Majority Question Responses

Question 1A: Yes, the OAP does recommend individuals receive COVID-19 boosters in line with current CDC recommendations. Please Refer to dear E colleague letter of April 27, 2023 announcing vaccine availability and recommendations of the CDC for specific categories of recipients.

Question 1B: The OAP recommends receiving COVID 19 boosters irrespective of natural immunity or antibodies. This is in line with CDC recommendations. The rationale for this approach is based in the goal of maximizing individual protection and minimizing harm in a setting of developing science. While recent research has shown that recent infection with COVID 19 provides protection from re-infection for a number of months, immunity at the individual level is variable. I am unaware of any current research that has defined an antibody titer level above or below which an individual is considered protected or unprotected from re-infection, making it difficult to determine how much of a protective benefit an individual patient has received from a primary infection. Additionally, some studies have indicated a booster provides an additive protective effect against re-infection. The degree of protection provided by natural immunity from an earlier COVID 19 viral infection may not protect against current coronavirus variants that are specifically targeted in new vaccine formulations. Given the excellent safety profile of the COVID 19 vaccine booster and the potential risks of severe acute COVID re-infection and/or ongoing complications of long COVID, the OAP continues to recommend vaccinations as a means to maximize individual protection in line with CDC guidelines. The OAP also remains committed to continuing review of ongoing research and adjusting recommendations based upon evolving science.

Question 1C: Authority to administer a vaccination product is consistent with either the FDA licensed product package insert (during regular operations only fully licensed vaccines are recommended) or during the pandemic the FDA emergency use authorization vaccine products are employed. In terms of individual medical recommendations as part of the patient-physician relationship, the OAP provides recommendations directly to patients based upon their individual health circumstance at the time of a medical encounter in both day to day and pandemic operations. Public health recommendations are conveyed to leadership for consideration as part of an overall response plan that may include multiple offices. The CDC and FDA have made extensive modifications to their pandemic coronavirus vaccine programs both from its emergency use authorized products (for example: vaccination agent modifications for new coronavirus variants, age-specific vaccines for infants and children, schedules and recommendations for booster doses of vaccine). The FDA also issues licenses to other fully approved labeled vaccine commercial products. The OAP conveys these recommendations published by CDC as the basis of individual patient recommendations.

Question 2A: The OAP was not involved in the drafting of U.S. Capitol Police Bulletin #21.96.

Question 2B: The OAP limits its role to providing medical-based recommendations to mitigate a health threat. An opinion on an appropriate means to enforce or penalize individuals for not executing recommendation is outside the scope of this office. The OAP has never recommended a category of individuals subject to arrest.

Question 3A: The mother's suites are spaces which are constructed, equipped, and cleaned on a regular basis by the Architect of the Capitol. The Office of Attending Physician supervises access control to the area by interacting with candidates to use the space and renewing their access to it on a 6-month basis as long as they may require. The OAP Registered Nurses inspect the suites each day for general cleanliness and serviceability of equipment. Issues of cleanliness and usability are addressed immediately when discrepancy arises. Larger matters such as decor, furnishings, climate control, and location would be matters to review with the Architect of the Capitol.

Question 3B: The office of attending physician maintains a daily usability and cleanliness inspection. The office receives occasional feedback from mothers during times of initial application for access to the space and during periodic access renewal on an *ad hoc* basis. The OAP provides all users of the mother's suites point of contact telephone numbers and e-mails points of contact to offer any suggestions, at any time. Concerns regarding access, cleanliness, or serviceability are addressed immediately by OAP. Other suggestions (décor, furniture, climate control, color schemes, etc.) are forwarded to the Architect of the Capitol for consideration with regard to their process for remodeling etc. The OAP has repeatedly recommended that all mother's suites be secured by proximity ID card electronic access to provide enhanced security, user accountability and approved access control; however, many of the mother's suites lack of this access control and rely upon a shared combination code for a Cypher lock on the door. The OAP restricts 24/7 access to the Congressional office building's mother's suites to Congressional ID card holders only. All authorized individuals have access to the mother's suites at all times. Mothers no longer requesting access to the suites are automatically disenrolled from the access list. (This could be a problematic area in the mother's suites secured only by cypher locks). Visitors and other categories of users needing the mother suites are accommodated for lactation space access by the OAP nurses in individual health units through accommodations during business hours only.

Question 3C: The matter of the modernization of the physical structure, furnishings, etc. of the mother's suites would require the Architect of the Capitol's involvement as the OAP does not have a budget or authority for that endeavor.

Minority Question Responses

Question 1A: Understanding COVID 19 is transmitted from infected individuals via droplets and aerosolized particles emitted from the nose or mouth and landing one another individual's nose or mouth, or landing on a surface which is then touched by someone else and carried to their face helps to frame the risks certain settings may pose. Areas that are enclosed or poorly ventilated, facilitate close physical contact between individuals, or facilitate activities where increased shedding may occur have been associated with increased transmission. Additionally, Capitol Hill entertains visitors from across the country and across the globe. People travelling from COVID hotspots may have an increased risk of being infected compared to non-hot spot areas. Mitigation efforts, including public access restrictions, were recommended to reduce the potential risk of infection to essential personnel on the complex.

Question 1B: There is a reasonable likelihood that infected, unmasked individuals who are unmasked would shed more particles into the environment and potentially increase exposure to others when compared to masked individuals. Quantifying any relevant risk deduction is difficult with existing

information. Early in the pandemic, in the absence of vaccine, the only mitigation measures available with those recommended by CDC regarding mask wear, social distancing, and surface cleansing.

Question 2A: Decisions regarding the reopening of the Capitol Hill complex were not made based solely on pandemic related medical conditions. During the period of pandemic operations, following widespread vaccine adoption and other physical measures, the OAP withdrew recommendations limiting campus wide attendance, and the building access limitations were a necessity imposed by security force staffing considerations.

Question 2B: My recommendations were personally conveyed to the bipartisan House Leadership at joint meetings. Security force planning officials were present at those meetings and answered questions from the Leaders directly regarding the security force personnel limitations requiring continued access restrictions.

Question 3A: On July 27, 2021, the CDC announced a reversal of their previous recommendation to wear masks in indoor spaces and regions characterized by high disease transmission risk without regard to previous vaccination status. Three months previously, the CDC relaxed mask wear requirements for those who have been vaccinated; however, a 4th of July weekend series of breakthrough Delta variant coronavirus cases from Provincetown, Massachusetts came to CDC attention. This cohort of patients demonstrated high viral levels in the nostrils of vaccinated and unvaccinated individuals alike and also showed transmission from vaccinated asymptomatic individuals to other individuals. Based upon concerns about the Provincetown cohort, the CDC acted in the best public health interests and recommended a reversal of their previous mask wear instruction that individuals should wear a mask when inside. The Delta agent coronavirus was far more contagious than any previous variant and the actual prevention of infection by vaccination was not supported. The benefits of vaccination were limited to reduction in the risk of serious adverse outcomes such as hospitalization or death. The Delta variant and subsequent variants led to reconsideration of the role of vaccination and recognition of virus evasion of the current vaccine immune protection.

Considerable confusion arose when CDC erroneously inserted a reference to a vaccine study in India (May 2021) as a basis for their mask wear reversal action rather than state their unpublished information from the Provincetown cohort. I can understand how a reader could interpret a reversal of previous guidance based on unpublished information and erroneous references from the country of India, as inconsistent. The CDC director subsequently issued clarifying statements to explain the basis of her decision on July 30,2021.

My considerations at the OAP on July 27th 2021, were not to revalidate the recommendations of the CDC but to act promptly to limit spread of disease among a highly vulnerable population in circumstances where disease transmission and breakthrough infection risk was established to be high, and for which multiple different geographic regional incidences of coronavirus were relevant (The Congress is a highly migratory population). I forwarded the CDC mask wear recommendation reversal when CDC published its recommendation on July 27th. In the 3 months after this decision, the delta variant coronavirus led to the deaths of over one hundred thirty-two thousand Americans, and increased attention to nonpharmaceutical control measures was a necessary intervention.

Question 3B: I am not aware of any person who wishes to live in a perpetual pandemic state.

Question 4A: Yes

Question 4B: In summary, the cited January 30, 2023 Cochrane Library article published findings from a review of 78 different randomized controlled trials and cluster randomized controlled trials that investigated the effect of physical interventions to interrupt or reduce the spread of respiratory virus. This study was built upon a prior review in 2020 to include some additional studies related to the COVID 19 pandemic. Specific outcome subsets included comparison of medical/surgical masks to no mask, N95 masks compared to medical/surgical masks, and hand hygiene compared to control. Related to masking, the authors findings report little to no difference between mask wear and the control group in terms of how many people caught a flu-like illness or confirmed flu/COVID. The authors note their confidence in these mask findings is low to moderate for subjective outcomes and moderate for more precisely defined laboratory diagnoses. They identify the following possible reasons for the reviewed studies did not observe a reduction in disease transmission with mask use: poor study design; insufficiently powered studies arising from low viral circulation in some studies; lower adherence with mask wearing, especially amongst children; quality of the masks used; self-contamination of the mask by hands; lack of protection from eye exposure from respiratory droplets allowing a route of entry of respiratory viruses into the nose via the lacrimal duct; saturation of masks with saliva from extended use promoting virus survival in proteinaceous material; and possible risk compensation behavior leading to an exaggerated sense of security.

Subsequent publications by the Editor-in-Chief of the Cochrane review group on March 10th,2023 indicated that the 3rd party summaries of this review of studies had inaccurately portrayed the Cochrane Jan 2023 conclusions stating there was no difference between wearing a mask or not. The actual finding from the Jan 2023 Cochrane review was that the collection of published studies had numerous limitations such that a definitive conclusion regarding the protective value of wearing a mask was not possible.

> "Many commentators have claimed that a recently updated Cochrane Review shows that 'masks don't work', which is an inaccurate and misleading interpretation," Dr. Karla Soares-Weiser, the editor-in-chief of the Cochrane Library, said in a March 10 statement.

Question 4C: Individuals properly wearing a high quality (N95 or KN 95), well fitted mask in interior spaces with others present, should be confident in the mask's ability to reduce the risk of acquiring coronavirus disease. Health care providers rely upon proper mask wear, high quality masks, and personal protective equipment every day to manage infectious diseases in medical centers throughout the world.

Question 5: Each Chamber promoted social distancing guidelines to best reduce risk of coronavirus in conjunction with Centers for Disease Control guidelines. The guidelines do not speak to parliamentary processes such as voting but highlight the increased risks for individuals of advanced age and medical conditions to assemble in close quarters in interior spaces during times of high disease transmission risk. The manner of conducting the business of the Congress, having individuals travel throughout the country several times per week, and then meet in interior spaces such as committee hearings or in legislative Chambers, falls into the highest risk of disease transmission requiring risk mitigation efforts. The OAP

did not engage in any discussion regarding the Members of Congress location to record their votes. Each Chamber provided measures of compliance and each Chamber provided challenges for improvement.

Question 6: Patient privacy and the security of medical personally identifiable information (PII) are high priorities for the OAP. The OAP utilizes an electronic medical record (EMR) supplied by a well-established third-party vendor that provides service to large proportion of similar sized medical practices in the United States. The OAP works with Housecall and House IT security to enact a layered security approach while protecting PII. The PII dataset is currently housed on an isolated hard wired internal House server with limited access. Contrary to many medical record implementations, it is not a "cloud-based" system. Internet connection or data transfer is not permitted. Any data transmitted to external services is limited in scope and conducted via an air gap process. The EMR application may only be accessed via designated OAP workstations, and staff must undergo a multifactor authentication process for entry. Once accessed, internal permissions allow staff to access only relevant records and functions to perform their required duties. Finally, access and keystroke logs provide an ability to review activities as needed.

Question 7: Approximately 120 per day

Question 8: The OAP employs limited telemedicine capabilities. If unable to conduct an in-person visit, Members may contact and interact with a physician 24 hours a day, 7 days a week via telephone audio and/or video from any location of their choosing. An appropriate treatment plan may be devised based on this interaction. However, telemedicine based diagnostic assessments, such as the ability to take vital signs or conduct advanced portions of the physical exam requiring more than visualization with the naked eye, are not available. If a patient's presentation requires a more advanced assessment, patients are directed to seek an in-person exam at an appropriate interval.

Question 9:

1. Enable specific obligation in legislation where Executive Branch Agencies shall support OAP when requested.

2. Create a non-partisan/non-political, bicameral subcommittee to absorb medical recommendations and implement changes throughout the Capitol complex during times of public health emergency.

3. Immediately augment OAP with a dedicated communications staff and publication staff for concise and prompt public health information during times of public health emergency.

3. Evaluate feasibility of a unified incident command structure (bicameral if possible) for public health emergencies similar to that used during fire/security threats.

5. Create senior-level direct supporting resource conduits to the OAP from the Centers for Disease Control and Prevention, National Institutes of Health, Department of Health and other entities as needed during all hazard public health emergencies.

6. Establish pre-existing relationships with local medical and public health resources to augment OAP personnel with on-site subject matter expertise and clinical support as needed.

7. Establish pre-existing relationships with local occupational health entity to interact with Hill-wide personnel flagged for additional review during daily health inventory screening.