Additional Questions for the Record
Dr. Mandy Cohen, Director, Centers for Disease Control and Prevention (CDC)
House E&C Oversight & Investigations Hearing
November 30, 2023

The Honorable Cathy McMorris Rodgers

1. **What specific actions will you take at the CDC to ensure that guidance and directives do not infringe upon Americans' personal freedoms?**

   Response: CDC's processes include engagement with external groups and the public as we develop public health guidance to better support our science-based recommendations and support the desired effects. The goal is to standardize how we share and receive feedback from those impacted by public health guidance and create guidance that is rooted in scientific evidence, is easy to understand, is associated with health benefits that matter to the primary audiences, is implementable, and balances risks with benefits.

2. **Reflecting on the challenges and the lessons learned from the COVID-19 pandemic, particularly regarding school closures and mask mandates, how will you ensure that the CDC's future recommendations are proportionate, timely, and balanced, safeguarding both public health and the fundamental rights and well-being of all Americans?**

   Response: Based on lessons learned during the COVID-19 pandemic, CDC developed a standardized approach to guidance formulation. The approach is options-based and informed by robust external engagement with partners so that CDC's guidance properly addresses the contextual factors and policy issues that influence the extent to which evidence-based public health actions are put into practice. Collaboration among program, science, communications, and policy disciplines within CDC helps the agency develop evidence-based options for public health action that are easy to understand, is associated with health benefits that matter to the primary audiences, is implementable, and balances risks with benefits.

3. **Considering the disproportionate impact on students from low-income families and the prediction of future economic repercussions, what specific strategies will you implement to prevent such outcomes from future health-related school closures?**

   Response: CDC remains committed to providing the appropriate public health information needed to enable all children to learn in school safely, in-person, and full-time given the importance of key services that schools offer and the benefits of in-person learning for children. A December 2020 MMWR summarizing CDC guidance on schools stated: "Because of their critical role for all children and the disproportionate impact that school closures can have on those with the least economic means, kindergarten through grade 12 schools should be the last settings to close after all other mitigation measures have been employed and the first to reopen when they can do so safely."[1]. In 2021, CDC released *Operational Strategy for K-12 Schools*, which presented a pathway to reopen America's schools and help schools remain open through consistent use of key prevention strategies. CDC's recommendations intended to provide broad guidance and serve as a foundation for local decision-making.

4. **Given the prior Director's decision to continue to keep schools closed due to political pressure, resulting in substantial educational setbacks for low-income students, can you clarify the criteria under which you believe school closures are warranted?**

[1] **CDC MMWR: Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020**

Response: Decisions regarding school operations are made by local officials. On February 12, 2021, CDC released the *Operational Strategy for K-12 Schools through Phased Prevention*, a roadmap to reopen schools that jurisdictions had closed during 2020 for in-person instruction and help them remain open through consistent use of mitigation strategies. The guidance emphasized implementing layered prevention strategies based on community needs to protect students, teachers, and members of their households while getting kids back in the classroom. Evidence available at the time suggested that many K-12 schools that strictly implemented mitigation strategies were able to safely open for in-person instruction and remain open. Essential to this layered prevention were five key mitigation strategies: universal and correct use of masks; physical distancing; handwashing and respiratory etiquette; cleaning and maintaining healthy facilities; and contact tracing in combination with isolation and quarantine. The document laid out an operational strategy to support in-person instruction through an integrated package of mitigation components.

CDC's recommendations, which are not requirements, are intended to provide broad guidance and serve as a foundation for local decision-making. CDC recommended that school administrators, working with local public health officials, assess the level of community transmission since the risk of introduction of a case in the school setting could depend on the level of community transmission. However, CDC noted that all schools have the option to provide in-person instruction (either full or hybrid) at any level of community transmission, and that strict adherence to mitigation strategies would help protect students, teachers, and members of their households. CDC's K-12 Operational Strategy recommended full in-person instruction for schools in areas of low or moderate community transmission, and hybrid instruction or reduced attendance in areas of substantial or high community transmission.

To maximize the benefits of in-person instruction, CDC's guidance indicated that schools that were open and successfully preventing transmission should remain open, even in communities with high levels of transmission, taking school-specific factors, such as adherence to prevention measures and the number of school-associated cases, into account. CDC's K-12 Operational Strategy included a pathway to reopen *all* schools and help *all* schools remain open through consistent use of mitigation tools. For schools whose doors were open, it provided the measures necessary to stay open safely; and for those that were not yet providing education in person, it provided the plan to swiftly and safely reopen.

As seen in the number of schools that were able to reopen following CDC's February guidance, the guidance was successful in providing the information and strategies needed to safely reopen schools. Before CDC released the K-12 Operational Strategy in February 2021, only 46 percent of school districts in the United States were providing full-time in-person instruction. By the end of the 2020-2021 school year, following CDC's release of the Operational Strategy for K-12 Schools, available data indicate that 63 percent of school districts were providing full-time in-person instruction, and most others were offering partial in-person instruction. In August and September 2021, 99 percent of school districts began the school year offering full in-person instruction to all students. This reflects CDC's commitment to supporting schools in safely reopening for in-person instruction through the K-12 Operational Strategy.

5. **Who are the experts and stakeholders you will consult to make these critical decisions, to ensure that we avoid unnecessary disruptions to our children's education?**

Response: A variety of stakeholders and partners rely on the CDC for the latest scientific information and data to inform their actions and decision-making. In the development of guidance of recommendations, CDC frequently engages with impacted groups to balance public health interventions with potential implementation challenges. CDC remains committed to releasing clear and timely information and is always looking for ways to improve its processes. As part of the CDC Moving Forward initiative, CDC is reviewing and, if necessary, modifying its process for developing public health guidance both during and outside public health emergencies. This review includes, as appropriate and consistent with applicable law, listening sessions and

outreach with a range of partners, including federal agencies, both public and private sector partners at the state, tribal, local, and territorial levels and other organizations involved in public health.

6. **In recognizing the vital role of education in shaping our nation's future, what comprehensive plan will the CDC implement to safeguard against the detrimental effects on children's academic and mental well-being, as seen in the pandemic, and what metrics will be used to measure the success of these interventions?**

   Response: CDC is committed to providing support and resources to young families. CDC is partnering across systems to build youth resilience and prevent adverse childhood experiences. CDC encourages and supports school-based prevention strategies to bolster young people's mental and behavioral health. CDC is launching *Strategies for Promoting Mental Health and Well-being in Schools*, which recommends effective approaches for prevention and mental health promotion in K-12 schools as well as additional tools and resources.

7. **Understanding that you did not hire Dr. Howard Zucker, his hiring suggests that CDC doesn't really plan to learn from its mistakes and overreach during COVID-19. His actions in New York, even allowing for the uncertainties at the time strike me as disqualifying for senior leadership at the CDC. He ordered, against CMS advice, that COVID positive seniors be sent back to nursing homes and then helped Governor Cuomo cover it up, in part by blaming their caregivers. Do you have confidence in Dr. Zucker? Do you plan on retaining him?**

   Response: Dr. Zucker has extensive experience as a public health leader, both domestically and internationally. He has previously served as the highest-ranking American at the World Health Organization, has overseen the world's essential medicines list, was chair of the International Medical Products Anti-Counterfeiting Taskforce, and served as the Department of Health and Human Services Deputy Assistant Secretary for Health. He has also worked on global health projects spanning the spectrum from communicable to non-communicable diseases. We are confident in Dr. Zucker's knowledge, planning, and strategy in support of the agency's global portfolio.

8. **The delay between scientific findings and CDC guidance updates has been a point of contention, leading to mistrust. What specific strategies will you implement to ensure that the CDC's guidance is timely, accurate, and in step with the latest scientific research?**

   Response: CDC's scientific experts continually monitor for, and incorporate, new evidence while developing public health guidance, and CDC invites external partners to identify guidance needs, both when new science is available or when there are changes to the acceptability and feasibility of current recommendations. Additionally, CDC's guidance development process includes post-release evaluation that allows for updates based on learnings from practice, science, and policy changes**.**

9. **Reflecting on instances where CDC guidance seemed to lag behind emerging scientific data, such as with mask efficacy and transmission modes of COVID-19, how do you plan to address this gap? What measures will be put in place to guarantee that CDC recommendations are promptly updated in response to new scientific insights?**

   Response: In April 2022, CDC leadership launched Moving Forward to identify how CDC can modernize systems and processes to better share science and data to better serve and protect the American public.

   One of the initiatives in this process was enhancing a standard framework for a consistent and transparent guidance process where CDC recommends action that an external entity or individual could take to prevent, control, or treat illness, disease, or injury. CDC is continuously evaluating and improving this process.

The process incorporates contextual factors and policy considerations that influence the extent to which evidence-based guidance are put into practice, and leverages CDC's external engagement with the public, key partners (e.g., other U.S. government agencies, state, tribal, local, and territorial public health agencies), constituents from public health and other health sectors, and other relevant parties. This also emphasizes the need for quick response to urgent guidance needs in public health emergencies.

10. **The CDC's previous messaging sometimes conflicted with emerging scientific data, creating public skepticism. Moving forward, how will you address the challenge of conveying complex and evolving scientific information to the public clearly, and accurately, and maintain public trust in the CDC's expertise?**

    Response: During the COVID-19 crisis, CDC produced a large number of policy guidance documents specific to the implementation needs of various stakeholders.

    After an extensive review of CDC's organizational structures, systems, and processes, the Agency launched its Moving Forward initiative in August 2022, which focus on several areas for improvement identified by the review, including "translating science into practical, easy to understand policy" and "prioritizing public health communications."

    CDC has multiple audiences for its scientific knowledge and implementation guidance documents, including State/local/territorial health officials, providers, researchers, employers, policy makers, media, and the public.

11. **Director Cohen, considering that half of the CDC's review was conducted by its own staff, how do you plan to ensure unbiased and rigorous self-evaluations in the future?**

    Response: CDC uses the Advisory Committee to the Director (ACD) that consists of experts from relevant fields, including health system and academic representation, to collect advice from external partners and provide a critical link for feedback to the agency from external public health officials. The ACD meets quarterly and includes working groups focused on providing recommendations to CDC in areas such as health equity, data modernization, and high-quality laboratories.

    The CDC Funded Recipient Experience Survey is another example of how CDC will collect feedback in the future. The survey is intended to help CDC understand how well its support and services meet state, tribal, local, and territorial funded recipients' needs within the grants management lifecycle.

12. **Given the potential for internal biases in self-assessment, would you consider implementing independent external reviews to provide a more objective evaluation of the CDC's performance?**

    Response: In April 2022, CDC leadership initiated a scientific and programmatic review to identify ways to improve and institutionalize how CDC develops and deploys its science, both in pandemic and non-emergency times. External experts with extensive experience in government management challenges conducted more than 100 interviews with CDC leadership, staff, and external partners.

13. **How do you propose to enhance the transparency and accountability of the CDC's internal review processes to the public and other stakeholders?**

    Response: CDC issues recommendations and information in a variety of ways, from sharing options for the general public and policymakers to consider, to guidance that can form the basis of organizational or public policy. External engagement for guidance that is likely to be used in formal policymaking includes using public forums that allow any interested party to provide input.

14. What steps will be taken to ensure that self-evaluations at the CDC accurately reflect both successes and areas needing improvement, without succumbing to internal pressures?

Response: CDC is developing tools that are intended to support consistent, objective evaluation of guidance understandability, acceptability, and feasibility. Often guidance is one tool used in a larger public health program and is evaluated as part of the full intervention package.

15. In the interest of fostering trust and credibility, would you commit to regularly commissioning independent audits or reviews of the CDC's programs and policies?

Response: Independent audits and reviews of CDC programs and policies are regularly commissioned by the Government Accountability Office (GAO) and the Office of Inspector General (OIG). These include timely, fact-based, non-partisan information in accordance with OIG guidelines, GAO's financial audit manual, the Yellow Book, the Green Book, Federal Information System Controls Audit Manual, and Cybersecurity Program Audit Guide. CDC follows OMB circular policies and procedures for use by executive agencies when considering reports issued by the OIG, GAO, and non-Federal auditors to complete these independent audits.

16. Less than 5% of CDC staff are clinically active professionals, how will you address this gap to enhance the agency's preparedness for public health emergencies?

Response: While broadly speaking, CDC does not provide direct clinical services, CDC recognizes that a diverse public health workforce ensures we have the capacity to address complex diseases and swiftly respond to new threats, and therefore require some staff with clinical expertise to advise our public health actions. CDC recruits for these highly skilled positions as needed. In addition, following recommendations in CDC's Moving Forward work, CDC plans to address developmental gaps in recruiting and obtaining clinical staff through the CDCReady Responder Program, though the scope of this activity is resource dependent.

17. With a similar proportion of staff being epidemiologists, critical for disease forecasting and response, what are your plans to strengthen this vital aspect of the CDC's workforce?

Response: CDC recognizes that a diverse public health workforce ensures we have the capacity to address complex diseases and swiftly respond to new threats. In April 2022, CDC launched the Center for Forecasting and Outbreak Analytics (CFA). CFA's goal is to enable timely, effective decision-making to improve outbreak response using data, models, and analytics. The center intends to support leaders with a focus on addressing the needs of the most vulnerable communities. It also seeks to develop a program to provide insights about infectious disease events to the public to inform individual decision making – the equivalent of the National Weather Service for infectious diseases.

In addition, CDC maintains the Epidemic Intelligence Service (EIS), a globally recognized applied epidemiology training program. Established in 1951, EIS has trained over 4,000 disease detectives who have investigated and responded to a wide range of public health challenges and emergencies. CDC has requested authority to non-competitively convert fellows, such as EIS fellows, so the agency can better retain these highly skilled epidemiologists at the end of their training.

18. The predominance of administrative and grants-related roles at the CDC has been highlighted. How do you intend to rebalance the staff composition to prioritize public health preparedness and response?

Response: CDC identified top needs for improvement through CDC Moving Forward, including to develop a CDC workforce ready to respond to future threats. To do this, CDC needs help from Congress to provide

legislative changes, such as workforce flexibilities to recruit and retain the very best experts in the world, for CDC to be the response agency Congress and Americans expect. For example, this includes authority to:

- Support a ready responder program that enables us to quickly assign staff in an outbreak situation.
- Appropriately compensate senior response employees who work overtime;
- Re-employ annuitants beyond the statutory limit to appropriately tap this skilled and ready workforce;
- Waive taxes for Loan Repayment programs to foster a highly skilled response pipeline; and
- Non-competitively convert fellows and term hires to better retain staff who are highly trained and in whom the agency has invested time and resources.

The Honorable Dr. Michael Burgess

1. **How is the CDC leveraging advanced technologies and public sector collaboration not only to detect new and emerging biological threats but also to quickly evaluate the potential risks these pathogens pose to public health?**

   Response: In 2022, CDC established the Center for Forecasting and Outbreak Analytics (CFA). This new Center helps develop forecasting and modeling tools to assist public health and other national, state, and local leaders in making informed decisions during large scale public health emergencies. CFA's work is just one example of how CDC is adapting to rapidly identify and respond to disease threats. Through CFA, CDC is expanding collaboration with private, public, and academic sector partners, particularly with respect to advancing disease forecasting innovation. In 2023, CFA released a 5-year strategic plan, naming "Innovate" as one of the goals in the plan and forming a division within the Center to work towards that goal. CFA is driving technological and analytic innovation in disease forecasting by working to:

   - Transform infectious disease forecasting, advanced analytics, and communication by engaging public, academic, and private sector performers;
   - Advance leading-edge analytic technology architectures for CDC and our partners; and
   - Establish technical specifications to support the flow of data and methods between CDC and collaborators.

   Through this new Center, CDC is leveraging advanced technologies and public sector collaboration to detect new and emerging biological threats, and quickly evaluate and communicate the potential risks these pathogens pose to public health.

   To support this work, in September 2023, CFA launched Insight Net, the first national network for outbreak and disease modeling. This 5-year cooperative agreement is engaging 13 awardees and more than 100 total network participants from the public, private, and academic sectors. Insight Net spans 24 states and 35 public health departments and is building capacity by developing and implementing powerful tools to improve speed, accuracy, and use of data & analytics during public health emergencies.

   In addition, CFA is developing a virtual computer infrastructure for disease forecasting and analysis. The Virtual Analyst Platform (VAP), which leverages advancements in cloud computing brought to CDC through the Data Modernization Initiative, is a network of secure analytic workspaces, making it possible for modelers to connect data sources via cloud-based computing technology and collaborate in real time. In the next year, CFA plans to expand the platform outside of CDC by creating custom analytic products for state and local jurisdictions that will support in real-time code sharing and disease modeling capabilities at the state and local levels.

Finally, CFA is developing ways to assess and communicate risk. For example, in the fall of 2023, CFA co-led work to deliver CDC's first Respiratory Disease Season Outlook, providing an assessment of COVID-19, influenza, and RSV strains expected to circulate late in 2023 and early 2024. CFA also produced and continues to update state-level disease transmission estimates (known as R_t) for COVID-19 and influenza, helping inform state and local leaders as well as the public about whether infections are increasing or decreasing in their communities.

2. **Valley fever (coccidioidomycosis) is an infection caused by the fungus Coccidioides. The fungus is known to live in the soil in the southwestern United States and has been documented to be spreading rapidly across arid regions. The illness is estimated to cost $3.9 billion annually due to Valley fever treatment, lost wages, and economic welfare losses.**

   According to the World Health Organization, Valley fever is a top 15 fungal pathogen that deserves further research and policy interventions to strengthen the global response to fungal infections and antifungal resistance.

   As we take the lessons learned from COVID-19 and apply them to the future, how is CDC planning to address threats antimicrobial resistance, such as those seen in cases of Valley fever, in its pandemic preparedness plan?

   Response: CDC investments in overall public health preparedness since 2002 also help combat AR threats. The Public Health Emergency Preparedness (PHEP) cooperative agreement is a critical source of funding and guidance for state, local, and territorial health departments nationwide. PHEP recipients use their PHEP funding to invest in epidemiology, laboratory, and surveillance capabilities and systems that support detection of AR threats, help prevent healthcare-associated infections (HAIs), and bolster pandemic preparedness and response.

   Through investments in the Antimicrobial Resistance (AR) Solutions Initiative and other funding sources, CDC supports work to achieve targets in the *National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025* and the *National Biodefense Strategy*. CDC invests in infrastructure, programs, and solutions designed to prevent, detect, contain, and respond to AR threats across healthcare settings, communities, the food supply, and the environment. Many of CDC's efforts to combat AR also help prevent the spread of other known and emerging infectious diseases and ensure the nation's readiness for the next pandemic.

   Domestic and global supplemental funding have significantly contributed to our efforts to combat AR, prevent healthcare-associated infections (HAIs), and bolster pandemic preparedness and response. One-time emergency supplemental funding investments, such as those from the American Rescue Plan Act (ARP), have strengthened our ability to prevent, detect, and rapidly respond to infectious disease threats, including those caused by antimicrobial-resistant pathogens. CDC is investing to strengthen and equip state, local, and territorial public health departments and other partner organizations with the resources needed to better fight infections in U.S. healthcare facilities, including COVID-19, infections caused by antimicrobial-resistant pathogens, and other known and emerging infectious diseases.

   Since 2016, CDC has built and expanded foundational infrastructure through annual and supplemental appropriations to slow the spread of AR across One Health (intersection of human, animal, environmental health), including by:

   - Equipping all states and several large cities with lab expertise through CDC's Antimicrobial Resistance Laboratory Network and on-the-ground experts through Healthcare-associated Infection (HAI)/AR Programs to detect, contain, and respond to outbreaks of resistant pathogens.

- Improving antibiotic and antifungal use and stewardship across healthcare and veterinary settings.
- Enhancing detection and tracking of resistant pathogens of healthcare-associated, foodborne, and community threats such as drug-resistant tuberculosis, extended-spectrum beta-lactamases-producing Enterobacterales, and gonorrhea.
- Spurring innovation through research investments using a One Health approach to prevent AR globally.
- Informing the development of new drugs and diagnostics by sharing isolates through the CDC & FDA Isolate Bank (pure samples of a pathogen) and CDC sequencing data.
- Supporting partners to as part of a global network to detect and respond to AR threats across the One Health spectrum through the Global Antimicrobial Resistance Laboratory and Response Network.

These investments are helping to slow the spread of HAIs, AR, and other infectious disease threats. For example, CDC investments in health department HAI/AR programs and the domestic AR Lab Network enabled the rapid detection of and effective response to an outbreak of extensively drug-resistant *Pseudomonas aeruginosa* associated with artificial tears and the first confirmed case of *Candida auris* in West Virginia. CDC investments in global AR surveillance and capacity building have helped us better understand and respond to the alarmingly high levels of AR and antibiotic use in low- and middle-income countries, and have supported interventions to combat AR globally during the COVID-19 pandemic.

3. How will CDC work with stakeholders to develop countermeasures and preventatives for Valley fever?

Response: CDC collaborates with U.S. government agencies and nongovernmental partners to develop prevention and detection tools to address Valley fever infections. For example, CDC collaborates with the National Institutes of Health in their efforts in research and development of future Valley fever vaccines to prevent infections. CDC also assesses adverse events resulting in hospitalizations or emergency room visits from antifungal medications.

Additionally, CDC recently worked with partners, including the Mycoses Study Group and Coccidioidomycosis Study Group, to develop a new clinical diagnosis tool for use in outpatient settings. CDC is engaging with key partners to disseminate and promote this tool and other innovative diagnostic solutions to address missed or delayed diagnoses of Valley fever, a critical challenge to combating this disease.

The Honorable Kelly Armstrong

1. **What specific legal or statutory authority empowers the CDC to purchase or otherwise obtain geolocation data on American citizens?**

   Response: Under the Public Health Service Act, CDC has general legal authority to request and collect data that can assist in its public health mission, including the ability to collect and make available information supporting public health situational awareness and research. Much of these data are collected through voluntary submissions, but CDC also has the authority to enter into contracts to procure data or services related to data, including contracts for situational awareness and research (See, e.g., 42 USC § 241). Additionally, the Department of Health and Human Services may take action in response to a public health emergency, including by entering into contracts and supporting investigations into the prevention of disease (42 USC § 247d). The acquisition of anonymized and aggregated mobility data may be material to the investigation of population impacts of certain public health incidents of concern and associated mitigation measures.

2. **Did the CDC obtain legal advice concluding that the CDC has statutory authority to procure or otherwise obtain geolocation data on American citizens? I am specifically referring to the CDC purchasing or obtaining geolocation data?**

   a. **If yes, the legal justification explaining the statutory authority.**

   Response: As noted above, the Public Health Service Act provides CDC with general legal authority to request and collect data that can assist in its public health mission, including the ability to collect and make available information supporting public health situational awareness and research. Much of these data are collected through voluntary submissions, but CDC also has the authority to enter into contracts to procure data or services related to data, including contracts for situational awareness and research (See, e.g., 42 USC § 241). Additionally, the Department of Health and Human Services may take action in response to a public health emergency, including by entering into contracts and supporting investigations into the prevention of disease (42 USC § 247d). The acquisition of anonymized and aggregated mobility data is material to the investigation of population impacts of public health incidents of concern and associated mitigation measures.

3. **Does the CDC possess statutory authority to obtain and examine "mobility pattern data" in and around "places of worship?"**

   a. If yes, do you believe that this does not violate the First Amendment's Free Exercise Clause?

   b. If yes, did the CDC obtain legal advice concluding that the data collection concerning "places of worship" did not violate the First Amendment's Free Exercise Clause?

   c. If yes, is it your legal opinion that this collection is legal under the First Amendment's Free Exercise Clause?

   Response: CDC did not obtain data that included Sensitive Points of Interest (SPOI). SPOI include, but are not limited to, churches, religious facilities, sensitive businesses, military and correctional facilities, social demonstrations, locations with firearms, and more. Even if places of worship were not excluded from some datasets, because the data is in aggregate form only, CDC would not be able to monitor travel to, from, or around a place of worship at the individual level.

4. **What specific appropriation program(s) provided funding for the purchase(s) of geolocation data?**

Response: For both SafeGraph and Cuebiq, CDC and other public health entities received the aggregated, anonymized data under no-cost programs from the emergence of COVID-19 until mid-2021, at which time CDC entered into one-year contracts with SafeGraph and Cuebiq through the COVID-19 response using funds from the Coronavirus Aid, Relief, and Economic Security (CARES) Act. (P.L. 116-136.) Both contracts have expired.

5. **What specific safeguards has the CDC put into place with vendors regarding the utilization and protection of this geolocation data?**

Response: CDC required that vendor provided datasets be anonymized and contain no personally identifiable information. CDC also required standard security requirements, privacy reviews, and risk assessments of the data and its use. Limitations were placed on the number of individuals who could access the datasets, and authentication was required for access. In addition to the datasets being anonymized, the data were provided at aggregate levels only.

6. **Within the past ten years, has the CDC requested that Congress enact legislation that expressly authorizes the purchase or acquisition of geolocation data?**

Response: As previously mentioned, the Public Health Service Act provides CDC with general legal authority to request and collect data that can assist in its public health mission, including the ability to collect and make available information supporting public health situational awareness and research. Much of these data are collected through voluntary submissions, but CDC also has the authority to enter into contracts to procure data or services related to data, including contracts for situational awareness and research (See, e.g., 42 USC § 241). Additionally, the Department of Health and Human Services may take action in response to a public health emergency, including by entering into contracts and supporting investigations into the prevention of disease (42 USC § 247d). The acquisition of anonymized and aggregated mobility data may be material to the investigation of population impacts of certain public health incidents of concern and associated mitigation measures.

7. **Please detail each instance of the CDC purchasing or otherwise obtaining geolocation data since 2013.**

   a. **For the data, include the following information:**
      - **What type of data was purchased?**
      - **What is the specific rationale for purchasing it?**
      - **Who was the data purchased from?**
      - **Where were the funds utilized to purchase or obtain this data appropriated from?**
      - **What is the amount of money spent on acquiring the dataset(s)?**
      - **What statutory authority granted the CDC the authority to purchase the data?**

Response: CDC does not purchase identifiable, individual level data with geocoded information.

8. **Are there any pending or completed regulatory investigations or legal challenges to the CDC's utilization of geolocation data? If so, list them.**

Response: CDC is not aware of any regulatory investigations or legal challenges.

9. **What was the rationale for choosing the vendors where the CDC procured geolocation data?**

Response: CDC uses a standard process for procuring goods, which includes evaluation of a vendor's prior performance and their ability to complete the contracted work. The procurement process also involves market

research to identify appropriate vendors. Mobility data vendors that did not meet CDC's acceptable privacy criteria were eliminated from consideration. At the time CDC was seeking to obtain these data and based on CDC's procurement processes, SafeGraph and Cuebiq were considered responsive to CDC's need for mobility data for use in public health research while taking into consideration appropriate privacy protections.

10. **Provide a detailed list of each instance in which the CDC's utilization of geolocation data targeted specific individuals or groups of individuals.**

    Response: The nature of these datasets makes it so that CDC is not able to target or track specific individuals. Specifically, the mobility data that CDC used contained multiple privacy controls that helped ensure an individual could not be reidentified. These datasets have allowed CDC to better understand the impacts of COVID-19 and other public health incidents of concern at a population level, not at an individual level.

11. **Director Walensky's letter dated July 8th, 2022 states that the geolocation data utilized by the CDC was anonymized. In a previous Energy and Commerce Hearing, Mr. Paul Ohm, a law professor and privacy researcher at Georgetown University Law Center, stated under testimony that "Really precise, longitudinal geological information is absolutely impossible to anonymize." This reidentification is especially true when collected on a rural population. Beyond my concerns about the CDC's ability to legally acquire this information, I have significant concerns about the CDC possessing the cyber security capability to manage and safeguard this information responsibly to prevent it from being accessed by bad actors.**

    - **Detail specific steps taken by the CDC to ensure this data is protected from being accessed by bad actors.**
    - **Detail specific steps the CDC took to ensure that reidentification is not possible on this data.**

    Response: The data provided to CDC was not only anonymized but aggregated and had other safeguards put in place by the vendor (e.g., differential privacy technique use, geomasking, data delays, suppression techniques) to prevent potential reidentification. Further, limitations placed on the number of individuals who could access the data, coupled with the authentication requirements and established CDC processes for approving the initiation and completion of scientific projects were in place to prevent any attempt at reengineering of person- (or device-) level information. CDC past contracts with SafeGraph and Cuebiq contained security requirements, privacy reviews, and risk assessment clauses. Multiple privacy controls were built into the datasets, including that the datasets be anonymized, and that there be no personally identifiable information included. Additionally, the data received was in aggregate form only, ensuring that the specific location, device, and timeline of an individual could not be determined. It is not possible for CDC to reverse any of the datasets' built in privacy controls and an individual's data cannot be reidentified by the CDC.

12. **Has the CDC shared geolocation data with government agencies, law enforcement agencies, or third-party groups?**

    a. **If yes, what entity or individual was it shared with, and what data was shared?**

    Response: CDC's contracts with both SafeGraph and Cuebiq prohibited sharing of data. CDC did not share data purchased under these contracts with other federal, state, or local agencies or private companies.

13. **Do you agree with Professor Ohm that it is impossible to anonymize precise longitudinal data?**

a. If not, please fully explain your understanding of reidentification and its practicality relating to the data procured or obtained by the CDC.

Response: The data provided to CDC was not only anonymized but aggregated and had other safeguards put in place by the vendor (e.g., differential privacy technique use, geomasking, data delays, suppression techniques) to prevent potential reidentification. Further, limitations placed on the number of individuals who could access the data, coupled with the authentication requirements and established CDC processes for approving the initiation and completion of scientific projects, were in place to prevent any attempt at reengineering of person- (or device-) level information.

14. Did the CDC obtain mobility pattern data before January 21st, 2020? (The first documented case of COVID-19 in the US.)

Response: In March 2020, SafeGraph, Cuebiq and Google offered mobility data access free-of-charge to government and academia. CDC did not purchase or use mobility data from these companies prior to March 2020. It is important to note that the data have been used to understand population-level impacts of COVID-19 policies, and can shed important light on other pressing public health problems, like natural disaster response, chronic disease prevention, and toxic environmental exposures. CDC does not and could not use these data for monitoring compliance with COVID-19 orders or individual tracking.

15. As we take the lessons learned from COVID-19 and apply them to the future, how is CDC planning to address endemic fungal threats, such as Valley fever, in its pandemic preparedness plan? How will CDC work with stakeholders to develop countermeasures and preventatives for Valley fever?

Response: CDC collaborates with U.S. government agencies and nongovernmental partners to develop prevention and detection tools to address Valley fever infections. For example, CDC collaborates with the National Institutes of Health in their efforts in research and development of future Valley fever vaccines to prevent infections. CDC also assesses adverse events resulting in hospitalizations or emergency room visits from antifungal medications.

Additionally, CDC recently worked with partners, including the Mycoses Study Group and Coccidioidomycosis Study Group, to develop a new clinical diagnosis tool for use in outpatient settings. CDC is engaging with key partners to disseminate and promote this tool and other innovative diagnostic solutions to address missed or delayed diagnoses of Valley fever, a critical challenge to combating this disease.

16. Valley fever (coccidioidomycosis) is an infection caused by the fungus Coccidioides. The fungus is known to live in the soil in the southwestern United States and has been documented to be spreading rapidly across arid regions. The illness is estimated to cost $3.9 billion annually due to Valley fever treatment, lost wages, and economic welfare losses. According to the World Health Organization, Valley fever is a top 15 fungal pathogen that deserves further research and policy interventions to strengthen the global response to fungal infections and antifungal resistance. What is CDC doing to protect against Valley fever?

Response: CDC investments in overall public health preparedness since 2002 also help combat AR threats. The Public Health Emergency Preparedness (PHEP) cooperative agreement is a critical source of funding and guidance for state, local, and territorial health departments nationwide. PHEP recipients use their PHEP funding to invest in epidemiology, laboratory, and surveillance capabilities and systems that support detection

of AR threats, help prevent healthcare-associated infections (HAIs), and bolster pandemic preparedness and response.

Through investments in the Antimicrobial Resistance (AR) Solutions Initiative and other funding sources, CDC supports work to achieve targets in the *National Action Plan for Combating Antibiotic-Resistant Bacteria, 2020-2025* and the *National Biodefense Strategy*. CDC invests in infrastructure, programs, and solutions designed to prevent, detect, contain, and respond to AR threats across healthcare settings, communities, the food supply, and the environment. Many of CDC's efforts to combat AR also help prevent the spread of other known and emerging infectious diseases and ensure the nation's readiness for the next pandemic.

Domestic and global supplemental funding have significantly contributed to our efforts to combat AR, prevent healthcare-associated infections (HAIs), and bolster pandemic preparedness and response. One-time emergency supplemental funding investments, such as those from the American Rescue Plan Act (ARP) have strengthened our ability to prevent, detect, and rapidly respond to infectious disease threats, including those caused by antimicrobial-resistant pathogens. CDC is investing to strengthen and equip state, local, and territorial public health departments and other partner organizations with the resources needed to better fight infections in U.S. healthcare facilities, including COVID-19, infections caused by antimicrobial-resistant pathogens, and other known and emerging infectious diseases.

Since 2016, CDC has built and expanded foundational infrastructure through annual and supplemental appropriations to slow the spread of AR across One Health (intersection of human, animal, environmental health), including by:

- Equipping all states and several large cities with lab expertise through CDC's Antimicrobial Resistance Laboratory Network and on-the-ground experts through Healthcare-associated Infection (HAI)/AR Programs to detect, contain, and respond to outbreaks of resistant pathogens.
- Improving antibiotic and antifungal use and stewardship across healthcare and veterinary settings.
- Enhancing detection and tracking of resistant pathogens of healthcare-associated, foodborne, and community threats such as drug-resistant tuberculosis, extended-spectrum beta-lactamases-producing Enterobacterales, and gonorrhea.
- Spurring innovation through research investments using a One Health approach to prevent AR globally.
- Informing the development of new drugs and diagnostics by sharing isolates through the CDC & FDA Isolate Bank (pure samples of a pathogen) and CDC sequencing data.
- Supporting partners to as part of a global network to detect and respond to AR threats across the One Health spectrum through the Global Antimicrobial Resistance Laboratory and Response Network.

These investments are helping to slow the spread of HAIs, AR, and other infectious disease threats. For example, CDC investments in health department HAI/AR programs and the domestic AR Lab Network enabled the rapid detection of and effective response to an outbreak of extensively drug-resistant *Pseudomonas aeruginosa* associated with artificial tears and the first confirmed case of *Candida auris* in West Virginia. CDC investments in global AR surveillance and capacity building have helped us better understand and respond to the alarmingly high levels of AR and antibiotic use in low- and middle-income countries, and have supported interventions to combat AR globally during the COVID-19 pandemic.

The Honorable Dan Crenshaw

1. **Can you provide a written response detailing, from start to finish, when you first received communication regarding the Reedley, CA biolab, and what the timeline for response was? You mention limitations under the current Select Agent Program for testing samples. Can you explain the following:**

    a. **why did the CDC fail to test – and reportedly refuse to test — samples containing potentially infectious agents;**

    b. **why did the CDC DSAT fail to test – and reportedly refuse to test — samples in containers and storage areas with labels naming select agents (despite having that remit);**

    c. **why did the CDC fail to forward requests for testing to NBACC or NBFAC;**

    d. **and what steps have been taken to prevent similar failures in the future.**

    Response: CDC was one of several federal agencies that supported state and local officials leading the investigation into the Reedley building. In March 2023, CDC was notified of the situation at the Reedley building. CDC offered to provide biosafety and biosecurity expertise to support the California Department of Public Health's investigation. However, the State initially informed CDC that no on-site assistance was needed. In April 2023, the California Department of Public Health requested on-site assistance to determine whether material in the building was in violation of Select Agent and Import Permit regulations. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review on May 2 to 4, 2023, dates that were established by local and state jurisdictions.

    CDC assessed specific inventory identified by city and state officials and took extensive photos and videos to document the freezers/storage containers and vials of biological samples. During the extensive two-and-a-half-day search of the identified freezers, CDC did not discover any label on a freezer or vials that identified any potential select agent or toxin at the time of their onsite support. While CDC did not see any mice or other animals at the time of this onsite support, state and local officials did request that CDC test frozen mice. However, it is not possible to extract viable samples from frozen mice.

    In accordance with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 U.S.C. 262a) (the Act), CDC only has authority over select agents and toxins and does not have authority over potentially infectious non-select agents. Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession. Therefore, CDC had no regulatory or inspection authority over the facility and the Act does not authorize CDC to seize material for testing.

    After the on-site review, CDC issued an import permit advisement letter to ensure Prestige Biotech, Inc.(PBI) knows the regulations for importing infectious substances into the United States and a Federal Select Agent Program advisement letter to PBI informing them of the requirements for possession, use, and transfer of select agents and toxins if the entity decides to possess them.

2. **CDC data released last Friday confirm that flu season is underway in the US, yet flu vaccination rates have decreased from last year, remain low overall, and CDC no longer has funding for vaccine confidence. Now that flu season is underway, what steps is CDC taking to continue to encourage the public to get vaccinated for flu?**

    Response: CDC remains concerned about decreases in rates of flu vaccination overall, and especially among certain groups that are more likely to experience poor outcomes associated with flu. CDC currently has jurisdictional and partner funding for vaccine confidence efforts, primarily funding was provided to the CDC

in the FY2023 Congressional appropriations bill. These funds are being used to improve vaccine confidence and address vaccine hesitancy by targeting hard-to-reach populations. By working with trusted community partners and organizations CDC is working to improve flu vaccination coverage among racial and ethnic minority groups. Vaccination is the best way to prevent flu and its potentially severe health outcomes, and CDC recommends that everyone 6 months and older get a flu shot every year.

To encourage the public to get vaccinated, CDC has two communication campaigns this season that focus on better reaching key populations who are more at risk for severe outcomes from flu, including:

- A very successful digital campaign called "Wild to Mild," which shows how flu vaccination not only prevents illnesses but can also 'tame' flu's symptoms from being 'wild' to 'mild' in people who get vaccinated but still get sick. This campaign is for the general public, with targeted outreach to parents of children 6 months-12 years and pregnant people.
- A CDC and American Medical Association collaboration with the Ad Council that focuses on encouraging flu vaccination among Black and Hispanic people.
- CDC's Partnering for Vaccine Equity (P4VE) grant program provides funding for local and community-based organizations to improve COVID-19 and flu vaccination coverage among various racial and ethnic minority groups.

CDC also conducts targeted outreach to healthcare providers to encourage them to make strong recommendations to their patients to get vaccinated.

3. Does CDC believe it understands the multifactorial causes of reduced trust in public health that occurred during the pandemic? Is the agency studying this issue, and employing data-driven approaches to rebuilding trust? How are CDC's real-time learnings about rebuilding public trust reflected in public guidance and communications this season? How will CDC continue to incorporate these learnings in planning for future guidance and communications?

Response: The COVID pandemic exposed challenges and gaps in CDC's core capabilities that led our agency to conduct an extensive review to identify lessons learned and make changes in our organizational structure, systems, and processes. CDC has done the hard work to make improvements to our operations, processes, and communications. We have a renewed focus on fast, accurate, and transparent communication to improve public trust. For example, CDC launched Clean Slate to overhaul the CDC.gov website and streamline content by more than 60% so that people will be better able to find the information they're looking for to protect their health.

In addition, there has been a great deal of work to define a consistent approach to guidance through CDC's Moving Forward initiative. A variety of stakeholders and partners will continue to rely on CDC to interpret the latest scientific information and data to inform their actions and decision-making. It is critical that our processes include engagement with external groups and the public as we develop public health guidance to better support our science-based recommendations and ensure they have the desired effects. CDC has continued to review and improve how we share and receive feedback from those impacted by public health guidance and create guidance that is: rooted in scientific evidence, easy to understand, associated with health benefits that matter to the primary audiences, implementable, and that balances risks with benefits.

Stakeholder engagement and listening is a core component. We want to make sure people have information they need to make informed decisions – this requires better communication from us, and we hope you are seeing that. For example, CDC has updated respiratory virus landing page with streamlined guidance for preventing spread and serious outcomes from these viruses.

The Honorable Neal Dunn

1. **You testified that there "were a number of inaccuracies in that (SCC report) report". Please list the inaccuracies of the report.**

Response: Despite the claims in the House Select Committee on the Chinese Communist Party's report that CDC was unresponsive to local officials' request assistance, CDC offered biosafety and biosecurity expertise to support the California Department of Public Health's investigation after notification. However, the State initially informed CDC that no on-site assistance was needed. In April 2023, the Department of Public Health requested on-site assistance to determine whether material in the building was in violation of Select Agent and Import Permit regulations. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions.

CDC assessed specific inventory identified by city and state officials and took extensive photos and videos to document the freezers/storage containers and vials of biological samples. During the extensive two-and-a-half-day search of the identified freezers, CDC did not discover any label on a freezer or vials that identified any potential select agent or toxin at the time of their onsite support.

The Committee's report discusses at length CDC's authority to seize and test samples. In accordance with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 U.S.C. 262a) (the Act), CDC only has authority over select agents and toxins and does not have authority over potentially infectious non-select agents. Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession. Therefore, CDC had no regulatory or inspection authority over the facility and the Act does not authorize CDC to seize material for testing.

The California Department of Public Health did request that CDC test frozen mice for SARS-CoV-2 antibodies. CDC explained that it was not possible to test frozen mice for SARS-CoV2 or other viruses because red blood cells lyse after freezing causing hemolysis and tissue break down. As a result, it is not possible to collect the plasma and serum needed to perform serological assays.

Although the Committee report claimed there was a freezer labeled Ebola, CDC did not discover any label on a freezer that identified Ebola virus or any other select agent or toxin at the time of the onsite support. In addition, when requested by CDC, the state was unable to provide any evidence of any storage or vials being labeled as "Ebola." Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession.

2. **Please provide the timeline of notifications to the CDC, the dates the CDC responded, and the outcomes of the responses.**

Response: CDC was one of several federal agencies that supported state and local officials leading the investigation into the Reedley building. In March 2023, CDC was notified of the situation at the Reedley building. CDC offered to provide biosafety and biosecurity expertise to support the California Department of Public Health's investigation. However, the State initially notified CDC that no on-site assistance was needed. In April 2023, the Department of Public Health requested on-site assistance to determine whether material in the building was in violation of Select Agent and Import Permit regulations. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions.

CDC assessed specific inventory identified by city and state officials and took extensive photos and videos to document the freezers/storage containers and vials of biological samples. During the extensive two-and-a-

half-day search of the identified freezers, CDC did not discover any label on a freezer or vials that identified any potential select agent or toxin at the time of their onsite support.

In accordance with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 U.S.C. 262a) (the Act), CDC only has authority over select agents and toxins and does not have authority over potentially infectious non-select agents. Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession. Therefore, CDC had no regulatory or inspection authority over the facility and the Act does not authorize CDC to seize material for testing.

3. **What was the date CDC physically deployed to Reedley lab?**

Response: In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions.

4. **Is it the standard practice of CDC to rely solely on the labels found in clandestine laboratories to ascertain what pathogens were present in the laboratory?**

a. If so, please explain why this is an acceptable practice.

Response: In collaboration with other federal agencies, CDC subject matter experts participated in the state-led onsite review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions. . CDC assessed specific inventory identified by city and state officials and took extensive photos and videos to document the freezers/storage containers and vials of biological samples. CDC also reviewed all documents that local officials made available. During the extensive two-and-a-half-day search of the identified freezers, CDC determined there was insufficient evidence to conclude that a select agent or toxin was in possession. .

Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession. In accordance with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 U.S.C. 262a) (the Act), CDC only has authority over select agents and toxins and does not have authority over potentially infectious non-select agents. The Act does not provide the CDC with the authority to seize and test suspected select agents and toxins.

5. **If not, please explain why the CDC refused to test pathogens in this case when Congress has documented evidence that local officials (a) had legal possession of the pathogens and (b) asked CDC to test the samples.**

Response: CDC was one of several federal agencies that supported state and local officials leading the investigation into the Reedley building. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions. At no time did federal, state, or local health officials determine that there was a threat of major biocontagion. Ultimately, biological samples at the site were destroyed in July 2023 at the direction of state and local officials. State and local officials determined this to be the best option to mitigate any future threat to public health.

6. **The CDC website defines select agents as: "biological agents and toxins that have been determined to have the potential to pose a severe threat to public health and safety, to animal and plant health, or to animal or plant products". Does HIV, tuberculosis, ebola, or malaria fit into that category?**

Response: HHS' Federal Select Agent regulations delineate the full list of agents and toxins that fall under the Department's regulatory oversight.[2] The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 USC 262a), requires the HHS Secretary to consider the following criteria in determining whether to list an agent or toxin: (1) The effect on human health of exposure to the agent or toxin; (2) the degree of contagiousness of the agent or toxin and the methods by which the agent or toxin is transferred to humans; (3) the availability and effectiveness of pharmacotherapies and immunizations to treat and prevent any illness resulting from infection by the agent or toxin; and (4) any other criteria, including the needs of children and other vulnerable populations, that the Secretary considers appropriate.

While Ebola is a select agent, CDC did not discover any label on a freezer that identified Ebola virus or any other select agent or toxin at the time of the onsite support. In addition, when requested by CDC, the state was unable to provide any evidence of any storage or vials being labeled as "Ebola." Based on CDC's on-site support, there was insufficient evidence to conclude that a select agent or toxin was in possession.

7. **Is it the CDC's position that it has no authority to test potential pathogens that are not Select Agents?**

   Response: The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 USC 262a) does not provide the HHS Secretary or CDC with the authority to seize and test suspected select agents and toxins and CDC does not have authority over potentially infectious non-select agents.

8. **Did the CDC perform any analytic tests to determine the true contents of the vials listed "covid" and/or "ebola"?**

   Response: During the extensive two-and-a-half-day search of the identified freezers, CDC did not discover any label on a freezer that identified Ebola virus or any other select agent or toxin at the time of the onsite support. In addition, when requested by CDC, the state was unable to provide any evidence of any storage or vials being labeled as "Ebola." Based on CDC's onsite support, there was insufficient evidence to conclude that a select agent or toxin was in possession.

   It should be noted that SARS-CoV-2, the coronavirus that causes COVID-19, is not a select agent.

9. **Is it the CDC's position that dangerous pathogens that are not Select Agents (such as MERS, AIDS, and antibiotic resistant tuberculosis) are outside of its authority? If so, what agency is the lead on responding to unlicensed or clandestine laboratories that contain these pathogens?**

   Response: In accordance with the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188; 42 USC 262a) (the Act), CDC only has authority to regulate select agents and toxins. The Act does not authorize CDC to oversee and CDC does not have authority over potentially infectious non-select agents.

   At no time did federal, state, or local health officials determine that there was a threat of major biocontagion. Ultimately, biological samples at the site were destroyed in July 2023 at the direction of state and local officials. State and local officials determined this to be the best option to mitigate any future threat to public health.

[2] https://www.ecfr.gov/current/title-42/chapter-I/subchapter-F/part-73
https://www.selectagents.gov/sat/list.htm

10. Congressman Costa and Reedley, California officials have stated at Congressional events that Reedley, California local officials notified CDC of this lab a significant time before Congressman Costa. The CDC Director stated at our hearing that CDC responded promptly to the Reedley, California request.

a. What CDC official records did the CDC Director rely upon when making this assertion? Please provide this document to the committee for review.

Response: CDC was one of several federal agencies that supported state and local officials leading the investigation into the Reedley building. In April 2023, the Department of Public Health requested on-site assistance to determine whether material in the building was in violation of Select Agent and Import Permit regulations. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions.

11. Does CDC maintain a record of requests made over the phone to the CDC for assistance?

Response: CDC's Emergency Operations Center (EOC) is the primary point of contact for jurisdictional partners to reach the agency by phone around the clock. Watch Officers in CDC's EOC are trained to make decisions about how and where to direct callers based on the information each caller provides. The EOC triages requests for assistance and quickly routes them to the appropriate CDC program and/or subject matter expert(s) for action based on response plans and standard operating procedures.

12. Does the CDC have a training and compliance program instructing its officials on how best to respond to requests for assistance regarding clandestine laboratories? If so, please provide this training to the committee for review. If not, does one need to be implemented?

Response: CDC's Emergency Operations Center (EOC) is the primary point of contact for jurisdictional partners to reach the agency by phone around the clock. The EOC is operational 24 hours/day and serves as a location for public health experts to monitor public health threats on a daily basis and manage emergency responses to those threats. The EOC maintains a trained response workforce to ensure that all requests for assistance are triaged and routed quickly to the appropriate CDC program and/or subject matter expert(s) for action, based on the information each caller provides during their encounter with the EOC.

13. Are you satisfied that CDC response was adequate to protect the California public from the threat of major biocontagion?

Response: CDC was one of several federal agencies that supported state and local officials leading the investigation into the Reedley building. In collaboration with other federal agencies, CDC subject matter experts participated in the state-led on-site review of specific inventory on May 2 to 4, 2023, dates that were established by local and state jurisdictions. At no time did federal, state, or local health officials determine that there was a threat of major biocontagion. Ultimately, biological samples at the site were destroyed in July 2023 at the direction of state and local officials. State and local officials determined this to be the best option to mitigate any future threat to public health.

<u>The Honorable Kat Cammack</u>

1. Dr. Cohen, one of the many lessons learned from COVID is the importance of modernizing the way we detect infectious diseases, so that we can spot outbreaks earlier and respond more effectively. I heard

you talk about the critical role of wastewater monitoring and see CDC rolling out a new Website this week to make this data more accessible. Can you give us a sense of the role that wastewater monitoring will play during this respiratory illness season--and when the sites you fund will start broadly testing wastewater for RSV and influenza and sharing that data publicly?

Response: Wastewater monitoring provides data that can alert communities to diseases before hospitals and clinics see a rise in cases. It is an important surveillance tool which can offer insights into disease trends in rural and underserved communities as it does not depend on access to healthcare. Infections can be tracked regardless of whether infected individuals have symptoms or seek healthcare or testing. This information can quickly provide insight into the amount of virus present in untreated wastewater in a community and can be used to better understand disease spread.

Using one-time COVID-19 supplemental funding, CDC established the National Wastewater Surveillance System (NWSS), which is a flexible and dynamic surveillance system offering innovative and cross-cutting capabilities that bolster our readiness to respond to infectious diseases. Since its launch, NWSS has expanded beyond COVID-19 surveillance to include surveillance for mpox.

In late November 2023, CDC launched an updated data dashboard with enhanced data visualizations, and easy-to-understand charts and maps displaying current levels of COVID-19 in wastewater across the United States. The dashboard offers views of national, regional, and state trends of COVID-19 detected in wastewater in all 50 states, U.S. territories, and select tribal nations. It also provides information on the predominant and emerging COVID-19 variants and data on mpox detected in wastewater across the U.S.

While CDC is working to further expand and enhance NWSS, some jurisdictions have already begun testing for additional pathogens, sharing this data with CDC, and even publicly.

CDC will continue to expand and enhance NWSS until supplemental funds are expended. This includes updating the NWSS data dashboard as additional data are available.

The Honorable Frank Pallone, Jr.

1. **Director Cohen, you spoke about the importance of wastewater surveillance in your work with state and local public health jurisdictions to rapidly detect disease spreading in their communities. I'm interested in learning about your plans to use wastewater surveillance to monitor for RSV, influenza and other pathogens beyond COVID-19. Could you please share more about the steps you are currently taking to ensure that a national wastewater surveillance system can give CDC the capability to track multiple existing infectious diseases simultaneously, quickly detect new threats, and share that information with our communities?**

   Response: Wastewater monitoring provides data that can alert communities to diseases before hospitals and clinics see a rise in cases. It is an important surveillance tool that can offer insights into disease trends in rural and underserved communities as it does not depend on access to healthcare. Infections can be tracked regardless of whether infected individuals have symptoms or seek healthcare or testing. This information can quickly provide insight into the amount of virus present in untreated wastewater in a community and can be used to better understand disease spread.

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While CDC is working to further expand and enhance NWSS, some jurisdictions have already begun testing for additional pathogens, sharing this data with CDC, and even publicly. CDC anticipates publishing new information describing how several states are using their wastewater data to on several respiratory pathogens to prioritize public health resources, update clinical guidance for healthcare providers in their community, plan vaccination clinics, and issue health alerts to inform public health action during the 2023-2024 respiratory season.[3]

CDC will continue to expand and enhance NWSS until supplemental funds are expended. This includes updating the NWSS data dashboard as additional data are available.

The Honorable Jan Schakowsky

1. **HICPAC's 2024 draft Guideline to Prevent Transmission of Pathogens in Healthcare Settings was unanimously approved on November 3rd, 2023. The guidance treats surgical masks as respiratory protection for health care workers exposed to infectious diseases - like COVID-19. Consequently, the guidance exempts employers from providing N95 respirators and shifts the responsibility onto the healthcare worker for acquiring adequate personal protective equipment. Stakeholders have expressed concerns that the draft guidance weakens existing infection control protection practices in health care settings.**

   Response: The updated draft guideline does not include any language exempting employers from providing N95 respirators or other personal protective equipment (PPE) when recommended, or requiring healthcare workers to provide their own PPE, nor does it decrease the protections outlined in the current guideline. It continues to require an N95 respirator when respiratory protection is indicated.

   The guideline is being updated on a phased basis. As HICPAC works through the entire guideline review, it is important to remember that the committee has every patient and healthcare worker in mind. This includes environmental services staff, nurses, and everyone else whose efforts help patients and residents receive the safe care they need.

2. **With respect to respiratory illnesses, pneumonia is not only one of the leading causes of hospitalization among U.S. adults, but also the leading hospital-acquired infection among U.S. hospitals, with non-ventilator hospital-acquired pneumonia (NVHAP) associated with 1 in 14 hospital deaths. I want to applaud CDC for recently recommending that hospitals should incorporate comprehensive oral care into patient care protocols for non-ventilated patients. In releasing a toolkit for hospital staff to use as a resource on best-practices, CDC cited a Department of Veterans Affairs oral care program that**

[3] Notes from the Field: The National Wastewater Surveillance System's Centers of Excellence Contributions to Public Health Action During the Respiratory Virus Season — Four States, 2022–23
https://www.cdc.gov/mmwr/volumes/72/wr/mm7248a4.htm

decreased pneumonia rates 40-60% and saved over $100,000 in direct healthcare costs for each case of NVHAP prevented.

Dr. Cohen, what else can the CDC do, in collaboration with other agencies like CMS, to increase prevention of NVHAP in healthcare settings?

Response: Routine oral health care in healthcare settings is often overlooked and patients may not receive oral hygiene supplies during hospital stays. In response, CDC developed the Oral Health in Healthcare Settings to Prevent Pneumonia Toolkit to serve as a ready-to-use resource on how to promote and provide oral care to hospitalized patients.[4] This resource can be used to educate healthcare team members and patients on the best quality oral care practices, the potential role of oral care in preventing non-ventilator hospital-acquired pneumonia (NV-HAP).

CDC is also funding a study with the Department of Veterans Affairs to look more closely at the effect of good oral hygiene on NV-HAP within their facilities, in addition to investing in innovations and collaborations with external investigators and partners to implement new ways to prevent healthcare-associated infections (HAIs), including those caused by antimicrobial-resistant pathogens. One such collaboration is the Prevention Epicenters Program, which is a network of public health experts.[5] Early detection of emerging pandemic threats is the foundation for rapid response and countermeasure development activities. Public health surveillance provides an ongoing picture of the patterns of disease, which is critical to implementation and evaluation of control measures and detection of new and emerging threats. Since pathogens do not recognize international borders, public health surveillance cannot stop at the border either. For the United States to be prepared for any pandemic, we must support and contribute to a globally connected network of public health surveillance systems by making investments across CDC to help detect new pathogens or variants weeks or months earlier. This investment would strengthen existing surveillance programs as well as build novel, pathogen-agnostic approaches like rapid genomic sequencing directly from clinical samples, so that we can get more and faster information from a sample. Investments would expand support for sentinel surveillance systems, novel pathogen-agnostic approaches, and influenza-like illness and other respiratory disease surveillance. With additional investments, the United States could also significantly increase our early warning capabilities with the addition of thousands more wastewater testing sites across the country to increase geographic representation and breadth/depth of sampling and allow for the addition of facility-based testing sites (e.g., in nursing homes, other congregate settings, and more). Techniques and infrastructure involving metagenomics, for example, that sequence a collection of genes in a single sample without the need for isolation or lab cultivation of a specific species, could greatly improve the speed and quality of clinical and public health decision making.

[4] https://www.cdc.gov/hai/prevent/Oral-Health-Toolkit.html
[5] https://www.cdc.gov/hai/epicenters/index.html