I just don't see COVID–19 going away at the new year. So I think we need to batten down the hatches for a long fight and really start to look at the habits we have today, the things we need to do, kind-of reinvent the way we do things, to deliver services to our people in inventive, agile, and innovative manners, because I don't believe we are going to go back to normal. I think we need to go forward to better, and I don't know what forward to better is yet.

I agree with the Governor of Illinois that we are exploring, deciding, making mistakes, learning from them along the way. If we can continue to share those things with the Federal Government, our States, in a more collaborative, cooperative manner, I think we will be better as a Nation, as regions, and things like that. But I just don't think the need and the assistance from the Federal Government will end on the 3lst of December. So that is one thing I am a little bit concerned about.

Mr. JOYCE. Thank you for your hard work. Thank you for your dedication to Alabama and to our country. Thank you for your insight.

Mr. Chairman, I yield the remainder of my time.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN of Texas. Thank you, Mr. Chairman. I thank the witnesses for appearing. I am also very grateful to the Ranking Member for his role that he has played in the process.

If I may, I would like to refer to some empirical evidence and then ask a question.

This is intelligence that relates to new cases as of 7/7/2020, new cases of coronavirus, I might add. In Texas, on 7/7/2020, a State with 29 million people, we had 10,028 cases. I would like to juxtapose Texas to Canada. Canada, population of 37 million, decidedly more than Texas, had 172 cases. Texas, 10,000; Canada, 172. This makes it intuitively obvious that we can do better, and I can't believe that the Canadians know more about the virus than we do. I can't believe that they have better medical facilities than we have. So there must be other things that are giving them the opportunity to have 172 cases on yesterday and Texas 10,028.

Dr. Shah, my dear friend, I would like for you to comment on this, if you would, the rationale for Canada being so successful as

opposed to my State that I love dearly, and I assume you love dearly as well as a resident.

Dr. SHAH. Well, thank you Congressman. Always good to see you and your support, leadership. Yes, I came to Texas because I do, too, love this State.

I will tell you that this is the concern that we have. When you say that there are 10,000 new cases that are being, you know, deemed positive on a single day and then you compare it to our neighbors to the north and it is markedly less than that, then that means that we as a Nation have to do markedly better. It is not about the politics; it is about the policies. It is not about the red or the blue; it is about all of us working together.

We just had 4th of July, and that means that we should be coming together as a Nation, because we are well beyond and behind the 8-ball when it comes to fighting this pandemic, and that concerns us across the country. That concerns us in Texas. That certainly should concern us here locally. So I agree with you, and that is a concern that we have.

I do think it is about that inconsistent messaging, and it is also about having the strategy that really allows us to continue to assure that everyone understands their role and everybody is working together. That is what we are not seeing.

Mr. GREEN of Texas. Thank you.

Colonel, if I may, I have had the opportunity to look at your record. You have served your country well, and I compliment you.

I have to ask you a question. I am a member of several fraternities. If my fraternity wanted to come to your State, say 6,000 strong, and we wanted to have a convention within a facility, not without, would you recommend that we have this in-person convention indoors, 6,000 strong?

Mr. HASTINGS. Congressman, my recommendation would be based upon our current safer-at-home guideline and campaign that the Governor has and the public health orders that are currently applicable in Alabama. So it does recommend that large gatherings, where you can't have social distancing, are not recommended. So if someone was asking for my recommendation, I would not recommend that, as part of the Unified Command, as the director of Alabama Emergency Management, and as a supporting partner with Alabama Department of Public Health on behalf of the strategy that Governor Ivey has in place right now.

Mr. GREEN of Texas. Dr. Shah, if you would, would you kindly respond to the example that I have accorded?

Dr. SHAH. I would agree that, just as you just heard from Mr. Hastings, we are very concerned about anytime you bring people together for any reason, regardless of why people may be passionate about it, that concern, from a public health standpoint, increases risk. You certainly don't want to do it in any community where you have increasing numbers of cases or tests that are coming back positive or hospitalizations; for example, in ours.

Mr. GREEN of Texas. Would it make a difference if all of us were of a given political persuasion, we are all a part of one political group, if you will, a party perhaps, would that make a difference?

Dr. SHAH. From a public health standpoint, no.

Mr. GREEN of Texas. Thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. Thank you very much.

Governor, I got your message that you are going to have to depart. Let me thank you very much for the time you have given us. I know you will stay as long as you can, but thank you very much, on behalf of the Ranking Member and myself, for being a witness for our committee.

Governor PRITZKER. Thank you very much, Mr. Chairman and Congressman Rogers.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentleman from California, Mr. Correa, for 5 minutes.

Mr. CORREA. Thank you, Mr. Chairman, for holding this most important hearing, and our Ranking Member as well, thank you very much. I want to thank our guests today for being here. I wish the Governor would have stayed on for 3 more minutes, I did have a question for all of you, and I still do.

I represent Central Orange County here in California. Ninety percent of our industry here, of our jobs are dependent on tourism. Our biggest employer here is Disneyland. Ninety-five percent of my constituents that work in the entertainment, hotels, restaurant business have been out of jobs for months now. As we have these economic stimulus packages that we in Washington have rolled out, as those come to an end, you are going to see people begin to hurt in a very serious manner.

Every weekend I am out giving food baskets, food to my constituents, folks driving in with nice cars that have not had a paycheck in weeks.

As I am listening to your testimony, and all of you—some of you mentioned it this morning or last night, the President came out and contradicted the CDC. I am also trying to figure out, as Americans, where do we turn to? What do we do to get a unified message to unify us and say, we have got to move student body left or student body right, pick a play and execute, as opposed to being contradictory as to what we are supposed to do?

So I am going to ask Mayor Shelton, Dr. Shah, and Colonel Hastings, what is the message out there for my constituents? We are a Democratic district, but you know what, we have a lot of my constituents that also follow the President's message very carefully.

What do we say to our constituents? In the context of getting our country back in order, making sure that folks are able to go back to work, but we have got to get this COVID–19 under control, what do we tell our constituents?

Dr. Shah.

Dr. SHAH. Well, this is—thank you, Congressman. This is exactly what I said about the inconsistent messaging. It creates confusion and even complacency and, unfortunately, it actually means that people take risks. They don't know exactly who is right or wrong, and they may make a decision to take a risk. From a health standpoint, that is a terrible way to make decisions, terrible. Because what it does is, at the end of the day, we now increase transmission and exposure, and that cooks upon each other, and the next thing you know you have increases in cases. So——

Mr. CORREA. Colonel Hastings, I have got 2 minutes. Go ahead and answer the question.

Mr. HASTINGS. Sure. Well, you know, we have an Alabama strategy and a grand strategy in phases of our State operations, and we want to make sure that everyone is behind that. But I think to what the doctor was saying is that it is not—in a digital world, this is not a binary answer; it is very analog. You can open the economy, but you have to comply with public health orders and CDC guidelines. You can open the economy, but when you close down your schools, you have got to figure out how do you deliver school to the children if the children can't come to you, like we did. Or if we close down businesses or services, instead of people coming and congregating, how do those people deliver those services to the people?

So where, yes, people are going to be suffering, and on July 3l, I am concerned about maybe a looming humanitarian crisis. You know, this time that we have right now, we need to take a step back, take a deep breath and go, how do we reinvent the way we do business, how do we reinvent how we connect with people, and we can do——

Mr. CORREA. How do we get that unified message? How do we get that unified message?

Mr. HASTINGS. Well, in Alabama, our strategy is mobilize Alabama for a whole-of-society response to slow the transmission of coronavirus to a level commensurate with our medical system's capacity to care for our citizens in order to buy time to find a vaccination——

Mr. CORREA. Thank you, Colonel Hastings.

In my last 30 seconds, Mayor Shelton, tell me.

Mr. SHELTON. The President of the United States needs to get on TV and have a call to unity, that he needs to dispel the conspiracy theories and the rumors that are hampering the efforts of government at all levels to respond. We need both parties in the House and Senate to continue to work on legislation that is going to get help where help is needed.

Mr. CORREA. Thank you very much, gentlemen.

Mr. Chairman, I yield.

Chairman THOMPSON. [Inaudible]

Mr. CORREA. You are muted, sir.

Chairman THOMPSON. The Chair recognizes the gentleman from Kansas City, Mr. Cleaver.

Mr. CLEAVER. Thank you, Mr. Chairman.

One of my big concerns is we politicize everything and, you know, we have things like, you know, your seatbelts, which is required to be in your automobiles and, I guess, motorcycle helmets to a lesser degree, they may be regulated [inaudible]. But it has become a—you know, if you support the President, you don't do this. I am so concerned about it because I think we are probably going to lose some lives over that, and may have already done so.

But, Dr. Shah, one of the things that I am talking about is in my birth State of Texas, you know, we have this contagion running rampant in Texas. Can we say to people in Texas—I have about a hundred, maybe probably more that I just don't know about, but at least a hundred of my family members live in Texas now. If I were to talk to them, can I tell them, with any degree of accuracy,

that everybody in Texas who wants to take the test can take the test?

Dr. SHAH. You know, that is—thank you, Congressman, and great to hear from somebody who is a Texan at heart.

What I would say is two things. I have been saying this is a tale of two cities. We've gotten better with testing, but we are not where we need to be as a Nation and certainly here in Texas. The key message that I have been saying—and people have asked me this question—if somebody wanted to get tested, could they get tested? The answer is, yes, likely, should be. But if the answer is—we have 5 million residents in Harris County alone, if today they said, I want to get tested today, the answer is absolutely no.

So the answer is really very much about we are better than where we were, but testing is a key foundation, and we need to really spend a lot of our efforts as a Nation on making sure testing capacity is even better than where it has been.

Mr. CLEAVER. Well, I am also concerned—thank you. Thank you, Doctor.

I am also concerned, though, however, that the politicalization has gone so wildly that I was at a meeting with some Members of Congress, and I was told that even if a vaccine is created, this particular Member—this is a Member of Congress who said, I am not going to take it, my family is not going to take it, and the people I know will not take it. Why would I take a vaccine—this is a Member of Congress—why would I take a vaccine that could very likely kill me?

So my question is—you deal with this stuff on an everyday basis—is that even if—I mean, you know, even if everybody can get tested, and even if we get a vaccine, we have intelligent human beings out saying openly that they are not going to take a test and that they are going to prevent their family from taking it and all the people they know.

So if a couple of Members say that, we are talking millions of people. I mean, each Member of Congress represents 800,000—roughly 800,000 people. If somebody even higher says, roll with me—I know you can't solve that problem, but with the vaccine, I mean, how many people do you think, Doctor, die each day from taking the polio vaccine or the flu vaccine?

Dr. SHAH. Well, Congressman, I think that is the concern. That is the mixed messaging. That is the issue. That is why there are other countries that are doing better, because they have come across, come around to the fact that we are all in this together, and we have become divided. That is the issue.

The other piece that you said earlier about the testing, I will say that it is not just the quantity of tests; it is also the quality of the test, the turnaround time, the lag of the testing. It is all that together, which means that this is a very critical time for us as a Nation. Unless we can get all of our efforts centered on fighting this pandemic, we are going to be in this longer and we are going to have more unfortunate or adverse outcomes.

Mr. CLEAVER. Thank you.

I took the [inaudible] yesterday. That is why I have a Band-Aid here. Every time I get a chance to take a test, I am going to take one, and I am trying to say that to everybody else.

So thanks, Doctor. This is somewhat frustrating, but thank you very much for what you do every day.

Dr. SHAH. Thank you. Thank you, Congressman.

Mr. CLEAVER. Thank you, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from New York for 5 minutes, Ms. Clarke.

Ms. CLARKE. Thank you very much, Mr. Chairman. I want to thank all of our witnesses for their expert testimony today.

As a New Yorker, we went through the eye of the storm, being the epicenter of this pandemic. We are going through a painstaking phase in an introduction to our economy once again. But nothing is more troubling to me as a Member of this committee than to see the type of spiking that we are seeing in the southern, midwestern parts of our country, particularly in the southwestern part of the country, particularly because it would seem to me that we would have learned observing what New York State went through.

My question is, you know, are States actually coordinating and having conversations with one another about the experiences that each State has gone through? Because it seems to me that we are stuck in Groundhog Day here, and this is costing lives across this Nation.

It would seem to me, Mr. Chairman, that there would be a coordinated effort to get a National platform, a National standard for making sure that there are PPEs for each and every State across this Nation, that the stockpiles that everyone is talking about is facilitated by the Federal Government and that that demand would be something that we could also rally behind as Members of Congress.

So my question, then, is to the general from Alabama. What conversations are you having with similar colleagues in other States that have experience, say, New Jersey, Connecticut, New York, that have gone through sort of the eye of the storm, if any?

Mr. HASTINGS. Personally, I like to catch up on the National news every evening at the end of the day, and ours is kind of regionally specific, I have to admit. We have calls with HHS/ASPR and FEMA Region 4. So among the Region 4 States we share, and we are sensitive to what is going on in other States, because as you guys are going through the eye of the storm, we were having trouble getting PPE and some resources because the Nation had prioritized some of those resources toward those hotspots that initially happened.

So because Alabama was kind-of a slow burn with the COVID–19 rise, we were having trouble getting some of those resources, and rightfully so. They were going to places like Chicago, Detroit, Pennsylvania in the Philadelphia area, New York City, and Georgia, and the hotspots in Region 4. But we have not had conversations with those northern tier States, other than through the National Emergency Management Agency giving out some documents that I go through once a week showing what all the different States are doing, and then it is up to me as an emergency manager to kind-of take a look at how the Nation is doing, how the region is doing, and especially how Alabama is doing, ma'am.

Ms. CLARKE. Well, let me follow-up this question very quickly with, do you think that there are lessons to be learned as you now face this that perhaps have already been learned by other jurisdictions in other parts of the country? If this is a National pandemic, you know, is there something that prohibits the type of conversation that would put you in a better footing to deal with the outbreak that you are experiencing in Alabama?

Mr. HASTINGS. No, I think there is. I think behind the scenes—and I can't speak specifically to it, but being in the conversations with Dr. Harris, our public health officer, and University of Alabama Birmingham Medicine, you can hear that both hospitals and the health care coalitions are sharing with their partners, and they are sharing lessons learned daily with whether it is PPE uses, how you flow patients in and out of health care hospitals and facilities. So that is going on behind the scenes.

Ms. CLARKE. All right. Very well.

My time is running down, but I would like to get your take on it, Dr. Shah.

Dr. SHAH. Congresswoman, thank you for that question. You know, I know that your State, unfortunately, has gone through a tremendous amount.

I think this is exactly what I was saying earlier where I see a role for the CDC to play across the system. I am absolutely convinced that we have to learn from each other. That is how you learn best. Unfortunately, in this emergency, we have not seen that sharing across the system, except on an ad hoc basis. Not that it doesn't happen, Congresswoman; it is happening in a public health world, but it is not happening as systematically as it should happen. Unfortunately, that is also a significant driver and sometimes repeating some of those issues that we could have learned from other communities.

Now, I will say that our county elected official, Judge Hidalgo, has been in touch with elected officials across the country, and I have also been in touch with health officials across the country. But I will tell you it is not systematic on the health side as it should be and as we have seen previously.

Thank you for that question.

Ms. CLARKE. I yield back, Mr. Chairman, and thank you for this very important hearing.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from Nevada, Ms. Titus.

Ms. TITUS. Thank you very much, Mr. Chairman. It is good to see you.

As I have sat here most of the morning, I am from——

Chairman THOMPSON. Good to see you.

Ms. TITUS. Thank you.

As I have sat here, I have heard a number of my Republican colleagues, some of whom are from some of the hottest spots in the country, grill the panel, especially the Governor, in a not-so-subtle attempt to defend the President's actions. The witnesses have responded with answers that are informed. They are straightforward. They are based in fact, not in partisan politics. I really want to commend them for that and thank them.

I would note, though, that in the Republicans' defense of the President, I haven't heard any of them mention, defend, or ask about the President's rallies in Tulsa, at Mt. Rushmore, and his future planned ones and how they put an extra burden on first responders, hospitals, and FEMA folks. I wonder if they believe the President when he says 99 percent of the cases are totally harmless and have that misinformation placed into the mixed message that the public is getting that stymies our attempts to get over this.

I am also just kind-of curious how many of these Members are going to attend their political convention next month, given all that is still going on and what is really happening in Florida. But I guess we will wait and see about that.

The question I really want to ask, though, first, is to Dr. Shah. My district is a lot like Harris County. We have a very large Hispanic population, and the numbers show that the virus is disproportionately affecting the members of that community. It is kind-of easy to understand why. You know, they work a lot of front-line jobs. They can't take off. They are essential workers. Many of them are uninsured. Many members of the community are afraid to come forward to be tested or get information or be treated because of immigration concerns. Also, they live in densely-populated neighborhoods. And even in one family, you may have extended family members or, you know, neighbors or something all living in one house. So it is fairly easily to figure out why.

But I am wondering what we can do to better serve that community, how we can better count those numbers, use that data, how local government can supplement what the Federal Government is having such a problem collecting. Can you tell us what you all are doing or maybe give us some suggestions?

Dr. SHAH. Sure. Congresswoman, thank you for that question. Thank you for your earlier comment about our answers as a collective.

Some of the things that we are doing, as you know, we have a large Hispanic population here in Harris County, and we have to match the diversity of our community with our own work force. So I think it starts there, and we have done that, not just in advance of COVID–19, but also during COVID–19 with the hiring of our contact tracers. We hired 300 contact tracers by May 22, and the diversity in that room, I will tell you, was incredible, including different languages.

The other piece is that we have to really be making sure that as our outreach engagement efforts are in the community, that they are also Spanish-speaking or bilingual, not just Spanish, but obviously in the case of Vietnamese or Mandarin Chinese, whatever that looks like, we have to be very much synced in with that.

Then we are also looking at and working with partners in media with that specific ethnicity in mind, so Spanish-speaking media or leaders that are in the Hispanic community, in particular, but also the African American community and beyond, to really make sure we have partnerships because, ultimately, they don't always think about the health department as being, you know, that partner. But when there is someone in between as being a trusted source, that also helps, especially in the faith community.

There are many other strategies that I could put out there, including putting our mobile testing in those areas and also making sure that, you know, we are doing our case investigation appropriately and, obviously, ensuring that we have resources in those communities.

But I think that is an excellent question, and that is something that every day we are very mindful of and responding to.

Ms. TITUS. Thank you. Thank you very much.

I will yield back, Mr. Chairman.

Chairman THOMPSON. [Inaudible]

Mr. HASTINGS. You are muted, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from California, Ms. Barragán, for 5 minutes.

Seeing as she is not with us, let me, in the interest of time, thank the witnesses for their valuable testimony and the Members for their questions.

Before adjourning, I ask unanimous consent to submit a statement for the record from the Robert Wood Johnson Foundation.

[The information follows:]

STATEMENT OF THE ROBERT WOOD JOHNSON FOUNDATION

HEALTH EQUITY PRINCIPLES FOR STATE AND LOCAL LEADERS IN RESPONDING TO, REOPENING, AND RECOVERING FROM COVID–19

OVERVIEW

COVID–19 has unleashed a dual threat to health equity in the United States: A pandemic that has sickened millions and killed tens of thousands and counting, and an economic downturn that has resulted in tens of millions of people losing jobs—the highest numbers since the Great Depression. The COVID pandemic underscores that:

- Our health is inextricably linked to that of our neighbors, family members, child- and adult-care providers, co-workers, school teachers, delivery service people, grocery store clerks, factory workers, and first responders, among others;
- Our current health care, public health, and economic systems do not adequately or equitably protect our well-being as a Nation; and
- Every community is experiencing harm, though certain groups are suffering disproportionately, including people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.

For communities and their residents to recover fully and fairly, State and local leaders should consider the following health equity principles in designing and implementing their responses. These principles are not a detailed public health guide for responding to the pandemic or reopening the economy, but rather a compass that continually points leaders toward an equitable and lasting recovery.

> *"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."*
>
> *What Is Health Equity? And What Difference Does a Definition Make?*
>
> *Robert Wood Johnson Foundation, 2017*

1.—Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics.

Pandemics and economic recessions exacerbate disparities that ultimately hurt us all. Therefore, State and local leaders cannot design equitable response and recovery strategies without monitoring COVID's impacts among socially and economically

marginalized groups.[1] Data disaggregation should follow best practices and extend not only to public health data on COVID cases, hospitalizations, and fatalities, but also to: Measures of access to testing, treatment, personal protective equipment (PPE), and safe places to isolate when sick; receipt of social and economic supports; and the downstream consequences of COVID on well-being, ranging from housing instability to food insecurity. Geographic identifiers would allow leaders and the public to understand the interplay between place and social factors, as counties with large black populations account for more than half of all COVID deaths, and rural communities and post-industrial cities generally fare worse in economic downturns. Legal mandates for data disaggregation are proliferating, but 11 States are still not reporting COVID deaths by race; 16 are not reporting by gender; and 26 are not reporting based on congregate living status (e.g., nursing homes, jails). Only 3 are reporting testing data by race and ethnicity. While States and cities can do more, the Federal Government should also support data disaggregation through funding and National standards.

Health Equity Principles

1. Collect, analyze and report disaggregated data.
2. Include those who are most affected in decisions, and benchmark progress based on their outcomes.
3. Establish and empower teams dedicated to racial equity.
4. Proactively fill policy gaps while advocating for more Federal support.
5. Invest in public health, health care, and social infrastructure.

2.—Include in decision making the people most affected by health and economic challenges, and benchmark progress based on their outcomes.

Our communities are stronger, more stable, and more prosperous when every person, including the most disadvantaged residents, is healthy and financially secure. Throughout the response and recovery, State and local leaders should ask: Are we making sure that people facing the greatest risks have access to PPE, testing and treatment, stable housing, and a way to support their families? And, are we creating ways for residents—particularly those hardest hit—to meaningfully participate in and shape the Government's recovery strategy?

Accordingly, policy makers should create space for leaders from these communities to be at decision-making tables and should regularly consult with community-based organizations that can identify barriers to accessing health and social services, lift up grassroots solutions, and disseminate public health guidance in culturally and linguistically appropriate ways. For example, they could recommend trusted, accessible locations for new testing sites and advise on how to diversify the pool of contact tracers, who will be crucial to tamping down the spread of infection in reopened communities. They could also collaborate with Government leaders to ensure that all people who are infected with coronavirus (or exposed to someone infected) have a safe, secure, and acceptable place to isolate or quarantine for 14 days. Key partners could include community health centers, small business associations, community organizing groups, and workers' rights organizations, among others. Ultimately, State and local leaders should measure the success of their response based not only on total death counts and aggregate economic impacts but also on the health and social outcomes of the most marginalized.

Are we making sure that people facing the greatest risks have access to PPE, testing and treatment, stable housing, and a way to support their families?

3.—Establish and empower teams dedicated to promoting racial equity in response and recovery efforts.

Race or ethnicity should not determine anyone's opportunity for good health or social well-being, but, as COVID has shown, we are far from this goal. People of color are more likely to be front-line workers, to live in dense or overcrowded housing, to lack health insurance, and to experience chronic diseases linked to unhealthy environments and structural racism. Therefore, State and local leaders should empower dedicated teams to address COVID-related racial disparities, as several leaders, Republican and Democrat, have already done. To be effective, these entities should: Include leaders of color from community, corporate, academic, and philanthropic sectors; be integrated as key members of the broader public health and economic recovery efforts; and be accountable to the public. These teams should foster

[1] People of color (African-Americans, Latinos, Asian Americans, American Indians, Alaska Natives, and Native Hawaiians and other Pacific Islanders), women, people living in congregate settings such as nursing homes and jails, people with physical and intellectual disabilities, LGBTQ people, immigrants, and people with limited English proficiency.

collaboration between State, local, and Tribal governments to assist Native communities; anticipate and mitigate negative consequences of current response strategies, such as bias in enforcement of public health guidelines; address racial discrimination within the health care system; and ensure access to tailored mental health services for people of color and immigrants who are experiencing added trauma, stigma, and fear. Ultimately, resources matter. State and local leaders must ensure that critical health and social supports are distributed fairly, proportionate to need, and free of undue restrictions to meet the needs of all groups, including black, Latino, Asian, and Indigenous communities.

State and local leaders must ensure that critical health and social supports are distributed fairly, proportionate to need, and free of undue restrictions to meet the needs of all groups, including black, Latino, Asian, and Indigenous communities.

4.—Proactively identify and address existing policy gaps while advocating for further Federal support.

The Congressional response to COVID has been historic in its scope and speed, but significant gaps remain. Additional Federal resources are needed for a broad range of health and social services, along with fiscal relief for States and communities facing historically large budget deficits due to COVID. Despite these challenges, State and local leaders must still find ways to take targeted policy actions. The following questions can help guide their response.

Who is left out?

Inclusion of all populations will strengthen the public health response and lessen the pandemic's economic fallout for all of society, but Federal actions to date have not included all who have been severely harmed by the pandemic. As a result, many States and communities have sought to fill gaps in eviction protections and paid sick and caregiving leave. Others are extending support to undocumented immigrants and mixed-status families through public-private partnerships, faith-based charities, and community-led mutual aid systems. Vital health care providers, including safety net hospitals and Indian Health Service facilities, have also been disadvantaged and need targeted support.

Will protections last long enough?

Many programs, such as expanded Medicaid funding, are tied to the Federal declaration of a public health emergency, which will likely end before the economic crisis does. Other policies, like enhanced unemployment insurance and mortgage relief, are set to expire on arbitrary dates. And still others, such as stimulus checks, were one-time payments. Instead, policy extensions should be tied to the extent of COVID infection in a State or community (or its anticipated spread) and/or to broader economic measures such as unemployment. This is particularly important as communities will likely experience reopenings and closings over the next 6 to 12 months as COVID reemerges.

Have programs that meet urgent needs been fully and fairly implemented?

All existing Federal resources should be used in a time of great need. For example, additional States should adopt provisions that would allow families with school-age children to receive added Supplemental Nutrition Assistance Program (SNAP) benefits, and more communities need innovative solutions to provide meals to young children who relied on schools or child care providers for breakfast and lunch. States should also revise eligibility, enrollment, and recertification processes that deter Medicaid use by children, pregnant women, and lawfully-residing immigrants.

5.—Invest in strengthening public health, health care, and social infrastructure to foster resilience.

Health, public health, and social infrastructure are critical for recovery and for our survival of the next pandemic, severe weather event, or economic downturn. A comprehensive public health system is the first line of defense for rural, Tribal, and urban communities. While a sizable Federal reinvestment in public health is needed, States and communities must also reverse steady cuts to the public health workforce and laboratory and data systems. Everyone in this country should have paid sick and family leave to care for themselves and loved ones; comprehensive health insurance to ensure access to care when sick and to protect against medical debt; and jobs and social supports that enable families to meet their basic needs and invest in the future. As millions are projected to lose employer-sponsored health insurance, Medicaid expansion becomes increasingly vital for its proven ability to boost health, reduce disparities, and provide a strong return on investment. In the longer term, policies such as earned income tax credits and wage increases for low-wage

workers can help secure economic opportunity and health for all. Finally, States and communities should invest in affordable, accessible high-speed internet, which is crucial to ensuring that everyone—not just the most privileged among us—is informed, connected to schools and jobs, and engaged civically.

> *Everyone in this country should have paid sick and family leave . . . comprehensive health insurance . . . and jobs and social supports that enable families to meet their basic needs and invest in the future.*

CONCLUSION

These principles can guide our Nation toward an equitable response and recovery and help sow the seeds of long-term, transformative change. States and cities have begun imagining and, in some cases, advancing toward this vision, putting a down payment on a fair and just future in which health equity is a reality. Returning to the ways things were is not an option.

Chairman THOMPSON. I understand Ms. Jackson Lee has a unanimous consent.

Ms. JACKSON LEE. Yes, Mr. Chairman. Can you hear me? Can you hear me?

Chairman THOMPSON. Yes, Ms. Jackson Lee.

Ms. JACKSON LEE. Thank you so very much.

I ask unanimous consent to place into the record current COVID–19 statistics in Houston, Texas, as of 7 a.m. at 7/8/20. Texas Coronavirus Timeline, *Houston Chronicle,* July 7, 2020, which captures the demise of our success story and also where we are today. *Houston Chronicle,* Evidence growing that Houston's main coronavirus strain is more contagious than the original, dated July 4, 2020. A pandemic plan was in place—by Stat News—Trump abandoned it, and science, in the face of COVID–19, dated May 17, 2020.

Ask unanimous consent to place these items into the record.

Chairman THOMPSON. Without objection.

[The information follows:]

DATA SUBMITTED BY HONORABLE SHEILA JACKSON LEE

Current COVID–19 Statistics as of 7 am 7/8/20:

US

CONFIRMED CASES: 3.05M
DEATHS: 133k

TEXAS

CONFIRMED CASES: 216,167
DEATHS: 2,758

HARRIS COUN1Y

CONFIRMED CASES: 39,311
DEATHS: 395

HOUSTON

CONFIRMED CASES: 55,122
DEATHS: 581

TEXAS CORONAVIRUS TIMELINE

By Stephanie Lamm, Zach Despart, Jeremy Blackman, Jasper Scherer and Taylor Goldenstein, July 7, 2020 10 o'clock a.m. https://www.houstonchronicle.com/projects/2020/texas-coronavirus-timeline/

A State once lauded as a model for COVID–19 containment came to "the verge of a nightmarish catastrophe" on the Fourth of July. Here's how it happened.

March 4, 2020

Dr. Jacquelyn Minter, director of Fort Bend County Health and Human Services, announces that a Fort Bend man in his 70's is the Houston area's first "presumptive positive" case of COVID–19.

March 11, 2020

The Houston Livestock Show and Rodeo is canceled after a Montgomery County man in his 40's becomes the first person in Texas to contract COVID–19 from community spread.

March 16, 2020

Harris County orders all bars closed and restaurants limited to takeout and delivery for 15 days. HISD schools close through at least April 10.

March 19, 2020

Gov. Greg Abbott issues an executive order that limits social gatherings to no more than 10 people, closes all schools, shuts down bars and restricts restaurants. Texas declares a public health disaster for the first time in more than 100 years.

March 24, 2020

Harris County Judge Lina Hidalgo and Houston Mayor Sylvester Turner announce a stay-home order for the county and city through April 3.

March 31, 2020

Gov. Abbott issues an order that reopens churches with limitations. Many congregations say they will continue to hold services on-line and abide by recommendations to prevent the spread of COVID–19.

April 17, 2020

Gov. Abbott announces he will reopen State parks, allow retailers to offer to-go sales and let physicians and nurses perform diagnostic tests and surgeries that had been put on hold to ensure hospital capacity for COVID–19 patients. "We have demonstrated that we can corral the coronavirus," Abbott says.

April 21, 2020

Harris County Judge Lina Hidalgo orders residents to cover their faces in public starting April 27. "If we get cocky, we get sloppy, we get right back to where we started, and all of the sacrifices people have been making have been in vain," Hidalgo says while wearing a homemade mask. "Let's not get complacent. Let's remember that we still have work to do."

April 26, 2020

White House coronavirus task force coordinator Dr. Deborah Birx holds out Houston as one of the places that give her "great hope" that the American economy can get rolling again.

April 27, 2020

The State is testing 14,000 people a day, less than half of Gov. Abbott's goal of 30,000 as he announces he will lift his stay-home order on May 1. Some health experts warn that testing and contact tracing in Texas are insufficient for this move. "Without robust testing, we remain in the dark," says U.S. Rep. Veronica Escobar, D–El Paso.

May 1, 2020

Gov. Abbott lifts his stay-at-home order as the State reports a record 50 deaths in a day from the virus.

May 4, 2020

Harris County officials extend their stay-home order through May 20, encouraging residents to report violations. "We need to remain vigilant for a phased reopening to work," County Judge Hidalgo writes on Twitter.

May 7, 2020

Gov. Abbott amends his coronavirus executive order, removing jail time as a possible punishment for those who break it. Abbott makes the revision as he heads to Washington, DC, to meet with President Donald Trump, who praises him.

May 8, 2020

Gov. Abbott slams Houston on National television over coronavirus restrictions and overstates the city's enforcement efforts. "In Houston, they were issuing fines and potential jail time for anybody who refused to wear a mask," he says. No arrests or fines had been issued.

May 18, 2020

Gov. Abbott presses ahead with the State's reopening, allowing nearly all businesses and activities to resume at a limited capacity. The State reports a record 58 deaths in a single day, though Abbott notes that the rate of people testing positive for the disease is falling.

May 25, 2020

More than 250 social distancing complaints are lodged with the city of Houston over Memorial Day weekend, including concerns regarding a packed pool party at a Midtown club. "I started getting pictures from City Council members and others saying, 'This is crazy,'" Mayor Sylvester Turner says.

May 21, 2020

Gov. Abbott says the Panhandle is turning a corner after having been hit especially hard by infections at meatpacking plants. Abbott says the infusion of State and Federal resources into the region are a model for how to contain hotspots in Texas going foiward.

June 3, 2020

All businesses operating at 25 percent capacity are permitted to expand occupancy to 50 percent—including bars—with certain exceptions. Amusement parks and carnivals in counties with less than 1,000 confirmed positive cases may open at 50 percent capacity. (Staff photo by Melissa Phillip)

June 5, 2020

Houston officials point to a 2-week rise in cases and hospitalizations, saying they suspect Memorial Day and the latest reopenings may be the cause. "If the numbers keep up in this direction, we could be headed to a place where we run out of hospital space," Harris County Judge Lina Hidalgo says.

June 12, 2020

Restaurants begin operating at 75 percent as the State records its highest number of COVID hospitalizations in a single day, 2,166. Bexar County Judge Nelson Wolff writes to Abbott asking that he be allowed to mandate masks. Gov. Abbott declines, saying: "Judge Wolff and I have a philosophical difference. He believes in government mandates. I believe in personal responsibility."

June 16, 2020

Texas reports 2,518 hospitalizations, nearly a 66-percent increase since Memorial Day. "It does raise concerns but as shown today there is no reason to be alarmed," Gov. Abbott says as he rejects requests from municipal leaders in Houston, San Antonio, Austin, Dallas, and Fort Worth for the ability to mandate masks.

June 17, 2020

Bexar County Judge Nelson Wolff in Bexar County tries again with a new mandate that businesses require masks at all times. Abbott says go ahead. "Government cannot require individuals to wear masks," Gov. Abbott tells WKTX in Waco. "However . . . local governments can require stores and businesses to require masks." Leaders in Harris and other counties prepare similar rules.

June 19, 2020

Amusement parks and carnivals in counties with more than 1,000 confirmed positive cases of COVID–19 are allowed to open at 50 percent capacity.

June 22, 2020

The positive test rate hits 9.76 percent, just shy of the number Gov. Abbott indicated would cause him to pause the State's reopening. Abbott pleads with Texans to practice social distancing and wear masks as he acknowledges that the virus is

now "spreading at an unacceptable rate." Health experts warn Houston could be the next epicenter of the National pandemic.

June 24, 2020

Officials in Bexar and Harris counties say they are in crisis and Gov. Abbott signals that the reopening is in jeopardy as COVID infections and hospitalizations surge in the State. "The numbers have completely spiked," Abbott says. The positive rate hits 11.76 percent.

June 25, 2020

Gov. Abbott delays further reopenings and orders hospitals in the 4 hardest-hit counties to postpone elective surgeries to make way for COVID patients. That night, Lt. Gov. Dan Patrick appears on National television to assure viewers that the State is not reversing course or running out of intensive care hospital beds. "We have seen a spike in cases. We expected that," Patrick says, pointing falsely to increased testing.

June 26, 2020

Gov. Abbott orders bars to close again and rolls back restaurant capacity to respond to increasing COVID hospitalizations. Infectious disease expert Peter Hotez tells CNN that deaths are a lagging indicator and will inevitably rise in the coming weeks: "This is a tragedy."

July 2, 2020

Gov. Abbott orders nearly all Texans to begin wearing face masks in public as the State enters the Fourth of July weekend amid a dire stretch of new infections, surging hospitalizations and with deaths beginning to mount.

"We have the ability to keep businesses open and move our economy forward—but it requires each of us to do our part to protect one another," he says.

July 4, 2020

"We're on the verge of a nightmarish catastrophe," says Vivian Ho, a health economist at Rice University and the Baylor College of Medicine, as the State logs 7,890 hospital beds occupied by COVID–19 patients, a 43 percent increase from the week before. "On May 1, I thought we actually had a chance to get this virus under control and get the economy opened up safely. I'm not sure we can get it under control anymore."

ARTICLE SUBMITTED BY HONORABLE SHEILA JACKSON LEE

EVIDENCE GROWING THAT HOUSTON'S MAIN CORONAVIRUS STRAIN IS MORE CONTAGIOUS THAN ORIGINAL

Todd Ackerman, July 4, 2020, Houston Chronicle, Updated: July 8, 2020 1:48 p.m.

https://www.houstonchronicle.com/news/houston-texas/houston/article/coronavirus-evidence-growing-houston-strain-mutant-15386157.php

Evidence is growing that a mutated coronavirus strain, the main one circulating in the Houston area, is more contagious than the original virus in China.

Two new research papers show that the newer strain is more transmissible, a possibility first suggested by a team of scientists in May. At the time, that suggestion was considered highly speculative by many scientists, including some in Houston.

"A summary of the data thus far suggests that this strain has gained a fitness advantage over the original and is more transmissible as a result," said Joseph Petrosino, Baylor College of Medicine chair of molecular virology and microbiology. "It is safe to say this version is more infectious."

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"A summary of the data thus far suggests that this strain has gained a fitness advantage over the original and is more transmissible as a result," said Joseph Petrosino, Baylor College of Medicine chair of molecular virology and microbiology. "It is safe to say this version is more infectious."

Petrosino said that although Baylor hasn't yet conducted a surveillance study, the area rate of positive tests and increase in hospitalizations point to a significantly higher prevalence of the virus strain now. He said Baylor is finding the mutated strain in as many as 80 percent of viruses it analyzes.

Houston Methodist researchers reported the strain was prevalent in the Houston area in a paper in mid-May. The paper said 70 percent of the specimens examined, taken from COVID–19 patients treated at Methodist from early March to March 30, showed a mutation to the spike proteins the coronavirus uses to attach to and enter human respiratory cells.

The week before, researchers at Los Alamos National Laboratory reported on the mutation. They said it doesn't make people sicker, but appears to facilitate the spread of the virus.

The Los Alamos team expanded on the findings in a peer-reviewed paper published in the journal Cell Thursday.

The Methodist researchers were among scientists skeptical of that conclusion. Dr. James Musser, the hospital's chairman of pathology and genomic medicine and a study author, said Friday he would like the science to play out a bit more as studies reviewed by scientists are published. He gave no update on the percentage of mutated strains analyzed at Methodist.

The mutation is thought to have occurred in Europe, then was introduced by travelers to the east coast of the U.S., particularly New York. It has since become the world's most dominant strain, accounting for about 65 percent of cases submitted to a major data base from around the world, according to one team of scientists.

Except for the new Cell publication, all of the papers are examples of what is known as "pre-prints," preliminary reports made public ahead of their peer-reviewed publication because of the discoveries' time-sensitive nature.

One of the papers, by a Scripps Research Institute team, showed that significantly increasing the number of functional spikes on the viral surface in laboratory experiments allowed the virus to bind to and infect cells. It said that the mutation provides greater flexibility to the spike's "backbone," which makes viral particles better able to navigate the process fully intact.

"Over time, it has figured out how to hold on better and not fall apart until it needs to," Michael Farzan, a paper author and co-chairman of the Scripps department of immunology and microbiology, said in a news release.

Another paper, by the New York Genome Center, found a huge increase in viral transmission when researchers switched from the original virus sequence to the mutated one, a change they interpret as an indication the new strain is more efficient at invading the human cell and taking over its reproductive machinery.

At least three other lab experiments suggest that the mutation makes the virus more infectious, the *Washington Post* reported Thursday. Those findings also appeared in pre-prints.

The mutation, known as D614G, involves one of roughly 1,300 amino acids that act as building blocks for the spike protein. Not much different from the original virus, it switched genetic instructions for the amino acid 614 from an aspartic acid (D) to a glycine (G).

In the Cell paper, the Los Alamos researchers wrote that patients with the D614G mutation have more virus in their bodies. Their laboratory experiments found the mutation is three to six times more capable of infecting human cells.

Strains of the virus circulating in the Houston also include the original one from China and one from South America, according to Methodist's study. The area's multiple-continent seeding contrasts with relatively single-continent seeding in New York and Seattle. Seattle's came mostly from Asia.

Many scientists, noting one paper found no evidence of increased transmissibility, say the evidence for D614G's greater contagiousness is still far from definitive. "This is an extraordinarily challenging problem, the evolution and demography are complex, so there's much more work to be done," Marc Suchard, a biostatistician at the UCLA School of Medicine, told the New York Times.

Though Baylor's Petrosino suggests the mutated strain is more prevalent, he adds that the recent spike is mostly a result of people's wanting to gather and being willing to take risks to do so.

"The bulk of it is from people not social distancing properly, not masking appropriately and a reluctance to participate in contact tracing," said Petrosino. "I think people have been getting tired of the safety measures and have started becoming more lax in their practices."

ARTICLE SUBMITTED BY HONORABLE SHEILA JACKSON LEE

A PANDEMIC PLAN WAS IN PLACE. TRUMP ABANDONED IT—AND SCIENCE—IN THE FACE OF COVID–19

By Jason Karlawish, May 17, 2020, STATNEWS, First Opinion

https://www.statnews.com/2020/05/17/the-art-of-the-pandemic-how-donald-trump-walked-the-u-s-into-the-covid-19-era/

President Obama was bothered. It was the summer of 2009 and he was in a meeting at the White House to talk about preparations for an expected autumn outbreak of swine flu. Elbows on the table, he thumbed through the pages of a report on preparations for it.

"So," he asked no one in particular, "if you guys are so smart, how come you're still making this in eggs?" he asked, referring to the nearly century-old process for making vaccines in chicken eggs.

Those around the table erupted into laughter. The president's quip was a moment of levity at an otherwise serious meeting.

The "smart guys" the president was jesting with were the members of the President's Council of Advisors on Science and Technology, or PCAST. Founded in 1990 by President George H.W. Bush, the council, administered by the White House Office of Science and Technology Policy (OSTP), is an advisory group of scientists and engineers appointed by the president to augment the science advice he receives from other White House advisors, departments, and agencies.

In June 2009, the recently inaugurated Obama had given his PCAST advisors their first assignment: What does the president need to do to prepare for an influenza pandemic? Five weeks later, on Aug. 7, they gave him their answers at a meeting in the White House's State Dining Room.

The story of this meeting and the ensuing 8 years of science-informed policymaking, which I have drawn from interviews with members of PCAST and internet archives of documents, show a president comfortable with having back-and-forth discussions with an assembly of the some of the nation's top scientific minds. The president was committed to integrating science into his day-to-day decisions. One of those decisions was how to plan for and respond to the outbreak of a pandemic illness.

Over the course of the Obama presidency, a pandemic infrastructure was put in place. It included recommendations for a top-level White House official devoted to planning and responding to emerging infectious threats and, to guide that person's work, the "Playbook for early response to high-consequence emerging infectious disease threats and biological incidents."

And then on Jan. 21, 2017, Donald Trump became president.

Beginning the morning after his inauguration, a spectacular science-related tragedy has unfolded. The Trump administration has systematically dismantled the executive branch's science infrastructure and rejected the role of science to inform policy, essentially reversing both Republican and Democrat Presidential administrations since World War II, when Vannevar Bush, an engineer, advised Presidents Franklin D. Roosevelt and Harry S. Truman.

President Trump's pursuit of anti-science policy has been so effective that as the first cases of COVID–19 were breaking out in Wuhan, China, no meaningful science policy infrastructure was in place to advise him. As a consequence, America is suffering from a pandemic without a plan. Our responses are ineffectual and inconsistent. We are increasingly divided by misinformation and invidious messaging. And it's not even over.

To understand how Trump walked America into this mess, and that his recent claim he "inherited practically nothing" in pandemic preparedness from the previous administration is plainly wrong, it helps to have a picture of the infrastructure he neglected and ignored.

On April 27, 2009, on the eve of his 100th day in office, Obama made a five-block trip from the White House to 2101 Constitution Ave. There, in the Great Hall of the National Academy of Sciences, he spoke about his administration's commitment to science.

"Science is more essential for our prosperity, our security, our health, our environment, and our quality of life than it has ever been before," he announced. He introduced the members of PCAST and explained how his administration would engage the scientific community directly in the work of public policy.

"I want to be sure that facts are driving scientific decisions—and not the other way around," the president said. The audience broke into laughter.

Obama explained that his science advisers were already briefing him daily on the emerging threat of swine flu, which some were projecting could kill thousands of Americans.

The day before this speech, which came just 12 days after the first case of swine flu had been reported in the U.S., Obama had declared a public health emergency. Three days after the speech he asked Congress for $1.5 billion to address this emergency.

In the weeks that followed, the White House science policy infrastructure he had introduced at the National Academy of Sciences set to work.

Although every president since Franklin Roosevelt has had some engagement with science policymaking, the degree of the contact between the president and his science advisers has varied.

George H.W. Bush met frequently with his head of OSTP, Allan Bromley, a physicist and former Yale classmate of the president. George W. Bush, in contrast, met just seven times with the head of his Office of Science Technology and Policy, John H. Marburger III, and eliminated two associate directors from the office. Obama's engagement with his science policy apparatus was singular. He met with his OSTP director, John Holdren, as often as seven times a week.

Holdren, a plasma physicist whose scientific career included 23 years co-directing the Energy and Resources Group at the University of California, Berkeley, had this regular and close contact with Obama because, in addition to leading the OSTP and acting as co-director of the President's Council of Advisors on Science and Technology, he was the assistant to the president for science and technology.

The title of assistant to the president grants its holder great privilege and power. Assistants to the president have direct access to the president. An assistant can schedule a meeting with the president or send a memo directly to the president. Even cabinet secretaries aren't afforded such direct and easy access. To send a memo or meet with the president, they must work through the assistant to the president for cabinet affairs.

There are, of course, many Federal agencies and departments engaged in science policy, such as the Centers for Disease Control and Prevention, the Food and Drug Administration, the National Aeronautics and Space Administration, the Departments of Agriculture and Energy, and more. Each has its own mission and focus. The PCAST provides the president with immediate daily access to science information and advice that are independent of the agendas of these various agencies and departments.

Easy and continuous access to science was of notable value to the administration's early, rapid, and sustained efforts to plan for a viral pandemic.

PCAST's "Preparations for 2009–H1N1 Influenza" identified multiple on-going efforts across the government to plan for a viral pandemic. It also made recommendations. One stands out.

During a pandemic, important decisions must be made rapidly and based on limited data. PCAST recommended designating one individual, preferably the homeland security adviser, to coordinate all policy development and report directly to the president.

Obama took that advice and asked John Brennan, a career CIA employee and assistant to the president for homeland security, to take on the task. Like Holdren, Brennan reported directly to the president. The two assistants worked closely together.

The initial flare of swine flu tapered off in the summer of 2009, but came back again in the fall as expected. The resurgence was managed well. Surveillance was in place, a vaccine was developed, and messaging had been implemented to quell unfounded fears of its risks.

What was clear, however, was that the next viral infection might not be so easily managed. Vaccines were not readily available for viruses such as Ebola and coronaviruses. The question wasn't whether a pandemic would occur, but when.

More work and reports followed.

A 2010 PCAST report answered the president's egg question. It recommended reengineering the influenza vaccine production enterprise.

Recombinant DNA technology and other methods are now used to make vaccines in addition to the egg-based method.

By 2016, the final year of the Obama Administration, much had been learned from swine flu about managing a pandemic, and more knowledge had been added from the responses to the 2014 Ebola outbreak in West Africa. From October 2014 through February 2015, Ron Klain, a former chief of staff to Vice President Joe Biden, was the White House Ebola response coordinator.

From this experience, Klain concluded that a director with singular focus was needed for a pandemic. "The next president should put a coordinating unit together

before an outbreak begins," he argued in his essay "Confronting the Pandemic Threat" in the spring 2016 Democracy Journal.

Klain called for a pandemic prevention directorate to make sure preparation and response are a priority from day one in a new administration and to oversee the government's response to a pandemic.

PCAST endorsed Klain's recommendation. In a November 2016 report, the council recommended that an assistant to the president for pandemic prevention and response should be part of the National Security Council staff. The council gave the incoming Trump administration what it called an important overarching observation: "There is significant overlap between some of the steps needed to protect the Nation from intentional biological attack and those needed to protect against natural outbreaks of new and emerging infectious diseases."

Another important event in 2016 was a Federal effort that engaged the work of PCAST, OSTP, and other agencies and departments to create the "Playbook for early response to high-consequence emerging infectious disease threats and biological incidents." This 69-page document was written to coordinate a response to an emerging disease threat anywhere in the world. It detailed decisionmaking rubrics with key decisions and questions such as these: "Determine whether to implement screening and monitoring measures, or other travel measures within the U.S. or press for measures globally" and "What are the key services and critical infrastructure that need to come back on line for society to return to normal?"

Together, the November 2016 PCAST report and the playbook were messages to the incoming president to pick up where the Obama Administration had left off, since more work was needed to prepare for and respond to a future pandemic.

None of that happened.

On the morning of Jan. 22, 2017, the day after Trump's inauguration, the PCAST website was taken down and all of its reports vanished from the White House website (though they can be found in the Obama White House archives).

For 2 years, the directorship of OSTP was vacant, the longest in its history. The staff was reduced by two-thirds. The current director, Kelvin Droegemeier, a professor of meteorology at the University of Oklahoma whose appointment was confirmed by the Senate on Jan. 2, 2019, isn't an assistant to the president and is unable to directly communicate with the president.

PCAST lay dormant until November 2019, when Trump appointed members to it. Unlike its predecessor, which included a diversity of scientists from academia and industry, the current version includes members drawn primarily from industry. Their charge has been narrowed. The council is to advise the president on "how does America win in the Industries of the Future and how do we prepare the workforce of the future to take advantage of this opportunity?" They're not to produce any reports (the prior PCAST produced 39 reports).

The minutes of the council's meeting on Feb. 3 and 4, 2020, include no discussion of the COVID–19 pandemic.

The sum of the work done by Trump's Council of Advisors on Science and Technology? Zero.

The follow-up on the 2016 recommendation for an assistant to the president dedicated to pandemic prevention and response also fell on deaf ears.

As Ebola was once again breaking out in West Africa, Rear Admiral Timothy Ziemer, who had been charged with creating a national biodefense strategy, resigned from Trump's National Security Council on May 11, 2018. At the time of his departure, that strategy hadn't yet been created.

The remaining staff members were faced with managing a portfolio that bundled together epidemics, biological threats, and weapons of mass destruction. Dividing their time among many responsibilities whose day-to-day urgencies can seem to be greater than preparing for a future pandemic is precisely what Ron Klain and PCAST had warned about in 2016. The Pandemic Playbook was neglected, and its existence has even been denied.

By the end of December 2019, as the COVID–19 epidemic began breaking out in China, Trump was largely without any coherent scientific input into his policymaking. Given that none of the president's assistants, the people with direct access to him via memo or meeting, have any scientific expertise, his nonresponse, even complacency, in the face of the emerging epidemic in China is sadly understandable.

On March 10, after a meeting with U.S. senators about COVID–19, the president remarked to the press that America was prepared and doing a great job. "And it will go away. Just stay calm. It will go away," he insisted.

The next day, the World Health Organization said that the global outbreak was a pandemic. And in the U.S. alone, as I write this nearly 1.5 million Americans have developed COVID–19 and nearly 90,000 have died from it.

Remarks such as "it will go away" cannot be excused as occasional gaffes or verbal missteps. They're the words of someone who simply doesn't understand science—and doesn't want to.

The COVID–19 pandemic is a problem that must be understood and addressed using sciences such as virology, epidemiology, public health, and biomedicine. Yet in the face of a crisis that needs science, America is led by an administration that not only isn't scientific but is actively anti-science.

Trump's remarks, from long before he was elected president and throughout his presidency, on a variety of topics including vaccines and autism, climate change, and wind farms, show he rejects scientific conclusions and methods.

From the stage of the White House briefing room, Trump has likened the COVID–19 virus to a bacterium that is resistant to antibiotics, insisted that the virus could not cause a pandemic, that warm weather, as well as sunlight, will kill it, and has repeatedly touted untested pharmaceuticals such as hydroxychloroquine and noxious household detergents as interventions to either prevent or treat infection.

Too little and too late Trump let scientists such as Anthony Fauci and Deborah Birx share the stage. But even then he has undercut their messages and spread confusion.

Trump, for example, asserted that Fauci was "playing both sides" (sides he did not name) in decisions about whether and how to reopen schools. Fauci, in fact, had called for an approach to reopen schools that was informed by evidence to respect regional differences. "We have a very large country and the dynamics of the outbreak on different, in different regions of the country. So I would imagine that situations regarding school will be very different in one region versus another, so it's not going to be universally, or homogeneous."

I'm a scientist. I don't believe in science—I reserve belief for religion. I trust in science to help me diagnose and treat my patients, to understand how Alzheimer's disease robs them of their memories and ability to function, and to find new treatments for it and other diseases. And now, during this awful pandemic, I desperately want my president to trust it too. And yet he won't even wear a mask.

Jason Karlawish is a physician, co-director of the Penn Memory Center, and author of the forthcoming book, "The Problem of Alzheimer's: How science, culture and politics turned a rare disease into a crisis and what we can do about it" (Macmillan/St. Martin's Press, November 2020).

Ms. JACKSON LEE. Thank you, Mr. Chairman.

Chairman THOMPSON. [Inaudible] Thank you very much, Ms. Jackson Lee.

We now have Ms. Barragán from California for 5 minutes.

Ms. BARRAGÁN. Thank you, Chairman Thompson, for convening this hearing today.

The Trump administration's response to the coronavirus pandemic has been inadequate. We have seen the pandemic raging through our country. We are seeing spikes. We have heard from public health officials that they tried early on, Dr. Bright in particular, to warn this administration, to request that they immediately start getting PPE, and that advice was not followed. We are still in the first wave of the pandemic, and public health experts warn of a disastrous second wave if we do not reduce the spread of the virus.

So it is crucial to ensure the Federal Government leads by both example and do direct assistance and that any and all reduction measures implemented or revised by the Government are backed by science and our public health officials.

I want to start my first question, Dr. Shah and Mayor Shelton, as part of the response to homelessness during COVID–19, FEMA has committed to reimburse 50 to 75 percent of expenses for shelter and temporary housing through their Public Assistance Program, Category B. Having a range this large makes it difficult for a continuum of care and other jurisdictions to project funding plans as this range is large. Along the same lines, we have been told that

it could take 4 to 5 years for localities to receive FEMA reimbursements.

Dr. Shah and Mayor Shelton, can you comment on what effect this has on the uncertainty of the ability to respond to the pandemic and recover from the crisis?

Dr. SHAH. Congresswoman, I will go first only because you said doctor first, so I will just go first and then turn it over.

You know, there are two inherent questions that you are asking. One is about homeless individuals and those, you know, that we are absolutely concerned about in our communities, obviously the concern about the inability potentially to isolate and/or potentially to spread infection if they test positive. On the flip side, the other question is really about the longer-term impact of uncertainty in reimbursement. I think both are critical. We have to do what we have to do to protect our communities now, and we oftentimes are thinking, unfortunately, of doing what we have to do today and then hoping that there is not this delay in the reimbursement side, because that then obviously gives—that uncertainty gives pause because there is only a limited number of dollars that you have to be able to do what you need to do to protect the community.

With that, I will yield to the mayor.

Mr. SHELTON. [Inaudible]

Ms. BARRAGÁN. Mr. Mayor, I think you are on mute.

Mr. SHELTON. Sorry about that.

Thank you, Doctor.

Thank you, Congresswoman, for the question and opportunity.

During the COVID crisis, we have continued our homelessness outreach here in the city of Tupelo. We contract with an organization, Mississippi United To End Homelessness, here in Tupelo. So we have continued those and just tried to do the best we can as far as, you know, safety precautions, masking, you know, that type thing. But we have continued our efforts there.

I can speak first-hand to the FEMA issue, though. We had a tornado, F3 tornado, hit the city of Tupelo in 2014, caused widespread damage throughout the city. President Obama quickly declared a National disaster, and, you know, we got Federal aid that was desperately needed and greatly appreciated. But we are still, you know, 6 years later, we are still dealing with the red tape for reimbursements and that type thing. So, you know, 6 years later, even though the help, we requested it, the President was gracious enough to send that help, but, you know, we are still dealing with that now, and we are in a new National disaster with this and other things along the way.

Ms. BARRAGÁN. Thank you.

Dr. Shah, you in your written testimony, talked about the public health department in Harris County faced strong pushback from congregate settings to investigate and test within facilities due to overlapping State and Federal jurisdictions of facilities.

I happen to represent Terminal Island Federal prison where there was almost a 70 percent outbreak of COVID–19. What specifically should the Federal Government be doing to help local public health departments combat the spread of coronavirus in congregate facilities?

Dr. SHAH. Thank you, Congresswoman. First, it is that support with resources, tools, what has worked in other settings, that technical assistance. The second is really a markedly more nuanced look at what are the authorities that are available, whether it is through the Federal Government or working with State governments, to allow for public health departments to be able to assess and test in these congregate settings.

In nursing homes, obviously, that is the highest level of concern in many ways, and I will say that our State was able to work with local health authorities to allow us to be able to go in and assess. But when we get past nursing homes into other tiers, it becomes more of a knocking on a door, sending correspondence, and not being able to have the authority to go in unless you have a bona-fide proven case, and that is the limitation that we have.

So this is where the Federal Government can really help with strategies and technical assistance and, if necessary, changing some of those authorities that would really allow, especially in a crisis like this, to be able to have public health departments or health authorities like myself to be able to do more so we can protect the most vulnerable in our communities.

Ms. BARRAGÁN. Thank you.

With that, I yield back.

Chairman THOMPSON. Thank you very much.

The Chair now recognizes the gentlelady from New Jersey, Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Mr. Chairman. Thank you for holding this hearing. Thank you to each of the witnesses for sharing very important information with us.

I would like to just sort-of establish a chronology that I think is relevant to our discussion here, because everyone is talking about, at least my colleagues on the other side of the aisle, about having never been here before and experiencing this virus and this pandemic and not ever having had this experience.

I want to harken us back to 2005 when the Bush administration released its National strategy for pandemic influenza, recognizing the prospects of a pandemic and saying that there needed to be greater coordination, domestic production, and stockpiling of medical supplies, et cetera.

Then in 2016, the Obama administration developed a strategic playbook on pandemic preparedness, a 69-page guidance on fighting pandemics. The incoming administration, the Trump administration, was indeed briefed on this playbook's existence but reportedly didn't heed the advice.

Also in 2016, the Obama administration, recognizing that you had to elevate these issues to the highest level, created the National Security Council Directive for Global Health Security and Biodefense in the White House, something that this President disbanded in the office in 2018.

In 2017, the Department of Defense finalized a report of a pandemic influenza saying that a catastrophic biological incident could threaten the Nation's human, animal, plant, and environment and health, et cetera.

Months before that, the Trump administration eliminated a position of a medical epidemiologist which was embedded in China's

disease control center, and leaving that post left us without on-the-ground knowledge when things were heating up immediately.

I say all that to say—and there is even more than that. I say all that to say that there was forewarning, forearming, and guidances on how to deal with something of this nature.

The one thing that was prominent in all of these discussions and these guidances were that you needed strategic, coordinated leadership at the very, very top. Instead of talking about this virus being a hoax, talking about it having a limited severity, talking about it being something that was just going away, the opposite has absolutely happened, and this administration has been an abysmal failure in keeping us Americans safe from the ravages of this pandemic.

I also wanted to just say for the record that we have been criticized for not being in Washington face-to-face doing business because the Senate is face-to-face doing business and the White House is face-to-face doing business, but we know with the Senate's failure to pass the HEROES Act and the White House failing to deal with these issues of coronavirus and trying to shut down any kind of medical information that is coming out and guidance, that neither of those entities is doing a job even though they are face-to-face.

But having said all that, I have got one question. Why am I still seeing lanes and lanes and hours and hours of cars in line waiting to be tested at this stage in this pandemic in any State? Why, oh why, oh why, is it taking more than 24 hours to have the results of the tests that were taken so that the contact tracing that would take place would be relevant and helpful?

So I want to ask that question of Dr. Shah and of Colonel Hastings.

Dr. SHAH. Thank you, Congresswoman. First is that the lines obviously are because we are seeing—at least in our communities, we are seeing increased demands, increased demand with limited supply, and there you go, there you get the results.

On the lab side, which I think is a really critical piece that I mentioned just quickly earlier, that is an on-going issue. Even on our FEMA Federal sites, the turnaround time in lab results is a problem, and sometimes it is a couple of weeks before we get those results back. It has gotten better, but it is not where it needs to be.

So the individual may not get their lab, and you know how it is, if any of us don't get a laboratory result, and what it means for us as a person and what it means for the physician or the health care provider and, absolutely, the public health, it is a problem. Because as you said, very appropriately, it delays the entire system.

Here is the final answer. We don't have a system, especially electronically. We should have a system so this should not be happening in our country today.

Mrs. WATSON COLEMAN. Is this not something that is attributed to the fact that we haven't had a rigorous, rational, and consistent Federal leadership and coordination around these issues?

Dr. SHAH. I think there is—there are a lot of things that play into this. I do think it starts with the Federal Government, but it is not limited to the Federal Government. I think there is some-

thing about how commercial labs are doing things, the recording, the requirements. We are getting incomplete, inaccurate. Sometimes we are just being told, "Umair Shah, no contact information." Before we can even trace the context, we have to go trace the case and figure out who that individual is, and then 4 or 5 days later, from a different line list from the State, we get that same individual as a duplicate, and now we have to go back and match. Then we are getting it by fax, and we are getting it by email. We are not getting it in the format that should be required. Again, we don't have a system.

Mrs. WATSON COLEMAN. Thank you, Dr. Shah. I submit to you that that still has to do with the lack of leadership, guidance, regulations and accountability, suggestions and helpfulness on the part of this failed administration, and with that, I yield back. Thank you, Mr. Chairman.

Chairman THOMPSON. Thank you. The gentlelady yields back.

The Chair recognizes the gentlelady from Orlando, Mrs. Val Demings.

Mrs. DEMINGS. Well, thank you so much, Mr. Chairman, and thank you so much to our witnesses who are with us today.

Dr. Shah, with regard to the vendors for testing kits, could you explain in more detail what challenges you have had with unreliable vendors, particularly regarding their efforts to sell you emerging testing technology?

Dr. SHAH. Well, Congresswoman, this is an on-going issue for us, and I will tell you that being the third-largest county in the United States, that when vendors and others see something in the news, whether it is contact tracing or laboratory or something else happening, they make contact. I have put my email information, I am active on social media, so people try to contact me directly, or our team members. I will tell you, this has really been a problem, because there has been no—there hasn't been a great way to have a clearinghouse, if you will, of the minimum of what you are looking for.

This is where, you know, I know the FDA has made strides. It has been overwhelming, because there are so many vendors, but that is a role that can also be at a Federal level, to really help give that technical assistance across the system.

The other piece of this, which I think is critical, is that everybody has become an expert in all of these, right? So contact tracing, now everyone says, I can do contact tracing for you, and the moment they see an increase in activity, some are doing it out of the goodness of their heart because they want to help, and others unfortunately are doing it because they want to make a buck, and it is really hard to decipher in between, and that has been a real challenge.

Mrs. DEMINGS. Doctor, you talked about how the Federal Government could, perhaps, help in this area, so local health departments and others don't have to try to figure out what is reliable or what is not. Could you give me some examples of how you feel the Federal Government could be a greater help to you?

Dr. SHAH. Sure. I have said this in both my oral testimony, and also my written testimony, so, please, if your staff can look at that more closely, there may be some additional ideas here. But I think,

in general, what it is, is that we are left fending for ourselves. It feels that we are learning every day something new. As the Congresswoman from New York had mentioned just earlier, instead of being able to learn from those other entities across the system, and/or getting the Federal guidance that says, here is the minimum standard that you should be looking at, you should be utilizing, or, here are the kinds of things you should be looking at—I get that we have to be careful in the private sector, we can't say, not this one, not that one—but at least give us those minimum standards that allow us to make informed decisions. That really would help us, rather than for us to be trying to do this on our own, and that is a challenge for us, and it remains—and I suspect it will remain for the next several months as we continue in different phases, including in the vaccine world.

As soon as we get to vaccines, it is also going to be this whole piece about how do we get supplies to you, how do we get other, you know, materials to you, who can do it better, who is going to—and again, we are going to have this avalanche of people reaching out, and we are not going to be able to handle all those requests.

Mrs. DEMINGS. Then finally, I know we have been talking about the lack of PPE equipment since the very beginning, but as we approach the fall and, you know, the stories of, are we going to see a resurgence, we aren't really sure what the landscape is going to look like, what particularly concerns you about supply chains moving into the fall?

Dr. SHAH. Well, you know, Colonel Hastings said it really nicely, which is that all of it concerns us, you know, and really, it is obviously what is happening in the health care system. We want to make sure we protect our health care providers, our first responders, the ones who are repetitively being, obviously, in contact with a COVID-positive patient.

In addition to that, we really are very concerned about making sure that the supply chain constraints are alleviated as we continue to have more demand, as you get into the fall season again, with flu and other infectious diseases. They do not miraculously go away. They have not miraculously made room for COVID–19. They are still there, or they will be there, and we have to make sure that whether it is gloves, or masks or gowns, or lab materials, that all of these are really there and the constraints are not, again, left to locals or States trying to figure out what is the best way to procure for their communities.

Mrs. DEMINGS. Dr. Shah, thank you so much.

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

Chairman THOMPSON. Thank you very much, Madam Congresswoman. Let me thank all of the witnesses again for bearing with us through some technology challenges, but the information you provided us has been very, very helpful. We are trying to get it right, not only because as Americans we have a responsibility to do that, but it is so, so very important that in getting it right, we can also save lives. So your testimony has been very, very helpful.

The Members of this committee, however, may have additional questions for you, and we ask that you respond expeditiously, in writing, to those questions. Without objections, the committee

record shall be kept open for 10 days. Hearing no further business, the committee stands adjourned.

[Whereupon, at 3:21 p.m., the committee was adjourned.]

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