Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"On the Front Line: How Governors are Battling the COVID-19 Pandemic"

June 2, 2020

The Honorable Jared Polis, Governor, State of Colorado

Questions from the Honorable Gus Bilirakis (R-FL)
Responses from The Honorable Jared Polis, Governor, State of Colorado

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1. **The Paycheck Protection Program and Healthcare Enhancement Act included $11 billion for states and local governments for purposes related to COVID-19 testing, including support for use by employers or in other settings.**
    a. **What role are employers playing in your state in your COVID-19 testing strategy as businesses begin to re-open in your state?**

    Employers and businesses are conducting regular symptom screening as part of our Safer at Home reopening phase. Health screening guidelines can be found here, and are included in every sector's guidance as well as the general guidance for all industries. By screening employees for symptoms, employers can reduce symptomatic exposure for others in the workplace and can direct symptomatic individuals to testing services.

    b. **What, if any, challenges have employers shared with you that limit their ability to increase COVID-19 testing as employees return to the office?**

    Employers are not necessarily responsible for testing their employees, although some are choosing to do so. Most have not encountered major challenges to conducting health screenings. The rare challenges that occur have tended to center around noncompliance with screening requests, and requests for supplies and materials used in the screenings. Colorado has a high proportion of professional service workers able to work from home. We are encouraging ongoing telecommuting where feasible for individual employers.

2. **Committee Republicans released a paper on COVID-19 testing and surveillance, highlighting among other things, the importance of surveillance in a pandemic.**
    a. What surveillance efforts are underway in your state for COVID-19?

    As of July 14, Colorado has 50 community-based test sites supported by the state's Department of Public Health and Environment. The state is providing 2,000 test kits per day to the Pepsi Center testing site in Denver and is working on a broad distribution of testing capacity to primary care physicians and hospitals. July 9 marked the highest testing day for Colorado with over 11,300 tests administered. There are currently 4 overflow testing contracts in place which, when combined, would allow the state to triple its testing capacity. As for contact tracing, of those cases with contact information 72% have been contacted within 24 hours, the mean time from

reporting of a case to interview is 1.6 days, and more than 200 ServiceCorp members have been onboarded to help with contact tracing.

b. Are these surveillance systems new, or are they pre-existing systems that are being leveraged for COVID-19?

Currently, the vast majority of our systems are pre-existing systems being leveraged for COVID-19. However additional systems have been created, such creation of a data portal that allow local public health partners to have access to all the data captured in the Colorado Electronic Disease Reporting System (CEDRS) and other CDPHE systems, such as Electronic Lab Reporting, or ELR.

i. If they are pre-existing systems, what other illnesses do they track?

CEDRS is the statewide system for all reportable conditions in Colorado (https://drive.google.com/file/d/16H86FrKGjoK3nDaYBpfqbR9YrcFNs9Gq/view). CEDRS exists both to capture diseases reported by healthcare and laboratory partners through ELR, faxes, and other mechanisms. More detailed reporting guidance can be found here https://www.colorado.gov/pacific/cdphe/report-a-disease. CEDRS, however, was never designed to be a contact tracing system. Therefore CDPHE is currently exploring options for a statewide contact tracing system that can be integrated with CEDRS and our REDCap Outbreak Database.

ELR exists to allow for a streamlined, expedient way for laboratories to report. Unfortunately, not all cases of disease are reported through ELR and we still rely on manual entry into CEDRS.

EMResource exists to capture information about hospital, ventilator and PPE capacity. That data is currently reported to HHS Protect.

c. How do these systems report up to HHS/CDC?

Data reporting systems to CDC and HHS, unfortunately, are not always streamlined. CEDRS reports data to CDC through a system called the National Notifiable Disease Surveillance System (NNDSS). We also report daily COVID-19 numbers through a survey link, which contains the numbers posted daily on CDC's website. Additionally, there is an electronic mechanism for ELR data to be sent to a national system at CDC called CELR.

d. How often does your state's system(s) report to the CDC? Real time, daily, weekly?

Both daily and weekly reporting continues, depending on the reporting mechanism listed above.

3. According to the CDC, the U.S. COVID-19 surveillance goals are to: (1) monitor the spread and intensity of COVID-19 disease in the U.S.; (2) understand disease severity and the spectrum of illness; (3) understand risk factors for severe disease and transmission; (4) monitor for changes in the virus that causes COVID-19; (5) estimate disease burden; and (6) produce data for forecasting COVID-19 spread and impact.

a. Do you feel that the surveillance systems in your state are sufficient to meet all of these goals?

Yes, the surveillance systems are sufficient to meet all of these goals. The way data is captured in both CEDRS and ELR allows us to view case trends and model predictions aggregated by county, age, race and other demographic information. Grouping data by these categories allows us to better understand how, when, where and why the disease is spreading throughout a community.

i. **If not, what improvements do you think need to be made?**

Not applicable

4. **One of the keys to Florida's success was its early deferment to local officials who were able to use local data to inform a community-tailored approach instead of a "one-size fits the state" solution.**
   a. **How important is local input and engagement in a responsible phased reopening?**

In Colorado, we have set up systems for counties and regions to apply for variances from the statewide orders to meet their specific needs and risks, as well as to apply for Protect Our Neighbor (later opening phase) status if their community meets baseline preparation and conditional criteria.

Additionally, we have partnered with local leaders for communication and input in several ongoing series of meetings, for example a weekly "Governor's Cooperation and Implementation Group" in which local leaders provide perspectives that help shape decision making in COVID reponse. We conduct weekly or biweekly meetings with stakeholder groups including local governments, hospitals, faith community, chambers of commerce, elected officials, business groups and many additional stakeholders. We highly value the knowledge and support of our local stakeholders and representatives.

   b. **How do current data models you're consulting account for policy nuances like a regional patchwork of stay-at-home orders in your state or input from hospitals and doctors?**

Colorado's COVID-19 data models rely heavily on current hospitalization data (reported by hospitals to the state), levels of social distancing, mask wearing, and contact tracing/case investigation capabilities. The current model does not reflect the variances the state has granted to various counties throughout Colorado (click here to learn more about Colorado's variance process). Nonetheless, the data modeling team, led by a group of experts from the Colorado School of Public Health, is working to include the impact of these county-by-county variances in the model.