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LESSONS FROM THE FRONTLINE:
COVID-19'S IMPACT ON AMERICAN HEALTH CARE

WEDNESDAY, MARCH 2, 2022

House of Representatives,
Subcommittee on Oversight and Investigations,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:36 a.m., in the John D. Dingell Room, 2123 Rayburn House Office Building, Hon. Diana DeGette, [chairwoman of the subcommittee] presiding.

Present: Representatives DeGette, Kuster, Rice, Schakowsky, Tonko, Ruiz, Peters, Schrier, Trahan, O'Halleran, Pallone (ex officio); Griffith, Burgess, McKinley, Palmer, Dunn, Joyce, and Rodgers (ex officio).

Also present: Representatives Sarbanes; and Carter.

Staff Present: Jesseca Boyer, Professional Staff Member; Austin Flack, Junior Professional Staff Member;

Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry Hamilton, Clerk; Fabrizio Herrera, Staff Assistant; Rebekah Jones, Oversight Counsel; Zach Kahan, Deputy Director Outreach and Member Service; Mackenzie Kuhl, Press Assistant; Kaitlyn Peel, Digital Director; Caroline Rinker, Press Assistant; Chloe Rodriguez, Clerk; Andrew Souvall, Director of Communications, Outreach, and Member Services; Xiaoyi Huang, GAO Detailee; Kate Arey, Minority Content Manager and Digital Assistant; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Marissa Gervasi, Minority Counsel, O&I; Grace Graham, Minority Chief Counsel, Health; Brittany Havens, Minority Professional Staff Member, O&I; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, O&I Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Alan Slobodin, Minority Chief Investigative Counsel, O&I; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

*Ms. DeGette. The Subcommittee on Oversight and Investigations hearing will now come to order.

Today the Subcommittee on Oversight and Investigations is holding a hearing entitled, "Lessons from the Frontline: COVID-19's Impact on American Health Care.'' Today's hearing will examine the COVID-19 pandemic's impacts, and how providers, the health care system, and patients can better prepare for future variants and future public health emergencies.

Due to the COVID-19 public health emergency, members can participate in today's hearing either in person or remotely, via online video conferencing.

In accordance with the updated guidance issued by the Attending Physician, members, staff, and members of the press present in the hearing room are not required to wear a mask.

For members participating remotely, your microphones will be set on mute for the purpose of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you wish to speak. Please note that, once you unmute your microphone, anything that is said in Webex will be heard over the loudspeakers in the committee room, and subject to be heard by the livestream and C-SPAN.

Because members are participating from different locations at today's hearing, all recognition of members,

such as for questions, will be in order of subcommittee seniority.

If at any time during the hearing I am unable to chair the hearing, the vice chair of the subcommittee, Mr. Peters, will serve as chair until I am able to return.

Documents for the record can be sent to Austin Flack at the email address we provided to staff. All documents will be entered into the record at the conclusion of the hearing.

And the chair will now recognize herself for purposes of an opening statement.

Over the past two years, this subcommittee has held eight hearings examining the COVID-19 response, covering everything from vaccine development and deployment to the impacts of the pandemic on children. Today this subcommittee continues the examination. They -- building on its long history of pandemic preparedness oversight.

We will hear from the on-the-ground providers about how the pandemic has impacted their own lives, the health care systems they work in, and the patients that they serve. Their frontline perspectives will provide insight into how we can better protect the health and safety of our communities throughout the remainder of this pandemic, and help us better prepare for future public health emergencies.

While our witnesses today represent an array of experiences, there are many other types of health care

providers serving a range of communities that have felt similar impacts from this pandemic: emergency medical technicians, nursing home and in-home health care providers, and physical and occupational therapists, to name a few.

As we all know, the COVID-19 pandemic has impacted nearly every aspect of American life. The health care system is no exception, which has faced these impacts head on. Resource constraints and workforce shortages existed long before the pandemic started, but have been exacerbated to alarming degrees over the last two years.

A recent poll found that nearly one in five health care workers quit their jobs during the pandemic, and nearly one-third of those remaining have seriously considered finding new jobs. And we have heard the reasons for some of this from the mental health experts who testified before this subcommittee two weeks ago. I have heard similar experiences during a recent visit with some of Colorado's health care workers, and I know many of you can attest that the feelings of burnout, exhaustion, and unmanageable stress are echoed in hospitals and health care settings throughout the country.

We must find a way to ensure these critical workers have the support they need. Of course, the cascading impacts of COVID-19 do not stop with the workforce alone. The COVID-19 surges due to new variant waves have led to significant capacity constraints within hospitals. And when hospitals

are overwhelmed, patient care can suffer. Heart attacks, car accidents, and other emergencies don't stop for COVID-19. Routine preventative care and so-called elective procedures, often involving lifesaving treatment, have been delayed due to surges in the pandemic.

But the end of a COVID-19 surge does not necessarily bring the relief we hope for, as patients seeking backlogged services flood facilities. Moreover, the combination of workforce strains and capacity challenges further compound historical inequities of health disparities, presenting further barriers to care for people of color and other under-served communities.

There is no single solution to these challenges, but we do have the tools to help alleviate some of these concerns today. The most effective way to fight the pandemic and lessen the burden on our health care system is for eligible Americans who have not gotten the COVID-19 vaccine to get vaccinated. CDC data shows that unvaccinated adults are 16 times more likely to be hospitalized, and 14 times more likely to die from COVID-19 than fully vaccinated adults.

Further, unvaccinated adults are an astounding 41 times more likely to die from COVID-19 than those who have been fully vaccinated and boosted. The science is clear: vaccines are safe and effective, and they are our best shot, literally, at alleviating the impacts of future surges of

COVID-19 on our health care system.

But vaccines alone will not help us prepare for future public health emergencies. We must identify what steps we can take now to rebuild and strengthen the health care workforce so that burnout, trauma, and resulting impacts on patient care can be avoided. And critically, we must ensure that future public health emergencies do not inflame existing disparities in access to care and health outcomes for vulnerable populations and marginalized communities.

Congress and the Biden Administration have begun to address some of these concerns through investments in prevention measures and health care workforce and systems support, but more must be done.

As a nation, we have relied on health care workers to bear a significant burden these last two years, working long hours and extra shifts, often at great risk to their own health and that of their families. We owe a debt of gratitude for their leadership and their sacrifices. I look forward to hearing all of their insights and recommendations for how we can work to keep America safe and healthy for the remainder of this pandemic and for the future.

[The prepared statement of Ms. DeGette follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. And I am now very pleased to recognize the ranking member, Mr. Griffith, for five minutes for an opening statement.

*Mr. Griffith. Thank you, Madam Chair, and I appreciate you holding this hearing. Understanding the lessons learned from the COVID-19 pandemic is crucial for future decision-making.

Americans need to learn to live with COVID-19, and the Federal Government needs to learn to better prepare for and handle future pandemics. It is our duty on this subcommittee to oversee the Federal Government's COVID-19 response, to examine what worked and what did not. I have heard from frontline workers in my district about both successes and failures experienced over the course of the last two years.

One of the best things to come out of this pandemic for rural areas like my district is increased use of telehealth. Thanks to flexibilities from the Centers for Medicaid and Medicare Services and others, residents who were shuttered into isolation could connect to their doctors and nurses virtually. From mental health appointments to cardiology checkups, doctors and patients alike were appreciative for the ability to use at-home equipment to monitor and assess.

Other emergency flexibilities implemented by Federal and state governments also helped to increase patient access to health care, such as allowing pharmacists to deliver

vaccines, and allowing hospitals to compound medications that were in short supply. As we move forward, this committee should examine which of these flexibilities should be available on a permanent basis.

During COVID-19 surges, many hospitals across the country had to think fast, often surprising even themselves with creative solutions. Ballad Health, a health care system that serves much of southwest Virginia, created a Safe at Home program. This program helped health care workers monitor COVID-19 patients at home by providing kits with a thermometer and a pulse oximeter. Nurses called patients to help monitor them from home, and helped schedule follow-up appointments for further care when necessary, based on patient self-monitoring.

The Ballad health system cared for thousands of patients this way. By screening patients at home, and preserving precious resources in the hospital for the sickest of patients, this program reduced hospital admittance rates, keeping beds open for those who needed them most.

Despite these successes, certain policies and mandates implemented throughout the course of the pandemic resulted in setbacks in my district. The decision to delay elective procedures eventually backfired for some patients and hospitals. The delay of treatment and preventative screenings resulted in worsened conditions for patients.

People often think of an elective surgery as -- think of elective surgery as referring to something cosmetic or optional. However, the term is broad, covering many critical procedures, including cancer screenings, hip replacements, hernia repairs, or the removal of kidney stones or an appendix.

We saw a temporary fix to manage staff shortages and the influx of COVID-19 cases ultimately leave patients frustrated, nervous, and in weakened health. And in some cases, like that of our friend, Congressman Andy Barr's wife, the delay in care became fatal.

Other challenges to our nation's health care systems were a result of over-burdensome Federal mandates. Vaccine mandates made people choose between personal choice or their livelihood, which we know made existing problems in recruiting and retaining health care workers in rural areas worse. Amid Federal COVID-19 vaccination mandates for health care facilities, health care workers have been fired for non-compliance, and some have resigned or quit. In a rural hospital the loss of staff is not only noticeable, but very damaging. Any loss of staff is detrimental to rural hospitals.

Through this pandemic, our nation's health care workforce has learned that it is possible to be resilient in a crisis. Even the smallest changes to care can have the

biggest impact on patient health, staffing, and hospitalization rates. This is especially true in rural districts with smaller staffs, where each person plays an important role in keeping the hospitals running. The mandate didn't work.

Now that being said, I agree with Chairwoman DeGette. I have been vaccinated. I think it is an effective tool. But making it a mandate has forced people to choose whether they continue to work in our local hospitals or in health care systems, or give up their jobs. It is critical that we take a closer look at the experiences of frontline workers and examine lessons learned as we discuss solutions to face the next pandemic.

I look forward to hearing from our witnesses, what they experienced on the front lines, and what we can do to incorporate their lessons that they learned as we prepare for the next pandemic.

[The prepared statement of Mr. Griffith follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Thank you very much, Madam Chair, and I yield back.

*Ms. DeGette. The chair now recognizes the chairman of the full committee, Mr. Pallone, for five minutes.

*The Chairman. Thank you, Chairwoman DeGette.

Today the committee will continue our oversight of the ongoing COVID-19 response by hearing from frontline health care workers who have served their communities throughout the pandemic. Their experiences offer valuable insights into our current response, and ways we can better be prepared for future public health emergencies.

And nearly four-and-a-half million Americans have been hospitalized due to COVID-19, and more than 930,000 Americans have lost their lives. No one has been unaffected by the pandemic, though seniors have been particularly vulnerable to the disease, and communities of color have faced disproportionate impacts.

Essential workers and frontline responders, such as the health care workers joining us today, have faced additional risk and burdens. Over the last two months the Omicron variant ripped through our communities, spreading quicker than prior variants. While Omicron appears to have peaked, the experience has shown that we must remain vigilant as new variants emerge, and we have to continue to use the tools available to us to prevent transmission of COVID-19, and

protect the most vulnerable among us.

Now, evidence shows that being fully vaccinated and boosted is the most effective way to fight COVID-19 and its impacts on our community. This remain true, even during the spread of the Omicron variant, where unvaccinated Americans continue to face a greater risk of severe disease and death than those fully vaccinated. Yet today in the United States, only 69 percent of eligible Americans are fully vaccinated, and just 45 percent have gotten a booster dose.

So I look forward to hearing from our witnesses about the efforts they found successful in encouraging people to get the vaccine and the booster dose because, unfortunately, despite all the available tools, the pandemic continues to substantially strain our nation's health care system.

The pandemic is exacerbating longstanding workforce shortages, capacity issues, and barriers to access for people of color and other under-served communities. As COVID-19 surges caused patients to overwhelm hospitals and medical facilities, health care workers have faced both mental and physical challenges. They are experiencing work overload, burnout, and increased anxiety or depression with women, Black, and Hispanic health care workers reporting higher stress. And as different variants have emerged, hospital capacity has at times surpassed the number of staff beds available.

So this week, more than 75 percent of ICU beds in hospitals across the United States remain occupied, despite the fact that the Omicron wave has crested. And this strain not only adds to health care workers' burden, but can affect patient care and, potentially, their health.

Capacity constraints, fear of contracting COVID-19, and other barriers to health care led to 4 in 10 adults delaying or avoiding medical care in the early days of the pandemic. One in eight adults, and an even higher rate for Black and Hispanic adults, postponed emergency care. And delayed preventative care and diagnosis can lead to chronic, life-threatening illnesses. As the pandemic continues, we must contend with these broader and longer-term impacts on Americans' health.

Fortunately, Congress and the Biden Administration have taken action to support America's health care workforce, and protect the health and safety of all Americans. The American Rescue Plan and the CARES Act provided billions of dollars in funding to address worker retention and wellness, and resources for health care providers serving children, low-income individuals, and seniors.

And then, last November, this committee passed legislation that would provide support to the health care workforce and expand access to important preventative services. The House-passed Build Back Better Act also

included key provisions to invest in public health infrastructure and the health care workforce.

The Biden Administration has also made hundreds of millions of tests and masks and COVID-19 vaccines and therapies available to Americans at no cost. The President talked even more about what he plans to do in the future last night, and these are critical steps to supporting the nation's health care system and the public's health. But more must be done to ease the burden on health care workers, and boost -- and booster -- and I say also bolster capacity.

So I just wanted to say, Madam Chair, I am grateful for the tireless commitment our nation's health care workers have shown for the last two years, and I look forward to hearing from our witnesses about their experiences on the front lines. Together we can strengthen America's continued response to the COVID-19 crisis.

If I could just say, Chairwoman DeGette, I know that many times you have approached me and talked about how we have to be better prepared. And I know that, even before the pandemic, when it started a couple of years ago, you were talking to me about, you know, long-term preparedness for viruses and other health care emergencies. And I appreciate the fact that you and the members of the committee, in general, you know, want us to think about the future.

You know, right now everybody is saying, "Oh, everything

is great,'' right? I mean, it is not. We still have a lot of problems. But more important -- and this is what you have always stressed, Diana -- we have to think about, you know, the next pandemic, or the next wave. And this is a very important part of this committee's function. So thank you.

[The prepared statement of The Chairman follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. I thank the chair. The chair now recognizes the ranking member of the full committee, Mrs. Rodgers, for five minutes.

*Mrs. Rodgers. Thank you, Chair DeGette, Republican Leader Griffith.

We owe it to today's witnesses and all our frontline heroes to listen to them, to understand their perspectives, and to provide solutions. The families who lost loved ones -- about 947,000 in the United States -- and those who have suffered and sacrificed during the pandemic are owed answers to many questions.

The first question, how did the pandemic start? Republicans on this committee have been leading a comprehensive investigation into the COVID-19 origins, and we continue to urge our colleagues on the other side of the aisle to join us in this pursuit. Understanding how this pandemic started is one of the most important public health questions of our time, and it is necessary to answer, hopefully, to prevent future pandemics.

Second, why weren't we better prepared? The Federal Government could have provided more resources to health care responders. For years, the Republicans on this committee have raised concerns about the wisdom of not funding frontline health care preparedness, instead of spending more than 80 million a year on the BioWatch program that started

in 2004. In a report to the bipartisan leadership on this committee, the GAO found this program doesn't have the science to show that it even works.

We have also raised concerns about relying on China and other foreign countries for critical medical supplies, which we all know we must address.

Third question: Why is CDC mixing politics with science? Lockdowns, distancing, and masking were almost exclusively emphasized by the CDC, while concerns about the effects on mental health and social and economic costs have been ignored. Fortunately, the Trump Administration led public-private efforts to expedite the development of effective vaccines and therapeutics.

The vaccines vastly reduced the risk of death and hospitalization, and now we have data on what many of us have known from the beginning: natural immunity protects robust protection, or provides robust protection. But even with the effect of vaccines and better understanding of who is most at risk, the Biden Administration has continued an unbalanced response, uninformed by these advances. There is far too much fear, and far too much confusion.

The CDC led from behind on the issue of school closures. Several countries in Europe never closed their schools. Some localities in the U.S., and even CDC Director Walensky herself, before she came to CDC, saw no difference in safety

between three feet and the CDC-recommended six feet distancing that was keeping schools closed. Yet when her agency put out the school guidance, she required six feet of distance. Why? Because she gave the teachers' union a policy pin.

As a direct result of CDC's guidelines, children have paid a significant price in mental health harms, lagging education, and lost time for social development. Even when schools were mostly reopened, CDC continued to force masking requirements, even for young children, in a departure from World Health Organization and UNICEF recommendations.

And the CDC continues to rely on discredited studies to force their masking agenda on kids. The CDC is supposed to -- suppressed a large study it funded that showed little benefit to masking in schools. It cherry-picked data by highlighting a discredited study, and suppressing another one.

But there is more. The CDC also collected data on vaccine and booster effectiveness, breakthrough infections, and wastewater analysis, but released very little of it. The CDC deprived hospitals and frontline workers of data that would have better informed mitigation and treatment efforts. All of these moves of the CDC have undermined trust in public health when it is needed most.

The fourth question: Why did the Biden Administration

take actions that made it harder on frontline health care workers?

Many hospitals struggled with staffing shortages, but vaccine mandates may have further worsened the staffing situation at hospitals. During the height of the Omicron surge, the Biden Administration took nearly $7 billion from the Provider Relief Fund, meant to help hospitals and clinics affected by the pandemic, and used it to buy COVID-19 vaccines and therapeutics. Congress has set aside that money to help providers pay for pandemic-related expenses, including staffing, personal protective equipment, care for the uninsured, and vaccine distribution. This relief was badly needed by rural hospitals that were competing to hire temporary contract staff.

These are just a few of the questions that this committee needs to pursue. We must get answers to ensure the frontline heroes, like all of you, have trust and confidence in public health.

[The prepared statement of Mrs. Rodgers follows:]

**********COMMITTEE INSERT**********

*Mrs. Rodgers. Thank you, Madam Chair. I yield back.

*Ms. DeGette. I thank the gentlelady.

I ask -- I now ask unanimous consent that members' written opening statements be made part of the record.

And without objection, so ordered.

I would now like to introduce our witnesses for today's hearing: Dr. Megan Ranney, an emergency physician at Rhode Island Hospital; Tawanda Austin, chief nursing officer at Emory University Hospital Midtown; Dr. Daniel Calac, chief medical officer for the Indian Health Council, Inc.; Dr. Laura E. Riley, obstetrician and gynecologist in chief at New York Presbyterian Hospital, all appearing on Webex. And then in person we have Dr. Lucy McBride, a private practice internist.

I want to thank all of the witnesses for appearing before the subcommittee today.

I know all of you are aware that the committee is holding an investigative hearing. And when we do so, we have the practice of taking testimony under oath. Does anyone have an objection to testifying under oath?

Let the record reflect the witnesses have responded no.

The chair then advises you, under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Does any of you wish to be accompanied by counsel?

Let the record reflect the witnesses have responded no.

And so would our witness in the room please rise, and everybody else please raise your hand, so you may be sworn in?

[Witnesses sworn.]

*Ms. DeGette. And let the record reflect that the witnesses have responded affirmatively, and you are now under oath and subject to the penalties set forth in title 18, section 1001 of the United States Code.

Now, at this time, the chair will recognize each witness for five minutes to provide their opening statement.

Before we begin, I would like to explain the lighting system for the witness testifying in person.

That would be you, Dr. McBride. In front of you is a series of lights. The light will initially be green. The light will turn yellow when you have one minute remaining, and so start to wrap up at that point. The light will turn red when the time expires.

Now, for the witnesses who are testifying remotely, there is a timer on the screen that counts down to the remaining time.

And so, first of all, I would like to introduce Dr. Ranney for five minutes.

Doctor?

TESTIMONY OF MEGAN RANNEY, M.D., M.P.H., EMERGENCY PHYSICIAN, RHODE ISLAND HOSPITAL; TAWANDA AUSTIN, M.S.N., R.N., N.E.-B.C., CHIEF NURSING OFFICER, EMORY UNIVERSITY HOSPITAL MIDTOWN; DANIEL CALAC, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH COUNCIL, INC.; LAURA E. RILEY, M.D.; OBSTETRICIAN AND GYNECOLOGIST-IN-CHIEF; NEW YORK PRESBYTERIAN HOSPITAL; AND LUCY MCBRIDE, M.D., INTERNIST, PRIVATE PRACTICE

TESTIMONY OF MEGAN RANNEY

*Dr. Ranney. Thank you so much. I appreciate the invitation to testify, Chair Pallone, Ranking Member Rodgers, Madam Chair, and members of the committee.

Monday marks three years since our first COVID case in Rhode Island. I was working in the emergency department that night, and I had continued to work on the frontlines of the COVID-19 response throughout the pandemic. I therefore testify today as a practicing, board-certified emergency physician, public health researcher, academic dean of the School of Public Health at Brown University, and mother of two school-aged children.

Let me start by recognizing that, in so many ways, we are in a better place than we were two months ago, much less two years ago. We have had quick development and rollout of vaccines, therapeutics, and use of masking, testing, and

ventilation during surges. Omicron cases are plummeting. But despite this progress, the situation in health care facilities has deteriorated to new lows.

Only a few weeks ago, a nurse in charge of my emergency department told me she was 10 nurses short for the [inaudible], and therefore forced to reduce services. She said, "I have been begging people to stay all day long, offering double time and double incentives, but the nursing staff is too burnt out.''

So today I will highlight challenges ahead, and then propose ways to leverage this fleeting window of opportunity we have to protect the health of America.

I also respectfully ask the members to read my written testimony, which contains many firsthand accounts of the challenges we face.

Let me start by discussing the profound impact of COVID on accelerating staff shortages and hospital overcrowding, particularly in emergency departments, the only place in our system that provides care to all, 24/7/365.

Some have reported that as many as one in five health care workers -- not just docs and nurses, but home health aides, EMTs, social workers, and more -- have left bedside care during the pandemic. These staff shortages are a problem across the nation, although rural communities are disproportionately hurt.

During COVID surges, due to these shortages, many hospitals have had to resort to extreme measures, calling in the National Guard, shutting down so-called elective procedures to try to save space for true emergencies like strokes and traumas. But even with these steps, we have been unable to care for patients in a timely manner.

One nurse recently told me that every day in the ER feels like she is going before the firing squad due to her inability to provide adequate care. Surgeons have shared their anguish at watching patients lose vital functions due to delays, which highlights the most significant reason for the staffing shortages: the mental and emotional effect of repeated COVID-19 surges on our health care providers. We keep showing up, but our work keeps getting tougher, and there are no reinforcements in sight.

In my own specialty, the proportion of emergency physicians experiencing burnout has increased from 43 to 60 percent during the pandemic. We also report increased [inaudible] injury, depression, PTSD, and workplace violence. We must fix these core issues to save health care.

Second, COVID has exposed weaknesses in our health care data information systems. We need good data, timely, accurate, transparent, and complete to make good decisions about what is needed, where, when, and for whom. Thanks to the CARES Act and the ARP, the CDC and HHS temporarily have

access to many important data streams, making earlier citizen-led data efforts unnecessary.

But important pieces of data are still missing, things like actual numbers of staff beds in hospitals. Lack of data related to race and ethnicity are particularly glaring. And it is unclear what will happen to even these preliminary data sources, once the public health emergency is over. I and others deeply fear the loss of hard-won data gains.

Third, we have continued problems with the health care system's supply chain. Although early PPE shortages have resolved, we face new and worsening problems with key tests, therapeutics, and equipment for both COVID and non-COVID-related care. The lifesaving work of folks like myself is heavily affected by these swings in supply. We are forced to substitute one preferred medication or treatment for another, and sometimes there is no substitute. This directly hurts patients.

Finally, the increasing politicization, misinformation, and public mistrust around COVID has had a deep impact on health care workers, public health, and the quality of care provided. Three-quarters of health care workers say that misinformation has negatively influenced both patients' decisions to get vaccinated and patient care.

But all of this can be fixed. As Americans, we have a long history of transforming public health crisis into

opportunity. In my written testimony I provide specific examples. Some were highlighted by President Biden last night, including systemic fixes to the health care delivery system; support for health care workers; investing in training and retaining all types of health care workers; treating the medical supply chain not as any other part of the U.S. economy, but rather as a concern of national security and health; and finally, rebuilding trust.

In close, every American wants to be able to show up in an emergency department and get timely, appropriate care for their emergency. Right now they can't. Throughout the pandemic we have relied too heavily on stopgap solutions, instead of addressing the underlying issues. I urge you, please think bigger and do more.

Thank you for your time.

[The prepared statement of Dr. Ranney follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor.

I am now pleased to recognize Ms. Austin for five minutes.

TESTIMONY OF TAWANDA AUSTIN

*Ms. Austin. Good morning, Subcommittee Chairwoman Diana DeGette, Subcommittee Ranking Member Morgan Griffith, members of the committee, and my fellow witnesses. Thank you for inviting me to participate in today's hearing. The views that I express today are my own views, and do not necessarily reflect the views of my employer.

My name is Tawanda Austin, and I serve as the chief nursing officer and vice president of patient care services at Emory University Hospital Midtown. I have been a nurse for over 20 years, and the COVID-19 pandemic presented the biggest challenge to the health care workforce in decades. Today I am going to talk about the multi-year mental and physical strain on nurses, hospital capacity challenges, and the worsening workforce shortage that Congress must address.

I recall rounding in our COVID ICU at the end of 2020, and I will never forget the exhaustion and despair that I saw on the nurses' faces. This is an ICU team that are innovators, and they are highly engaged, a team that proudly received a third Beacon Award during the pandemic. So it was not customary to see them look so defeated. As I walked around getting a pulse check on the nurses, one nurse says to me, "Walk with me. I want to show you something.''

She took me to four patients' rooms. We stood on the

outside of each of those rooms, peering through the glass windows, as she explained to me how severely ill each of those patients were, and she outlined the numerous medications and complex therapies they each were receiving. She paused and said, in her best clinical estimation, that not a single one of those patients would survive.

I believe her mission was purposeful. She wanted me to experience in just those few minutes what it was like to be on the front line, how devastating it was to do everything possible to save a patient's life, only to lose them in the end. I remember feeling deflated because, as a leader, it is my duty to support, to help find solutions to problems, to offer comfort when it is needed. But I didn't feel that that was enough in that moment.

As I continued to make rounds in the ICU, I stopped to check on another nurse, who appeared to be the most exhausted of all the nurses that I had encountered that day, and I asked how she was doing. She explained to me that she was caring for two patients that day, although one really required intensive one-to-one care. She was extremely overwhelmed, and stretched too thin. She had spent most of her day in this one patient's room, and had not been able to check in on the other patient as often as she wanted. On this day, like many others, the unit was short-staffed. But fortunately, the nurse in charge was able to support her with

the care of her second patient.

These are just a few of the all-too-common stories that have emerged from hospitals during the COVID-19 pandemic. I share these stories with you today because they illustrate the incredible pressure on our staff, who have been caring for COVID patients for nearly 750 days.

In addition to the physical strain, there is the mental stress that is plaguing our workforce. The morale of nurses has declined over time, as they continue to care for patients who are extremely ill and who are suffering and dying.

Additionally, nurses have shared stories of being verbally attacked for implementing COVID-19 safety restrictions. Patients' families have become frustrated and distressed, taking their emotions out on nurses, and workplace violence is at an all-time high.

The COVID-19 pandemic has tested the capacity of all hospitals. We are facing extremely long wait times in our emergency departments. And at the beginning of COVID, Emory paused our elective procedures, and providers were redistributed to our COVID units to support testing and to support our vaccine clinics. But now that we are back at regular operations, we again feel the immense shortage of nurses.

Early in the pandemic we saw nurses leave. Now we are experiencing additional staffing issues, as support staff

have also fled the industry, adding to the nurses' daily burden. While we face challenges, Emory nurses have stepped up. The COVID-19 pandemic forced our nurses to find new and innovative solutions to the challenges brought on by this public health crisis. Emory nurses placed baby monitors in the COVID rooms, and this allowed them an additional way to communicate with patients quickly, and make patients feel less isolated. It also saved on PPE, by consolidating the nurse's visits into the room. So instead of donning PPE to go in and hear the patient's request, the nurses received the request over the baby monitor, and entered the room once to deliver the needed care.

As we emerge from this pandemic, various lessons can be learned from the experiences of health care professionals.

First, we need a far more robust workforce to combat burnout and overall shortage of providers. I urge Congress to fund pathways for more young people to enter the nursing field, and programs to retain our staff.

Second, we need to address issues surrounding travel nursing agencies. While these businesses offer the chance for hospitals to bolster their workforce during surges, their costs have risen to unsustainable levels. Congress should take action so that hospitals remain financially viable, and avoid the risk of having to reduce services or, even worse, avoid the risk of shutting their doors.

Finally, I urge Congress to take a deeper look into the rising trend of violence towards health care workers, and find steps to mitigate this trend.

I look forward to your questions. Thank you.

[The prepared statement of Ms. Austin follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much.

Dr. Calac, now I recognize you for five minutes.

TESTIMONY OF DANIEL CALAC

*Dr. Calac. Good day to Chairman DeGette, Chair Congressman Pallone, Congressman Rodgers, and Republican Leader Griffith. Thank you so much. My thanks to all the health care workers' hard work over the last two years.

The testimony provided today is not necessarily reflective of my corporation. I would like to provide a brief description of the effect and response to COVID during the period of March 2020 to 2022, January.

So the context of this response is based in the Southern California area. My primary role at the facility is chief medical officer at this facility for the past 19 years. I serve as the primary care provider for the panel of patients that services nine American Indian tribes in these areas.

We currently operate out of a 30,000-square-foot facility that is located approximately 40 miles northeast of San Diego. There is an additional 12,000-square-foot facility about 25 additional miles from the main site, in the mountainous areas. We provide a multi-disciplinary, ambulatory care facility that provides care to approximately 20,000 American Indian clients in the surrounding area. However, about 5,000 of those are active patients.

The organization provides multiple disciplines, including internal medicine, family practice, pediatrics,

general dentistry, behavioral health, public health outreach. We also provide additional sub-specialties, including orthodontics, endodontics, orthopedics, acupuncture, optometry, OB/GYN, substance use disorder management, marriage and family therapy, pharmacy services, and podiatry.

The organization also contracts with outside agencies that are in neighboring cities 20 or 30 miles away.

I provide care, as a primary care physician, as I mentioned, in internal medicine. I am also pediatrician-trained, and also provide hospice care services to our community.

So our COVID response in that time is spread over the northern half of San Diego County. And so, just for references, the area covers about 10,000 square miles. Of note, the southern California area is home to over 30 different tribal entities with different cultures, different dialects, and, hence, the need to be culturally appropriate in these types of primary care delivery. One can, obviously, see the issues regarding delivering COVID-sensitive response care to these communities.

In this setting a pandemic has not been seen to this magnitude since the early 1900s. In a community where the average lifespan is 10 to 15 years less than the average American, the tribes in the surrounding area were required to mount a response that was replete with challenges, including

dealing with the geographic diversity, the economic issues that have been persistent over the past 100 years.

Considering the limited resources from which to work, the tribes provided a boots-on-the-ground workforce by -- and spreading information by word of mouth, fliers, social media, when appropriate.

It is important to acknowledge that, in the area that I work, only half of the tribes have access to the -- to internet or any type of significant social media because of the geographic diversity and the limits of providing telehealth in these areas.

Additionally, challenges exacerbated by health literacy makes receiving, processing, and disseminating true and accurate information a monumental challenge, especially in our older demographics, 60 to 70 years of age.

From a corporate standpoint, we managed to provide a unified approach, despite the closure of our internal services. The services that we provided, including preventive health services, were deferred because of the limitations of providing access in-house. We were required to provide most of our service out in a setting that consisted of our parking lot.

So I wanted to leave the committee with recommendations on this experience, and recommending a persistent and consistent outlook and perspective, and continued funding in

dealing with the issues of long-term COVID, and the effects of COVID in communities such as the rural one that I serve, looking at providing additional perspectives in infrastructure on telehealth for the delivery of health care to these outlying communities, and especially to look at the effects the pandemic has had on the pediatric population, in terms of delayed delivery of health care services, the issues of specialty services for the community, and also to address workplace shortages that persist in the communities that are served by Indian Health Services under Health and Human Services. Thank you.

[The prepared statement of Dr. Calac follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor.

Dr. Riley, I am now recognizing you for five minutes.

TESTIMONY OF LAURA E. RILEY

*Dr. Riley. Thank you, Chairs DeGette, Pallone, and Ranking Members for inviting me to speak with you today. My name is Dr. Laura Riley, and I am an obstetrician, gynecologist in chief at New York Presbyterian Hospital/Weill Cornell Medicine.

As a maternal fetal medicine specialist and expert on obstetric infectious disease, I have dedicated my career to ensuring patients have healthy pregnancies. I am a member of the advisory committee on immunization practices workgroup on COVID vaccines, and I currently serve as the chair of the American College of Obstetricians and Gynecologists' immunization, infectious disease, and public health preparedness expert workgroup.

While many of my colleagues in other specialties were forced to delay non-emergency services during COVID surges, our labor and delivery unit remained operational at full speed, caring at great personal risk for our laboring patients.

The ongoing pandemic has placed an incredible strain on our health care system and its workforce. Many labor and delivery units, including my own, are struggling with these mounting shortages. Obstetrics is practiced in a team. And when members of the team are missing, that can negatively

impact patient care.

While there is no one solution to these workforce challenges, greater investment in and training of health care professionals, from physicians and nurses to technicians, as well as efforts to diversify our health care workforce, are absolutely critical.

The early days of the pandemic were a time of extreme anxiety and confusion, especially for our pregnant patients. Many were left wondering if they should attend their prenatal appointments, and if it was safe to deliver at the hospital. During that time it was essential to reiterate to my patients that it was safe to deliver, and that their entire maternity team is committed to making sure that they get the support they need to birth confidently, safely, and respectfully.

One of the most important health care system shifts during the pandemic was to increase the utilization and coverage of telemedicine. Remote visits have become an expectation of patients, and I strongly urge their continued coverage, including extending flexibilities such as audio-only to meet patient needs.

Additionally, an ongoing and urgent concern is our health system's failing of historically marginalized communities, who are disproportionately impacted by the pandemic. A key lesson learned is that equity must be a focus of pandemic preparedness and response.

The impact of COVID-19 on the patients I serve is significant and ongoing. When the pandemic first began, we worried, based on our experience with flu, that COVID-19 may be worse in pregnant individuals. Those fears were confirmed, as we found that they are at increased risk of severe illness and death. Despite this evidence, and urgent calls from the medical community, pregnant and lactating individuals were initially excluded from COVID-19 vaccine trials, and continue to be excluded from therapeutic trials. That meant that, when the vaccines became available, we had very little data on their safety in pregnancy, resulting in confusion and fueling misinformation.

While ACOG and the CDC were finally able to make an affirmative recommendation for vaccination during pregnancy last summer, the long delay contributed to low vaccination rates among pregnant individuals and the rise of adverse outcomes.

The COVID-19 pandemic is exacerbating the maternal mortality crisis. In September 2021, the CDC released an advisory following the record-breaking COVID-19-related deaths among pregnant individuals in a single month. Of note, their primary recommendation was to increase efforts to protect pregnant and lactating individuals through accelerated vaccine -- vaccination effort. Unfortunately, vaccine hesitancy remains today, and I continue to counsel my

unvaccinated pregnant patients on the vaccine's protection of their health and their newborn's health.

These routine exclusions of pregnant and lactating individuals from research, presumably for their protection, leaves them disproportionately vulnerable, and may have, in this instance, contributed to avoidable loss of life. As we reflect on the pandemic and lessons learned, it is past time to shift the narrative on research in this population. Instead of protecting them from research, we should be protecting them through research.

Thank you for the opportunity to share my experiences and expertise with you today. I look forward to your questions.

[The prepared statement of Dr. Riley follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor.

And now, Dr. McBride, I am very pleased to recognize you for five minutes.

TESTIMONY OF LUCY MCBRIDE

*Dr. McBride. Good morning, and thank you to Chairs DeGette and Pallone, and to Ranking Members Rodgers and Griffin (sic) for inviting me today.

My name is Dr. Lucy McBride. I am here as a board certified primary care physician in Washington, D.C. I have been practicing medicine for 20 years. I have dedicated my life and my career to helping people understand the inseparability of mental and physical health, whether it is my teenage patients or my octogenarian patients. I trained at the Harvard Medical School and at Johns Hopkins Hospital.

I am not here today to be clear with any political agenda whatsoever, but rather to share my perspective on the pandemic as someone who has seen patients every day, patients who are on the receiving end of complex and often confusing public health information, and who are trying to make sense of the news.

This is a watershed moment of the pandemic. We have learned enormous amounts about the virus over the last two years. We have learned exactly who is most susceptible to the severe consequences from COVID-19, and we have now incredibly safe and effective vaccines and therapeutics. But we are not done. COVID continues to cause widespread death and destruction. We have a lot of work to do to increase

vaccine uptake.

We have also unmasked major problems in our health care system -- in particular, the erosion of trust in public health and the lack of access to needed medical care just when people need it most. As a result, we are dealing with a parallel pandemic of mental health and crisis and surging rates of underlying conditions like obesity, and people just don't know where to go for advice.

I have seen everything over the course of the pandemic. I have had patients hospitalized from COVID. I have had patients die from COVID. I have patients with long COVID. I have patients with COVID right now. I have also witnessed the social, emotional, and mental health toll of the pandemic itself, and from all of the losses that come along with losing friends and families -- family members to the virus, but also from lost jobs, sense of normalcy, social disruptions, isolation, and loneliness, and just from navigating the deluge of information coming at people every day, and the politicization of science.

I see the emotional distress and the very real physical manifestations of stacked stressors, from insomnia to stress eating to substance use disorder, and the accompanying surging levels of medical conditions like diabetes, obesity, and depression. What I see in my patients every day is mirrored in the medical data.

Take, for example, my patient from earlier this week, a single mother with two children, one a middle schooler with special needs, and the other who is a college student suffering from depression. Stressed to the max, my patient finds herself drinking too much, eating, not exercising. And as a result, her blood pressure and her weight have soared during the pandemic. Naturally, she worries about COVID-19, but that is only one of the myriad health issues that she and I are working on together.

So I am here to bring my firsthand appreciation for what I am seeing, and for what I see people needing most. And that is access to a trusted primary care provider, something that 80 million Americans do not have, particularly in rural and poverty-stricken urban areas. Of course, I am a little biased, because I am a primary care doctor myself. But really, COVID-19 is an outpatient disease. The ERs and ICUs have, obviously, been critical for our most sick patients, and are certainly where the news focus is, and where doctors like Megan Ranney have been doing heroic and essential work.

But the fact is that the vast majority of patients with COVID-19 are out in the world, and not in the ICUs. ERs were flooded not only because people were severely and sometimes critically and fatally ill, but also because they were scared and sick, and navigating the pandemic alone without access to a guide. So there are three unmet needs that I see in the

community that we need to face.

One is all the information -- misinformation we are seeing. More than ever, people need a trusted medical provider to receive fact-based, nuanced medical advice. Just last month a study in JAMA showed that the COVID vaccine uptake increases with the number of PCPs per capita.

Number two is a place to manage underlying conditions. We know that, in addition to age, one of the biggest risk factors for severe outcomes from COVID is underlying conditions. And we manage those, not with ER visits, but rather with longitudinal relationships with a primary care doctor for guidance on things like nutrition, sleep, exercise, stress management.

And three, people need a place to help apply broad public health advice to their unique lived experience and situation. I spent countless hours on the phone over the last two years helping people manage everyday questions: which COVID test? Which vaccine? Do I need a booster? And people need help navigating these everyday decisions, and balancing risks.

There is no better role for primary care than in a global health crisis. My hope is that our children grow up in an America where they have unfettered access to primary care, a hub for problem-solving, a place where mental and behavioral health and physical health meet, where people can

be fully seen and heard, and where they don't have to worry about who to trust. They don't land in Dr. Ranney's ER because they have underlying health conditions that aren't managed. And when they are short of breath, they don't have to wonder, is this COVID or is this a panic attack? Or they can get their COVID test and talk about their anxiety, and navigate that mental health condition that is so common.

As we dig through the rubble of the pandemic and prepare for the next one, we must invest proactively in medical systems founded on relationships, rapport, and reason. Investing in primary care is the way we invest in our health and our collective well-being. Thank you very much.

[The prepared statement of Dr. McBride follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor, and thank you for your work on the front lines.

Thanks to all of our witnesses for their hard work.

It is now time for members to have the opportunity to ask you questions, and so the chair will recognize herself for five minutes.

You know, when we hear the testimony today from all of our witnesses, and when we hear from our constituents in our districts, we know that this crisis is impacting health care workers across all levels, from primary care physicians to nursing to emergency care, and on and on. And only when we understand where we fell short can we better understand what we need to do for the future. As the chairman said, I am all about recognizing the positives and the challenges, and seeing what we need to do. And so what I want to do with our witnesses today is drill down in what the witnesses feel are the critical steps for Congress and the Federal Government to take to prepare for tomorrow's challenges.

So, Dr. Ranney, I am going to start with you first. Your testimony mentions needing a "culture of preparedness'' to effectively manage national disasters. What action do you think would be key to being better prepared in the future?

*Dr. Ranney. Thank you for the question. So I will note that organizations like ASPR have previously outlined good preparedness plans, ways to set up health care systems

that have adequate resiliency with staff, with supply, with real-time data to be able to respond, identify surges when they start, respond appropriately from stop -- to stop them from getting worse, and then to deploy health care workers across the country, as needed.

Right now, though, we need to shore up our workforce. So that is both about retaining current health care workers, helping them individually manage their burnout -- distress, stopping or reducing the impact of workplace violence, and creating those systemic fixes so that we have, particularly for our nurses, having adequate nursing staffing ratios, and about training up new health care providers, so that we can refill the ranks from all the folks that have left.

And then the third part is working on creating new models of access to care. I do appreciate Dr. McBride's points about primary care providers, the minority chair's -- Minority Griffith Member's comments about telehealth. Also, new digital health modalities, as well, can make a big difference.

And then, at the bottom of it, setting up a better data infrastructure. So the wastewater monitoring that CDC is now beginning to implement into its data systems are critical. Setting up other data systems that we have accurate information not just on race, ethnicity, and age of cases, but also hospitalizations, so that we have real-time data on

staffed hospital beds, so that we have real-time data on supply shortages. Again, personal protective equipment was --

*Ms. DeGette. I am going to -- I am sorry, I am going to need to interrupt you, so I can --

*Dr. Ranney. No problem.

*Ms. DeGette. -- get to the rest of my questions.

*Dr. Ranney. Go ahead.

*Ms. DeGette. I want to ask you, Ms. Austin, the same question. What do you think we need to do to support nurses and address the challenges in the future?

[No response.]

*Ms. DeGette. Okay, I will come back to you, Ms. Austin, I think we are having a technical issue.

I want to ask you, Dr. Riley. You have noted the availability of vaccines and treatments that were instrumental in supporting the health and well-being of your patients, but there was a delay in the evidence necessary to assure safety and efficacy among pregnant and lactating women. Briefly, what can we do to recommend -- to address this in the future?

*Dr. Riley. I think -- thank you for the question. I think it is really important that we figure out how we are going to involve pregnant and lactating women in research earlier in the process.

Research could have been done on the vaccine, giving us information about safety that would have allowed us to vaccinate even more women. The long delay allowed us to then fill that in with the mistrust and, you know, all sorts of things on the social [inaudible], which have led to fewer pregnant women being vaccinated than we would hope.

I think the other [inaudible] that we need to really focus on is the surveillance systems which, in the past, did not include information on pregnancy and lactating women. And those surveillance systems, which have now been stood up for COVID-19, need to remain in place. So not only do we need surveillance of disease, we also need surveillance of vaccine use and vaccine safety, which are absolutely critical. Thank you.

*Ms. DeGette. Ms. Austin, do we have you back?

*Ms. Austin. Yes, I apologize. I lost audio for just a few minutes there. Thank you so much --

*Ms. DeGette. Technology is our friend.

*Ms. Austin. -- the question.

*Ms. DeGette. Go ahead. Go ahead. The question was what steps do you think that we can take to support nurses and address the challenges we found with COVID?

*Ms. Austin. Yes, I think the biggest opportunity for our nurses, I hear all the time, is our staffing shortages. I think, if there is anything at all that could be done, it

is just investing in our accredited nursing residency programs.

Emory has one of only two nursing residency programs in the State of Georgia, and it is truly a pipeline for us. Over the last couple of years we have brought in about 500 new nurses, new graduate nurses, and our goal this year is to bring in over 700. So I think that anything that could be done to help partner with the Federal Government to grow our program would be really helpful.

*Ms. DeGette. Thank you so much.

Dr. McBride, I am out of time, but I -- you know, my daughter is a primary care doctor in San Francisco, and I know the work that all of you do. I would be interested if you could just very briefly tell us what Congress can do to help support primary care doctors going forward, because there is a severe shortage, as you say.

*Dr. McBride. So right. Before the pandemic we had an enormous shortage of primary care physicians, particularly as patients age, and if you have Baby Boomers, and people are living longer. So here's my advice.

First, we have a supply problem. We need to incentivize people coming out of medical school to come into primary care professions. Right now the incentives are to go into specialties that are more procedural-based, and we need to -- in my opinion, I am biased, obviously -- make primary care

the kind of crown jewel of medicine, because it is the place -- it is the ground game, it is where trust is born, it is where relationships and rapport are born, to be able to dispense trust and nuanced information. And if we have better primary care, particularly with behavioral health and mental health services woven in with PAs, NPs, doctors, and extensions of us, then we can do better to prevent mental health despair, physical health problems.

And so it is about getting more people in medical school to go into primary care. It is also about --

*Ms. DeGette. I am sorry to interrupt you, but my time is way expired, and I appreciate the ranking member. I know -- I am sure we can get more from you. Thank you.

And I am going to recognize Mr. Griffith for five minutes.

*Mr. Griffith. Thank you very much. I am going to ask for a little indulgence, too, because I want us to go back to Dr. Riley for just a second on one of your questions, because part of our duty is not only to get information for ourselves, but to make sure people back home that might be watching on C-SPAN have an opportunity, too.

And Dr. Riley, you mentioned surveillance systems. Define that for us. You were talking about nursing and so forth.

*Dr. Riley. So I was talking about having information

on COVID infection specifically for pregnant women and lactating women. So that surveillance system that the CDC, you know, ultimately stood up allowed us to then figure out that, in fact, COVID infection was worse for pregnant women.

*Mr. Griffith. I got that. But the problem is, I am not sure folks back home understand what you mean by "surveillance system'' that the CDC stood up. That is what I am trying to get at --

*Dr. Riley. Oh, I am sorry.

*Mr. Griffith. -- just a definition.

*Dr. Riley. Okay.

*Mr. Griffith. That is all right.

*Dr. Riley. So a way of counting cases of -- you know, being able to recognize that the patients coming into the hospital are pregnant or not pregnant, lactating/not lactating, race ethnicity, so getting more information on patients as they come into the hospital or as they leave the intensive care unit, so that you can figure out exactly who is getting sickest.

*Mr. Griffith. Thank you very much. That is very helpful.

Dr. McBride, at the beginning of the pandemic the Centers for Medicare and Medicaid Services announced that all elective, non-essential procedures should be delayed during COVID-19 outbreak. CMS also stated that the decision to

proceed with these procedures would be made by the clinician, patient hospitals, state and local health departments, et cetera. But as a result of that, patients and doctors across the U.S. postponed procedures. More recently, during the Omicron outbreak, some states and hospital systems continue to grapple with the decision to delay elective, or so-called elective, procedures to manage care for COVID-19 patients.

Looking back on the decisions to postpone procedures, were there any options besides across-the-board postponements that we could have made?

*Dr. McBride. So, as we all know, hindsight is 20/20.

*Mr. Griffith. Yes, ma'am.

*Dr. McBride. But I do think it is important to realize, moving forward -- because we will have another wave of COVID-19, we will have another pandemic, whether it is in 6 years, 6 months, or 6 decades -- to recognize that COVID is only one threat to our health and well-being. It is enormous, right? We have lost almost 950,000 American lives. People are suffering from long COVID and other sequela from the virus. But I think it is also important to realize that elective surgeries, for example, are essential for people to keep people healthy, to prevent the underlying conditions that then put them at higher risk for poor outcomes.

So I don't claim to have the solution, but I think we need to make sure that we gather as much information now on

the virus, who exactly it affects, so that we tailor our mitigation measures more appropriately to the actual risk, and that we don't do more harm than good with mitigations.

*Mr. Griffith. And I appreciate that, because there are situations where harm was done because, as I said in my opening, most people, when they hear elective, they think you are talking about something that doesn't need to be done, or cosmetic surgery, or something like that, when in often cases it is the diagnosis phase, where you are trying to figure out what is wrong. And it may not appear to be an emergency today, but, as we know, unfortunately, sometimes it is actually an emergency, or the test would have turned up something that needed to be dealt with right away.

All right. Also Dr. McBride, and then also Dr. Riley, during the COVID-19 pandemic health care providers had to adopt remote methods to care for their patients by using telemedicine. This is especially important in under-served and isolated communities, where it is more difficult to access care. We know that telemedicine can save lives, and I am glad that the health care facilities in my district have taken advantage of the Federal grant funds to enhance their capabilities.

Did you use telehealth during the pandemic? And if so, what type of equipment did you need to use to monitor patients from home?

We will start with you, Dr. McBride, then we will go to you, Dr. Riley.

*Dr. McBride. Thank you for that question. So telehealth was a lifeline during the pandemic. I actually wrote an opinion piece in The Washington Post in the spring of 2020 with the former FCC Chairman Reed Hundt about the urgent need to get universal broadband access to all Americans, particularly, as you said, for those in rural communities and marginalized communities, who don't have access to internet service, which right now is a beautiful adjunct to, for example, primary care.

Particularly with mental health care, which, as you know, is a surging and crisis in this country, you know, in-person therapy, in-person Alcoholics Anonymous is probably better than virtual, but virtual therapy and virtual AA is better than no therapy and no AA. So if we can get people the access to the internet services they need, then we can reach the far corners of --

*Mr. Griffith. And I agree with that. What did you use in your practice, or what did you need to update or improve in your practice to make that happen?

*Dr. McBride. We had to do a control/alt/delete on how we practice medicine, if you will.

[Laughter.]

*Dr. McBride. We -- so basically, Zoom and Microsoft

Teams, we had to -- you know, I remember the days of getting my 92-year-old patient, for example, to log in to Zoom, and do the passwords. I became a tech support, in addition to a doctor, trying to help her manage her sore throat. Is it COVID? Is it something else? On Zoom.

So, you know, we need better tech capabilities. We need better tech support, not just doctors --

*Mr. Griffith. All right.

*Dr. McBride. -- and we need [inaudible] --

*Mr. Griffith. And I have --

*Dr. McBride. -- access.

*Mr. Griffith. I have to cut you off, because my time is up.

And Dr. Riley, I will probably ask that as a written question. If you could give me your answer in writing to those questions, I would greatly appreciate it.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. But I must yield back.

*Ms. DeGette. I thank the gentleman.

All the Members of Congress also became tech support experts, as well, Doctor.

The chair now recognizes the chairman of the full committee, Mr. Pallone, for five minutes.

*The Chairman. Thank you, Chairwoman DeGette. I want to ask Ms. Austin, initially.

You stated in your testimony -- and I quote -- "The COVID-19 pandemic forced our nursing workforce to find new and innovative solutions to the challenges brought on by this public health crisis.'' So if I could ask you, do you think the availability of new tools, such as the COVID-19 vaccines and treatments, has helped your team and other nurses in the country keep these challenges from being worse in the United States? And, if so, how?

*Ms. Austin. I would say yes to that. You know, our nurses really appreciated the opportunity -- when our vaccines came out, they appreciated the opportunity to take the vaccine. They appreciated the opportunity that there were patients, family members that were taking the vaccine. Because again, you know, what nurses are fearful of, most of them, is being exposed and having to take, you know, the virus home to their family members. So I think that vaccination is, for most nurses, is appreciated.

And I do think it helps with [inaudible], and all the other things that they are doing. It is one less thing to worry about while they are trying to take great care of patients.

*The Chairman. Thank you.

Dr. Riley, your patients have had specific needs in thinking about their own safety and health, and that of their families for the past two years. What is the availability -- what has the availability of COVID-19 vaccines meant to your patients, Dr. Riley?

*Dr. Riley. It has been tremendously helpful to patients. I think, for those who have availed themselves of the vaccine, I think that there is good data to suggest that it certainly has helped them, personally. So women are less likely to become ill and land in the ICU if, in fact, they are vaccinated, pregnant and vaccinated.

I think also we now have good data that suggests that the antibodies that those women make after vaccination are transmitted to the newborn, and can be protective through newborns, who can sometimes get sick.

So I think that, you know, patients who are unvaccinated are the ones that we are really trying to target now, so that they can protect their own health, as well as the health of their babies.

*The Chairman. The committee has supported a range of

legislation intended to support health care workers and the broader health infrastructure, including 48 million in funding recently made available by the American Rescue Plan for community-based organizations in rural and tribal communities to expand public health capacity. So, Dr. Calac, I wanted to ask you, how critical are the investments such as those in the communities you serve with the Indian Health Council?

*Dr. Calac. Thank you for your question. Those needs are critical.

I would like to segue off of Ms. Austin's question, in terms of nursing, the importance of nursing not only in facilities and in hospitals, but also in public health settings, where you send out nurses to these rural communities to support the needs of patients that cannot come in, or cannot have access to a telehealth platform and receive the care that they need.

So in terms of the continued funding supports for health care workers, it is critical that we not only look at nursing, but also other forms of health care providers, including physicians. I might just support and recommend programs like Indians Into Medicine, which is a five-year program looking at providing funding for Indians going into medicine. And quoting the 2017 Association of American Medical Colleges data, where we had, between 2012 and 2017,

93,000 medical graduates, and only 131 of those were identified as American Indian and Alaska Native. So 93,000, and only 131 physicians that would potentially go back to the communities to serve those rural areas that we just spoke of.

*The Chairman. Let me just -- one more question for Dr. Ranney about -- you know, we have a number of -- we passed legislation to address behavioral health, and how that impacts health providers.

Dr. Ranney, how do these targeted investments in behavioral health, or the behavioral health needs of health care professionals, you know, how important are they? If you just would comment on that.

*Dr. Ranney. So briefly, they are just tremendously important.

The Lorna Breen Act, which, obviously, was named for one of my fellow emergency physicians who killed herself after taking care of COVID patients and then catching COVID herself in the early days of the pandemic, is just a tremendous step forwards.

In the face of burnout, PTSD, depression, so many health care providers are leaving. And as the other witnesses testified, a teammate's departure isn't just about losing that staff member. It is also about the overall culture of the team. So providing individual-level support, reducing stigma to getting that support, encouraging state medical

licensure boards and hospitals to not ask about behavioral health treatment when licensing, those are all critical steps to helping us be healthy, so that we can better take care of our patients.

*The Chairman. Thank you.

And thank you, Chairwoman DeGette.

*Ms. DeGette. The chair would like to remind all of the members who are appearing on Webex that they need to mute themselves, both the witnesses and the members. We are getting feedback because people aren't muting themselves. Thank you.

The chair now recognizes Mrs. Rodgers for five minutes.

*Mrs. Rodgers. Thank you, Madam Chair. This will not be the last pandemic we face, and I believe that it is critical that we learn from our response to not only prepare us for future pandemics, but to ensure we do not repeat the costly and harmful policies that we have seen over the last couple of years.

To that end, John Hopkins recently published a report that lockdowns had little to no effect on COVID-19 mortality, but certainly brought significant social and economic cost. Dr. McBride, in your -- your written testimony you speak to this, and you note that we failed to tailor our mitigation efforts to those highest at risk. Can you please explain how this happened, and why it was especially harmful?

*Dr. McBride. So I think, in the panicked spring of 2020, when we didn't know much, if anything at all, about the novel coronavirus, it arguably made sense to do everything we could, right, to prevent all of the widespread death and destruction. I think the two biggest failures in my mind in the public health response were the closures of schools and the prolonged closures of schools.

We know now that, in a public health emergency, schools should be the last to close and the first to open. And we imposed very strict interventions on children, who we now know face the lowest risk of any age cohort for severe consequences from COVID-19. That is not to dismiss the ongoing suffering of families who have lost children to COVID-19. The death of a child is tragic, regardless of the cause. And we -- it is not to dismiss kids with long COVID, with MIS-C. It is not to dismiss any of the devastation. It is simply to say that closing schools has done harm to our youngest generation.

And secondly, the other major health -- public health failure in my mind was that we did not protect our most frail elderly patients as well as we could during the early days of the pandemic. We know that there is an increase in risk of severe consequences and death from COVID that goes with age. And we could have done things like paying home health or nursing home aides to work at one nursing home facility,

instead of many, because they were unwittingly spreading the disease, even though they were trying to help protect their patients.

And so I think, you know, as I said earlier, hindsight is 2020. I do not ascribe mal intent to anyone. I simply think that it is really important moving forward -- because, again, we will face another pandemic, we will face another COVID wave -- that we tailor our mitigations, and we appropriately calibrate the risk mitigation measures to the population at risk, and then arm people with tools and information to use to protect themselves.

Again, I will go back to my main argument in my testimony. This is another reason why we need primary care hubs. We need patients to be able to pair the broad public health advice with their unique lived experience, age, underlying health conditions. We can do a lot better the next time around.

*Mrs. Rodgers. As a mom, I really appreciate your voice, your fighting on the front lines to get our kids, our children, back in school.

Just as a follow-up, do you believe it was foreseeable? You talked about the impact of the prolonged closures of schools. Do you believe it was foreseeable?

*Dr. McBride. I think we know that school is essential, not only for learning. It is also essential for kids who

aren't safe at home. Kids don't always come from a happy, healthy home. Kids use school for their food. They use it -- they need it for their emotional health. They need it for social bonds. That is where kids get their athletic activities.

We have seen surging rates of obesity and children in part -- not fully, but in part -- because kids have been relatively inactive and on screens much more than they were pre-pandemic. Although that was -- I am a mother, I know the screens are not an easy problem to solve.

But I think it was foreseeable that school closures would cause harm. I think we thought that this was going to be a short-term, two-week flatten-the-curve proposition.

*Mrs. Rodgers. Yes.

*Dr. McBride. But here we are, two years --

*Mrs. Rodgers. Yes.

*Dr. McBride. -- into the pandemic.

*Mrs. Rodgers. Yes.

*Dr. McBride. We have so much accumulated data on who is at highest risk.

*Mrs. Rodgers. Yes.

*Dr. McBride. And I think we need to really, really --

*Mrs. Rodgers. Before I run out of time, would you just speak briefly if you have reviewed the data at CDC around the mask mandate on our kids, and its impact?

*Dr. McBride. Sure. No, I have looked very, very closely at the mask mandate data. And what I would say is that there is no real-world compelling evidence at this moment, in March, 2022, that mask mandates in schools have meaningful effects on the transmission of the virus in the schools.

That is not to say that masks don't work, or can't work. I am not anti-mask. I was wearing a mask all day yesterday in my office, seeing a sick patient. It is simply to say that the burden of proof is on the intervention.

The norm is to see faces in schools, to see the broad range of expression on teachers and coaches and mentors' faces and on peers' faces. It is to say that there are unintended harms of a mandate, for example, on children who are autistic, children who have speech and language delays, children who have English as a second language. And even for neurotypical children, seeing people's faces is the norm.

*Mrs. Rodgers. Thank you, thank you.

*Dr. McBride. So any intervention that we impose --

*Mrs. Rodgers. Yes.

*Dr. McBride. -- particularly if it is mandated, needs to have more benefit than harm.

*Mrs. Rodgers. Thank you. My time has expired.

I appreciate a little extra time there. I yield back.

*Ms. DeGette. You bet. The chair now recognizes Ms. Kuster for five minutes.

*Ms. Kuster. Thank you, and I just can't resist going back to the last witness.

We all would like to have the children in schools, and certainly now, and we would all -- delighted to get rid of our masks. Do you think, if the previous President had taken the vaccine publicly a year ago, when he chose to take it privately and not tell anyone, that that would have made a difference in vaccine uptake, and would have ended this pandemic earlier?

*Dr. McBride. I think --

*Ms. Kuster. That is to the previous witness.

*Dr. McBride. Is that for me?

*Ms. Kuster. Yes.

*Dr. McBride. Absolutely. I think if the previous President had modeled vaccine confidence, it would have made an -- absolutely, a big difference. And one of my jobs in medicine is --

*Ms. Kuster. It would have saved hundreds of thousands of lives, possibly, and certainly would have saved many, many children from harm.

So I will dive back into my remarks, but I can't leave that unsaid.

Like many places throughout the country, my home state

of New Hampshire [inaudible] surge caused by Omicron over the last few months. And at one point in December there was not a single available bed in the five-state area in our region.

I spoke with hospital leaders across my district in December, who detailed the serious impact of COVID-19 on workforce bed availability and delays in health care. And in my own family, we have had delays in health care directly related to the COVID surge.

Like all Americans, I am glad to see that the Omicron surge is largely behind us, but it must be underscored that this surge and the tragic deaths that followed were driven overwhelmingly by unvaccinated Americans.

Throughout the pandemic, hospitals and health care providers have had to delay elective procedures to be able to respond to surges in COVID-19 cases and hospitalizations. My own brother's surgery has recently been delayed. Hopefully, it will happen today. But all of us are scrambling in our families to rearrange travel schedules and to try to be there for those who we love.

Dr. Ranney, your testimony mentioned colonoscopies, heart surgeries, and even brain surgeries as the type of surgeries postponed or disrupted. Can you give us a better understanding of the types of services that are considered elective?

And what are some potential implications of delaying

these procedures?

*Dr. Ranney. Thank you, Representative. So to be clear, again, these elective surgeries are not cosmetic; they are things that are utterly necessary. It is about removing a pituitary mass, something -- a mass in the brain that is threatening your sight. It is about removing cancer. It is about repairing an aorta before it bursts.

And what happens when these surgeries get delayed is that they triage according to what is the most likely to be most life-threatening. Those are the ones that get moved up. So I know of many patients who had their surgeries delayed, ended up with emergent conditions, ended up in my ER, and then we had to make space for them.

The trouble was, though, is that so many of our nurses were redeployed to take care of COVID patients that we couldn't adequately staff post-surgical ICU beds. And this was true, of course, not just in my own hospital system, but in others across the country, which then created a knock-on effect of having to keep patients in the emergency department longer before they could get the surgeries.

One of my colleagues, actually, in Wisconsin recently told me that he is diagnosing more advanced cancer now and recurrences of cancer than he ever has, because of folks having to put off these procedures, imaging studies and so on, due to COVID, and due to the staffing limitations they

are in.

*Ms. Kuster. And in our situation, I am having to fly across the country tomorrow evening because they won't keep my brother in the hospital post-surgery because of COVID. So this is really impacting people's lives.

Studies confirm patients also made the decision to delay medical care, and you have mentioned that. A CDC study earlier in the pandemic found 4 in 10 adults delayed or avoided care, including urgent and emergency care, a trend that is continuing. What is -- you have mentioned delaying care and the consequences. But I am wondering, delaying screenings and preventative care, if you could, review the consequences on both patients and the health care delivery system.

*Dr. Ranney. Absolutely. So early in the pandemic, when our COVID visits were high, overall number of visits dropped. That has also happened during the Delta surge and during the Omicron surge. And what we found was actually in parallel: the number of at-home cardiac arrests increased, the number of strokes that we couldn't treat increased, because people stayed out when they really should be coming in to get evaluated.

We are also seeing delays in things like dental care that result in people coming in with major cavities or tooth abscesses. We are seeing delays in diagnoses of cancer, and,

of course, we are seeing increases in untreated behavioral health problems, opioid overdoses, and the like, problems that pre-existed before the pandemic, but have worsened over the last two years.

*Ms. Kuster. And we do intend to --

*Ms. DeGette. Thank you so much.

*Ms. Kuster. -- to that. Thank you, my time --

*Ms. DeGette. The gentlelady's time has expired.

*Ms. Kuster. I yield back.

*Ms. DeGette. Mr. Burgess?

*Mr. Burgess. Thank you, and thanks to our witnesses for being here today. This is exactly the type of hearing that we should have been having over these last two years, so I am grateful that we are having it. I hope this is not the last.

I hope we will continue to do this type of work because, as you will recall, the congressional approach to the pandemic were massive supplemental emergency appropriations, but we are an authorizing committee. We are supposed to do the work. We are supposed to take the testimony from the experts and come up with how the money is most correctly to be spent, and then the appropriators write the check. But these last two years, we have written a lot of checks without doing the groundwork ahead of time, so we can do some of it after the fact.

But the Congressional Budget Office was in my personal office earlier this week, and they said there is, I think, around $350 billion of unspent, unobligated funds in all of the appropriations packages we did as emergency measures over the past two years. So when I hear discussion about we need more money for this, for that, I don't disagree. But that is because this committee has not done the authorization work that it should have done over these last two years.

Now, having said that, let me -- Dr. Riley, I will not get through every question that I have got to get through, so I will be submitting some of these questions in writing, and look forward to your responses.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. But Dr. Riley, if I could ask you, we actually have a doctor's caucus here in Congress. The surgeon general came and talked to us a couple of weeks ago. He said, doing his rounds around the country, he was very concerned about physician burnout, as am I, as all of you.

But one of the things that was sort of left unmentioned is every year we turn around and we start cutting Dr. McBride's pay, and Dr. Riley's pay because of the physician fee schedule in Medicare. So I will just ask you, Dr. Riley. Do you think, if we as a committee, would spend the time addressing issues like provider pay, that that would help some of the workforce issues and the burnout issues?

*Dr. Riley. Thank you for the question. I suspect yes. I mean, I think that, you know, people want and deserve to be compensated for the work that they do.

I do think that there is also the opportunity to incentivize certain aspects of medicine. I think that we are -- you know, we are facing a really important challenge right now, where every aspect of health care, whether you are a physician, a nurse, a technician, a genetic counselor, et cetera, all of those people are absolutely critical to what we do, but all need to be compensated. And there is quite a bit of, you know, technical education that needs to go into that.

So yes, I do think that --

*Mr. Burgess. Yes. And I will have to move on because, again, time is so short.

So Dr. Ranney, I had a question for you. I have got a hospital. It is not in my district, it is just outside of my district. As everyone knows, with coronavirus, we do have some things that can be administered as an outpatient. That is a wonderful benefit. Once someone gets sick enough to be in the ICU, once they have had the course of steroids, after they have failed Remdesivir, there is not much on the shelf to be able to administer to those patients to try to save them.

There is work going on. In fact, one of the hospitals just outside of my district is working with a compound called Zyesami that is a vasoactive intestinal peptide, which seems to show a lot of promise, just in general. And this is what has been so frustrating with the FDA through this pandemic. You get something into a phase three trial, so it is more likely than not to be beneficial. You have got nothing else, and a sick patient in the ICU on the ventilator.

So what about the access to late-stage therapeutics in coronavirus patients who are in critical care?

*Dr. Ranney. So I think the emergency use authorization -- thank you for the question. I think emergency use authorizations are a critical tool for us to use during a pandemic to improve the speed at which we have access to

therapeutics that have good safety data and decent efficacy data.

I don't want to spend any time or money on things that --

*Mr. Burgess. Yes, I have got to interrupt you there, because --

*Dr. Ranney. Yes.

*Mr. Burgess. -- I agree with you. The problem is this particular compound, that application is gummed up in the FDA. They might get to it in September. We have situations where it is not the regulation, but we have personalities that we can't get past, and that is one of the things that needs to change as we go forward in this pandemic.

I thank all of our witnesses for being here. I know how valuable your time is.

I will yield back to the chair.

*Ms. DeGette. I thank the gentleman. Ms. Schakowsky, you are now recognized for five minutes.

*Ms. Schakowsky. Thank you, Chairman DeGette, and I appreciate your holding this hearing. We owe our nurses and doctors and all of the frontline health care workers an enormous debt, and the title of this hearing, lessons from the front, really drives home what I believe is the point that we have to listen to our health care workers, and give them the supplies and the support and the resources that they

are asking for.

And though they are not here at this hearing today. I want to recognize that labor unions that represent frontline health care workers have provided a path for critical health and safety protections for workers and for patients. And for this reason I would ask to put into the record a December 2021 report from National Nurses United, the largest national union representing registered nurses from around the country.

*Ms. DeGette. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Schakowsky. Thank you. The nurses and health care workforce is in crisis, and it has been for, actually, a long time. And we know that there is a shortage of good-paying, permanent nursing jobs, where nurses and -- are fully valued, and their work at -- for their work at the bedside. And this is exactly why we need to invest in permanent jobs, with good wages, and benefits, and safe staffing standards.

I am very proud that I have introduced legislation, and leading the legislation called Nurse Staffing Standards for Hospital Patient Safety and Quality Care, and I would like to talk to -- ask Dr. Ranney.

In reviewing your written testimony, I noted that -- I noted and appreciate, actually, that you referenced the dire need to implement minimum nursing standards. And I wondered if you could talk more about the science and the evidence that backs up the need to have minimum nursing staffing ratios.

*Dr. Ranney. Absolutely, and I can share specific studies after the hearing. I don't have all of the exact numbers at my fingertips, but the short version is that there is ample evidence that having low nurse-to-patient ratios improves patient outcomes, decreases patient mortality, decreases staff burnout, not just for nurses, but also for the rest of the team. Asking nurses to take care of more than a certain standard number of patients, with a lower

number of patients acceptable in the intensive care unit compared to on hospital floors, but going past that limit increases, again, both patient harm and nurse and others' burnout.

*Ms. Schakowsky. Is that the lack of the -- any kind of staffing ratios, and is there a reason for burnout of nurses, that they just feel overwhelmed?

And we do see a flight of nurses. That was mentioned by one of our other witnesses, and that that would help to keep people on the job.

[Pause.]

*Ms. Schakowsky. Dr. Ranney?

*Dr. Ranney. Absolutely. Thank you. That would absolutely help to keep people on the job.

Speaking to nurses that are in states that have nursing staffing ratios versus those without, there is a really big difference in terms of their quality of care provided, their are levels of burnout, and their willingness to stay there.

*Ms. Schakowsky. So I really appreciate that, because we are talking not only about the nurses themselves and their ability to stay on the job, but I think the data that you referred to that shows that the outcomes for patients really improves, and I have talked to nurses who are so worried that they have not been able to make sure that the medication is correct, and we know that there are -- is a good deal of harm

that happens in hospitals that -- some of which can be attributed to the fact that the nurses can't spend enough time. So I just thank you for that.

And you know, we want to do everything we can to make sure that both the workers and the patients have what they need, as we go forward.

And so I yield back. Thank you.

*Ms. DeGette. I thank the gentlelady. Mr. McKinley, you are now recognized for five minutes.

*Mr. McKinley. Thank you, Madam Chairwoman. Lessons learned from the pandemic. There are several things that I am going to try to get through in a short time.

Several of the hospitals in West Virginia have indicated that they seem to have increased efforts to hack into their hospital records. I don't know whether that is unique to West Virginia. Has it been -- for all -- anyone of the panel, have they seen that across the country during this pandemic, that people are trying to get access to health records? Can anyone comment about that, just quickly?

Hearing none, let me go to Ms. Austin --

*Dr. Ranney. This is Dr. Ranney --

*Mr. McKinley. -- if I could.

*Dr. Ranney. -- just to say that there -- the issue of cyber attacks on health care records is an issue that has been going on for a very long time, and I can provide data

from Dr. --

*Mr. McKinley. Increase. Has there been an increase in this? That is what I am trying to get to.

*Dr. Ranney. That I am not sure. I will find out.

*Mr. McKinley. Okay. To Austin down in Emory, we have had -- my wife was a critical care nurse for 45 years, and we have known about this shortage of nursing care for some time, and -- but during the pandemic there was a call or demand for increased nursing care. And so the traveling nurses really took off on this.

And so hospitals like Emory, or the larger hospitals all across America, are paying -- I know, we have records of it -- as much as $200 an hour for the first 1,000 hours that they worked. That is exacerbating the shortage that Schakowsky just talked about. Larger hospitals can afford to pay that. But rural hospitals, like we have in West Virginia, and in eastern Ohio or elsewhere, rural areas, can't compete with that. We are -- they are being robbed of their nurses.

So I am curious. What is the solution? They can't afford to pay more, or they would have been doing that. How are small hospitals supposed to exist during a pandemic when their nurses are being robbed to go someplace else? Can one of the panelists comment about that?

*Ms. Austin. Thank you for that question. I am happy to. I would like to acknowledge and thank your wife for her

many years of nursing service.

I think that is -- the question that you asked is a question that all hospitals are asking themselves, whether it is a rural hospital, or a larger hospital in a metro city.

One thing I talked about earlier is the ability to bolster any types of training programs to actually increase the nursing pipeline, I think, could be really helpful. That way we can decrease, I think, the dependency on contract labor. Contract labor is not sustainable. In my health care organization we are having a lot of conversations about how to mitigate the labor cost for travelers. I mean, it is -- in the beginning it is meant to be a very temporary way to supplement, say, nurses that are on leaves of absences. It is not a way that we want to staff our hospitals, because, again, I say it is just not sustainable, financially.

*Mr. McKinley. Thank you very much. I may reclaim my time. I am trying to get two quick questions.

During the pandemic also there was this shortage of PPE, and we were seeing companies like Premier that were trying to level out to make sure that it was distributed. But yet this committee, or the Energy and Commerce, has before it a bill that is going to restrict. We know we need more plastics, but yet we have, in this committee, an effort to try to restrict increased plastic production in America. It just doesn't make sense to me.

So what they are talking about under -- you know, it was the Clean Future Act. Under section 902 it says, for the next three years, there will be no new plastic manufacturing in America. I think -- it just befuddles me as to why we would do this, when we need the plastic.

But Dr. McBride, I want to turn to you at the last of it and say, because of the children with mental health, I am curious to see what we are saying in -- for schools. Are we going to continue to depend on our teachers to try to take on the mental health issue?

Can you talk to me a little bit? Because this is very frustrating, when I see, as we come through the pandemic, how we deal with this.

*Dr. McBride. Absolutely. I mean, teachers are some of the unsung heroes of the pandemic.

*Mr. McKinley. Yes.

*Dr. McBride. We owe a debt of gratitude for our frontline health workers, our essential workers, our teachers.

We cannot ask teachers to be mental health providers. I mean, I think one of the reasons -- at least the teachers I know and care for as patients -- go into teaching is to be not only someone who educates children, but also a mentor, and a guide, and provide emotional support.

But in order to help children, you know, recover from

the stacked stresses of the pandemic, regardless of their lived experience, and in order to bolster their mental health moving forward, we need to make sure that educators are aware of mental health issues.

And here is an idea that I -- one of my friends works in D.C. here. She is a pediatrician, and her clinic is annexed to Anacostia High School. If we can build in primary care, and annex it to schools, particularly schools in marginalized, under-served, often urban communities, where people can get vaccines, or they can get basic primary care, and they can get access to truthful information right in the school setting, that would do a lot to bolster the mental and, therefore, physical health of children and adolescents. Make it easy to get access to mental health care, even at school or annexed to school, because teachers cannot do -- they are wonderful, but they can't do everything.

*Mr. McKinley. Thank you.

*Ms. DeGette. Thank you.

*Mr. McKinley. I have run out of time --

*Ms. DeGette. The chair now recognizes Mr. --

*Mr. McKinley. I yield back.

*Ms. DeGette. Mr. Tonko.

*Mr. Tonko. Thank you, Madam Chair. The pandemic has adversely impacted our nation's health care workers, and leading many to experience work overload, burnout, and

feelings of anxiety or depression. In addition to what we have heard this morning, a survey of pandemic frontline health care workers found a majority experienced worry and stress negatively affecting their mental health, with 3 in 10 needing mental health services as a result of the pandemic.

This is one of the reasons that I have introduced H.R. 1716, the COVID-19 Mental Health Research Act, along with my colleague and friend, Congressman Katko. This bipartisan legislation would fund research to study the effects of COVID-19 as a pandemic, and what effect it has had on the mental health of Americans, including its impact on health care providers.

So, Dr. Ranney, as an ER doctor, I imagine that workplace stress is commonplace. Can you describe how the pandemic has impacted the mental health of emergency physicians, and what you mean by -- and I quote -- "moral injury'' that you make mention of in your testimony?

*Dr. Ranney. Thank you for the question, Representative. I have stories in my written testimony around the effects of both treating COVID-positive patients for two years on end, and the effect of the continued staffing shortages on the emotional health of frontline providers. It is things like not being able to care for your patients because you are too busy with others. It is about having patients wait out in the waiting room, who you know

are desperately ill, but who you simply can't get to because there aren't staffed beds back in the emergency department.

Moral injury is really a concept that derives from wartime. It is the idea of being exposed to or having to make choices that go against the moral fiber of your being, that go against how you were trained, your faith, your sense of integrity, simply because you have no other options. And that is what health care providers have faced over and over during the pandemic. We have been forced to make decisions that we would not normally make, that we know are hurting patients or their families, simply because there is no other choice, because there is no space, because there are no staff, because there are no optimal medications, or sometimes because the equipment that we depend on is not available.

It is, at this point in the pandemic, a totally preventable occurrence if we had adequate staff and adequate supply chains.

*Mr. Tonko. So with that being said, Doctor, what can we do to, beyond that, better support health care workers during this pandemic and beyond?

*Dr. Ranney. Thank you, Congressman. So there is a combination of individual level support. Again, things like your bill, the Lorna Breen Act, some innovative projects that are being done at hospitals around the country. I highlight in my testimony Project Cobalt, that is being developed by

colleagues at Penn to provide digital therapeutic support to health care providers. It is about destigmatizing reaching out for mental health care and behavioral health care.

But most of all, it is about supporting us in our daily jobs. Those individual-level solutions are important for helping those of us that have been there, but what we really need is things like loan repayment programs, increased staffing, improved ability to, honestly, just support our patients, do our jobs, and support their families.

*Mr. Tonko. Thank you.

A study by the Occupational Safety and Health Administration found that, prior to the pandemic, health care workers were already four times as likely to face workplace violence, such as physical assaults or threats, than workers in private industry. Since the pandemic we have seen disturbing reports about verbal and physical abuse directed toward health care workers. Some hospitals have even had to issue panic buttons to their staff.

Ms. Austin, the nurses often bear the brunt of this abuse. In fact, as you mentioned in your testimony, nurses have been verbally attacked for implementing COVID-19 safety restrictions, and patients and families take their emotions out on nurses. Did your nursing team witness an increase in verbal and physical attacks over the last two years? And, if so, how have you and your colleagues coped?

*Ms. Austin. Yes, we have. One thing that we have done here at our hospital is we have instituted a workplace violence prevention team. We have encouraged our nurses to report every instance of either verbal or physical abuse. Often times, what we have found is that nurses believe that, you know, this is just what is supposed to happen, and they take on the verbal -- usually not the physical, but the verbal abuse they will let go. And so we have done a lot of work to encourage nurses to report every single instance.

Our workplace violence prevention team will respond to every single instance to ensure that our nurses are supported, to make sure that we have had conversations with patients. We have involved our public safety department, if that was necessary. We make sure that our leaders are rallying around our staff, so that they know that they have full support from our hospital around these types of instances.

*Mr. Tonko. Thank you very much, and Madam Chair, I yield back.

*Ms. DeGette. I thank the gentleman. The chair now recognizes Mr. Palmer for five minutes.

*Mr. Palmer. I thank the witnesses for being here, and for the chairwoman holding this hearing.

One of the things that I think has been touched on a little bit is the impact of the lockdowns on school children.

But I haven't heard anyone talk about this, Dr. McBride, the surge in teen suicides. I mean, we have seen a record number of teen suicides. It got so bad in Las Vegas that it forced the Las Vegas schools to reopen.

I know that the medical community has been overwhelmed with the -- treating COVID patients, but added to that are the complications of being locked out of jobs, being locked out of schools, being cut off socially from peers and friends. Hasn't that added to your workload?

To Dr. McBride, yes, thank you.

*Dr. McBride. Absolutely. I mean, I think it is important to recognize that ER visits for mental health concerns, suicide rates cannot possibly measure the breadth and depth of people's despair, as defined by having depression, anxiety, OCD, PTSD, substance use disorder.

I would also say, to make it clear, that there are many, many routes of people's underlying health conditions in the mental health sphere. In other words, people have lost loved ones to COVID-19. That is a trauma. People have also lost a sense of normalcy in their fourth-grade classroom. That is also a loss.

So I think that the roots of the mental health crisis are broad and varied, but I think it is not a coincidence that the surgeon general --

*Mr. Palmer. Let me ask for a little clarification

here, because when you start talking about how broad it is, that implies that there are underlying conditions that may have been made worse by the lockdowns. But that is true of physical health, as well.

*Dr. McBride. Sure.

*Mr. Palmer. So the bottom line is here -- and I am looking at this Johns Hopkins -- it is not a report, it is an assessment of existing research, and I just want to read what it said, that "The lockdowns during the initial phase of the COVID-19 pandemic have had devastating effects. They have contributed to reducing economic activity, rising unemployment, reducing schooling, causing political unrest, contributing to domestic violence, undermining liberal democracy. These costs to society must be compared to the benefits of lockdowns, which our meta analysis has shown are marginal, at best.'' And then it concludes with this, "such a standard benefit cost calculation leads to a strong conclusion: lockdowns should be rejected out of hand as a pandemic policy instrument.''

And the thing that bothers me about this is that we knew this before this report came out. And as a consequence, I mean, there is all kinds of research out there and studies that show that we had this surge in teen suicide, particularly among women. We had teachers quitting. We now -- you talk about a shortage of health care workers, we now

have a shortage of teachers. And a lot of it has to do with the lockdowns.

Dr. McBride?

*Dr. McBride. So I think you are absolutely right, that lockdowns have done enormous harm on our social fabric, on our economy, on our physical health. And I think it is not a coincidence that the surgeon general has issued a concerning report about pediatric and teen mental health. And we know that the AARP, the American Association of Pediatrics, the American Association of Child and Adolescent Psychiatrists, and the Children's Hospital Association issued a very concerning report in October, saying that kids are at high risk, and are experiencing unprecedented levels of anxiety and depression. So it is not a coincidence.

And I think that, moving forward, we need to be better at recognizing that health is about more than the absence of COVID-19, and that people face myriad threats to their health and well-being from depression, diabetes, obesity, substance use disorder, and highly contagious respiratory viruses. That is our job in health care, is to think broadly about health.

*Mr. Palmer. My -- one of my biggest concerns about this, aside from all of the other things that we have just discussed, is this massive loss of public confidence in medicine and science, and in the political leadership of this

country. We have to get back to science, we have to get back to medicine, and we have got to figure out a way to restore the public's confidence in those who make these type decisions, that they cannot be political.

With that, Madam Chairman, I yield back.

*Ms. DeGette. I thank the gentleman, and I agree. The chair now recognizes Mr. Ruiz for five minutes, virtually.

*Mr. Ruiz. Thank you, Chairwoman. This is a very special day and hearing for me, not only because of the topic, but because a good old friend is part of the hearing witnesses.

I texted Dr. Dan Calac earlier today, and I said who would have ever imagined, during those long hours of studying at Harvard Medical School for our exams, that one day he would be a witness in a hearing before Congress, and I would be a member of that committee. And we worked tirelessly fighting to reduce disparities and fighting for health equity as medical students, as residents. And now here we are, doing the same work, and I am so proud of the work and his leadership throughout all of this.

So thank you, Doctor, my good friend, Dan Calac, for being here.

The nation's health system relies on a range of professions and people to support the health of all people in all communities. From the public health infrastructure

within Federal, state, local, tribal, and territorial health agencies to the networks of non-profits and private health care facilities, it takes every entity working together to prepare for and respond to public health emergencies, in addition to preventing disease and promoting Americans' health every day.

Unfortunately, the COVID-19 pandemic has been a stark example of the consequences of failing to support a robust public health infrastructure. According to a Kaiser Health News and Associated Press analysis from August 2020, in the decade prior to the pandemic at least 38,000 state and local public health agency jobs had been eliminated, 38 jobs had been -- thousand jobs -- had been eliminated in public health. And now, two years into this pandemic, we are continuing to grapple with the consequences of our weakened public health infrastructure.

Dr. Calac, has the weakened public health infrastructure impacted your patients and communities across the public health information and education about COVID-19 (sic)?

And would strengthening this infrastructure, especially within the IHS system, help address access and health disparities and inequities Native Americans face? And if so, how?

*Dr. Calac. Thank you, Congressman Ruiz. There is, as we all have seen in the past couple of years, a tremendous

disparity that has been uncovered by the pandemic in the delivery of health care services. And it is no more evident than what we see in health and human services, and especially in providing health care to those rural communities, and also those communities with under-represented individuals who are at increased risk for health disparity, whether they exist in rural communities, or they are in urban communities, in impoverished areas.

The placement, as we had spoke about with many of the interviewees and the people on the panel today, is the workforce needs. So it is an interesting predicament we are right now, and I really recognize the fact that we have two American Indian individuals on this subcommittee, which is not typical for Congress.

But the issue of dealing with what we are going to do with the problem moving forward, and so I think we have multiple lessons to garner information from. But what are we going to do, in terms of workforce?

*Mr. Ruiz. I am glad you said what do we do moving forward, because in some of the more under-served parts of my district, community health workers, or the promotoras, played a vital role in keeping my constituents safe and healthy. They were the ones educating those communities on how to obtain and use PPE, how to access testing, and the importance of getting vaccinated, and build trust between the community

and the health care professionals. They became critical liaisons between my constituents and health and community support systems like the county health department, churches, and our health care district.

This certainly is not the last pandemic that we will face, and there are lessons that we learned through this one that we can carry into our planning for the future. Dr. Calac, as a provider who cares for a widely under-served population, I know you have seen the unique challenges that those communities face. Do you see an increased role in our use of community health workers, both in future pandemics and in our public health education systems in general?

*Dr. Calac. Community health workers and public health nurses and primary care providers, together, can provide that role for those areas at most risk.

*Mr. Ruiz. Thank you.

*Dr. Calac. And looking at options for loan repayment, as one of our panelists had mentioned, I know that the loan repayment through the Indian Health Service is not a tax-deferred loan payment. There is a current bill in Congress looking at providing a tax-deferred option for the loan repayment. I am currently an -- I was an Indian Health Service recipient of that scholarship, and I am looking forward to more progress --

*Mr. Ruiz. Thank you, Dan. I have about --

*Dr. Calac. -- in the future.

*Mr. Ruiz. -- 10 seconds left. I want to ask Dr. Ranney.

You talked about how health care delays caused worsening health outcomes. We have a lack of access in under-served communities. How has those health delays affected the disparities that we see in under-served populations' health?

*Dr. Ranney. Thank you, Representative, and it is a joy to see you, and thank you for representing our specialty in Congress.

Very briefly, we already had wide disparities according to race and ethnicity in health outcomes. Those have only worsened during COVID, both in terms of COVID outcomes and in terms of access to other preventative care and timely treatment. Our safety net hospitals have been the worst affected by the pandemic, by PPE shortages, and, of course, by COVID itself.

*Mr. Ruiz. Thank you very much --

*Ms. DeGette. Thank you so much.

*Mr. Ruiz. I yield back.

*Ms. DeGette. The gentleman's time has expired. The chair now recognizes Mr. Dunn for five minutes.

*Mr. Dunn. Thank you very much, Madam Chair and Ranking Member Griffith, for hosting us here today to discuss the impacts of COVID-19 on American health care. The impacts

across all medical specialties are so wide-ranging that it would be literally impossible to adequately address them in a single hearing. It is my hope, however, that this committee will continue this important work.

Dr. McBride, I greatly appreciate your remarks and ongoing work to raise awareness of the detrimental effects of masking policies and school closures on our nation's children with no proven benefit. President Biden's COVID response team and public health officials have actually failed our children in this regard. America is behind the curve on in-person schooling and school masking policies, and the most concerning impact that I am hearing about is a sharp uptick in suicidal ideation among children, as well as record numbers of children presenting to emergency rooms having attempted suicide. This is a government-manufactured tragedy.

I am also learning of developmental and learning delays among children, which is concerning in its own right. This Administration's public health policies have been an outright failure, and destroyed the credibility of our public health officials, as my colleague, Mr. Palmer, noted.

The -- I would like at this point, if I may, to enter into the record an article published last week in the New York Times: "The CDC Isn't Publishing Large Portions of the COVID Data it Collects.'' I will submit that for the record,

if I may.

Do I have consent, Madam Chair?

[No response.]

*Mr. Dunn. Do I have your consent for the -- to put that in the record?

*Ms. DeGette. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Dunn. Thank you so very much.

To make matters worse, the New York Times has just revealed what many of us had been suspecting, that is that the CDC had been cherry-picking its data and its studies to suit their message as a means to a political end. Not -- they were controlling people, not disease, controlling people. Americans can't make good decisions for themselves and their families when they have no trust in the public health institutions. CDC has violated that trust, and this subcommittee needs to hear directly from them on that subject.

While the mental health impacts of the pandemic are already apparent, the long-term physical health impacts are only beginning to become apparent. In my specialty, urology, a record number of newly-diagnosed prostate cancer cases are presenting as metastatic disease -- that is to say too late to cure. We know early screening saves lives, and I can't stress enough how important it will be for people to get back to their doctor's office and make up for the missed opportunities of the last two years.

Dr. McBride, to that end, as you know well, hospitals facing a surge of COVID-19 cases postponed many semi-elective surgeries and medical services. Do you think that the postponements and now rescheduling of those elective and semi-elective procedures could be contributing to the current

high case volumes, even as Omicron is subsiding?

*Dr. McBride. Thank you very much for that question. Yes, I think that delaying care for underlying health conditions has caused major problems.

Pre-pandemic we had surging rates of obesity, substance use disorder, and under --

*Mr. Dunn. Lots of things.

*Dr. McBride. And -- excuse me?

*Mr. Dunn. Lots of things. Let me ask you. In your hospital, would you say it is bed capacity or staffing shortages that are most critical to the hospital's capacity to take new patients?

*Dr. McBride. I am sorry, can you repeat the question?

*Mr. Dunn. Bedding? Bed -- shortage of beds, or shortage of staff? Which is more critical in your hospital?

*Dr. McBride. So I am not sure I am the right person to answer that question, because I work mostly in the outpatient setting.

*Mr. Dunn. Okay, that is fair enough. I have been surveying a lot of hospitals in my district, and they all say it is the staffing.

I would also like to ask you this. We know that the public health agencies failed a lot on the messaging, specifically on natural immunity. Can -- they have only recently recognized that. Can you tell us how -- what that

meant to our COVID response?

And tell me also if there is any disease that we vaccinate for after somebody recovers from that disease. So smallpox, yellow fever, diphtheria. Do we come in behind the disease and vaccinate? I can't think of one.

*Dr. McBride. Well, I mean, I can think of one off the top of my head, which is the chickenpox virus that lives latent in our system. If we had chickenpox as a child, we boost people later in life to prevent shingles, which is the reactivation of chicken pox.

*Mr. Dunn. That is a different, very different virus --

*Dr. McBride. Well, sure.

*Mr. Dunn. -- vaccine.

*Dr. McBride. Excuse me?

*Mr. Dunn. It is a different vaccine.

*Dr. McBride. Yes.

*Mr. Dunn. Yes. So, I mean, but you don't reintroduce chickenpox to the --

*Dr. McBride. So let's talk about natural immunity. So I don't love the word "natural immunity,'' because it --

*Mr. Dunn. From infection.

*Dr. McBride. But what I would call -- you know, there is vaccine-induced immunity and there is infection-acquired immunity. We all, ultimately, will be --

*Mr. Dunn. I see my time is running out. I am just

going to say that, when I was in med school, they taught us that mandates undermine public confidence in public health. And --

*Ms. DeGette. Would the --

*Mr. Dunn. -- we didn't do that.

But I yield back, Madam Chair.

*Ms. DeGette. Dr. McBride, do you want to finish your answer on that?

*Dr. McBride. About the --

*Ms. DeGette. Natural immunity versus --

*Dr. McBride. Sure. So there is infection-acquired immunity and there is vaccine immunity. We all, ultimately, will be tragically exposed to coronavirus, whether we want to or not. It doesn't mean we will all get infected or get sick.

We would rather be prepared by getting vaccinated when we are ultimately faced with the virus, because the vaccines, as we know, take the claws and the fangs away from the virus, and turn it into a more manageable disease.

At the same time --

*Ms. DeGette. Thank you.

*Dr. McBride. -- it is important to recognize infection-acquired immunity is real. And in some people and populations it is more durable and superior to vaccine-induced immunity. It is important we recognize that the

human immune system is not a political body, that it has basically -- that it is the human immune system, and that we need to recognize people's lived experiences, people who have been exposed and infected, and to weave that into decision-making in the doctor's office as to whether or not to get a third shot, or a fourth shot, or whatever we may end up doing in our public health guidance.

And also, we need to recognize that that should drive public policy when we are thinking about mandates.

*Ms. DeGette. Thank you. Thank you so much. It goes back to, as Mr. Palmer said, science.

Let's now recognize Miss Rice for five minutes.

*Miss Rice. Thank you, Madam Chair.

The public health and health care workforce shortages in the United States, obviously, pre-dated the pandemic. But as we all know, it has made an already bad situation rise to the level of a crisis situation over the past two years. Even before COVID-19, public health departments faced a workforce shortage created by limited resources and an exodus of retiring workers. These existing challenges were further amplified under the strains of the pandemic.

But the shortage in health professionals isn't just limited to the public health sector. Estimates by the Health Resources and Services Administration predict that, by 2030, the demand for all types of primary care providers, including

physicians, nurse practitioners, physician assistants will exceed supply of these workers by more than 15 percent. Demand for nursing occupations in long-term care settings is likewise expected to grow 46 percent by 2030. So it is clear that we need strategies and solutions to address this provider gap.

Ms. Austin, can you share more about your experience in managing Emory Midtown's nursing team through staff shortages during the pandemic?

And let us know what your biggest challenge in keeping your shifts actually staffed --

*Ms. Austin. Yes, thank you for the question.

You know, we talked earlier about the cost of travel contracts. What we have done here at Emory is that we have invested in contract labor, one, because we know that, when nurses have the support that they need, when nursing ratios are adequate and are safe, our patients receive better care. That is a big thing that we stand on here at Emory, is quality patient outcomes. We couldn't have done it without contract labor. We want to make sure that, again, our nurses have safe staffing ratios.

And even prior to the pandemic, we had what I would consider probably one of the best nursing staffing ratios in the city, and we get that information from nurses who come to us from other hospitals. So I would say that we have

typically done a really good job with that. We are ahead of most health systems in that respect.

But we are not immune to what has happened during this pandemic, where we have seen nurses leave. So we have had to again bolster our staff using contract labor to ensure our patients receive the care and have the outcomes that we would want them to.

*Miss Rice. Thank you.

Dr. Riley, you reference in your testimony the Association of American Medical Colleges, the fact that they found that the strains that COVID-19 placed on the health -- workforce has been felt most acutely by women, physicians, and physicians of color. And as you stated, the field of obstetrics and gynecology has been particularly impacted.

How have these shortages affected maternity care teams and patients in your practice?

*Dr. Riley. So I think that the concern is that, because we work in a team, when we are missing even one or two people, you know, and their expertise, it is really difficult to give patients the experience that they deserve.

So we, you know, break our necks to be sure it is safe, but being able to take the time to teach breastfeeding, and take the time to, you know, get people ready to go home with this newborn that they don't know what to do with, those are the things that tend to get lost. And so I think that the --

you know, unfortunately, I suspect that there are patients who will say, "My experience was not as great as it could have been.'' And I think that that is really pretty tragic.

I do think also, as we think going forward, it is not going to be a quick fix to -- we can't just plug people into the workforce. And so I really think that we need to think way back, and start at STEM. We need people who are going to be able to, you know, really work on the science, as people have said multiple times during this conversation. And we need to start that as early as, you know, third grade, fourth grade, whatever it is, and get people excited about science, because we just need so much help.

*Miss Rice. You know, you make a good point, Doctor, because, you know, if there is one thing that we have seen also, maybe one of the upsides, was that there has been this increased interest in people getting involved in the medical field, whether it is from, you know, EMTs to nursing to doctors. And we should do everything we can to enable people to enter those fields [inaudible]. Obviously, as we have all been talking about, we need to increase the pool of this workforce.

So thank you all so much for coming and testifying today, and I yield back the balance of my time.

Thank you, Madam Chair.

*Ms. DeGette. I thank the gentlelady. Mr. Joyce, you

are now recognized for five minutes.

*Mr. Joyce. Thank you, Chair DeGette, for yielding, and to Ranking Member Griffith for holding this hearing today. I would also like to thank our distinguished panel of physicians and health providers for not only appearing here today, but for all the work that you have done during this pandemic.

Dr. McBride, recently entered into this hearing, a New York Times article reported that the CDC over the last year collected extensive data on vaccine and booster effectiveness, breakthrough infections, and wastewater collection for the presence of virus, but subsequently released very little information of this data.

Even what was released included the CDC Morbidity and Mortality Weekly Report, which was published in late January of this year -- showed that during the Delta surge case rates for those with previous infection, what we consider acquired immunity, and no vaccination were substantially lower, almost four to five times lower, than those who were previously vaccinated, four to five times lower with acquired or natural immunity, and hospitalization rates followed a similar pattern.

What is the impact of the CDC withholding data or delaying the release of that data for you, as a health care professional on the front line treating those with COVID-19?

Does this withholding data fracture your relationship to utilize CDC information when you are one on one with the patient?

*Dr. McBride. Thank you for that question. Trust is the glue in patient care and in public health. And I do worry that we have seen an erosion of trust in doctors and in public health institutions.

We need our institutions to succeed. I want the CDC to succeed. We need to have broad public health advice. We also need clear communication of truthful, real-time data and information. We need to have -- as Dr. Ranney touched on, we need to understand who is in the hospital. Is it an incidental COVID infection, or is it someone who has -- is in the hospital for COVID-19? Is that person -- you know, we need to know in terms of racial and ethnicity data. We need to know, do they have underlying conditions? We have so much work to do to have the public understand and trust what the CDC is telling us.

One of the parts of my job that has been very, very challenging during the pandemic is helping people make sense of the news and the changing guidance. You know, people don't have the luxury of paying attention to COVID like I have every single day for the last two years. And so they are calling me with just everyday decisions. And I think one of the challenges is that, even people who are paying

attention have a hard time making sense of the guidance, and there has been an erosion of trust, because they see the New York Times article, for example, last weekend talking about withholding of information.

Again, I do not ascribe mal intent or ill intent. I simply think we need much more transparency and trust and communication of facts to the general public.

I think another thing is, for people to trust the CDC, the CDC needs to trust people. It needs to trust people with -- it needs to trust people that they can handle murky and muddy information. When I have a patient who has a diagnosis, but I am not yet sure what the trajectory is, it doesn't help my patient for me to withhold information or to not tell them the full truth. I want to give them hope when it is rooted in the facts and the science, but I also want to be honest and real with them about what is going on. Same goes for the public.

People are smarter than we give them credit for. The public is paying attention to a lot of the data that is coming out. And I think, if the CDC could more transparently communicate facts and data in real time, then we, as primary care doctors, can act more as the lieutenants for the CDC, and transmit that information to our patients for their everyday lives. Should I go to school? Should I go to work? Which vaccine? How many booster shots do I need?

*Mr. Joyce. Does that -- my time is limited, but does that lack of transparency and transfer of information, which you just discussed, does that make your job more difficult --

*Dr. McBride. Absolutely.

*Mr. Joyce. -- as a Johns Hopkins-trained physician, someone who is used to dealing with data, used to dealing with this every day of how you practice, does that lack of transparency from the CDC make your job as a physician more difficult?

*Dr. McBride. It absolutely does. And one of the reasons why I have cut my practice in half in the pandemic, and am donating 50 percent of my time doing advocacy work and pro bono work, is that I am trying to help people -- stripped of politics, stripped of ideology, no financial incentive, I am reaching now almost 20,000 people with a weekly newsletter to dispense nuanced, contextualized information to a wide audience. I am reaching people in rural America. I am reaching people in urban areas who don't have access to primary care doctors.

It is hard when the CDC is putting the burden on the general public, and when we don't have access -- 80 million Americans, as I said earlier, don't have access to a primary care doctor to translate the information -- sometimes confusing, and sometimes not the full picture -- into everyday decision-making.

And so again, we need trust, transparency, first and foremost. We need primary care doctors out there for people to have access to information that -- and we need primary care doctors to be able to trust the CDC.

Again, I believe in the CDC.

*Ms. DeGette. The gentleman's time has expired --

*Dr. McBride. I trust the CDC in many ways, but we need to do better.

*Ms. DeGette. The gentleman's time has expired. Thank you.

*Mr. Joyce. Thank you, and I yield.

*Ms. DeGette. The chair now recognizes Ms. Schrier for five minutes.

*Ms. Schrier. Thank you very much, Madam Chair. This has been quite a two years, and we have learned a ton, and a lot of those topics have been discussed already today. I think that there are questions that are still going to come at us, and that may hit us very hard. My question is going to be directed at Dr. Riley, so I will just give that heads up.

I am a pediatrician, 20 years in practice. I have experienced vaccine hesitancy, which is about one percent of my -- of the parents that I would see who would flat-out say, no, not immunizing, no way, no how. Probably around 10 percent, 15 percent. Just -- questions, they just -- very

legitimate questions. I just had to meet them where they are, answer some questions, make them feel reassured. And then we moved on, and got everybody vaccinated. I have just been blown away by how politicized this has become, by the extreme misinformation out there, and vaccine -- it is not just hesitancy, it is like a rabid sense that is anti-vaccine.

The question I think we may be headed for now is what will this now do to routine childhood vaccinations that -- it is not just going to be a question of whether children in school should be required to have a COVID vaccine, it is -- I am wondering -- perhaps going to be a question of re-examining every routine childhood vaccine, measles, mumps, chickenpox, you name it, and questioning that.

And so, Dr. Riley, I was just wondering if you could comment on any concerns you might have there, or what you thought might be coming our way.

*Dr. Riley. I certainly agree with your thought that vaccine hesitancy is, you know, truly a problem. I think the WHO just recently named vaccine hesitancy as a global health issue to really be grappled with. And I think that we have to recognize that, as people lose confidence in science, which is unfortunate, and as our inability to communicate in all the different ways that we need to, that just fuels the vaccine hesitancy.

I think that we have to get back to the basics, understand, you know, the diseases that we are trying to prevent, let the public understand the diseases and how devastating they can be, and then, you know, re-educate on the benefits of vaccines, not -- in addition to the safety, but also the benefits to prevent disease. And I think that that is, you know, sort of where we are going to need to go.

But I share your concern as I try and, you know, explain to pregnant women every day that this is -- you know, the COVID vaccine is something that we feel will decrease the likelihood that they themselves will be ill, and that there is evidence now that there is protection for their babies.

*Ms. Schrier. Thank you, and I share those concerns. In fact, I am even a little bit more concerned now, because even seeing how many people have died in this country, how many people are in the hospital, you know, the vast difference between vaccinated people who are safe from being in the hospital or dying, and those not -- even with that data, there is still extreme hesitancy. And so I wonder if conversations about measles and how devastating that can be will even carry.

Speaking of lack of trust, just a quick question for Dr. Ranney: public health. There is tremendous need across the board. We don't have a public health infrastructure, and then distrust grew in our public health system. Do you think

that, if we had a baseline public health infrastructure, where in routine cases they would be doing well baby visits at homes, and helping with mental health and substance abuse disorders, if we had that infrastructure already in place, do you think we would have more success rolling out a big public health campaign, come any future pandemic?

*Dr. Ranney. Thank you, Representative. Absolutely. Our investing today adequately in our public health infrastructure is critical for us dealing with future surges of COVID, and whatever comes next.

Community health workers and peer specialists are important. Disciplining physicians who are active purveyors of disinformation is critically important, and our correctly interpreting and sharing those interpretations of data with our patients is important.

And I actually want to take a moment to correct some of the prior information that has been shared. There actually was not a dramatic increase in pediatric suicides during lockdowns. In fact, pediatric suicides dropped dramatically during lockdowns, and we have seen a small increase in adolescent girls emergency department visits, most significantly over the last couple of months. So I just want to correct the record on that part.

But overall, investing in public health infrastructure, ensuring that they have adequate workforce, adequate tools,

adequate ability to get data and then share it nationally, which will speed up the sharing of data by the CDC if they get good data from local departments, is absolutely critical to our meeting the challenges of the future head on.

*Ms. Schrier. Thank you very much. Thank you for setting the record straight. I yield back.

*Ms. DeGette. Thank you so much. The chair now recognizes Mrs. Trahan for five minutes.

*Mrs. Trahan. Thank you, Chairwoman DeGette and Ranking Member Upton, for holding this important hearing.

As many of my colleagues have mentioned today, the COVID-19 pandemic brought health care workforce issues to the forefront as it exposed gaps and weaknesses in our nation's preparedness for public health emergencies. And these workforce issues are present across health care workforces, and have highlighted the need for public health, behavioral health, EMS, primary care, and long-term care professionals.

The effects of these shortages are especially felt in under-served communities, which have historically experienced diminished access to health care services. Indeed, nearly half of the counties in Massachusetts have shortages of infectious disease physicians, and our westernmost county has zero. That is why I introduced the Bolstering Infectious Outbreaks Preparedness Workforce Act with Congressman McKinley, which will offer student loan repayment as a major

new incentive to recruit more physicians, nurses, and other health care professionals to work in infectious diseases [inaudible] preparedness in communities with the greatest need.

So, Dr. Ranney, why is access to loan forgiveness, especially for medical specialties with lower average annual salaries like ID physicians, important in building up and retaining a robust and diverse health care workforce?

*Dr. Ranney. Thank you very much for that question. So the average physician graduates with more than $200,000 of debt. They go through residency, where their debt continues to grow, and then that can dissuade folks from taking on some of the lower-paid professions. Many folks that do go into primary care actually choose to not take insurance, and to take direct concierge care payments instead, in order to increase their income.

I myself was the benefit of the loan repayment program in order to pay off my medical school loans. I know that Dr. Calac was, as well. It is critical, in terms of getting physicians and other health care professionals to be able to work on the front lines in under-served communities, to be able to spend time doing research, and to do other critically important public health functions, and to not take those higher remunerating jobs, to not have to go to areas that pay better.

I will also say that loan repayment would make a big difference for those that have been on the front line for the last couple of years as a small token of gratitude to help retain frontline providers who have been there throughout the pandemic. Having a loan repayment program such as Congresswoman Maloney's would be helpful for those who have served throughout the pandemic.

*Mrs. Trahan. Absolutely, and I thank you for flagging Chairwoman Maloney's bill, because I couldn't agree more.

I am going to switch gears because the President mentioned last night in his State of the Union address the importance of Congress conquering other public health crises, such as rising substance use disorder rates that require specialized health care professionals.

And I would like to just ask you one more question, Dr. Ranney. As you noted, the importance of American Rescue Plan workforce investments, including for substance use disorder treatment and recovery programs, you know, I was encouraged to see that Brown University's Warren Alpert Medical School class of 2020 graduates were the first in the nation to graduate with training that allows them to prescribe medications to treat opioid use disorder in any U.S. state.

So as a trained emergency physician, you interact with patients seeking treatment for a range of physical and mental health issues, and often have opportunities to provide

effective interventions for individuals with an opioid or other substance use disorder. In your experience, do you agree that more patients with OUD could be helped if comprehensive training on how to identify, treat, and manage patients with a substance use disorder was the standard?

*Dr. Ranney. One hundred percent I agree. In my emergency department, thanks to the leadership of our former director of health, Dr. Alexander Scott, as well as our former governor, now Secretary of Commerce Raimondo, we actually have standard screening -- we have standard protocols for every patient that comes in with opioid use disorder.

We prescribe Suboxone at the bedside during an emergency department visit for folks who have overdosed on opioids. That has been shown over and over again by my fellow emergency physicians, as well as addiction medicine specialists, to be the best way to help prevent overdose deaths.

Surrounding that with a suite of pre-recovery supports is also critical, whether in-person or remote. This is one of the most important things that we can do to help folks who are subject to opioid use disorder.

And I will strongly urge that we actually get rid of the X waiver requirement, which is a huge barrier to prescribing a medication that is no more dangerous -- and perhaps more

helpful -- than many of the medications that we prescribe every day for many other disorders.

*Mrs. Trahan. Well, thank you. I appreciate both of those answers.

And to all the other witnesses, thank you for your testimony today.

I yield back. Thank you, Madam Chair.

*Ms. DeGette. I thank the gentlelady. The chair now recognizes Mr. O'Halleran for five minutes.

*Mr. O'Halleran. Thank you, Madam Chair and Ranking Member, for holding this meeting. Thank you to the panelists for their presentations today.

The issues that we have heard from today's witnesses are not new. The pandemic has strained our health systems and exposed our doctors, nurses, and frontline workers to overwhelming conditions and a constant struggle to treat patients and save lives.

I was happy to spend the last two weeks touring my district and talking to health care providers and administrators. These are rural and tribal providers, and they are struggling. Some of these struggles are not new. Payment models continue to discriminate against rural providers, and health care systems continue to incentivize doctors and providers to settle in urban and suburban areas and practice medicine in well-resourced settings.

But what is new are incredible staffing challenges. Hospitals, community health centers, our doctors' offices, paramedics, EMTs, and ambulatory services, among others, are all suffering from the same staffing issues, and it is harming access to care in rural and tribal areas. This is an area that is -- this committee needs to be focused on, and I look forward to working with anyone who is interested in actually addressing the issues that rural and tribal communities are facing.

Just as a side issue, you know, a lot of people will say, "Well, why don't they just move into urban areas?'' Well, we need them out in rural areas for producing the food, bringing water in, making sure our transportation systems work, on and on and on. This is a combination that is needed critically in our future.

So, Dr. Calac, thank you for joining us today. Your testimony highlights this longstanding lack of investment in Indian Health Services facilities. Can you elaborate on some of the challenges the Indian Health Council faced in providing quality medical services within your community before the pandemic?

*Dr. Calac. Thank you for the question. Just a couple of comments regarding the workforce that currently exists now.

So I am one of only two pediatricians in the area

surrounding a 50-square -- or 50-mile radius from our site. So that poses a challenge to provide that pediatric care.

But also, with the same concern for the demographic, the need to have kids enter STEM programs such as the Native American Research Centers for Health, which is a NIH-funded program to retain and recruit Native Americans to go into medical school and/or research, is an important program that actually highlights your concerns and the needs for promoting recruitment and retention for this workforce.

And I would also like to comment on the fact that my son is actually one of -- actually, the only M.D./Ph.D. who will be at University of California San Diego, providing -- or finishing up his studies there over the last four years. But he will be the only Native American from this area to accomplish that feat.

So I think just examples of those wide disparities show a need to have a continued workforce, and some of the challenges that tribes and rural areas as a whole across the country are facing.

*Mr. O'Halleran. Well, thank you, Doctor. And this is another question for you.

Since my time in Congress I have focused on addressing longstanding failures of the Federal Government to provide support to tribal communities and, for that matter, rural communities throughout our country.

However, since the pandemic, Congress has taken several actions to support tribal communities, including increasing funding through the CARES Act, the American Rescue Plan, and the bipartisan Infrastructure Investment Jobs Act. Which programs have been most effective throughout the pandemic?

And, should we rework -- and should be reworked to provide additional support to tribal health care?

And if you can, comment also to rural health care.

*Dr. Calac. Yes, thank you. The funds that have been provided through the CARES Act and through several different funding mechanisms to support the tribal missions in the area have been phenomenal. And without those funds we would not have been providing the care that we have done so with testing, tracing, treatment for those individuals afflicted with COVID, and providing the supportive care for the preventive health care measures that we have had to catch up on.

It is said that pediatrics are almost a year and a half back, in terms of preventive health exams. So I think looking at Indian Health Service funding and other public health service programs, since the budgets have been relatively flat over the last 10 years, is an important first step.

*Mr. O'Halleran. Well -- and thank you, Doctor. Thank you, Madam Chair, and I yield.

*Ms. DeGette. I thank the gentleman.

We have several members of the full committee who have asked to waive on, and we are always pleased to accommodate them. So first I will recognize Mr. Carter for five minutes.

*Mr. Carter. Thank you, Madam Chair, and thank all of you for participating in this. It is extremely important.

I want to ask kind of a general question, and I will start with you, Dr. Ranney. What data do you think the CDC should be collecting at this time that it hasn't collected?

*Dr. Ranney. Thank you for that question. You know, the big challenge that the CDC faces is that there is very little mandated data from local or state health departments that is required to be reported to the CDC.

There is also a lack of standardization of data, which means that, when the CDC gets it, they have to spend a lot of time cleaning and verifying it, which then delays release of the data to the public.

And there is simply an absence of much data, such as others have outlined: age, race and ethnicity, income level, et cetera, of cases and hospitalizations. There is a lack of data around adequate staffed beds. HHS reports hospital beds and hospital capacity, ,period but doesn't take account for staffing shortages.

The wastewater data is a great thing that is going to be really important for us for predicting future surges. I

could go on.

The best analogy that I can make is I think back to when we fought the epidemic of car crash deaths back in the 1970s. We developed NHTSA, and we developed multiple, well-funded data initiatives within NHTSA, such as the fatality accident reporting system, the EMS information systems. Those are critical ways that we can monitor in real time new reasons for increasing car crashes and car crash deaths, and then change things accordingly. We need the same type of system in place for COVID data to allow us to have early warnings, and to respond in kind.

*Mr. Carter. Well, thank you. Thank you for that.

Dr. Riley, I will ask you the same thing. What data should the CDC be collecting at this time that you don't think that they are collecting?

*Dr. Riley. So I really think I would just add on to that, that one of the major issues that doesn't ever come up is whether or not someone is pregnant or lactating. And so that field alone would allow us to understand, you know, what is happening to that particular patient population.

And as I said in my testimony earlier, I think that we need to understand two things: one is what is the impact of COVID infection on pregnancy and lactating women; and then what is the effect of or the effects of vaccination on that same population. But without asking those questions, we are

sort of left not knowing.

*Mr. Carter. Hey, great responses, thank both of you.

Dr. McBride, I will go to you. Do you think there should be a wider variety, if you will, of voices that -- at the COVID-19 response itself? Are we including enough different people, and enough different -- and a variety of people, of professionals?

*Dr. McBride. Thank you for that question. I think the more voices, the more diverse array of experiences and areas of expertise, the better.

Personally, I wish that there were more mental health experts --

*Mr. Carter. Exactly.

*Dr. McBride. -- in the COVID-19 -- because this is a collective trauma, this is like no other experience in at least my lifetime, but it is a collective trauma that really warrants careful attention to individual and population mental health.

But yes, absolutely. We need all sorts of races, ethnicities, income levels, areas of expertise --

*Mr. Carter. Absolutely, good.

*Dr. McBride. All of it.

*Mr. Carter. Thank you. Thank you.

Ms. Austin, I wanted to ask you very quickly, in -- do you feel like -- that the clarity that you got from CDC for

your nursing staff on when to wear PPE, and what kind of PPE, do you think that that was sufficient?

*Ms. Austin. I think early on we had a great deal of trust in the information that we were receiving from the CDC. I think the thing that caused a little bit of concern was when some of those things changed. I have heard from many of the nurses at the -- on the front lines, is their concerns about the changing mandates, the changing information.

So I would just say that, yes, there was concern about the information that changed. But overall, I would say that I respect the CDC's position, and have followed their guidance throughout this pandemic.

*Mr. Carter. Good.

And Dr. Calac, I guess you are the only one I haven't asked a question. The same question there. Any -- the consistency of the CDC and the information you were getting.

*Dr. Calac. I would just echo Ms. Austin's comment. Yes, the PPE that -- we have been trained for many years in its use in multiple different situations, other than just COVID, I think was a usable practice that we had instituted.

However, the effectiveness of different masks, whether they be two layers, cloth, N95s, was somewhat disparate as we moved forward in the pandemic. But still looking forward to additional support and improved guidance as we round out the pandemic and looking forward to the next.

*Mr. Carter. My time has expired. Thank you, Madam Chair.

*Ms. DeGette. I thank the gentleman. The chair now recognizes Mr. Sarbanes for five minutes.

*Mr. Sarbanes. Thank you very much, Madam Chair, and thank you for allowing me to waive on to this hearing today. I appreciate it very much.

Obviously, the focus here has largely been on workforce shortages, particularly aggravated or exacerbated by the pandemic, when we look at the health care workforce. But we know these shortages have been accumulating. It is a, I guess, a strange turn of phrase, "shortages accumulating,'' but that is what has been happening for years now. And we are just looking at new and extra dimensions of that challenge.

I have been focused on this for a long time, was able to work to get a provision into the Affordable Care Act that would create a National Health Care Workforce Commission to kind of systematically look at and assess what the shortages are, and put forward recommendations, policy recommendations, on how to address, and we are going to continue to try to bring that focus to bear. But we also have to get creative, I think, and innovative about how to meet those shortages, whether it is nurses or physicians, other caregivers in the continuum of care.

And Dr. Ranney, I apologize if I am not pronouncing your name correctly, but I would be interested in getting your perspective. I have a bill that I am re-introducing called the Primary Care Physician Reentry Act. It would direct the Department of Health and Human Services to establish a demonstration program that could facilitate physician reentry into primary care clinical practice after an absence from their practice for one reason or another after retirement to try to create an incentive, an expedited process of bringing these physicians back.

Do you think that that is a good idea, could that help us?

Do you think that it would be appealing to retired physicians?

Do you think it could help us address this workforce shortage?

If you could speak to that, I would appreciate it.

*Dr. Ranney. Thank you. I am not familiar with your bill, but look forward to learning about it.

I will also say that Dr. McBride is the primary care doc, not me, so I will let her talk about what will get folks into primary care.

But I do think that providing avenues, on-ramps to get physicians who have left bedside care back comfortable with the current clinical care environment, with current data

around medical care, and getting them back into the clinical sphere is certainly something that would be helpful.

Whether it is about retired physicians or others who have left bedside care for a variety of other reasons, having a way to re-acclimate, to build up our clinical skills, and get back into bedside care is a terrific idea.

*Mr. Sarbanes. Thank you.

Dr. McBride, if you could, give me a quick thumbs up or thumbs down on that as a possible benefit, in terms of getting more physicians into the --

*Dr. McBride. Yes, absolutely --

*Mr. Sarbanes. -- to address the shortage, I would appreciate it.

*Dr. McBride. Whatever we can do to get more people into primary care. And not just to get more people in primary care, but to incentivize them to go into primary care, instead of subspecialty medicine, for example.

You know, those of us in primary care went into this field to be able to have time with patients, to establish a relationship so they can talk to you about their depression, their anxiety, and their dementia, and their diabetes, and their myriad health issues.

My patient who is 82 I saw earlier this week. He is on 15 medications. He has a new heart valve. He has atrial fibrillation. He has hypertension. He has diabetes. And he

has newly lost his wife. If I have five minutes to talk to the patient, I really cannot do my job. I cannot do what needs to be done.

So we need to make sure that we are not only incentivizing doctors out of medical school to go into primary care, we need to change the system so that time with a trusted guide is the commodity, instead of, you know, treating primary care as just sort of a referral mill, where -- and where the rapport and the relationship is, and the -- isn't the commodity.

The commodity needs to be the trust, the rapport, and the relationship. There is a lot we can do when we sit down with our patients and talk to them, look them in the eye, and help them kind of meet their broad human needs by understanding who they are as a person, and what their specific vulnerabilities are, and how to protect them from the myriad threats that people face, whether it is COVID-19, or loss, or, you know, other health harms.

*Mr. Sarbanes. I appreciate that, and I like that idea of the commodity of trust, and how we can invest in it and make sure that we reimburse for it in a way that creates the right incentives.

Dr. Ranney, I have just got a couple of seconds left here. Why shouldn't there be a school-based health center in every school in America to address not just physical health

needs on the part of our students, but the increasing mental health needs that they need, fully staffed with counselors, with mental health professionals, with social workers, et cetera? If you could speak to that briefly, I would appreciate it.

*Dr. Ranney. I will say that, heck, right now I would just take a school nurse in every school in America. That, in and of itself, would be tremendous. School-based health centers are great, both for getting kids and families care, and they can be augmented with telehealth or with digital care.

I will also add that, in addition to getting physicians in the workforce, we also need all the staff around us. We are a team. It is not just a physician, it is also nurses, medical assistant, home health aides, and more.

*Mr. Sarbanes. Thank you very much.

Madam Chair, thank you.

*Ms. DeGette. I thank the gentleman.

I have got to tell you, Mr. Griffith and I both want to thank all of the witnesses for coming today. You were a wonderful panel, and a wonderful team. You gave us a lot of great information, and we will use it going forward.

I want to remind members that, pursuant to committee rules, that they have 10 business days to submit additional questions for the record to be answered by witnesses that

appear in front of the subcommittee.

And I want to ask the witnesses, if you do get these questions, if you can, respond promptly to any of them.

And with that, the subcommittee is adjourned.

[Whereupon, at 1:16 p.m., the subcommittee was adjourned.]