

**TESTIMONY**

**OF**

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**BEFORE THE**

**COMMITTEE ON HEALTH, EDUCATION, LABOR & PENSIONS**

**U.S. SENATE**

**EXAMINING OUR COVID-19 RESPONSE: AN UPDATE FROM FEDERAL**

**OFFICIALS**

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**RELEASE ONLY UPON DELIVERY**

Chairwoman Murray, Ranking Burr, and distinguished members of the Committee. It is an honor to appear before you today to discuss the Centers for Disease Control and Prevention's (CDC) ongoing response to the COVID-19 pandemic. I am grateful for this opportunity to address this committee as well as for your partnership and leadership in responding to COVID-19.

It is my privilege to represent CDC. CDC is America's health protection agency. We work 24/7 to prevent illness, save lives, and protect America from threats to our health, safety, and security. CDC is proud of its key role in preparedness and response to public health concerns here in the U.S. and abroad. Addressing infectious diseases and pandemics, like COVID-19, is central to our mission. CDC's expertise lies in our ability to study emerging pathogens like SARS-CoV-2, to understand how they are transmitted, and to translate that knowledge into timely public health action. By deploying experts on the ground to support our state, Tribal, local, and territorial partners, we translate science into guidance that protects individuals, communities, and populations. In our work with other Federal agencies we ensure the safe and appropriate use of medical countermeasures, including vaccines, and collaborate with the academic sector to further our understanding of new diseases.

I've had the honor of being the Director of this agency for just under two months, and it is clear to me that all of this work is done by expert staff with great dedication to, and pride in, their work. They work tirelessly to respond to the COVID-19 pandemic, and I am committed to making sure that their efforts to conduct and analyze the data allow science to drive our path forward.

### **CDC Efforts to Date**

As you are aware, COVID-19 cases have decreased from their highest points in December and early January. As of March 12<sup>th</sup>, the weekly average number of cases has decreased by 11 percent over the previous week's average. The number of deaths has also fallen, with an 19 percent change over the same period.

We are hopeful. And, still, we must remain cautious. The average daily case rate is still more than twice the rate seen last September before cases started rising through the fall.

It goes without saying, we have been tested over the past year. It has been an extraordinarily difficult time for the United States. And I want to take a moment to recognize the more than 500,000 Americans, half a million mothers, fathers, sisters, brothers, wives, husbands, grandparents, and children, who have died because of the pandemic. Every loss is felt. By grieving families, by friends who are unable to say goodbye because of hospital mitigation strategies, by communities devastated by the disparate impact of this virus.

As hard as this has been, we can still persevere. If we can just stay the course a little longer and maintain evidence-based mitigation measures, while vaccinations continue to ramp up, we can prevent a lot of disease and save a lot of lives.

Right now, we are in a race to stop transmission. Variants of this virus that have slight genetic differences from the initial strain have emerged and available data suggest some are more transmissible. CDC is taking steps to expand sequence surveillance across the U.S. to improve our understanding about the impact of these variants on vaccine effectiveness, severity of disease, transmission, and mortality.

We must continue to use every tool we have to fight this virus: wearing masks, social distancing, handwashing, and administering vaccines.

The scale of this unprecedented public health emergency requires unprecedented action — at CDC, more than 8,500 CDC personnel have been part of our COVID-19 response, both at CDC headquarters and in the field. More than 1,500 staff have taken part in over 3,000 deployments to nearly 300 cities across the U.S. and around the world.

CDC is working to ensure that public health decisions are based on the highest-quality scientific information.

Since the start of the pandemic, over 200 COVID-19 studies have been published in the Morbidity and Mortality Weekly Report (MMWR) on topics ranging from health disparities exacerbated during the pandemic, to mitigation strategies to prevent spread, to emergence of new variants, and CDC has produced more than 5,000 documents to provide information and guidance for government agencies, businesses, and the public.

The new resources provided by **President Biden's American Rescue Plan** will further **scale up the public health efforts needed to contain the virus**, through six critical priorities:

- a strengthened national vaccination program,
- increased testing to protect at-risk populations,
- expansion of the public health workforce,
- protection for vulnerable populations,
- a commitment to U.S. leadership in the global response, and
- enhanced surveillance to identify emerging strains.

Now I want to take a moment to give you a more in-depth update on some key areas for the COVID-19 response.

## **Variants**

COVID-19 has brought to the forefront how interconnected we are as a global community and the importance of our international scientific relationships.

In the fall of 2020, several SARS-CoV-2 variants emerged, some of which appear to spread more easily than others. An increase in viral transmission could reverse the progress we've made and the downward trend in COVID-19 cases that we have seen since early January. We are at risk, once again, of overtaxing an overwhelmed health system. Furthermore, there is concern with how well the variants are neutralized by antibodies elicited through prior infection or vaccination. The emergence of variants is, of course, concerning, and it underscores the critical need for genomic surveillance and increased vigilance in the implementation of public health mitigation measures.

In anticipation of these ongoing threats, the Department of Health and Human Services (HHS) established the SARS-CoV-2 Interagency Group to improve coordination across the CDC, National Institutes of Health, Food and Drug Administration (FDA), Biomedical Advanced Research and Development Authority, United States Department of Agriculture, and Department of Defense. This interagency group is focused on the rapid characterization of the emerging variants of concern and is actively monitoring the potential impact on critical SARS-CoV-2 countermeasures including vaccines, therapeutics, and diagnostics.

Of the emerging variants, three have captured our attention and have the highest risk to the public health: B.1.1.7, B.1.351, and P.1.

The B.1.1.7 variant, originally identified in the United Kingdom, was first identified in the United States on December 29, 2020. As of March 15, 2021, CDC is reporting 4,500 cases in 50 jurisdictions that are attributed to the B.1.1.7 variant. As of March 10, data from CDC national surveillance showed that B.1.1.7 viruses represented 7 percent of the viruses circulating for the week ending February 27<sup>th</sup>, but the current trajectory suggests that the B.1.1.7 variant may now account for as much as 25 – 30 percent of US viruses. The prevalence of B.1.1.7 is expected to continue to increase as a proportion of all cases. Importantly, variant proportions are dynamic and are not the same in all parts of the country.

The B.1.351 variant, first identified in South Africa, and the P.1 variant, first identified in Brazil, have also been identified in the United States. CDC is reporting 81 B.1.351 cases in 20 jurisdictions and 15 P.1. cases in nine jurisdictions.

New data from a collaboration between CDC and Emory University suggest that antibodies generated against previous infection or vaccination with the Moderna vaccine are able to neutralize the B.1.1.7 variant but have reduced neutralization against the B.1.351 variant. It is unclear what impact this will have on the real-world effectiveness of current vaccines against the B.1.351 variant, and efforts are ongoing to better understand the impact of the variants on medical countermeasures. CDC has been acting on multiple fronts to increase surveillance in the United States to detect variants of SARS-CoV-2.

At CDC, we're contracting with several large commercial diagnostic laboratories to get viral sequence data from around the country. These laboratories are currently providing data on about 6,000 virus samples per week and will expand to capture 25,000 samples per week, with support from the funding the Administration announced last month and resources provided by the American Rescue Plan Act. In addition, public health laboratories around the country are sending CDC samples from 750 cases each week. These samples will allow us to both get the viral sequences and isolate the viruses so that we can do additional laboratory testing to better understand virulence, transmissibility and the potential impacts on diagnostic tests, therapeutics, and vaccines. Moreover, U.S. state and local public health laboratories are also sequencing 4,000 specimens per week and using the data to better understand the local epidemiology and to control

outbreaks. In addition, U.S. academic institutions and industry are also sequencing another 4,000 viruses per week. These efforts are coordinated through CDC's SPHERES collaboration, which is a new national genomics consortium to coordinate large-scale SARS-CoV-2 sequencing across the country. In all, the U.S. is currently sequencing about four percent of the roughly 400,000 weekly cases. These partnerships with commercial labs, state and local health departments, and academic and research institutions will continue to grow and the amount of sequencing will increase in coming weeks especially with the investment in sequencing included in the American Rescue Plan.

Each new variant can present different challenges. But each can be stopped by the same methods: rigorous and increased compliance with public health mitigation strategies such as vaccination, physical distancing, use of masks, hand hygiene, and isolation and quarantine.

### **Health Equity**

COVID-19 has highlighted long-standing systemic health and social inequities. Data repeatedly show the disproportionate impact of COVID-19 on racial and ethnic minority populations, as well as other population groups such as people living in rural or frontier areas, people experiencing homelessness, essential and frontline workers, people with disabilities, people with substance use disorders, people who are incarcerated, and non-U.S.-born persons. Inequities in social determinants of health, such as poverty, housing, and healthcare access, have influenced a wide range of health and quality-of-life outcomes for these groups experiencing disproportionate impacts.

These factors and others are associated with more COVID-19 cases, hospitalizations, and deaths. Not surprisingly, they intersect with higher rates of some medical conditions in these same populations that increase one's risk of severe illness from COVID-19.

Health equity must be a cornerstone of our public health work. We need the best possible data to identify the challenges and measure our progress as we implement solutions. While we have seen big improvements over the last year, we know that there are still critical gaps in these data. For example, race and ethnicity data continue to be missing from approximately half of the laboratory tests reported to CDC. Progress has been slow because there are many data requisition forms and data interfaces in the data exchange pathway that have to be updated. This pandemic

response has illustrated the long-standing need for improvements in the public health data network. Congress has been supportive of CDC and has responded to our partners' concerns about our antiquated data systems by providing resources to CDC for the data modernization initiative, the first comprehensive strategy to modernize data, technology, and workforce capabilities—together and at once. CDC is collaborating with our partners in the field to improve data collection and sharing.

CDC is committed to addressing these gaps, not only for the COVID-19 response, but for all public health data. And as we do this work, we will simultaneously take action on what we know – that these disparities exist and that they are unacceptable.

CDC's Chief Health Equity Officer has been leading our Health Equity Strategy to accelerate progress in reducing COVID-19 disparities. The strategy commits to expanding evidence-based approaches to reduce disparities in COVID-19 hospitalizations and deaths; increase testing, contact tracing, isolation options, and healthcare in populations at increased risk for COVID-19; prioritize equity in distribution and administration of COVID-19 vaccines; reduce stigma and bias; and expand a diverse workforce. We are engaging with community-based organizations and diverse leaders to conduct outreach that is culturally and linguistically responsive and make strides for populations at increased risk of getting sick and dying from COVID-19

To operationalize the Health Equity Strategy, CDC is supporting activities and interventions with organizations across multiple sectors, including community- and faith-based organizations that have been able to provide more insight about the challenges and needs of the populations of focus. They have also helped us to reach these populations with tailored prevention messages about COVID-19. With their guidance, CDC has developed toolkits and other resources to address the unique needs of, and to help, communities that have been disproportionately impacted by COVID-19.

For example, CDC is providing funding for the Southern Alliance to address COVID-19 among non-Hispanic Blacks and/or African Americans living in the southeast region of the United States. The goal of this project is to enlist established and trusted community members to encourage the adoption of COVID-19 preventive and community mitigation strategies. These include improving chronic disease management, COVID-19 testing, facilitating contact tracing,

promoting face covering and social distancing, and identifying mental health issues associated with COVID-19.

CDC is also funding the National Center for Farmworker Health to enhance coordination among a national network of agricultural worker-serving organizations and to strengthen their outreach capacity to address the ongoing COVID-19 threat to agricultural communities. With a focus on addressing COVID-19 educational needs among farmworkers, using materials in their native language, the National Center for Farmworker Health is encouraging vaccination, collaborating with other state and local organizations to facilitate farmworkers' access to the vaccines and other prevention resources, and finding and sharing replicable promising practices that support agricultural workers and employers during the pandemic and that may prevent COVID-19 outbreaks in rural communities.

CDC has also led and supported initiatives to reduce the spread of COVID-19 in Tribal communities. We know that clean water is essential to meeting basic health needs – and in the context of the pandemic, necessary to ensure handwashing and hygiene. CDC led a survey of all 110 Navajo Chapters to identify those with the lowest level of water access and the highest COVID-19 infection rates. CDC and the Indian Health Service partnered with the Navajo Tribal Utility Authority and the Navajo Engineering and Construction Authority to install new water access points for 59 Navajo Chapters with the greatest needs.

Another example of CDC efforts to support critical and underserved populations is CDC's funding of the University of Minnesota's National Resource Center for Refugees, Immigrants, and Migrants (NRC-RIM), which provides assistance and resources to state and local health departments working with refugee, immigrant, and migrant communities that have been disproportionately affected by COVID-19. Their work provides health departments with toolkits to improve communication, community engagement, case investigation, contact tracing, and testing in these populations. The resource center also provides a centralized location for resources related to COVID-19 vaccines, which are accessible in multiple languages and tailored to refugee, immigrant, and migrant communities.

CDC has directed its COVID-19 funding towards activities and programs that will help lay the foundation for long-term improvements in health equity. As we expand our testing and mitigation efforts through the American Rescue Plan, we also will be focused on prioritizing



increased access to testing in the communities hardest hit by the pandemic and expanding screening testing in at-risk populations. CDC remains focused on this goal and dedicated to working as a partner with others.

## **Vaccines**

Vaccination is a critical tool in bringing this unprecedented pandemic to an end. In the year since COVID-19 infections were first identified, the FDA has issued Emergency Use Authorizations (EUA) for three vaccines that meet the expectations for safety and effectiveness for emergency use that are being distributed and administered as we speak. We should all take a moment and acknowledge that this is a remarkable accomplishment. When someone asks me which of these vaccines is the best vaccine to take, my answer is simple: take whichever vaccine you are offered. Each vaccine – Johnson & Johnson/Janssen, Moderna, and Pfizer – is very effective at preventing serious illness, hospitalization, and death from COVID-19.

Building on long-standing relationships with state and local partners, CDC has worked tirelessly to ensure that we are getting vaccines into arms as quickly, safely, and equitably as possible. As of March 15, over 135 million doses have been delivered, and more than 109 million doses of COVID-19 vaccine have been administered in just 13 weeks. This is a whole-of-society effort, and it is inspiring to see people across government, business, and communities coming together to complete this important lifesaving task.

I would like to touch on four core areas that drive CDC's vaccine work: safety, confidence, access, and equity. Vaccines are rigorously studied during clinical trials and there is a vast network of safety systems that monitor vaccines once they are in use and safety protocols to monitor people when they receive the vaccine. It is important that we continually deliver the message that these vaccines are safe.

Strong confidence in vaccines within communities leads to more people getting vaccinated, and to fewer COVID-19 illnesses, hospitalizations, and deaths. CDC is working in coordination with national, state, tribal, and local governmental and non-governmental partners to build trust in the vaccine, the vaccinator, and the vaccination system. We will continue to work with these critical partners to address barriers to vaccinations, including in communities of color and disproportionately affected groups.

In January 2021, CDC awarded \$3 billion from the 2021 Coronavirus Response and Relief Supplemental Appropriations Act to state, local, and territorial health departments to ensure broad-based distribution, access, and vaccine coverage nationwide. CDC requires that at least 10 percent of these funds be directed to vaccinating high-risk and underserved populations.

In order to enhance vaccine uptake among underserved communities of color and to build trust and confidence in the vaccine itself, CDC has developed a comprehensive program of approximately 20 national organizations that support hundreds of local and community-based organizations to improve both COVID-19 and influenza vaccination coverage among racial and ethnic groups who have historically had, and continue to experience, health disparities.

Also critical to prioritizing equity in vaccine distribution is improving access to underserved communities and disproportionately affected populations who have historically had less access to healthcare. To that end, CDC is working closely with the Federal Emergency Management Agency (FEMA) and other federal partners to get vaccines to communities that may have limited healthcare access. This includes coordination with FEMA around their Community Vaccination Centers and partnering with the Health Resources and Services Administration (HRSA) to launch a program to directly allocate COVID-19 vaccines in select HRSA-funded health centers. Both approaches will help ensure that our nation's underserved communities and disproportionately affected populations are equitably vaccinated.

The Federal Retail Pharmacy Program (RPP) is another important component in the work CDC is doing to provide greater access to COVID-19 vaccines to communities of color and other underserved populations. CDC is partnering with 21 national pharmacy organizations and independent pharmacy networks that represent over 40,000 locations nationwide to ensure that the public has access to COVID-19 vaccines in a familiar setting. Almost 90 percent of Americans live within 5 miles of a retail pharmacy. Earlier this month, the RPP began to prioritize vaccinating teachers, school staff and childcare workers. Pharmacies have also been critical to vaccinating residents and staff in long-term care settings. Currently, there are over 14,000 pharmacy locations participating in the program nationwide – an increase of over 10,000 since the program began, including 4,000 new locations in just the past week – that have

received nearly 14 million doses of vaccine, increasing access to COVID-19 vaccination across the country while decreasing the burden on state, local, and territorial health departments.

Health equity remains a cornerstone of CDC's vaccination efforts, and we need the best possible data to both identify the challenges and measure our progress as we implement solutions. At the end of February, CDC hosted a virtual National Forum on COVID-19 Vaccine. The Forum focused on vaccine confidence, data to drive vaccine implementation, and equity in vaccine distribution. We gathered over 13,000 people from 6,700 organizations, from every state, Washington DC, nearly all territories and 197 Tribes or tribal organizations – excited to learn, teach, and bring back to their communities a renewed enthusiasm for the massive task ahead and the urgent need to administer COVID-19 vaccines as efficiently and equitably as we can. They each provided critical feedback, which we are actively incorporating into our plans.

Looking to the future, we are optimistic that, in collaboration with our state, Tribal, local, and territorial partners, we have built a vaccine implementation infrastructure that will expand vaccination coverage to allow our communities to resume some aspects of a normal life. Active investigations will continue to determine how much vaccines reduce asymptomatic infection and transmission, how long vaccine protection lasts, and to what extent vaccines protect against emerging SARS-CoV-2 variants. Last week, CDC released new guidelines for fully vaccinated people, and we look forward to revising this guidance as the science develops and as more of the population is protected through vaccination.

## **Schools**

Since becoming the director of the CDC, I have stressed the importance of getting children back to school for in-person learning. The safest way to open schools is to ensure that there is as little disease as possible in the community. The lower the amount of disease in the community, the less likely it is that cases will be introduced into the school environment. This means that all community members, students, families, teachers, and school staff should take actions to protect themselves and the community where they live, work, learn, play and worship.

CDC recommends that, among community institutions, schools should be the first to open and the last to close. Because of the benefits of in-person learning and the key support

services schools offer, it is critical for K-12 schools to open, and stay open, as safely and as soon as possible. This is especially true in low-resourced communities, which may include large representations of racial and ethnic minority groups and students with disabilities. CDC began working on guidance, resources, and tools for safe school reopening in March 2020 when the first schools closed. As CDC learned more about COVID-19, we continually updated our guidance, resources, and tools for schools, parents, teachers, and other staff.

In February of this year, CDC released new science-based resources and tools to help schools safely reopen and stay open for in-person learning. Specifically, CDC conducted an in-depth review of the science and released the *Science Brief: Transmission of SARS-CoV-2 in K-12 Schools*<sup>1</sup>, which informed CDC's *Operational Strategy for K-12 Schools through Phased Mitigation*<sup>2</sup>. In developing the K-12 Operational Strategy, CDC gathered input from school superintendents, school officers and nurses, national associations with a focus on education, organizations that represent elected officials, and others. These new resources complement CDC's existing guidance and tools for K-12 schools, including a toolkit to assess risks and implement prevention strategies to reduce the spread of SARS-CoV-2 in schools, a quick guide to assist teachers in modifying the layout of their classroom in a way that reduces the risk of virus spread, and updated materials about ventilation strategies in school and child-care settings. CDC will continue to collaborate closely with our colleagues at the U.S. Department of Education to make sure that all schools have access to the latest understanding and guidance.

Evidence indicates that many K-12 schools that have implemented prevention strategies to reduce the spread of SARS-CoV-2 consistently and correctly have been able to safely open for in-person instruction and remain open. The K-12 Operational Strategy outlines options for *all* schools – at any level of community transmission – to provide either full or hybrid in-person instruction through strict adherence to prevention strategies. Regardless of the level of SARS-CoV-2 spread in the community, CDC recommends using a combination of five key strategies to reduce the spread of SARS-CoV-2 in schools and help protect teachers, students, and staff. These strategies are universal and include the correct use of masks, physical distancing, handwashing and respiratory etiquette, cleaning and maintaining healthy facilities, proper

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<sup>1</sup> [https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/transmission\\_k\\_12\\_schools.html](https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/transmission_k_12_schools.html)

<sup>2</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/operation-strategy.html>

ventilation, and contact tracing, in combination with isolation and quarantine, in collaboration with the health department. We also point to the added layers of prevention to be gained from regular testing and vaccination.

Universal and correct use of masks and physical distancing are two prevention strategies that are most essential to reducing SARS-CoV-2 transmission, but a layered approach that uses all five of these strategies will provide the greatest level of protection.

Teachers and school staff hold jobs critical to the continued functioning of our communities and our society, and are at potential occupational risk of exposure to SARS-CoV-2. We must treat in-person learning like the essential service that it is and get teachers, childcare workers, and other school staff vaccinated as soon as possible. Vaccination for teachers, staff, and among surrounding communities is one of the several layers of prevention strategies to reduce SARS-CoV-2 transmission in schools outlined in our K-12 Operational Strategy. CDC is committed to working with our federal, state, and local partners to achieve President Biden's goal, in accordance with the [HHS Secretarial directive](#) related to making educators eligible along with other priority groups, to provide a first dose of the vaccine to every educator, school staff member, and childcare worker by the end of March.

SARS-CoV-2 is still a relatively new pathogen, and we are learning more about it and how it impacts different people and communities all the time. CDC's K-12 Operational Strategy presents recommendations based on the best-available evidence at the time of release. As science and data on SARS-CoV-2 and COVID-19 continue to evolve, we will update our guidance and recommendations to reflect new evidence. CDC stands committed to providing the best, most current data and scientific understanding available to protect the health, safety, and well-being of our communities, including our students, teachers, and school staff.

### **Looking to the future**

I want to highlight that I'm cognizant that over the last 12 years, the United States has faced four significant emerging infectious disease threats – the H1N1 influenza pandemic, Ebola, Zika, and COVID-19. While urgency demanded rapid and unique responses to each of these threats, none resulted in the sustained improvements and investments needed in our nation's public health infrastructure.

This lack of preparation continues to present significant challenges in our ongoing fight to tackle COVID-19. These experiences have proven that public health emergencies and, specifically, infectious disease threats are here to stay.

Looking to the future, I want to work within the Administration and with you to address long-standing vulnerabilities in our core public health infrastructure, including data, workforce, laboratory, domestic preparedness, and global health security.

To avoid the substantial economic costs associated with both large-scale emergencies and chronic public health concerns, we must be willing to make investments in our public health system. We also must offer up our technical expertise to support efforts to advance global health security.

## **Conclusion**

In closing, I want to emphasize that, while we must remain vigilant and continue to use every tool we have to fight this virus, there are reasons to be hopeful. I am optimistic that we are moving in the right direction. I am looking forward to seeing more kids in school, more families able to connect with one another safely, and our nation beginning to move forward and heal. We are committed to continuing to advance the science around COVID-19; moving more vaccines into more communities – especially those communities most at-risk for COVID-19 infection – and working to improve health equity.

The next few months will be critical, and we need everyone to continue to wear masks properly, practice social distancing and handwashing, and get vaccinated. I recognize that everyone is fatigued after a very long year. It is as critical as ever to continue these lifesaving efforts.

I look forward to working together to address both the immediate challenges ahead in our fight against COVID-19, along with the weaknesses in our public health infrastructure that left our country vulnerable to this pandemic. CDC is grateful for your support.

We will continue to work tirelessly to ensure the health of this Nation and the world. Together, we will get through this pandemic and work to continue building a sustainable and resilient public health system that can respond effectively to emerging threats and to the ongoing

public health needs of every American. Thank you again for the invitation to testify today and I look forward to answering your questions.