COMMITTEE ON OVERSIGHT AND REFORM

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: DANIEL JERNIGAN, M.D.

MONDAY, DECEMBER 13, 2021

The Interview Commenced at 9:00 a.m.

Appearances.

For the SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

[Redacted]

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[Redacted]

[Redacted]

For the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

KEVIN BARSTOW, Senior Counsel

JENNIFER SCHMALZ

JoANN MARTINEZ, HHS

ERIC WORTMAN, CDC

Exhibits

Exhibits (cont.)

P R O C E E D I N G S

[Majority Counsel]. This is a transcribed interview of Dr. Daniel Jernigan conducted by the House Select Subcommittee on the Coronavirus Crisis. This interview was requested by Chairman James Clyburn as part of the Committee's oversight of the federal government's response to the coronavirus pandemic.

BY [MAJORITY COUNSEL].

Q Dr. Jernigan, good morning. I'd like to ask you to state your full name and spell your last name for the record.

A My name is Daniel D. Jernigan. Last name J-E-R-N-I-G-A-N.

Q Dr. Jernigan, my name is [Redacted], I'm Majority counsel for the Select Subcommittee. I want to thank you for appearing virtually today. We recognize that you're here voluntarily. We greatly appreciate you taking time away from your important duties at the CDC.

If we can just go through the ground rules now. So first is the presence of counsel. Under the Committee's rules, you are allowed to have an attorney present to advise you during this interview.

Do you have an attorney present in your personal capacity today?

A No.

[Majority Counsel]. Is there agency counsel present?

Mr. Barstow. Yes.

[Majority Counsel]. And agency counsel, can you please introduce yourself for the record.

Mr. Barstow. Kevin Barstow, senior counsel at HHS.

[Majority Counsel]. And any additional agency staff here virtually? Can you please introduce yourselves for the record.

Mr. Wortman. Eric Wortman, CDC.

Ms. Martinez. JoAnn Martinez, HHS.

Ms. Schmalz. Jenn Schmalz, HHS.

[Majority Counsel]. And then any of my colleagues on the Majority staff?

[Majority Counsel]. I'm [Redacted] for the Majority.

[Majority Counsel]. [Redacted] for the Majority.

[Majority Counsel]. And Minority staff as well.

[Minority Counsel]. Hey, Dr. Jernigan. [Redacted] with Minority.

[Minority Counsel]. Hi Dr. Jernigan. This is [Redacted]. Thank you for joining us today.

BY [MAJORITY COUNSEL].

Q Before we begin, I'd like to go over the ground rules.

As previously agreed to by the Majority staff and HHS staff, the scope of this interview is the government's

response to the coronavirus pandemic from December 1, 2019 through January 20, 2021.

The way this interview will proceed is as follows: The Majority and Minority staffs will alternate asking questions, one hour per side per round, until each side is finished with their questioning. The Majority staff will begin and proceed for an hour and the Minority staff will then have an hour to ask questions. We'll alternate back and forth in this manner until both sides have no more questions.

We have agreed that if we are in the middle of a line of questioning, we may end a few minutes before or go a few minutes past an hour to wrap up a particular topic. In this interview, while one member of staff may lead the questioning, additional staff may ask questions from time to time.

There is a court reporter taking down everything I say and everything you say to make a written record of the interview. For the record to be clear, please wait until I finish each question before you begin your answer and I will wait until you finish your response before asking the next question. The court reporter cannot record nonverbal answers, such as shaking your head, so it's important that you answer each question with an audible verbal answer.

Do you understand?

A Yes.

Q We want you to answer the questions in the most complete and truthful manner possible, so we are going to take our time. If you have any questions or do not understand any of the questions, please let us know. We will be happy to clarify or rephrase our questions. Do you understand?

A Yes.

Q If I ask about conversations or events in the past and you are unable to recall the exact words or details, you should testify to the substance of those conversations or events to the best of your recollection. If you recall only part of a conversation or event, you should give us your best recollection of those events or parts of conversations that you recall.

Do you understand?

A Yes.

Q If you need a break at any time, please let us know. We are happy to accommodate you. Ordinarily we take a five-minute break at the end of each hour of questioning, but if you need a break before that, just let us know. To the extent there is a pending question, I would just ask that you just finish the question before taking a break.

Do you understand that?

A Yes.

Q Although you are here voluntarily, and we will not swear you in, you are required by law to answer questions from Congress truthfully. This also applies to questions posed by congressional staff in an interview.

Do you understand?

A Yes.

Q If at any time you knowingly make false statements, you could be subject to criminal prosecution.

Do you understand?

A Yes.

Q Is there any reason you are unable to provide truthful answers in today's interview?

A No.

Q The Select Subcommittee follows the rules of the Committee on Oversight and Reform. Please note, if you wish to assert a privilege over any statement today, that assertion must comply with the rules of the Committee on Oversight and Reform. Committee Rule 16(c)(1) states for the chair to consider assertions of privilege over testimony or statements, witnesses or entities must clearly state the specific privilege being asserted and the reason for the assertion on or before the scheduled date of testimony or appearance.

Do you understand?

A Yes.

Q Do you have any questions before we get started?

A No.

Q I think a good place for us to start is to learn a little bit about you and your career at CDC. Currently you serve as the deputy director for public health science and surveillance; is that right?

A Yes.

Q And how many years total have you been with the CDC?

A I started in 1994. So 27, 28 years.

Q Can you briefly walk us through your career path at CDC?

A So after completing an internal medicine residency, I moved to the office program. There I studied respiratory disease.

[Transmission interference.]

The Witness. So after the internal medicine residency, I came to CDC in the academic intelligence service in 1994, worked in the respiratory diseases branch. From there, completed that two-year fellowship training, physically moved to Washington State still working with CDC, but assigned to the Washington State Department of Health in the epidemiology section where I completed a preventive medicine residency.

Continued there as a staff epidemiologist for two years, 1999 returned to Atlanta working in the office of the emerging infections. From there, moved to being a section chief in the division of health care quality promotion investigating hospital infections.

Then after that, became the deputy director for the influenza division in 2007, and then became the director of the influenza division in 2014-2015. Subsequently, I took a detail as this deputy director for public health science and surveillance in 2021 in February, and then took the job permanently around August or September of this year.

Q In January 2020, the beginning of our area of discussion, what was your role then?

A At that time, I was director of the influenza division. It sits in the National Center for Immunization and Respiratory Diseases at CDC.

Q Who did you report to at that time?

A I reported to Dr. Nancy Messonnier, the director of the National Center for Respiratory Disease.

Q And in your role, who did you most interact with most frequently aside from Dr. Messonnier?

A The activities within the division are varied considerably. There are international activities, domestic activities. On a day-to-day basis I interacted with Dr. Messonnier, others in the leadership team at NCIRD; and

depending on the lead, you'd interact with the deputy directors and their principal deputy director and the director of the agency as well as working with HHS operating divisions for BARDA NIH, NIAID, FDA, DoD, USDA, and also -- state health departments.

Q Did you interact regularly with Director Redfield in that position?

A Off and on, depending on the issue for the appearance of novel influenza viruses. Swan or avian influenza viruses we certainly would provide updates to him as a part of routine messaging on immunology. Influenza, seasonal influenza, seasonal influenza vaccine campaign kickoffs, those kinds of activities, and then any needed inputs for influenza-related questions.

Q When did you first learn of a potentially new virus circulating in Wuhan?

A When you're referring to the SARS-Co-V-2, we were notified on December 31st from influenza division staff that were permanently deployed to Beijing. At that time, the staff had received information from colleagues that were at the Wuhan consulate regarding concerns about a seafood market and potential for respiratory disease transmission in that setting. That information got from the embassy's consulate there to others at the embassy, and then to our own staff which were embedded at the embassy.

Our influenza staff there connected with the deployed staff supervisors who were individuals that are stateside with our -- assigned to each of the regions where we had influenza division staff. That individual summarized the information that she had learned and provided that to me to comment on.

There was a concomitant read that occurred as well where the principal deputy director had become aware of similar concerns about increased numbers of cases of respiratory disease, sent an email to Dr. Messonnier, who then emailed me at almost approximately the same time, around 9:30 on whenever the 31st was. Whatever day.

Q Can you talk a little bit about the staff that you had? You mentioned the influenza focused staff in China. What other staff was present in country at that time?

A So I can't speak to the breadth of the USG individuals or those that were connected in with our activities there. We had an FTE US citizen that was based at the embassy just for influenza. There were also staff supporting other mostly infectious disease activities working with our influenza person, and then there was a management official supported by CDC working in that same space.

Also, with that group were staff that were Chinese

citizens who were with the CDC on influenza. The group there was placed many years back and we've had a series of individuals that have served in that capacity, notably early to help develop capabilities within China to include virus detection and report it.

So the connection would be towards the U.S. CDC based at the embassy and the China CDC which eventually moved far outside of Beijing. That connection was maintained to understand influenza virus evolution and to help include flu strains selections for use in the United States.

Q How many total CDC staff are we talking about were working out of the embassy?

A For FTE U.S. citizens, three. And then non-U.S. locally hired, three. But those are just the ones that I interfaced with or our division would interface with. I can't speak to others. I don't know if FDA, HIV, or others had staff there at that time.

Q It's been reported that due to budgetary constraints, that the number of CDC personnel in China was cut back in recent years. Is that accurate?

A The numbers of staff were decreasing; the reasons for I can't speak to. But the remaining staff, influenza was one of the few remaining staff.

Q And so that's three influenza staff there in the embassy?

A As I can recall at this point, yeah.

Q Okay. And so you were communicating with those folks directly around New Year's Day?

A 12/31. It's a 12-hour or so difference in time. The initiation of communications started before we were awake and they continued after staff in the U.S. or Eastern Standard Time were at work. So the first communications were in the middle of the night. And then the engagement with the back and forth started to occur in the morning on December 31st. Those were largely between the person that was assigned to supervise our deployed staff at CDC, between her and them and between her and the office.

Q And who was that who was supervising the deployed staff?

A Hold on a second. Okay. So Carolyn Green was the individual who was the supervisor. Carolyn Green served as our staff Beijing for four years prior to returning and somebody to replace her. So she was fluent in Mandarin and understood the context and the technical epidemiologic issues very well.

Q Can you tell us -- I know it's been a few years. Can you tell us in broad strokes what you were told from those influenza folks about the potentially novel virus at that time?

A So the initial communications, given that many of the staff that are either in Beijing or employed by the division have had experience with respiratory diseases in southeast Asia and Asia. So there are often identification of outbreaks of respiratory disease that eventually are identified through something as a known pathogen.

So the information is very important early on to find out if they had tested in a valid way whether or not there were other respiratory problems like influenza RSV, et cetera. So a lot of that early conversation was about how much they had already tested, how confident were they that they did not have a diagnosis.

So the discussions with China CDC from the available information to the Wuhan group were attempting to try and understand that better. Is this something we really don't know what it is, or is it something that just had not been fully tested yet.

Q And from that initial report, what was known in terms of ruling out other known pathogens?

A Within a matter of hours we did learn that the China CDC was sending a group of their own, mostly influenza staff, to evaluate the epidemiology, to understand who was getting sick, where they were getting sick, et cetera, to collect new specimens and also to verify that the full breadth of testing of various

pathogens was underway.

I can't recall exactly, but within a day or so we understood that the usual pathogens that might be a cause, influenza RSV, parainfluenza et cetera, that those tests were performed using valid testing capabilities. So that helps to understand the potential that this puts it into a category of unrecognized or unexplained that then prompts a series of different discussions about how best to evaluate that, is something that happens whenever these kinds of clusters emerge.

Q What were you doing sort of in response to this report from China?

A So very early on we were able to do a number of things. First was to make sure that our leadership was aware. And so our high leadership was actually -- that is, the principal deputy director was already engaged on the 31st asking questions and then she and Dr. Messonnier, who was involved in discussions, were informing Dr. Redfield about the potential for this cluster.

It's routine that when something like that emerges, we try to characterize as much as we know and take that information up through leadership chains so that the leadership has a sense about what's going on and they're not surprised by the virus.

Q Did you brief the director at that time?

A Not on the 31st. I believe Dr. Messonnier was providing those to Dr. Redfield.

Q When did you first interact with the director about this?

A Probably the next day. I'm trying to think. I believe there were emails that we would be providing with updates that got forwarded -- I believe got forwarded to him. I can't recall when the first personal -- in-person communication was. But there were a number of activities happening very early on where we, I believe on the 31st, actually gathered a group at CDC called the unexplained respiratory disease outbreak group or U-R-D-O or URDO.

That group has been in place for many years and is made up of various subject matter experts at CDC, feds, including some from outside of the CDC, but still feds, that listened to the findings at that time and then walked through a differential diagnosis trying to figure out what are the possible qualities of the cluster.

So that group also looks at what is the highest potential here, what's the likelihood that SARS was in our midst. It was China, it was a known potential given past issues with SARS in China. The other would have been novel influenza, which we had been looking for by setting up other different systems in place. And they followed the H7N9 enormous outbreak that they had in 2013. They

established a group called the Unknown Etiology Group. So it was that group that was identifying cases and doing the rule-out of other diagnostic tests in order to better understand what the causes were.

So SARS was a possible cause; and, therefore, to identify what might be causing it, you can then ask do we have diagnostics that we can use for it? Are there vaccines for it? Are there therapies for it?

And so that running through of potential countermeasures as an exercise, really, while you're trying to figure out what the main problems are is an activity that we do to help decide what are the first things that we should be doing in order to help prepare for this given that it might be any one of a number of different pathogens.

Q Who are the other agencies represented in that URDO group?

A I'm going to say for that one it was all just CDC. In the past, there are some members of the Department of Defense that would join, depending on the need. There are also the USDA if there's a strong concern about zoonotic transmission. Those are really the main ones. For that call, I do not recall there being but CDC on that group.

Q In those early days, when was the first

engagement with agencies outside of CDC?

A I'm trying to think. Right now, I know that on the 31st, we did reach out to some DoD colleagues. We reached out to our -- I would have to check the dates, but very early on, once something like this emerges, we connected with members of a group called the flu risk management meeting, FRMM, which is an interagency group with CDC, FDA, NIH, mostly NAID, BARDA, DoD, USDA, VA, CMS. And maybe HRSA. But in general, the main players are NIH, FDA, CDC, BARDA, DoD.

That group interfaces with each other on a monthly basis to review current influenza risks. So that group is in many ways prepared to be the right people to also talk to these other emerging issues. And so members of that group were contacted over those first few days. I don't have the exact connections with them.

But between Department of State through our colleagues in Beijing and our colleagues that were supervising them as well as through some reach-outs to DoD and then the communication up through HHS, those were the predominant parties we were engaging with. That's USG. We were also engaging with the global programs at WHO, who then bilaterally with some countries as well.

Q When was the first engagement with the National Security Council?

A I do not recall. That's probably known, but I do not recall. The communication up generally included National Security Council. So as information was brought up to the director of CDC, the sharing of that information with NSC usually occurred. So I would have to go back and check exactly when they were first engaged.

Q But it would have been around this time, early first week of January?

A Yeah.

Q Okay. And we understand that the incident management structure was stood up on January 7th; is that correct?

A So the CDC follows a process called graduated response framework, GRF. And that GRF indicates that outbreaks rise in the engagement and participation across the agency based on different needs. Initially, an outbreak would start in a division and then can elevate to the center level, which here would be the NCIRD and then from there to the CDC-wide emergency operation centers. So the NCIRD, emergency operation center, was stood up on the 7th of January.

Q Okay. Maybe it would be helpful for us to hear sort of in broad strokes how that graduated movement from the center to the incident response system works.

A So it can apply to any infectious or

noninfectious problem. For infectious diseases, probably most recognizable might be food borne. A particular outbreak has been identified by a state health department. They contact CDC. CDC works with them on the verification of what their findings, in terms of the pathogen, assist with some of the characterizations of some of the pathogen itself and then works with them on the investigations that they are doing.

Usually we don't get pulled in until they become way more complex. But as that foodborne outbreak rises to incorporate, for instance, more than one state, the need for greater communication and coordination between CDC, FDA, any state health departments warrants a rising of that effort either to be pulling in additional staff from that division or to actually rise up to the level of the center framework.

So the needs that might prompt that would be considerable need to communicate up both from a communication to leadership to communicate down to those that are being infected at the state health departments and to the public, but also to work with congressional leaders as well to make sure that they are kept abreast of the issues as they're known. But then also, if there are needs for resources with the center or agency can provide the movement up to -- eventually to the CDC EOC is warranted by

that increasing amount of need for communication engagement, resource management, potentially needed additional finances and higher level decision-making with great society impact.

Q Let's talk specifically on how the response to the initial reports went through that. So I guess the center that was -- first went to the center and that would have been the NCIRD?

A Yes.

Q Okay. And that happened around January 7th?

A Yes.

Q And then how did it gradually move from there?

A The communication of there not being other causes of the cluster, and then it was indicated by China to be a new coronavirus, that prompted that initial startup at the center level given what experience had been in place for SARS 1 and for MERS as well as for influenza pandemic and influenza responses to novel flu.

So for that reason, the recognition was there that additional support was needed, that began the organization of having task forces or clusters of folks that are in working groups centered around different topical needs. So communications, laboratory, epidemiology, considerations of pharmaceutical interventions and policy.

Those groups were the natural placements of

individuals based on how we had been responding to influenza emergencies in the past, leading to other infectious disease, respiratory emergencies in the past as well as conforming to a CDC -- CDC's accepted approach to how we implement the incident management system.

Q Talk a little bit about this in practical terms. Those task forces get stood up and they draw experts from different centers, or is it all --

A At the center level response, you're usually pulled from staff within that center in part because the expertise generally sits there. But you can pull in individuals from other centers as well. There is some support that that response can get from the division of emergency operations at CDC in terms of logistical support, travel, and things like that. So as we rise to that center level, you can access assets from outside of the center as well.

Q And then moving from the center level to the incident management structure, when did that happen?

A So around the 20th or 21st of January, was the point at which we had identified that first U.S. case. So the U.S. case, I think, really prompted the movement into that larger and more capable environment where the incident manager then does not report to the NCIRD director, but instead reports to the agency director. And the IM

structure pulls heavily across the agency in order to have the right expertise and to make things move more quickly.

Q And at that time you were named the first incident manager; is that right?

A When the CDC EOC was established for this response, yes, I was the first incident manager.

Q So in terms of staff, what are we talking about, numbers, in the incident management system when you started it?

A I don't have the exact numbers and they vary over time. But the general structure is one in which there's incident manager, there's a principal deputy incident manager and then there are either two to four deputy incident managers that have portfolios over other different topics. Below that are task forces like I mentioned before for communications, community mitigation, laboratory, epidemiology, data analysis and visualization, global migration and quarantine, and several others that I cannot recall right now. But I'm sure you've probably seen the structures.

That incident management structure then -- I'm trying to think just from my own experience in the past. We've had up to 50 people just on one of those task forces at the peak of activity in the past. So the actual numbers, I don't have somebody to provide those to you, but this is a

structure that is designed to be outside of the bureaucratic structures that the agency maintains so that the lines of supervision now are set within the incident management structure and are not impinged on by the individuals stated or duty station or described supervisory chain.

The budget itself is separated from the budget of places where those people are coming from, so it makes for much more rapid movement of resources, change in structure, change in decision making, et cetera. So it's something that the CDC has arrived at after years of our DoD colleagues and others helping to stand it up.

Q Were you involved physically moving the staff to the EOC as well?

A Usually, yeah. I think -- yes. There is an actual emergency operation center which sits in [Redacted]. And in general, for almost all responses, the leadership of the responses moved to that location so they're within close proximity and have rapid meetings and rapid decision-making.

The conference rooms across the agency are transformed into the working rooms for the various different task forces. And just depending on the size of the response, the agency will support those needs with the space that's needed.

Q And when you started as incident manager on January 20th, can you tell us about your immediate priorities?

A I can't give you the exact list, but we had a regular routine of having the priorities stated at the beginning of each of our meetings so we can revisit them. But they were about understanding the potential transmission and severity of the infections that were occurring, and to protect Americans through means for mitigating the impact of the virus, which varied based on where you are in that response and in communicating with others.

So I don't have the list of the priorities that we started with, but they are around generally characterizing and intervening as appropriate based on the science and information that we had at the time.

(Exhibit No. 1 was identified for the record.)

BY [MAJORITY COUNSEL].

Q We'll get into some of the specifics. I think it might be helpful to look at Exhibit Number 1, which is what you coauthored about the initial public health response in January. And this was released on February 5th; is that correct?

A Yeah, it's dated February 4th. Yes. Actually, it looks like the 7th, so it may be embargoed.

Q And for the record, the title of this report is "Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak - United States, December 31, 2019 to February 4th, 2020."

A Yes, this indicates the primary focus of being to slow it down, to prepare folks and prepare us for it and to understand the virus better.

Q So I guess this report summarizes those early steps. Can you tell us what goes into publishing a report like this and the rationale for putting this all out there in this way?

A So the MMWR does a number of different things. One is to communicate quickly what is known about a particular problem and to describe what the interventions, what the public needs to take are, what does it mean.

In addition, they do also serve as a record of what's happened so that anyone needing to come over at different times to be a part of that response either in a public health setting or elsewhere, and use these documents to see as record of what happened and the activities that had been put in place at the time.

So we had put out various different communications, I think, but this one was intended to be summarizing of what had happened so far and the broader direction that we were heading with the response.

Q Okay. And looking at page 2 of the report, the second column underneath the blue box there, beginning the discussion of the quarantine stations. And one of the early steps were these airport screenings that began on January 17th; is that right?

A Yes, I think that the enhanced screening started around that time, yes.

Q And can you tell us what led to the decision to begin the enhanced screenings?

A The location of the source of the virus was fairly well understood to be in Wuhan and Hubei and coming from China. And so screening is one component of a set of other components that can be used in order to help with the identification of cases. But also the process itself does tend to keep some travelers from deciding to even come.

So these, again, I think were intended to provide time so that we could be more prepared, although it also provided more time for us to have in order to characterize the virus and understand how well it was being transmitted.

Q Can you tell us a little bit about that process that went into this decision to begin the enhanced screening?

A The details, a lot of that I really don't recall much of it at this point. There are experts at CDC that had been dealing in this space of travel-associated

regulations and policies and travel-associated interventions that were taking the primary role in engaging with the various different components of the federal government that are responsible for border and customs activities.

Q Do you recall your role in this process?

A As incident manager, I was interfacing with the director of that group who was representing us on a number of different calls. And those decisions were brought through the incident management structure and we provided it to the director as recommendations for going through with these different kinds of interventions.

Q Who was the director of that group?

A Marty Cetron.

Q And obviously as you said, this took coordination amongst different agencies in the federal government. Was the White House involved in this decision January 17th enhanced screenings?

A The January 17th one, I actually can't recall all the details of that, but there were throughout this period National Security Council groups that were informed, meetings were occurring. I do recall going to the meetings. I don't recall what the dates are or necessarily the folks that were on them.

Those discussions around border issues were engaged

with the National Security Council, which is often the case with something that is important as working -- changing how things happen at the border. That does require engagements from across the agency.

Q I know it's difficult now to remember specific calls, but do you remember who you were engaging with from the National Security Council?

A I actually do not recall right now.

Q So the first paragraph on the next page, page 3, it says, "As of February 1st, there were a total of 3,099 persons on 437 flights screened, five symptomatic travelers were referred by CDC to local health care providers for further medical evaluation and one of these persons tested positive for COVID" -- "for 2019 nCoV."

So talk to us a little bit about these figures and why so few cases were being detected from the screenings.

A So the interpretation that so few were being detected, I think it's really there were so few cases that were coming through this process I think is what you're asking. The imposition of screening can in fact lead individuals that may not want to get tested and be identified, they may not travel. So you are already beginning your collection of those to be tested that would not -- they wouldn't be there because they had elected not to travel. So that's one thing that the screening.

The other is it is true that most people traveling are not positive and, therefore, it isn't actually picking up as an actual prevalence of those numbers. The other is that there may have been individuals that didn't truthfully respond to the questions and, therefore, were not able to be tested because they did not meet the criteria or they did not truthfully answer the questions. So there are reasons why you could have decreased numbers.

But in general, this as a means for detecting cases was one part of an overall set of activities that are needed in able to help identify more cases. The expectation was most transmission globally was happening in one place and, therefore, imposing these kinds of efforts for that group made the most sense at targeting how you were trying to identify cases.

Q Given what CDC learned later about importations from Europe, do you think screening passengers from Europe would have detected more early cases?

A Whether or not the numbers and prevalence would be different from this amount I don't know. The numbers of persons traveling from those airports by various means by which they can get to the U.S. makes for a more complicated effort. But the identification of Europe as a potential source of infection, similar to what we understood about Wuhan, is a reasonable decision to add

them to screening as well.

Q I guess we'll get into this a little later; but were there discussions about doing similar screenings for travelers from Europe around that time?

A A lot of the experience in the past with travel screening and border issues came from working with influenza in the past where lots of people would be given -- that most people would not be having significant problems. And so the general approach was to not implement border efforts like these for flu.

Some of those were implemented during 2009, so there were some data that demonstrated the use of border efforts could have an impact at slowing introduction. So the decisions about the significant impact on business and other travel has to be weighed against the potential to decrease the chance of those persons coming and transmitting in the United States. So at that time, this effort was the appropriate one for the amount of transmissions we were seeing in that area of the world.

Q Did that change over the next month or so as the outbreak was occurring in Europe?

A Say that one more time.

Q Did that change over the next month as outbreaks became apparent in Europe?

A Absolutely. As the understanding of the virus

changed, as we increased information about transmission, the identification of cases inside the United States, et cetera, so all of those played into decision-making about border -- the use of border measures as a means for control.

Q Are you aware of anyone at CDC requesting additional data from airlines regarding passengers?

A There were a number of discussions, again mostly driven by already existing regarding capture of information about travelers. So the means for collecting that data as efficient and timely a manner did, I believe, require a lot of discussions that I think eventually were addressed.

But there were measures, as I'm remembering them all, the CDC and the HHS assisted in helping to collect some of that information so that we were getting as quick information as possible about those individuals so that it could assist with any potential contact tracing that might exist.

Q And did CDC run into any resistance from the airlines about that specific data needed for contact tracing?

A From what I recall, the effort was considered a big lift, I think, by the airlines in that the amount of information was more than they had been required to do

previously and in order for it to be implemented would require a significant amount of information technology changes.

Q Is that something CDC was working with other government agencies on getting?

A I believe there were a number of engagements with other parts of the federal government and that's one that, I think, Dr. Cetron may be able to answer. I don't recall all the components of that issue.

Q Do you recall if airlines started providing that information to CDC?

A I don't remember the dates. I do remember that we deployed staff to collect information and that -- I don't recall all the details of when those changes occurred. I just recall that they were an issue for a period of time.

Q Moving forward to the other early steps. So as we discussed, the first case from international travel was reported on January 21st. The second on January 24th. Can you talk about, in that week between the 17th and the 24th, how did the confirmation of these cases change the CDC's response?

A So the confirmation in the first case certainly led to an accelerated activities in the standing up of our CDC operations center. A number of activities

were initiated and also working through the kinds of communications and recommendations that needed to be made for informing the public, indicating what public health officials can do and what individuals can do.

The lockdown of Wuhan during this period of time also identified that there was a significant activity happening in China that was beyond what we had seen with the prior large respiratory outbreaks that indicated that the concern level was definitely rising over the potential for impact was rising as well.

We worked to evaluate the first sequences that were released from China on the viral sequence of the SARS-Co-V-2 virus, evaluating whether or not our own diagnostics were going to be able to detect that or if new diagnostics were needed. Evaluated with BARDA and others the potential for any therapeutics that might be available that could be used.

And then also began looking through past pandemic planning materials to assure that we were addressing the needed steps with have to do with all those different pieces that become task forces communications, implementation of laboratory diagnostics and surveillance. All of those things were stood up.

So through that period, as the EOC was standing up, we were assuring that each of those arms of the response

were doing the planning and working to rapidly implement the needed components for situational awareness and were preparing for significant interventions needed.

[Majority Counsel]. My hour is up, so if that's a good place to turn it over to my colleagues.

Well, before that, we can take a five-minute break.

The Witness. Sure, great.

[Majority Counsel]. We'll start back up at 10:05.

(Recess.)

[Majority Counsel]. I'll turn it over to our colleagues from the Minority for the next hour.

BY [MINORITY COUNSEL].

Q Dr. Jernigan, [Redacted] from the Republican staff. I just have a few quick questions.

Are there still U.S. government imposed travel restrictions related to the Omicron variant of COVID-19?

A I am not a part of the response. I really can't speak to the current policies.

[Minority Counsel]. That's all we have then. I'll let you get back.

[Majority Counsel]. Okay.

BY [MAJORITY COUNSEL].

Q So we were in the January 21st/January 24th, time frame. I want to move forward to the end of January, January 30th when the first instance of person-to-person

spread was announced by the CDC. So that announcement was made on January 30th. And can you tell us a little bit about what was learned from that development?

A So the characteristics of the virus and how it moves through the population is something that is needed for a number of different reasons, for how we intervene, how we model and forecast what may happen. So I believe up to that point there were probably reports from other places where the capability for the virus to be spreading from person to person could occur.

So there was an increasing understanding that once that community transmission was characterized, that is, how fast it was spreading, how much the disease was going from one to more than one person, that information really helps understand the kinds of efforts you need to be intervening with.

For SARS 1, we did not see a lot of transmission outside of settings where there was significant viral contamination like in the hospital during intubation. So in recognition, verification of the ability of that virus to move from person to person without stopping was critical to meeting those definitions of pandemic, but also for the expectation that there would be continued spread within the community.

So as that was characterized in the United States, it

indicated that travel association would not be a targeted part of the identification of potential cases, but that the aspects of any travel association was an important component that affected case defintion.

Q The first instance of person-to-person spread was announced on January 30th. The first instance of possible community spread was reported on February 26th; is that --

A Say that one more time.

Q The first instance of possible community spread was reported about a month later on February 26th; is that right?

A I'd have to go back to my notes to find out the actual time.

Q But is that timeline --

A The act of community spread, I'd have to look back and see what the timeframes are. I know that the -- the expectation of that likely occurrence was we expected that could be happening given what we were seeing elsewhere in the world with the virus.

Q Okay. But the actual announcement from CDC -- I'll show it to you as an exhibit after a break. But it was on February 26th, there was a media statement that said, "CDC confirms possible instance of community spread of COVID-19 in the U.S."

A That's not --

Q I can get it for you. But this gap between January 30th, the first instance of person-to-person spread and then the first instance of community spread, can you tell us why that gap existed?

A So I'd have to recall that at the time the person-to-person spread indicated that there was movement from one person to another. Trying to think if that was the Chicago one or not. And then I think later the demonstration of there being continued transmission within the community may be what you're referring to on the 26th.

Q Do you not believe that community spread was occurring before that time, before February 26th?

A So -- and again, I'd have to go back and review things. But the anticipation might have been unrecognized cases in travelers prior to our first case identified in Washington state. There is that chance. There are some I think that would indicate that, especially on the East Coast where there were travelers returning from Europe, that there might be ongoing spread in that setting as well.

There were some studies that tried to characterize how much we thought that was happening, if I'm recalling. But those studies didn't indicate that there was a significant amount of transmission. We recognize now that

even a few seeding events because of the spread that this virus can have, the transmissions can have, that there could be, especially once we understood that there was asymptomatic transmission, that that transmission could have been occurring.

However, as a cause of severe illness or as a cause of significant identified illness in those returning travelers or those in contact with them, the system that was in place did not detect those. Was that missing significant transmission? I can't say, but there are some indications that would say that that is not the case. The active transmission really began after that first period, so it started to detect cases.

Q What were the systems in place to detect that kind of spread at the time?

A So the influenza, which was closest model for what was likely to come, for that system there were syndromic surveillance that was in place that was utilizing automated electronic reporting of regulations from emergency departments. I don't have a number of the total. But 60 or so percent of all emergency departments in the U.S. were participating in that.

So as a detector of increased respiratory encounters, there was not a signal there. The difficulty is that the timing of the first case was consistent with the influenza

season and so there were significant other respiratory diseases that were circulating at the time.

In addition, we at CDC can monitor through a system called NREVSS or National Respiratory and Enteric Virus Surveillance System. That's a network of hospitals that have persons that are reporting every laboratory test both positive and negative for respiratory diseases.

And so our -- that system would be looking at those being admitted for respiratory problems. That additionally did not indicate a significant increase in the negatives showing up, which would have been an indicator of increasing spread of unknown illness cause.

As we initiated enhanced surveillance looking at those individuals recently traveling by screening at airports and then also by utilizing central surveillance systems that were established for influenza specimens collected through those systems which each state and large jurisdictions are supported with. Those systems were anticipated to help identify cases and have them submit.

In addition to communicating, the recommendation to test those that met certain criteria, that led to the condition of specimens to public health labs, which then, depending on the timing, could be tested at CDC or should be tested at state health departments.

We worked with CMS to also utilize the real time

systems that they have for testing -- excuse me, for reporting based on claims, which is information that's been turned around quickly. We worked at the National Center for Health Statistics to monitor all causal mortality and the mortality due to pneumonia and respiratory diseases, which is now the sort of gold standard for monitoring deaths for COVID.

We established, based on our hospitalization network called FluSurv-NET, that was translated into COVID-NET which established or based, I believe about 30 million people under surveillance in central locations of hospitalizations. Each was able to detect and characterize hospitalized cases and help with the first indications of the disparities in health equity that eventually became apparent. There were -- later, in the response for vaccine effectiveness, that was also utilized.

Again, we attempted to establish additional community-based surveillance networks to characterize the full spectrum of infections occurring through selected communities.

Q So you described a number of different surveillance systems there. I know this is your area of expertise. So maybe we can just break this down a little bit in practical terms. Let's start with the syndromic surveillance, you said 16 percent of --

A I think it's 60. It's currently 70 or more.
Q Okay.
A But the expansion has continued significantly. So this is the National Syndrome of Surveillance Program or NSSP. So there's information on the web -- CDC website that describes it more fully. But it captures every encounter in emergency departments and large urgent care centers representing about 70 percent of all of them in the U.S. with about a 24-hour turnaround for information about those encounters.
Q We're talking about actual data and not data from at that time 60 percent of emergency rooms, not projections; is that right?
A These are data that come from the electronic health records, admission, discharge, and transfers. It's a feed of actual computer data from those systems in real time.
Q And at that time, if we're talking late January to the end of February, about 60 percent of emergency rooms?
A Initially it was 70 percent. It may have been less than 60. I don't recall.
Q And the second system you described was the NREVSS system?
A NREVSS.

Q Okay. Can you tell us how that works and how the reporting work?

A So that's on the web as well. That's the National Enteric Respiratory Viruses system. So that's a means for monitoring RSV, other enteroviruses, parainfluenza, and some others, coronaviruses. Like coronavirus, maybe not SARS.

And so that is a network of generally web-based entry from laboratory and infection control personnel at hospitals where they collect on a weekly basis for the numbers of tests that have been performed for those particular reagents and also the positives for them. So that's a means for how RSV is monitored nationally as well as other viral pathogens.

So that system was in place, and the indication that more tests were being performed and the tests were not positive would be -- would have been a signal for increased activity of unexplained respiratory pathogens.

Q Given that there wasn't a scaleup of the diagnostic tests for this virus yet, the running of other tests and the negative results is an indication that something else is out there?

A Correct. I think the recommendations were that systems should utilize the breadth of tests that were available and then to hone in on the facts of whether or

not that individual was a case or not of SARS-Co-V-2.

Q The influenza system at the Sentinel Public Health Lab, that was started in mid-February; is that right?

A That system was initiated in the 1960s or '70s. That was a system that had been in place for a number of years in various different forms. So it varies from state to state, but in general, there are networks of primary care providers who swabbed individuals who come in with respiratory disease, place those swabs into a transport media or into a bag and send them to the public health laboratory where they were further characterized for respiratory disease as part of our ongoing surveillance.

So that system was in place, and those specimens, because of the types of symptoms, would have been highly correlated with modern SARS-Co-V-2 case would have been and therefore the identification of an increase in negatives there before testing was available would also have been an indicator. And once reagents were available at those jurisdictions, then that system could be utilized to assist in identifying cases from the community.

Q And looking at this period, there were people working under you looking at all of this data. Can you tell us a bit about how that worked in the incident management structure and across these different systems

what they were seeing?

A So as the incident management structure was stood up from the 20th or so on, initially we had an epi and surveillance task force which accounted for both emergent case-based surveillance, which we haven't talked about yet, as well as the ongoing networks and investigations that were put in place.

So to re-characterize the situation, CDC and other public health agencies needed to do more than just ask for the numbers of cases that are being detected. They also need deep dives of investigations in order to fully characterize severity, transmission, household transmission, et cetera.

So the decision was made to separate out into two task forces because the level of effort was so strong where there was an epidemiology task force that was largely managing the big networks as well as standing up teams of investigators to various sites in order to fully characterize the impact and the -- and epidemiologic factors that help us to make better intervention policies.

The surveillance task force became more of a situational awareness, data analysis and visualization group and that group became fully supporting the emergent case-based surveillance activity.

Just as an aside, influenza occurs commonly. The

majority of cases are mild, but a handful can have significant impact. And for that reason the detection of influenza as a monitoring approach, in order to make best policies, focuses on severe illness. And so hospital networks for the flu are a general driver of information of events used to make policy and help with vaccine target selection.

So the same approach was initiated with COVID-NET, which we talked about a second ago. But flu does not try to capture every case of influenza mostly because most people don't get tested, and that most of the testing occurs in settings where the information cannot be captured. And so it has not historically been captured.

So with SARS, with the recognition that every case was going to be counted, the traditional approach of portable diseases be investigated by the health department, and then fully characterized, turned into a confirmed case, and then reported to CDC was a process that did not scale with the need for the case-based surveillance. And that need was the response again to support that need with a much more robust approach to that.

Those are the structures that were stood up during that period of time to help support the different agencies.

Q Dr. Messonnier announced publicly on February 14th the use of those Sentinel labs. And that was in

Los Angeles, San Francisco, Seattle, Chicago, and New York City. And those labs were going to start using the influenza surveillance system, but start testing for the new virus; is that right?

A Correct. Initially, the anticipation was that the Sentinel approach, because it had -- was in place and was collecting specimens was an ideal approach for getting a quick view of what was happening in the community once COVID testing was available. So the Sentinel systems were in place.

The enhancements to those by providing support and by providing the diagnostics early to those ones that you just listed were an attempt to not only captured those that were symptomatic when coming in for respiratory problems, but also for -- to try and get asymptomatic transmission as well. So the community testing was intended to help give additional information about the potential for asymptomatic spread within the community in addition to the work that's normally done for the flu Sentinel.

That process was lengthy in order to get those systems set up. There were differences in execution, differences in opinions on how best to design and implement that approach. I think as we move forward to help support the implementation of those activities, we recognized that the risks to those public health agencies at identifying

the first cases of asymptomatic spread led to more difficulties in executing than had been anticipated.

Q What were those difficulties?

A That public health agency or state leadership would not or did not want to be the first to have community spread identified in their close communities. There were complications around the collection of specimens from individuals that would have been needed to be identified in order to help first characterize community spread that once identified or once detected, the onus on the public health agencies would be to require those individuals to isolate and do contact tracing on them.

So it was suggested then that in order to do asymptomatic evaluation, informed consent would need to occur for each of those individuals that was providing the specimens. So that then initiated a series of requirements based on state laws and federal laws around protection of humans in studies.

Q And do you believe that setback, the responses, impacted the ability to detect community spread earlier?

A For that particular system that was being established, there were differences in how it should be implemented within the jurisdictions at leadership levels as well as the implications of how that study could be

implemented created issues for the successful implementation.

Q Would national leadership of surveillance and testing have made a difference in terms of making it a uniform system in getting past those sort of roadblocks between jurisdiction?

A In general, I think identification of common approaches and agreements across agencies is always a good thing in terms of speed and assurance, best implementation, but also of getting data that may be most accurate.

Q Moving forward, in late January, January 29th, the President announced the formation of the coronavirus task force and that was originally chaired by Secretary of Health and Human Services, Alex Azar. Did you as incident manager provide any input on the structure of this task force?

A I don't believe so.

Q Any input on the agenda of the task force at that time?

A Not the agenda, per se. I think we were in communication with the secretary's office regarding updates on the things we were learning and then engaging with Dr. Redfield on the intervention plans and investigation plans. And there was continued dialogue between the secretary's office and our office; and with the standup of

the task force, the connection to that task force to our director through the secretary, it was consistent with the communication channels that we were having.

Q Can you talk specifically about your role in that communication chain with the director?

A I don't recall the actual times, but we would meet as a response early in the morning and then we would have a subsequent meeting with Dr. Redfield at 9:00 or 9:30. We would present the incident management updates, sometimes with him present; sometimes he was not able to attend.

Those incident management updates, we walked through each of the different activities like we talked about with the task forces. That information was summarized and provided, and then there were -- I don't remember if the secretary's briefings were in the early morning, and then those sort of changed to occurring in the afternoon.

Q Did the standup of the coronavirus task force in the White House, did that change your responsibilities as incident manager?

A Not -- I don't believe it did. It has since formalized the engagements of what the CDC was doing into a forum group. In some ways, an effort at the agency was disproportionate to that from other agencies and the structure of the task force was such that it was -- I think

the full breadth of all the activities happening within CDC it's difficult to have groups fully represented or communicated to that group simply because there was so much happening, the focus was on a number of health issues at that time.

Q Why was it difficult? You mentioned the breadth of things that CDC was doing. Why was it difficult to get that communicated to the task force?

A I think we -- the process we had been using through the early years was to have a number of task forces that reported in and then summarized that information that's presented as a set of slides as a situation report on a daily basis.

When we opened that up to folks from around the inter-agencies, I don't know how frequently they were able to get the full breadth of that information and summarizing of that information into the White House task force. I don't know if we achieved really a sufficient means of communicating that information to them. I think the focus was more on near-term issues around borders and other things like that.

Q But you also -- I guess in this period, also, repatriation would be one of those near term?

A Correct. There were critical needs for getting U.S. citizens back to the U.S., that are very

reasonable activities, but I think they did pick up a significant amount of discussions that were happening.

Q What do you think wasn't being put on the agenda that should have been at that time?

A I think just from past history, past exercises, past agents for other respiratory disease outbreaks, the thinking forward of what plans would be needed, what official direction that this might go. If so, what kinds of communication messages or preparations needed to be occurring in order to assure that the public has a sense about what might happen, but also the needs for supporting health care and supporting nonpharmaceutical interventions for the stopping of transmission, that all of these things needed to be a part of the full breadth of the engagements.

Q And did you personally try to get those longer-term priorities on the agenda of the White House task force?

A From experience from the past publications that we've had on frameworks for how to engage during pandemics, with an understanding of the potential of a large respiratory outbreak would take, and then also based on past developments of guidance around communication, those were -- those documents and prior plans that we anticipated would be a part of the conversation for how to

develop the approach for the coronavirus response.

Q Anticipated that being part of the discussion, did that come to pass while you were incident manager?

A So there were some discussions within the CM. I don't remember the exact groups, but they were focused mostly around how to engage the inter-agency for a whole of government response for repatriation and for those kinds of activities. So there was coordination with all parties, but certainly State, HHS, NSC, et cetera. That coordination is a role for the NSC, but the NSC historically also plays a role of coordinating planning and they developed subgroups within the response structure at the NSC in order to ensure that those alternatives are being considered and that planning is set in motion.

Q Do you recall who you were engaging with at the NSC?

A I don't.

Q You were engaging with the NSC, but it seems like those longer-term issues were not getting on the agenda ultimately of the task force?

A I think there was historic NSC engagement around planning and pandemic preparedness which had led to a number of different national plans. In addition, the expectation would be a broader interagency response with a well-known lead related to exercises that we had had

previously in 2019 as a whole of government response. And those exercises did follow along the existing plans for how the government would respond, including the considerations about mitigation measures that might be needed based on severity of the emerging pandemic.

So those documents were presented. They were largely not from the current Administration, they were from prior administrations. And so I don't know the decisions that were made about the need for current planning efforts in the capacity level that might not be targeted to this particular coronavirus.

Q You were previously engaged on those plans, those plans existed, but they weren't put into place essentially is what you're saying in --

A I think the revision of those plans, I think, is an area that -- where progress could have been made more quickly. I think the efforts to revise those plans was not -- not chosen.

Q Do you know why?

A I think that the -- I think there was a sense that prior plans represented plans from the previous administration when in fact many of those plans were established in the prior -- to the prior administration in that new plans would be needed or that those plans did not represent the current approach or a new approach might be

needed.

Q Who communicated to you that that was the position of the current administration?

A There was not a direct communication about that. I think that's my assessment of various conversations that I can't recall.

Q Generally, who did you get that sense from, those conversations, with people in the administration?

A Through NSC and, yeah, generally -- yeah, leadership within the administration.

Q And who did you generally deal with in the administration at that time related to those discussions of pandemic planning?

A There were staff that I can't recall the names of now. The secretary we were having to coordinate a lot of those discussions as well as the staff of the CDC.

Q And did that decision to not follow the previous administration's plan cause delay in those important long-term measures?

A It's hard to say. All plans have to be revised. And so I think the focus on what might have occurred based on some of the prior planning, I think, either laid out a set of areas where a determination of what plans were needed and what kinds of revisions were needed for those plans would have been helpful as a

coordinating activity out of the NSC.

Q What specifically in those plans do you think should have been on the agenda at this particular time?

A I think we anticipated ongoing transmissions in the community and the need to implement nonpharmaceutical interventions prior to the vaccine and prior to there being therapeutics. Those are difficult measures to implement, and so the identification of some if/then scenarios would be revisited with a certain level of severity -- a certain level of transmission given a certain period we would like to then implement these kinds of measures.

And so I think walking through and indeed determining what the accessibility, both the public accessibility as well as the administration, would be a reasonable set of activities to have been working through. So they had been occurring just outside of the engagement, but I was not aware of significant activity. If it was occurring, I was not part of it.

Q And the general sense you got was that the existing plan was not going to be followed for those particular interventions?

A Just to be fair, I do not know how familiar they were with them. And I think the individuals that may have had experience with those plans and had participated

in the development of those were not available to help. And so it's hard to say. I think that the focus on those would be reasonable, but there may have been not enough people, people that were available to assist.

Q Why were those folks not available who had expertise?

A I think those efforts had been changed, the structures of NSC had been changed, and so the availability of those staff to be called on I think was not there.

Q Are you referring to something that was reported in the news that restructuring of the NSC, the staff, particularly focused on pandemic preparedness; is that right?

A So I am speaking to the experience of the absence of those individuals. How that happened, I don't have knowledge of.

Q What impact did the absence of those individuals on the NSC staff have on the response at that time?

A The coordination of interagency activities was one of the responsibilities for the NSC. And so I think recognition of the assets that were available and how those assets had been exercised or used in past outbreaks, I think, would have been an area where the expertise would have assisted in accelerating that kind of planning, but

also the structures in place to assure that that rollout of the response could be successful.

Q Turning to January 31st, that's the day that the secretary declared a public health emergency and that was also the day that by presidential proclamation entry from China was suspended and called for additional screening and possible quarantine.

Can you tell us about your involvement in that decision on January 31st to suspend travel from China?

A This is, again, an area where Dr. Cetron would be more familiar with the details. But the decision to do that was one that had a considerable amount of discussion, in part because as a party that engages with WHO on a weekly basis, the longstanding approach was to not try and stop international travel. I think that was mentioned previously.

The data from past responses suggested that there could be benefit from it. As the severity was becoming clear, as the Wuhan lockdown was demonstrating, and as the identification of cases in the United States was occurring, and certainly happening elsewhere around the globe, we evaluated the longstanding stance on the issue, as CDC arrived at a decision to go forward with those efforts at that time.

And so the federal quarantine rule had not been used

in years. I can't recall exactly, but that was a decision that made sense, and was where we arrived at CDC through a number of engagements and discussions within our agency. But the decision there was one in which we, and I, was on board with.

Q Moving into February, that announcement made on January 31st, what were the priorities for the incident response moving into that timeframe in February? We can go to Exhibit 2 is a slide show. The COVID incident manager update from Monday, February 24th.

(Exhibit No. 2 was identified for the record.)

The Witness. I think the priorities are listed there. If you look at specific priorities that we had stated, because we revised each day.

BY [MAJORITY COUNSEL].

Q I think I'm just generally looking for, what were you concerned about? What was the focus of the work in February?

A Yeah. So I mean, I think these state it well, that we were focused on detection as best we could, utilizing the capabilities that we had at CDC for diagnostic testing. So detecting cases, detecting contacts to those cases, and assuring that we were minimizing the potential on the transmission, if there was any.

We wanted to work not only through the U.S., but work

with outside partners to make sure we were understanding the virus as fast as possible, how transmissible it was, how severe it was, and what kind of disease profile that the virus was going to cause. It would help us with policies around infectious control, policies around treatments of individuals, and for best approaches to community mitigation as well.

We were focused elsewhere, also, on getting those U.S. citizens that were being caught in situations where they had the potential to not be able to leave, and trying to get those folks repatriated. Issues around border control. And actually what FEMA implemented seemed reasonable and would have been similar to what we had at the time.

And then we, the staff at CDC, was historically connected with the countermeasures and nonpharmaceutical resources, assuring that they focused on PPE, focused on vaccine development, better diagnostic development, as well as assuring that the needed support for the therapeutics was also available. So countermeasures, border control, identification of cases with contact, communicating what was going on, with this overall goal to really slow the introduction, characterize the virus, and prepare the American public.

Q And just taking a step back, looking at

Exhibit 2, can you tell us how these meetings worked, the IM update?

A We would have -- I don't know, there's an agenda listed here. The meeting would open, some comments would be made by me, the immediate priorities would be put up.

As that changed, we would communicate what those were, but we wanted everyone to be focused on the main effort at hand. We moved to -- the next slide is a revision of a diagram from federal management planning efforts, in order to help us understand where we were in the current issues, both globally and domestically.

This was intended to connect back to existing recommendations about how to respond, based on what area you're in. So the goals here would be to continue to speak about where we are now, but looking to the right, what is going to happen is what do we need to do within that interim where we are, and what do we do with subsequent efforts.

The next slide, which has the --

Q You don't need to go slide by slide.

A The first ones are all parts of past planning efforts that needed to be put at the front of our discussion, in order to ground folks to be thinking about not only now, but what will happen as well.

Q And these meetings occurred how frequently?

A I'm trying to think. It certainly became daily all three weekends, starting in the end of January, February. But in the case of these, I think they may have been on an every other day basis, with sort of a smaller strategy discussion around the same time. But the goal was to use these to bring everybody up to speed to the full response, to watch this, and understand what each other was doing for ease of the administration.

Q The full response within CDC, within the incident management structure?

A It's within the incident management structure, but the availability of other people at CDC, usually leadership positions, to watch. In addition, others, as the response went on, were added to the meeting. The balances between communicating with those that need to be communicated, and assuring others know about it. But the capability for this information to then get misused or sent out widely would be available for these participants.

Q Who came to participate in the meetings?

A Certainly all of the incident management staff. We -- in terms of leadership, you know, I would look back at the list of all those that are receiving it. But certainly high leadership was ASPR, it was OASH was on, and others.

So we made it possible for a very specific group of folks to be able to join. And then Dr. Birx eventually later on was sent copies of this on a daily basis. And then the White House task force eventually did start to participate as well.

Q And moving to the priority slide, again, I think that is slide number 5, ending 434. The third bullet there that says, "characterize the transmission, notably human to human transmission, and potential for asymptomatic transmission." What was known at this time or around this time about asymptomatic transmission?

A Not a lot. This is at what time? You're talking about at this time?

Q At this time, let's talk about this time, so the 24th.

A So I'm trying to -- there were studies that were coming out that indicated that asymptomatic transmission was possible throughout February, if I'm recalling, and the likelihood of that. But there was a sense that we would be getting some of that.

Influenza had the capability to transmit asymptomatically, so this was not something that was fully outside the realm of expectation. SARS in the past and MERS was generally felt to be only transmissible at the point at which it was noted.

However, with this virus, it did become clear that while asymptomatic itself, we weren't clear about, what some refer to a paucisymptomatic or low symptomatic transmission was a rising concern. And therefore, the expectation was asymptomatic or some degree of the overall transmission could be attributed to transmission that was occurring outside of an individual's symptoms.

So it was -- I don't recall exactly at the point in which we called it. It may be in here, but I don't recall when we made that proclamation.

Q Looking back, was the focus on symptoms, for example in the airport screenings, you know, what -- by focusing on symptoms, do you think that importations of the virus were missed? And going forward, what have you learned about that particular focus on symptoms early on?

A There were a couple of things. One was that the focus on symptoms was driven by the available experience with SARS and MERS, which at this point, the virus was different from, but still fell into that same space, hence the term SARS-CoV-2.

So the focus on symptoms, I think, intended to help characterize or help to funnel individuals into the process in which they were then to be tested. The starting of asymptomatic cases among the total travelers, given the symptomatic to asymptomatic detection rate, would have

been -- it would have been hard to have justified, based on the information we knew about the virus at the time.

In addition to us -- to folks focusing on symptoms, the individual was also asked to monitor themselves after they had left the screening. And therefore, that additional potential for those individuals to be detected, once they developed symptoms helped with the identification of -- in terms of it may have been asymptomatic, but became symptomatic.

The system would not have picked up individuals who were asymptomatic at screening. And in that status, even though they were carrying the virus and able to transmit, however the degree to which that level of transmission participated in the overall community transmission, I don't recall how significant that part is. It can occur, but it may not be the predominant means for transmission compared to symptomatic and asymptomatic individuals.

Q I think that this would be a good time. My hour is up, and I will turn to my colleague from the minority to see if they have any questions. Before we do that, I'll ask you if you want to take a five-minute break or are you okay with it?

A I think maybe we can take a five-minute break. That would be helpful.

(Recess.)

BY [MAJORITY COUNSEL].

Q Slide 53?

A This one is Exhibit 2?

Q Yes.

A Slide number 50 what?

Q 53. And in the PDF, it's page number 56.

A 56. All right. Okay. Is this the -- what's the title of this?

Q Modeling team.

A I've got importation risk. Is that the one you're talking about?

Q The one prior.

A Okay. All right.

Q Okay. I wanted to ask you about the work being done by the modeling team and the predictive work that was being done by CDC around that time.

A Based on past responses, the important role of modeling and forecasting was something that we began incorporating into the planned standup of a response, and then exercised it in 2018-2019. And then implemented it for this response. And so as a team, it's -- we stood up that team. It's a mixture of individuals with various locations within the agency that had different modeling expertise that worked in concert to address scenario modeling and near-term forecasting.

Q What data did they use to focus on?

A So they used various different data sources, depending on the type of effort that they have. For those doing forecasting, they generally focused on a small set of well-characterized information about the numbers of emergent cases, hospitalizations, and deaths. And the location of those individuals, to assist with predictions for forecasts of cases, hospitalizations, and deaths.

For scenario modeling, which would be trying to answer questions about what are some different possibilities that might occur based on different kinds of interventions, and based on the characteristics of the virus known at that time. So for those scenario models, it would be used on both the case information, but also various data taken from CDC investigations, and other investigations that had been published that informed the transmissions severity characteristics of the virus.

Q Looking at this slide on the February 24th, it says that "modeling indicates that it is likely that some U.S. importations have been missed, e.g. New York, New Jersey, Connecticut area. There have likely been additional introductions from China into countries that have not yet recorded cases, e.g. Thailand and Indonesia. And there is an increasing importation risk in multiple U.S. states and territories from multiple countries with

emerging outbreaks, in California, Guam, Connecticut, New Jersey, New York, and Hawaii." Can you talk a little bit about this, these predictions for modeling and how CDC uses this prediction?

A So the information that's provided from forecasts, which are generally in the two to four-week range, and based on prior disease characteristics of prior -- prior data, those forecasts are intended to help say what might happen in the next few weeks, in terms of case numbers. That's perhaps more important for quick identification of what hospitals might be seeing, and where, based on hot spot analysis of where virus may be having the biggest impact, which could assist in research allocations and implementation of policies by jurisdictions that could be targeted to those locations.

For the scenario model, at this level, it's really intended to help identify what we might be seeing, in terms of increased transmission in the U.S., and where that might be happening, to help inform the longer term identification of what might happen in a few months.

So between the forecasting and scenario modeling, both intended to help to characterize what has been happening with disease spread, and then to help determine how the -- what effect various different interventions on the slowing of that impact.

Q Moving forward to slide 54, "importation risk in U.S. from Wuhan," and it indicates that there's an 85 percent chance of at least one imported case in New York, New Jersey, Connecticut area. Along the lines of the other findings. Are these predictions shared outside of CDC?

A So I can't recall this one directly listed in note E, why it's in a circle up there. We had in a color copy, that would be a yellow circle, where yellow indicates that it's at a level not for the public, but not at a highly controlled level of distribution.

That system was set up -- I don't know if it was COVID or before, but it was set up for us to be able to have anyone who was watching this know what they could share more easily. And so that sort of moderate level 1 meant that it -- had nothing to put up on our web. It may not have been publicly available, but was information that could be shared with leadership and with others.

So the data basically support the sense that while we had screening in place, while we had some detection capabilities, the anticipation was that there were cases -- that the chances of there being imported cases certainly existed, and they had not been detected, and therefore could serve as seeds of community spread.

Q Is that something you briefed others outside of CDC on?

A These data were all made available to leadership. We circulated these slides whenever the data was produced. Our expectation was the findings that we were coming up with could be shared with leadership. I can't recall whether this one -- if we had a separate briefing on this alone or not. But these slides, by the 26th and 25th, were getting a fairly broad distribution.

Q And beyond the specific data, was this idea that cases were missed, and there had been an importation likely in the U.S., was that something that was being communicated by CDC to other agencies?

A I don't know the specific instance, but it is this kind of information that should be communicated, that data. There is not an expectation that we captured every case. I think this was done in order for us to get a handle on how, given the approach that we were using, and given the opportunities for somebody to come here with the disease, what are we missing?

So this was intended to help us understand the magnitude of what was not being captured. No surveillance system is perfect. Case-based reporting of every case is not actually case-based reporting of every case. And so these kinds of efforts are intended to help hone our understanding of what we are missing, or what we are able to capture through the methods that we used.

Q So, of course, no system is perfect, but this prediction is pretty good, pretty spot on as that area became the epicenter within the next two weeks, two to three weeks. Was the warning about these importations a topic of discussion for the White House task force, for example?

A I'm trying to think when actually it was discussed. When did the task force actually get stood up? That was --

Q The task force was stood up on January 29th under Secretary Azar?

A Okay. So at this point, we would have been well -- this is the kind of thing that the White House task force would have been communicating. We certainly would have been providing and informing through slide decks and key points. I don't recall how we communicated this information. But the fact is that a yellow meant that it was meant for wide communication within the leadership, and within the response.

Q Were you aware, at that time, about preparations for these importations in the areas as predicted?

A There was lots of discussions, and we were trying to communicate where the greatest likelihood of importation would be. And I think the question, per Dr.

Cetron, that there are set number of locations where most individuals come to. And therefore, an expectation of where they reside. And looked at the community transmission is something that we would have communicated, but also the local jurisdictions that were responsible for those would have been aware of, to start with.

Q Around this time, the following day, Dr. Messonnier gave her telebriefing that got widely reported, there seemed to be a shift in communications from the CDC, from containment to an understanding that the virus was going to spread in the United States. Can you talk about that process, in terms of your role moving from containment to anticipating community spread and mitigation?

A So I think there was a sense, there was a bright line between containment and mitigation, which was not the way that we were -- it was not the way we had experienced in the past, and was not our anticipated measure.

I think there is -- there were desires to have a very specific trigger at which we stopped doing one kind of thing, and start doing another thing. And in fact, many recognized that the virus could be having one impact in one area of the country and another impact elsewhere.

So the containment, either through border issues or

from varying enriched and targeted case and contact investigation versus beginning the implementation of community mitigation efforts, those two kinds of approaches need to occur at the same time, perhaps at different levels.

So that expectation that there would be impact in different places at different times in the U.S. was, therefore, a need for the country to have targeted community mitigations, as well as advanced containment approaches. All of that, we needed to view that as a combined effort that was fluid and what was happening in the jurisdictions. So that's what we were communicating the need was.

But the anticipation that even though one community was trying to contain, the expectation is that community will, at some point, be having to mitigate, because the containment won't stop the eventual movement of that virus into that community. The containment was intended to slow the spread, give time for preparation, and give time to better understand the virus and develop countermeasures.

Q Can you talk specifically about the community mitigation work that the CDC was doing? And I think slide 71 on page 74 of the PDF details this work.

A Hold on. Slide 74?

Q Slide 71, on page 74.

A Next --
Q Sorry for the --
A So slide 71, is that what you're saying?
Q Slide 71, right.
A The number at the lower right-hand corner.
Q Of the actual slide, yes.
A Okay. What's the title of your slide?
Q CMTF: Interim School/IHE Guidance.
A Okay.
Q Is that where you are?
A Yes.
Q Okay. Maybe you can tell us broadly about the community mitigation task force and what they were doing at this time.
A So as a part of pandemic planning in the past and for this response, a dedicated group that focuses on the nonpharmaceutical interventions stood up at the beginning, with the anticipation that based on severity and transmissibility, the implementation of various mitigation efforts would be done.

And so that group went through the process of identifying, what are those different interventions, what do we know about the communities' acceptance of things, what is needed in terms of socializing these leadership and with others that may not be familiar with them, either in

the media or in other public health jurisdictions, and other parts of the business community.

These focused on the potential for mask use, the potential for canceling of mass gatherings or the decreasing of those recommended to be in mass gathering numbers. The implementation of school closures, changes in transportation, social distancing, like six feet, et cetera. And measures -- every day protective measures for the public to take for themselves, and hygiene and social distancing, the stopping of -- eventually, the stopping of elective procedures at healthcare facilities, changes in staffing, increased use of telework, et cetera. All of those were components of a described mitigation plan that had been last revised in 2017.

Q And were all those steps also part of that plan that you discussed earlier, just general pandemic plan that was put together by the previous administration, elements of it?

A Yes. So it was initiated in the administration -- in the Bush administration. And it was managed in or updated in the subsequent administration. So those -- yes, that plan. There was a series of documents that had been developed. And then there were documents that were derivative of those that were operational plans for agencies, as well as operational plans for departments

and for the U.S.

Q And I'm going to ask you specifically about the third bullet here. That reads, "continuing to adjust plain language planning guides for key community settings and audiences to incorporate available COVID-19 specific information using guides previously released for pandemic influenza." And it says, "guides for households and individuals, mass gatherings, community and faith-based organizations in clearance." Can you tell us what these plain language guides were?

A These were taking what were described, technical documents with mitigation, documents that we talked about in the contexts that were in those documents, and turning them into actionable efforts for the community to be able to implement, be it either from a community level, jurisdiction government support within those jurisdictions, as well as the public health agencies, but also for individuals to take, so that they have guidance on what they can do as individuals.

Q The sub-bullet there, guides for household individuals, mass gatherings, community and faith-based organizations in clearance. What does "in clearance" mean?

A In clearance within the incident management structure at CDC is a set of individuals that have been identified as clearance coordinators for each of the task

forces. So this particular task force dealing with these issues would meet, has a person assigned to help with the review to assure that it reaches the right readable level.

But also that the recommendations in it do not fall counter to other recommendations that have been previously made. Therefore, if they do change the recommendations, recognize the impact that that has on assuring that the public is getting a single set of recommendations, rather than having to change it all the time.

But that clearance also, then, assures that other parts of the response that has -- that are affected by these recommendations can review them to ensure that, for instance, some guidance for lab workers is not in any way called into question with some information that would leak out.

Then that would go through the clearance chain, all the way up to the incident manager. And the final recommendations are generally also reviewed by the principal deputy at CDC. And the director can also review them as well. But the clearance through the incident management structure would end with the communications task force, finalizing those recommendations, once they're completed, and then could be posted on the web.

Q Typically, did that process involve approval by agencies outside of CDC?

A Depending on the type of recommendations. There is a best practice of receiving review from those other agencies that have -- that are impacted by it. So for instance, schools would warrant the input from the Department of Education, et cetera.

So there were processes, whereby contacts and designated representatives for those different groups could review these materials, in order to provide input. For some of those, there were direct deployments to our own response, so that there were designated individuals that could represent those entities within the response.

Q The guides listed here, do they go out to the public on CDC's website?

A I am -- I actually cannot recall right now. There were recommendations, and I don't know the time at which those actually were posted. I don't recall the dates of that. But these typically would go on our website. These having participation, if I'm remembering the timing, participation from a number of others within leadership that were -- because of the impact that many of these recommendations would have.

Q In media reports, it was said that a number of guidances were developed and released sort of piece by piece after a drawn-out process of input from others in government. As far as you know, were these guides subject

to that process of review by other agencies outside of CDC?

A These guides received significant review from other agencies, but also from within the department.

Q Do you recall if these were released on CDC's website, these specific ones that were in clearance? Were they released --

A I don't recall from this slide whether these were documents that had been initiated by CDC that entered into a process of review, or whether it's -- yeah, I don't recall from this slide which sets these are referring to. They were eventually guides were presented on CDC's website. I don't know at this point, to this date, which ones these are referring to.

Q So this is, I guess, the formal work that was being done by the community mitigation task force. What additional steps were being taken at that time to prepare for community spread and taking mitigation measures?

A So the -- the process of trying to foreshadow that these types of measures would need to be taken is something that, in general, CDC has had as its practice of communicating to the public the potential for something that might be disruptive, working with key opinion leaders in the community to help also communicate that message. So that the general discussion in the media and across the government would be leaning into the potential for the use

of these. And then identifying where the public might have trouble with some of the them. And then ensuring that the communications of them are made in a way that would maximize the implementation of them.

Q What was being done, specifically -- if you recall, what was being done, specifically, to get leaders in government to possibly prepare the public to take these sorts of measures?

A So one would be beginning to communicate how the experience of other countries, the information that we were learning, the combination of community spread, eventually. All of those things. Just indicating that there are measures that can be taken, and that those measures can occur at a community level or the individual level, and begin moving forward with the expression of that. And with the expectations that more details and more understanding would occur as the public becomes familiar with that approach, because it's not something that we do, or had done in a long time.

Q Were you personally discussing these measures, and preparing the public for them with other leaders in government?

A Yes, I mean, the expectation would be that these need to be developed and made public, or at least be presented. Yes, there were discussions about that.

Q Who specifically in government were you speaking to about that?

A At this time, I can't recall exactly. Eventually, as the new approach to the task force was implemented, this discussion moved to working with the new members of the White House task force.

Q What was that new approach that you're talking about?

A Just that the -- not a new approach, but the process, you mean? That the discussion moved to the White House, to help work through what those needs were.

Q Did that coincide with the Vice President taking over with the task force?

A Yes, with the Vice President taking over the task force, and members of that task force enhanced focus on engagement on these issues certainly increased.

Q At this time, was there engagement with the White House task force on these particular issues, community mitigation?

A Yes. I mean, were we having discussions? We were discussing these things through our own incident management structure, with the director, who was a participant in the task force, and a number of others that I cannot recall, who all were involved over a period of time working through the approach with the development of

these guides.

Q Moving forward, you mentioned what was going on in other countries, in terms of community mitigation. I just want to move to the next slide, slide 72. I want to make sure we're both looking at the same slide. This is -- the title is "Extensive Community Mitigation Measures, Italy, February 18 through 23rd, 2020." And it says "greater than 130 confirmed cases." So walk us through what you were seeing in Italy at this time.

A So this was -- I can't recall the exact date. This was either the beginning of, or well into the lockdown that they were implementing.

Q And this slide describes a number of community mitigation measures in Italy, and has a timeline of the outbreak. What were you taking from this information from Italy, in terms of the risks to the United States?

A In a community of a Western country, with a similar approach to public health and health care, that the system could be overwhelmed. And the impact on the country could be extremely high. So if this was to be entered into the U.S., we would have a significant problem.

Q Is that something you communicated outside of CDC?

A Yes, I think that was a fairly -- the conclusions were there for many to make on their own. But

we were definitely communicating with our leadership.

Q Had you briefed the White House task force on this situation in Italy around this time?

A I can't recall. I don't believe I did. I don't recall if we had a specific presentation. The standup of the new White House task force, and the connection to the incident management structure at CDC was -- the pathways to communication were not clear.

Q I am going to go back to that point, but just sticking on Italy for now. Within CDC, looking at what was going on in Italy, were there discussions about broader travel restrictions?

A Throughout this period, and even subsequent, if I'm recalling, there was a continual review of all the of the impacts that were happening in countries. And then a process had been identified of how to use that to determine what level of travel restrictions would be recommended.

So there was a persistent increase in the numbers of countries, the levels of travel restrictions, and subsequent impact on global and persons traveling. So there was a lot of discussion about the impacts of those -- of information like this on travel recommendations.

Q What was your position at this time on the

24th, as incident manager on restrictions on travelers from Europe?

A It's like we mentioned. We historically had been cautious about the implementation of travel restrictions. However, because of the continued information available about severity and transmission and potential impact, the use of travel restrictions was something that I agreed to, and made sense, in terms of one of the many measures that you can use in order to try and have as much of the intervention as you can, based on the learned approach.

Q Why were the restrictions on travelers from Europe not implemented in February?

A I would have to recall when we added Europe. I know we were adding different countries, I think we eventually added Schengen, et cetera. And so I don't recall the time in which we did it, but my anticipation was we would continue to increase those based on the factors that we had identified. The decision to significantly impact travel from Europe was one that did have to take into account the impact on business and other things that it might create. And so many of those factors, I think, were being considered at the time.

Q As far as the restrictions, it seemed that they went into effect on March 11th. One thing we've

learned through our interviews of several people at CDC, that a decision to restrict travel was delayed, and that CDC had been advocating for a restriction for the Schengen countries, and it was delayed for a period of time. Do you recall that period of delay?

A I don't recall the specific times about it. Just the implementation of travel restrictions, I think, given the amount of spread, it was an essential move to take. All the decisions that led to the eventual timing of it, I can't recall at this point.

Q So this slide deck gives us a good snapshot of what was going on in the pandemic on February 24th, and the -- we didn't talk specifically about these slides, but it seems like the first, I would say, five, six slides are focused on repatriation and those sorts of issues. If you want, you can just take a look through to refresh your recollection. And I think this starts on slide 10.

A Okay.

Q Yeah, and the things that go on from there. A number of commentators have made the point that critical time was lost focusing on the smaller issues of getting Americans back, and dealing with outbreaks on cruise ships, when in the words of one leader of the CDC, a tsunami was about to hit the United States. Do you agree with that assessment?

A The focus early on was on repatriation. Among the tactics of that, I think we discussed earlier on about the need to be preparing and planning for what might occur. And so the focus on the tactics, I think was -- we were not able to focus on some of the larger planning and strategy, because of the significant focus on those tactical issues around repatriation.

Q Any other failures looking back?

A What?

Q Do you consider that a failure on looking back, the focus on that issue?

A I know all responses have difficulties. And the improved planning and the focus on strategy and the potential for there to be interventions in place that were planned out and developed earlier would have been helpful for the overall response.

Q Do you think it contributed to the number of infections and deaths in the first wave, that lack of planning?

A It's hard to say. I have not been in any specific assessments or looked at what the change in impact would have been. The recognition of the potential for transmission might have had a significant impact on individuals' behaviors early that might have led to fewer deaths, fewer cases. I don't have any information to

support that.

Q After -- this presentation was February 24th, and on February 25th, Dr. Messonnier gave a telebriefing during which she warned of the risk of community spread, and said we will see community spread in this country. It's not so much a question of if this will happen anymore, but rather a question of exactly when. So did you collaborate with Dr. Messonnier on preparing for this telebriefing?

A So in general, we prepared talking points and went through for review. The development of those is done through a group that helps support the primary voice of the response, which was, at that time, Dr. Messonnier.

And so the main issue was to identify what caused these issues trying to be communicated, and what significant recent issues needed to be addressed. Over a number of weeks, there was a sense that we could see what was about to happen, and that the need to begin communicating that to the public needed to start.

And so this was one of the opportunities to begin to communicate the potential of needed changes, interventions, and expectations that the public may have to do something that's very different from what they're used to.

Q And obviously, it's been reported that there was a negative reaction to Dr. Messonnier's remarks within

the government. And the very next day, there was that change in leadership to the coronavirus task force. You mentioned that the pathway of communication changed. Can you tell us what you meant by that, with the change in leadership of the task force?

A Previously, through the incident management structure, where we continued to do the data collection, analysis, interpretation, translation. That was -- and we continued to do that, I think, on a daily basis, and providing that information through various different mechanisms.

The direct communications between ourselves and Dr. Redfield and the Secretary were the primary means whereby we would communicate into that task force. So the change in the leadership meant that a different path should have been established or might have been established, but that we would continue to communicate through the Secretary and through our director.

However, additional staff on that task force, I think -- the means for communicating to them was not clear. The connection between incident manager and -- the incident manager, our director, and the White House task force was not clear.

Q How did that impact your work, that lack of clarity?

A I think that as the White House task force matured with the sources of information available to them, and leading to decision-making, we weren't as -- we did not know what those data sources were necessarily. We didn't know how the decisions were being made. And the engagement with the agency to utilize the resources that we were continuing to put up, they weren't clear on how our engagement was going to be utilized.

Q What do you mean by that, engagement in terms of --

A The use of the analytics capabilities, the modeling, the epidemiological investigations, the situational awareness and the situational reporting, and the means by which recommendations would be developed and communicated to the public.

Q Did you get that sense, that the line of communication had broken down?

A There was an inability for any staff to communicate with the media. This -- CDC would usually have different layers of engagement with the media. One would be at a technical level with those in the media who are highly technically astute, in order for them to understand the decisions and the science and the emerging characteristics of the virus.

And then there were public offerings or at least

telebriefings, et cetera, that would be available for questions to be answered or specific messages to be communicated and captured broadly. The capability for the agency to engage either at that lower technical level, or at the broader telebriefing level, I think was limited that through mostly requests to have those engagements more -- decisions were not passed down to us on whether or not they were allowed.

Q A request would come in, and then they would never get to you. Is that what you're saying?

A So a request for some engagement with just a technical journalist would not be approved, or we would not know if it had been approved. And so de facto, those engagements would have to end because of deadlines.

Q Was it communicated to you that communications that could alarm the public had to go through the Vice President's office?

A I don't recall that in particular, but I think my experience at that time, I think all communications were not allowed. There were very few.

Q What effect did that have on the folks working on the response at CDC?

A It had a significant impact on morale. It had an impact on what was an expected approach to how the agency engages the community, and in anticipation on how

national leadership and engagement with our state partners may have been impacted, because of the lack of the ability to have that routine communication.

Routine communications can not only inform, but can also correct if there are problems, and so -- in terms of the interpretation of what we were trying to communicate. So I think the absence of those had an impact with their -- there are no solutions or the public is not sure what's going on. So for that reason, it's important to have that ongoing communication, so that certainly we could communicate, but also any change in findings were things that the public themselves could do could be communicated.

Q What was the impact on morale in this?

A I think the response felt that this was -- that the work that they were providing was not being recognized, or was not having an impact. And so I think the significant amount of information was being developed and provided. We could not tell if it was being routinely reviewed by those at the highest leadership level.

Q What specific work are you talking about?

A Investigations, data that were coming through. I think that's where the importance of the MMWR became a critical vehicle, because it was one of the one places for that ongoing communication about findings, about new information, about changes, recommendations, could be

communicated.

Q Were you aware of any telebriefings that the CDC requested to you that were denied by the Office of the Vice President?

A Can I state specific instances of it? I can't recall at this point. The frequency of the telebriefings gave an indication that the path had changed, and the inability for there to be any lower-level communications was an ongoing concern that persisted.

Q By lower-level communications, you mean?

A With media. I mean, even to the -- I think there were -- non-COVID communications were not being approved. And we could not tell if that was a problem with the process or a problem of decision-making.

Q While you were incident manager, did you look into the process, and why this was -- why things were not being approved?

A Yes. And most of that was done through, first, the deputy director and with Dr. Redfield, in order to help mitigate that, and through our office of the associate director of communications.

Q What discussions did you have with Dr. Redfield about this?

A The awareness of the stopping of a lot of the capability to communicate. He indicated that that was not

in line with what I anticipated public health approaches had been in the past, and was -- would have a negative impact on our ability -- would have -- to meet the public health issue.

Q When did you have that discussion with Director Redfield?

A I don't recall specific dates. That was a discussion that occurred on various specific times with different levels of leadership.

Q And what was the response from him?

A I actually don't recall specific responses. Just that the process was unclear and that a number of different parts of leadership wanted to participate in reviewing the materials.

Q Sticking with telebriefings, specifically, and I'll just ask you this one last question. What impact do you think that had, the inability to get that information out during critical times? I guess there was a three-month gap between March 10th and June 12th in CDC telebriefings. What do you think that impact was on the response?

A So the -- there were different impacts. From a public health partner standpoint, our partners looked to those leaders to demonstrate what the national recommendations are, the direction that CDC is recommending to take place.

So the stopping of these coming from CDC and the moving of that to an interim task force structure meant that the independence of those recommendations, it wasn't clear how CDC was participating in those recommendations. And therefore, partners were not certain about the guidance being provided.

I think the CDC also, at least from an operational standpoint, were not aware of the number of recommendations being developed. And therefore, as those recommendations would be developed and be communicated from the task force, the agency was not able to provide background or reasons for changes or some of the recommendations that were being made. So CDC's usual engagement with our public health partners is to explain, to support. And so in that sense, we were not able to communicate recommendations that were being developed.

Q What impact do you think that had on the course of the pandemic?

A Well, the decisions that needed to be made are very big decisions. And those decisions really should be coming from the highest levels of the government. The incorporation of engagement with the CDC should have been a component of that. And from the time that I had as incident manager, the use of the agency as an arm of that response could have been more optimized.

Q Our hour is up. And I wanted to check with my colleagues to see if they have any questions now, or maybe ask Kevin if now would be a good time to take a lunch break?

Mr. Barstow. How many more lines do you think you have? A couple more?

[Majority Counsel]. I think probably around an hour left.

Mr. Barstow. Okay.

The Witness. I think we could power through if you would like to, depending on -- we could try and do that. Maybe take five minutes.

[Majority Counsel]. Okay. I just want to check with colleagues on that, if that's okay with them.

[Minority Counsel]. That's fine with us. We have no questions right now, so we are in favor of powering through.

[Majority Counsel]. So five minutes and then power through.

(Recess.)

[Majority Counsel]. Back on the record.

BY [MAJORITY COUNSEL].

Q So I wanted to show you three documents that are agendas related to the White House coronavirus task force. They are Exhibits 4, 5, and 6.

(Exhibit Nos. 4, 5, and 6 were identified for the record.)

The Witness. Okay.

BY [MAJORITY COUNSEL].

Q Maybe I can start by asking you, generally, after that change in leadership of the task force, how did you -- what were your interactions directly with the group?

A So our pathway of information and engagement is through Dr. Redfield, along with the -- well, Dr. Redfield continued to participate in the -- as the CDC representative to that group.

So we would communicate through Dr. Redfield to the group. There were not direct or routine engagements with Dr. Birx at that time. And I can't recall when we started providing a direct mailing to her of our incident management updates, so that she could be aware of the data and available resources to her.

Q You personally briefed Dr. Redfield and debriefed with him after the meeting?

A So, yes, there was an a.m. briefing that we had with him. And there was established -- and I can't recall when -- there was a post either telebrief, that is White House telebrief, or post White House task force briefing that we established, in order to hear from him what the outcomes from the meeting were.

The meetings themselves, if there were any record of it or tracking, that would have been needed to be communicated to the various operating divisions. I was not aware of any task tracking capability to know that decisions were made, and the expectations for those paths that had been provided to them.

Q In your personal view, did the observation you noted earlier about shorter term agenda items versus longer term planning persist through March?

A During March still, I think the focus was on more of that shorter term planning. However, the continued increasing number of global cases, the experience in Europe, and the eventual state level and jurisdictional level decisions on either school closures or other kinds of efforts, I think the focus on the need for the broad intervention approach certainly rose to the fore.

I think there was some increase in that strategy component. That increased strategy component was at the White House, and it was not communicated with similar efforts we might have had at CDC.

Q Did folks at CDC continue to work on these issues, it just wasn't getting communicated to the White House task force?

A It wasn't clear how to engage. I think as the White House task force developed capabilities for doing

analyses and modeling, the role that CDC played, and also the role, the eventual shared activity that the NRCC played, those -- it was not clear who was doing what activities, and whether engaging the CDC and utilizing the resources we had, if that could have been improved.

We would have recommended greater engagement, participation, and meetings, et cetera, with what was a group of -- at the analytic level at the White House that was developing, which was similar in responsibility and charge to efforts the CDC had.

Q They were duplicative?

A Yeah, I think for most of the period, it was not clear what was happening there. And with the -- to say that they were duplicative would have indicated that we had good visibility of what efforts were actually ongoing.

Q You just didn't know what was being done in this area of community mitigation and planning and analysis?

A Yeah, mostly around the analysis of available data, determination of the potential impact of those findings, and the use of that information to help direct resources for the response.

Q I want to take a look at these documents, starting with Exhibit 4, which is a White House coronavirus subtask force agenda from March 3rd, 9:00 a.m.

First, let me ask you, what is the subtask force?

A So I would have to revisit the structures that happened within -- like I said, this is -- hold on just a second. So this is the Office of the Vice President coronavirus subtask force agenda. The structures that were used for the task force, I can't recall what the organizational chart looked like. We were more familiar with the NSC, PCC, sub-PCCs, and other structures that get utilized. This one is utilizing a different organizational structure that I can't -- I don't recall.

Q And looking at item 2, you and Dr. Cetron provided an update to the subtask force. Do you recall that?

A Yes.

Q And what would these updates entail?

A These would be largely describing the numbers of cases globally, the numbers of cases domestically. Depending on the time, there would have maybe been some of the repatriation issues as well. And then mostly situational awareness information, both for what we're seeing with the virus, and numbers of cases. And then probably from Marty, some information on the screening at the borders and the identification of cases.

Q And you gave your briefing. How did these meetings work?

A I don't recall how many of these I actually attended, but the information was provided. And I presume that they were then translated and summarized, and presented to the task force itself. And then I presume decisions were queued up at the task force for arriving at recommendations.

Q For the items on this agenda, were you involved in the discussions and decision-making?

A I think we may have been present. I think depending on some of these, Marty probably would have been involved. Yes, a lot of this is, again, talking about the -- what to do about these individuals, recommendations around travel, et cetera. So on number 2, 4, and 6, I think we provided some input on the phone.

Q Do you recall, in terms of due-outs from these meetings, how tasks were assigned, and what was expected of CDC or other agencies, how that worked?

A Yes. So for these, there would have been tasks identified that could have been provided to the agencies. So it was the subtask force agenda, which I'm not sure which subtask it was. So there would have been some articulation of what the expectations were. I can't recall right now specifically, but at this level, there would have been.

Q Who would be assigned those tasks?

A I presume the chief of staff would have been assigned. I don't recall who actually was providing them.

Q Looking forward to Exhibit 5, and item 6 is the Europe travel advisory. Were you involved in discussions that you can recall?

A I don't recall if I was or not. I believe Marty was present, and certainly would have been.

Q Okay. And then did you see, in terms of how the meetings were run and the change in leadership that occurred when the Vice President took over, did that lack of clarity and communication affect the work that was actually being done in this subtask force or --

A I actually don't recall the outcome of this task force. I don't recall how long this particular one lasted.

Q Is that something that happened, that subtask force would be assembled, and then not last a period of time? Just tell us how --

A I think certainly throughout the response, the structures that you use can change in order to be most effective, based on the need. So I can't speak now to how this -- what happened at this particular coronavirus task force. I think I led the response for another 20 days. And then there's another incident manager. So I don't recall what happened after this. But with the

establishment of the NRCC, some of these structures changed, in that -- what happened with this task force, I'm not sure.

Q How would you describe the functioning of these task forces and subtask forces at this time, generally?

A I think they were mostly focused on providing information up, on articulating detectible steps that needed to occur, and then identifying how to best coordinate across the different agencies that are involved in these particular tasks.

Q The meetings were effective in coordinating across agencies?

A I can't speak to their effectiveness, but just as a means by which a lot of that coordination was occurring, as I recall.

Q I want to briefly ask you about the CDC's testing efforts while you were incident manager. And for that discussion, there are two other exhibits, Exhibit 7 and Exhibit 8.

(Exhibit Nos. 7 and 8 were identified for the record.)

BY [MAJORITY COUNSEL].

Q Exhibit 7 is an executive summary prepared by HHS's office of general counsel, and Exhibit 8 are some

interview notes of Dr. Steven Lindstrom from this work that the HHS office of general counsel did.

On a high level, and I think we can -- the contamination issues have been well documented. We can avoid getting into the sort of nitty gritty of what happened in the lab. But can you tell us, on a high level, how CDC's labs respond once a potentially pandemic disease is identified like this?

A With the identification of a novel pathogen that required the development of new diagnostics, the CDC has, in several instances in the past, taken the subject matter expertise, and applied that to the design of a new test. And then at CDC begins the process of developing that test, so that it can be distributed to public health laboratories.

With this particular test, it was more designed based on the sequences that were available, that was manufactured for use at CDC. And then through a separate manufacturing process was made available for uses at public health labs.

As that process occurred, we -- I don't know if it's in some later information that there was a design problem in one of the components of that test that was given -- was making it such that you could not use those test results.

In addition, there was the detection of a very low level of contamination that was not from the components

that were described in Exhibit 7. So Exhibit 7 is not correct, in terms of its assessment of what happened, but has components of it that are consistent with the assays.

So that assay was devised initially and sent out to public health laboratories, so that they could do testing for public health. It was not a component of commercial manufacturing. It was not a component of what hospitals can use for detecting. This particular test was specifically for use in public health laboratories.

Q The conclusion in Exhibit 7 is incorrect?

A The conclusion that there was contamination of the device in -- let me make sure. Hold on. The point I'm making is that the problem was not contamination. It was a design problem. And I believe this document concluded there's a contamination problem.

Q And one of the larger takeaways from the interview of Dr. Lindstrom is the resources issue. And I wonder if you could speak to that, the initial work being done at the respiratory virus diagnostic lab. Looking back, was that lab understaffed or under-resourced, in terms of its ability to develop this test and to scale it up?

A Dr. Lindstrom's experience and capabilities to develop these tests was one that had been demonstrated in the past, successfully developing such tests. And so we

really looked to Dr. Lindstrom to help us understand what the resource requirements were.

So as a part of the laboratory task force, the capability for how to expand the development of that test to other parts of the agency is one that could be a decision that he would make. And that the time needed to do that, relative to the time needed for these tests to be developed, was one that the expansion of that lab to bring on additional staff required time spent away from actually doing the test. So that was a balance decision that Dr. Lindstrom needed to make.

Q Looking at Exhibit 8, it says he made the comparison to the flu. And he said, "we didn't have what the flu lab -- what we had in the flu lab, a system of people with knowledge, resources, staff, appropriate for all stages of manufacturing, quality design, while also doing diagnostic testing." And I think there are only three or four -- he noted that there are only three or four people at CDC who could do this work. Do you agree with that assessment?

A There are other parts of the agency that have expertise in FDA diagnostic manufacturing. There are components and different parts that can provide that, because there are different assays that have been approved in the past. So I think with a request to bring in those

additional staff, those additional staff could have been made available to him.

Q But that didn't happen here, at least initially. And the RVD was working with that small staff.

A RVD made the decision to work with that small staff.

Q Looking back, was that a mistake? What should have happened?

A I think a rapid expansion or participation from a broader set of folks at CDC would have been helpful.

Q And another point that has been made is that there are certain quality control resources that exist in private labs that weren't present in the CDC lab, one being an operational lead who could walk someone through, and was knowledgeable about the entire process. Do you agree with that assessment, that the CDC lab was lacking in that sort of process expertise?

A So this particular lab, I don't recall the quality manager, how they would set up their quality management systems. But quality management is an issue at CDC that had been addressed, and is being addressed through a number of efforts now.

And so could there have been better quality management in this lab? Yes. Is that the -- a need that we're addressing? Yes. That is something that, in this

particular situation, a more robust quality system would have been advantageous to this outcome.

Q Taking a step back, would efforts outside of CDC to develop national testing and surveillance systems have prevented some of these problems?

A With the speed with which the U.S. might have had tests available to use, I believe there are processes that could have been improved in that space as well. And so those largely fall to FDA and their approach to regulating laboratory results tests, and to their regulations put forth in the Emergency Use Act processes that they have outlined.

And so changes to those also occurred during the response. And I think they -- those changes were a reflection that improvements could have been made there as well that would have allowed for the commercial laboratory to have tests soon, and to allow hospitals to make their own tests and use them, similar to what happened in other countries.

Q It's been reported that in the March, April timeframe, the White House had convened a working group to begin designing a national testing plan, but it was later dropped to, it said, state governors to primarily lead testing. Were you aware of that working group for a national testing plan?

A If I'm recalling, there were efforts that the Assistant Secretary for Health was helping to put forward that were trying to address the very broad issues that were emerging out of the agent/reagent shortages, and the capability to manufacture diagnostics.

And so those are very broad, big issues that require engagement from high levels of the U.S. government, and coordination across the U.S., in terms of how diagnostics are used, and who should get them in order to make sure that we get the most information with a limited numbers of tests. The issues around the rollout of that testing plan, I don't recall at this point.

Q Were you involved in the discussions with the ASPR?

A With the ASPR or with the OASH?

Q With the -- yeah.

A So my engagement on testing was largely with Dr. Giroir and OASH.

Q I wanted to ask you about your transition to the NRCC. And how did that come about?

A So I forget the exact date, but there was a point at which the decision was made to move towards the combined FEMA-HHS structures that we had been considering prior to the coronavirus, but which would be needed for a large-scale response.

So those were named, and I believe the other things followed at that same time, with that stand-up of that actual physical combined activity meant that there should be significant CDC engagement in that, anticipating that what we were doing was within the management structure needed to be connected in with this broader interagency USG effort. So the decision was to have me stop being the incident manager and be a part of the National Response Coordination Center.

Q FEMA released an assessment in January of 2021 about the whole of government response. And I just want to show you a couple of diagrams. One is a timeline and that's Exhibit 12.

(Exhibit No. 12 was identified for the record.)

The Witness. Okay.

BY [MAJORITY COUNSEL].

Q And yeah, figure 10, interagency coordination timeline. So I guess the philosophy that the Trump administration applied to the work of the NRCC was that the pandemic response should be locally executed, state managed, and federally supported. Can you tell us a little bit about how that worked on the ground from your perspective at the NRCC?

A That terminology, I believe, is particularly used terminology by FEMA about how they do their work. The

coordination of resources that are available at this point requires a significant amount of effort. And so in order to make that happen, FEMA, HHS, and DoD were significantly engaged in working through how to get various agencies and resources, et cetera, to the people that needed it. So for that reason, the statement is a reflection of how routinely resources get utilized, so --

Q What were your -- I know you were part of what was called the Unified Coordination Group. Can you tell us when you arrived at the NRCC, what your role was, and what you were focused on?

A So I think the anticipation was the initial structure would be FEMA, HHS ASPR, and CDC. It was a joint coordination group where the decision-making would occur in that three-part community.

After a while, the structures changed, such that the decision-making then became the ASPR -- with 6 administrative, the Assistant Secretary for Health. So those three were the decisionmakers for any resource determination, for development of new countermeasures, purchase of resources, and the overall distribution of planning.

So when CDC participated in a special adviser or interim adviser role, rather than in a decision-making role, the connection to the CDC as the management structure

is not -- is not formed. It was -- instead, there was a decision to have task forces all coming into the FEMA, HHS lane.

So for that reason, CDC's participation became mostly the coordination of mitigation guidance as the mitigation team, and then also in participating in data -- the data situational awareness. So there was not a good plug-in for what was a large response from CDC into this apparatus here, which was mostly focused on resource allocation. The strategy was happening mostly at the White House task force, with the group that was there. And the connection between the NRCC and that group at the White House, it was also not optimally connected.

Q Why?

A Why was that?

Q Why was that?

A I am not certain. I believe that there was a sense that strategy in disease monitoring, and expectations, were occurring at the White House group. And the implementation, operations, and execution were happening at the NRCC. Our anticipation and hope was that the NRCC was the strategy and operational incident management structure that we had anticipated.

Q And what was the impact on that? I guess the strategy was coming down from the task force to the NRCC,

rather than the NRCC being involved in strategy?

A I think the needs of the operational components of the response are that forecasting and area modeling are being utilized to most optimally make resource allocations. And if that activity is happening as a separate component of the response, and not directly providing that information to the operations, meaning that the two separate groups are trying to decide where best to push and put the resources.

Q Do you think that resources were misallocated as a result?

A I don't have any information that suggests that they were misallocated, but the coordination of that, and the coordination with what might happen in the outbreak, it was not optimal because of that separation.

Q Can you provide additional detail, in terms of areas where that wasn't optimal?

A I think -- I believe that at the White House task force, Dr. Birx was not aware of everything that was happening with the NRCC. And that there was not routine communication except through the FEMA administrator through the White House task force.

And so for that reason, I think the fact that modeling activities, forecasting, hot spot analysis, all of that was happening in two separate places. And that on

realization of that, the request was for the NRCC to not do that forecasting for any of that scenario modeling. So that became difficult for FEMA especially, who routinely referred those kinds of activities to who was best to administer those resources.

Q And just what was the result of FEMA not knowing, and this disconnect between the data and the modeling at the White House task force, and sort of the people who would get resources out on the ground?

A So the outcome was that FEMA, HHS, and NRCC continued doing their assessments, and it was just not being reported in connection with the similar kinds of efforts that were happening with the White House task force, or Dr. Birx at that point.

The rate of activity happening in the NRCC, supported largely through the DoD, was a significant commitment. And so the connection is that the anticipated disease spread outcomes, recommendations, including mitigation, a better connection there would have been a more coordinated response, because the containment and mitigation efforts were housed in FEMA as a specific CDC task group.

As those mitigation efforts became formed, that is, about how to -- what to do when certainly states and jurisdictions reach a certain level of disease transmission, certain kinds of mitigation efforts could be

turned on and off. We had been moving for that through the NRCC, and did present that to Dr. Birx. And I think that was a first opportunity, whereby we started to have better coordination between the activities happening there, and what was happening with CDC around the issue.

Q And do you think this lack of coordination between these two pieces impacted what states ultimately did in that area?

A I don't know if I have data to support that, but I think that the coordination of messaging, coordination of forecasting, provision of interpretation in the translation of that, both in terms of recommendations and in what's communicated to the public, an alignment with that, makes for a more coordinated messaging, and for the potential for the actions to be more coordinated as well.

Q And looking at the timeline here, it says that by August 28, the UCG daily meetings ended. What does that mean, and why did they end?

A I would have to go back. I would have to revisit these. In the summer months, as you can see, there was an anticipated --

[Transmission interference.]

[Majority Counsel]. Back on.

BY [MAJORITY COUNSEL].

Q So, Dr. Jernigan, this timeline indicates that

the UCG stopped meeting on August 28th. Do you recall why that was?

A So the expectation was that this combined structure with FEMA, HHS, NRCC was to coordinate a lot of the deployment efforts and support development of countermeasures and ventilators and other resources, et cetera.

So I think there was an expectation that the wave would slow, and then the interagency NRCC would no longer need to be in place, and that the work -- the activities could go to the programs that were responsible for them.

I don't recall at which point the NRCC actually did slow down, but between -- prior to this time, somewhere in June, there was a connection between the White House task force and the NRCC that essentially hard-coded a lot of the activities happening there under Dr. Birx with what was happening at the NRCC. So that was the initiation of sort of joint data analysis, and hot spot determination activities. So that was -- that helped to connect what was not well connected previously.

Q And you said CDC was acting in an advisory role at the NRCC.

A Yes. We were participating in an advisory role. And then also as the lead for one of the task forces, and then as a participant in the data group.

Q And which task force?

A Community mitigation task force.

Q There were a number of communication issues and parallel streams between the NRCC and the White House task force. Do you think more leadership and coordination from the federal government on these issues would have been more effective? I'm thinking now of the sorts of things that were delegated to the states early on, like testing and supply issues.

A Stated as broadly impacting throughout the U.S., the execution of activities has to be delegated to states and to the local jurisdictions. There's just simply -- the federal government doesn't have the capability to execute those things as a strategy development and provision of direct -- direction to the states.

I do think there's a role for that. And the use of the federal government as a lead in harmonizing the views by which policies would be developed and executed, I believe that harmonization was a useful way of addressing something that is as impactful as the pandemic has been.

Q And do you feel that that harmonization was lacking?

A I think that the coordination between the different parts of the response was not optimized. It

needed to be better coordinated. And that the use of CDC and its resources in helping to develop the interpretation and recommendations and the approaches taken could have been improved.

Q I want to move on to another topic, and that's data during this time period. And CDC's access to data and use of data. I understand that you are now leading the CDC data modernization initiative. And as part of that work, are you reviewing the CDC's use of data during the first year of pandemic?

Mr. Barstow. I think that is getting a little bit outside the scope, if you're talking about efforts that are happening right now. If you want to maybe rephrase the question about efforts during --

[Majority Counsel]. Sure.

BY [MAJORITY COUNSEL].

Q What do you think were the greatest challenges, in terms of data to the CDC in this time period, December of 2019 to January 2021?

A Heading into the very first part of the response was a longstanding issue of a number of factors. One, workforce, that the people that can do data science and can implement changes quickly, the workforce just simply wasn't there, both at CDC and also in the states and locals.

The data itself was being transmitted in ways that we cannot scale through use of fax, the use of phone calls, through some electronic reporting. But not any capability to scale. The systems were utilizing data to be submitted from one person to many people with multiple different connections, so there was not efficiency of data movement.

Access to automated electronic laboratory and other reporting was not in place, except for some things that were unscalable. So as the response initiated, the capabilities for states to be able to take in the information about a case and rapidly report it led to delays in investigations, but also delays in getting that information to CDC.

So there became, then, this lag in case information, because the systems were not able to manage it quickly. As a workaround, states began to put that information up on their websites. And so that allowed for the CDC, but also for the general public, to capture that information, and make it available, based on what was being presented at the websites.

The -- there are a number of other factors that have been looked at, but I think, in general, the lack of capability to scale, the workforce, and the -- notably policies and data use agreements were not there. So for that last issue, there are numerous data use agreements

that needed to be worked through, because there was not a common data use agreement with states. And the CDC did not have authority to collect that information as a federal agency.

The means by which the required reporting occurred during the response was through the capabilities that CMS has, and that the Secretary has in times of emergency. So between authorities and policies, absence of workforce, lack of resources over time, and inefficient approaches to data sharing, all of those things led to problems with data at the front end of this response.

Q I want to ask you specifically about hospital reporting data, and the change in hospital data collection systems in January 2020. Before -- I mean, July of 2020. Before July of 2020, how did CDC collect hospital data?

A So at the early -- prior to the pandemic, CDC has established agreements with multiple hospitals, most hospitals in the United States, to collect information on various hospital associated issues, antimicrobial resistance, lyme infections, and so forth.

So that process, through the National Healthcare Safety Network, was in place, and was asked early in the response to use that system in order to collect additional information about impacts on the health care system. So hospitalized cases, but also things about ventilators and

ICUs available, and other resources.

So that information initiated. Around 1500 hospitals were already starting to report, and the use of that system, NHSN, was stopped. And the use of an alternative system, Teletracking, was put in place to do the same kind of work.

Q What brought on that change to Teletracking?

A The full information behind that, I don't have access to. I was not a part of a lot of that. I think those that were looking to help identify potential ways of solving the problem of needing to get that hospital data either at the White House task force or at the HHS leadership level, I don't think they fully recognized what resources were in place and were available.

And so a decision was made to go with a solution that was one of several different vendors that were available that would provide that same manual data entry that was already underway. And so through various discussions, the decision was made to have Teletracking be one of a few means for getting the data through, and then subsequently was identified as the only means for doing that.

Q Why did that happen, when it became the only means for getting the hospital data?

A I would have to check back on my notes and all, but the -- I believe between April, I think, around

that time, where some of those decisions would be made. I don't recall right now.

Q How did the two systems compare in terms of the ability to collect accurate data?

A So one of them, NHSN, was already in the case at over 5,000 hospitals, and subsequently became available at another 50,000 long-term care facilities. I don't know what the market share of Teletracking was at the beginning, but I think the expectation was, with this software, it was going to be able to improve the turnaround time for changes that needed to be made. It also was able to collect information outside of the routine requirements for data collection that OMB manages.

Q And were those expectations borne out?

A I think we -- there was a lack of an understanding that it was not software, but, in fact, a program that takes information from hospitals and can make it -- knows how to verify that that information is correct, and has a team of individuals that are responsible for making it happen.

And so when the decision was made, I think the realization was that the software itself is only one part, and that the CDC surveillance system is not just software, but is a whole process of data validation, data cleansing, and updating that had to be recreated for the Teletracking

system to work.

Q At that time, were there identified problems that needed an immediate replacement in the CDC system?

A As I'm recalling, there were some issues that the security updates needed. I think those were something that were, and have been addressed. There were some -- I think the main issue was around the turnaround time to add components for the reporting.

And so because NHSN had been in place for so long, they had a very good understanding of how an infection control practitioner or hospital would be able to answer certain questions. And so the program felt it was best to test some of those questions to assure that they could be selected, and they would not be incorrectly filled in.

So it's a quality step, which allows for validation that data is going to be correct when collected. I think that was viewed as taking too long. And so for that reason, the decision to not utilize it may have been one based on incorrect information.

Q And Dr. Redfield testified before the Subcommittee that he learned about the decision to move to Teletracking after the decision was made. Did that lack of awareness of the change affect CDC's ability to collect data?

A Yes. So the recommendation to no longer use

NHSN would impact our ability to collect that information. So I think there was a difference. Again, there's a coordination issue there, like was mentioned before. CMS has a longstanding history within NHSN, and had made recommendations to use NHSN. But the Secretary's office decided to support Teletracking. And I believe the decision was with the White House task force to no longer recommend the use of NHSN.

Q The timing of this, in the middle of a pandemic, did that -- I just want you to -- looking back at it, how did that impact the CDC and its use of this data that was very important to the response?

A It removed the CDC from being the analytic arm of the data, and placed that with the Office of the Secretary and the White House.

Q It was reported that a number of CDC officials were angered by this, and one had resigned who was working on data issues. Did this change have an impact on CDC's morale?

A Yes, the impact on morale was there. I think improved coordination and engagement with the CDC would have been beneficial to understand better what the decision-making was, but also to identify changes to systems that could have a lasting impact on our overall ability to improve surveillance. That should have been a

consideration as well.

Q Why should that have been a consideration?

A The introduction of a new system that -- not a new system, but a new software that is managed out of the Office of the Secretary as a primary surveillance tool, or as a primary response tool is a programmatic decision that is not in concert with how we've been doing things in the past. It does not put through management of that program next or close to the agency that has mission responsibility for that.

Q Are you aware of the rationale to make that change at that time?

A I don't have the specifics on it. I know that the decision to make that -- I don't know who the decider was on that. But, yeah, I was not provided the information that would have illuminated the process by which they arrived at that decision.

Q Okay.

[Majority Counsel]. I'm being told we're at our hour. I have, in total, probably ten minutes left, but I wanted to check with our colleagues in the minority to see if they have any questions for you at this time.

[Minority Counsel]. We do not, [Redacted]. You can continue.

BY [MAJORITY COUNSEL].

Q So I'm hoping that we can wrap up by taking a few steps back, and looking at the response overall. I think you highlighted a number of areas where coordination was not ideal. I'm wondering if you could look back and assess whether there are any policies or procedures that you wish had been in place while you were working on the pandemic response.

A I think the availability of interagency planning efforts and plans are something that should be revisited, exercised, and modified. And then an ongoing effort in doing that is useful for when a crisis does occur. I think the full exercising of how the federal government and its different entities work together, and what the decision-making processes are from the highest level to the execution level, how -- what those look like, and how they are -- how the full response can know what that process is.

There are some benefits that might occur by having authorities at the federal government, either at CDC or HHS, to facilitate the reporting of information to the federal government during a time of crisis and decisions about ongoing sustainability for surveillance efforts or for others, in order to prevent something like the situation we had at the very front of the response. So sustainability, use of data, ease of data capture, and

response coordination, I think, are the three main areas.

Q I think one thing you've also touched on a few times are the impacts of a number of decisions on CDC's morale, in terms of times that their experts were sidelined. Are there any other instances that you can recall that we didn't discuss today of that happening?

A Not that I can think of. I think many issues have been identified a number of different places. I don't think I have anything further to add.

Q Do you have any sense of the impact that these hits to CDC's morale had during this time period?

A So this crisis that has continued is not an easy thing, and the agency has gone through significant crises in the past which had been difficult. So there is an expectation that the group would be impacted by such a long response.

Additional issues that lead the agency to not be able to see that their efforts are having an impact, I think those can have an impact on morale. But the important thing is not necessarily with morale, but is the recognition that the resources that the agency has, the experience that it has should be utilized components of any national response.

[Majority Counsel]. I have no more questions for you, Dr. Jernigan. I want to thank you both for your time

and for your service at CDC. I know that this has been an incredibly challenging time for you and your colleagues. And we admire your service, and thank you for participating. With that, we can go off the record.

(Whereupon, at 1:34 p.m., the proceedings concluded.)

Corrections to the December 13, 2021 Interview of Daniel Jernigan by the Committee on Oversight and Reform, Select Subcommittee on the Coronavirus Crisis, US House of Representatives

Provided December 23, 2021 to Jennifer Schmalz HHS/ASL

1. Page 5, Line 76: Change name to correct "Daniel B. Jernigan". Middle initial is incorrect.
2. Page 10, Line 204: Change to "… I moved to the Epidemic Intelligence Service Program. There I studied respiratory disease epidemiology."
3. Page 10, Line 208: Change to "…I came to CDC in the Epidemic Intelligence Service in 1994, …"
4. Page 12, Line 248: Change to "…Swan…" to "Swine"
5. Page 13, Line 267: Change to "…with our Division and are assigned to…"
6. Page 13, Line 271: Change to "…read…" to "thread"
7. Page 14, Line 295: Change to "…towards" to "between"
8. Page 15, Line 330: Change to "Carolyn Greene"
9. Page 16, Line 345: Change to "…eventually are identified to be a known pathogen"
10. Page 19, Line 415: Change to "…They, the China CDC, established a group called the Pneumonia of Unknown Etiology (PUE) group".
11. Page 20, Line 461: Change to "also engaging with the Global Influenza Program at WHO and bilaterally with some countries as well.
12. Page 22, Line 509: Change "infected" to "affected"
13. Page 25, Line 587: Change "50" to "500". The Epidemiology and Lab Task force in 2009 H1N1 had over 500 at its peak.
14. Page 25, Line 589: Change to "…I can have somebody to provide those to you…"
15. Page 26, Line 594: Change "stated" to "status"
16. Page 26, Line 600: Change to "…at after years based on examples from our DOD colleagues…"
17. Page 29, Line 681: Change "times" to "…I think were intended to provide time so that we could be more prepared".
18. Page 31, Line 739: Change to "So that's one thing that screening causes, i.e., some travelers with symptoms elect not to travel"
19. Page 38, Line 914: Change to "..So as that was characterized in the United States early in the pandemic, it indicated that travel association <u>would</u> be a targeted part…"
20. Page 41, Line 982-84: Change to "utilizing automated electronic reporting of healthcare encounters from emergency departments".
21. Page 42, Line 1011: Change "condition" to "submission"
22. Page 43 line 1029: Change to "There were other systems later in the response for vaccine effectiveness…"
23. Page 44 line 1043: Change to "this is the National Syndromic Surveillance Program…"
24. Page 44 line 1060: Change to "It was around 60 to 70 percent of all emergency departments. I do not recall the exact number".
25. Page 45 line1068: Change to "National Respiratory and Enteric Viruses Surveillance System".
26. Page 48 line 1155: Change "portable" to "reportable"
27. Page 50 line 1195-96: Change to "…in their communities. There were apprehensions around the collection of specimens…"
28. Page 50 line 1200: Change to "would be to require identification of those individuals…"

29. Page 50 line 1214-16: Change to “could be implemented created issues for the successful implementation.”
30. Page 52 line 1260: Change to “It formalized the engagements of what CDC was doing into a formed group.
31. Page 54 line 1290: Change “pick” to “take”
32. Page 55 line 1318: Change to “So there were some discussions within the interagency”
33. Page 56 line 1338: Change to “expectation would be a broader interagency response would be needed and led to exercises…”
34. Page 56 line 1348 change “in” to “and”
35. Page 56 line 1361 change to “when in fact many of those plans were established in many prior administrations. I think there was a sense that new plans would be needed or that prior plans did not represent the current approach or a new approach might be needed.”
36. Page 58 line 1403 change “accessibility” to “acceptability” in both cases.
37. Page 60 line 1452 change to “in part because as a partner that engages with WHO on a regular basis, the longstanding…”
38. Page 62 line 1494 change “infectious” to “infection control”
39. Page 62 line 1510 change to “cases and contacts”
40. Page 63 line 1532 change “interim” to “interval”
41. Page 64 line 1542 change “three” to “through”
42. Page 64 line 1548 change to “for ease of administering the needs of the response”
43. Page 65 line 1566 change to “And then Dr Birx eventually was sent copies of this on a daily basis”
44. Page 65 line 1589 change to “at the point at which it was noted that fever was present.”
45. Page 66 line 1591 change to “..it did become clear that while asymptomatic transmission was not clear, what some refer…”
46. Page 70 line 1702 Change “research” to “resource”
47. Page 71 line 1720 Change to “directly listed in note E. There is a circle at the top with a “Y”. If we had a color copy, that would be a yellow circle, where yellow indicates…” (the point here is the circled “Y” tells the reader that the information is not for public distribution and is pre-decisional).
48. Page 74 line 1791 Change to “And therefore, there was an expectation of where cases might reside and community transmission could occur. These are things we would have communicated…”
49. Page 76 line 1863 Change to “…these with leadership…”
50. Page 79 line 1927 Change to “…for instance, some guidance for lab workers is not in any way called into question by new contrary guidance when it is released.” The “leak out” is incorrect.
51. Page 89 line 2178 Change to “And so the main issue was to identify what needed to be communicated, and what…”
52. Page 103 line 2537 Change to “I think I was in the response for another 20 days. And then there’s a transition to a new incident manager”.
53. Page 104 line 2547 remove “detectible” I can’t recall what the actual word was there.
54. Page 105 line 2584 Change to “As that process occurred, we – I don’t know if it’s in some later information you’ve been provided, but there was a design problem in one…”
55. Page 108 line 2643 Change all “RBG” to “RVB”, including line 2643.

56. Page 109 line 2674 Change to "…regulating Laboratory-Developed Tests (LDT), and to their…"
57. Page 112 line 2756 Change to "…decision-making then became the ASPR, the FEMA Administrator, and the Assistant Secretary for Health."
58. Page 112 line 2762 Change to "So then CDC participated in a special advisor or interim advisor role, rather than in a decision-making role. The connection to the CDC's management structure was not formal. "
59. Page 114 line 2792 change "area" to "scenario"
60. Page 115 line 2815 change "for" to "or"
61. Page 115 line 2837 change "certainly" to "certain"
62. Page 121 line 2984 change "lyme" to "intravenous line"
63. Page 123 line 3019 change to "…was already in place at over 5,000, and subsequently became available at another 15,000 long-term care facilities."
64. Page 123 line 3029 should read "…there was a lack of an understanding that NHSN was not just software, but, in fact, was a program that…"
65. Page 126 line 3097 Change to "It does not put the management.."
66. Page 127 line 3139 change to "…use of data,"