USING BUDGET PRINCIPLES TO PREPARE FOR FUTURE PANDEMICS AND OTHER DISASTERS

HEARING

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SUBCOMMITTEE ON LEGISLATIVE AND BUDGET PROCESS

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WEDNESDAY, JANUARY 19, 2022

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON LEGISLATIVE AND BUDGET PROCESS,
COMMITTEE ON RULES,
Washington, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., via Webex, Hon. Joseph Morelle [chairman of the subcommittee] presiding.

Present: Representatives Morelle, Ross, McGovern, and Burgess.

Mr. MORELLE. The Subcommittee on Legislative and Budget Process of the Committee on Rules will come to order.

I want to begin by welcoming our witnesses and thank them for being here today. And I would like to thank my colleagues Chairman McGovern of the Rules Committee and Mr. Burgess, our ranking member of the subcommittee and a member of the Rules Committee, for joining as well.

Today's hearing will focus on the importance of making strategic investments across the Federal budget to build economic resiliency and ensure an efficient Federal response to future pandemics and other disasters.

Disaster preparedness includes not only ensuring that existing programs are adequately funded but that systems are in place to efficiently distribute the funding as well. It is critical for the United States Government to make these investments before the next disaster occurs. And we have seen that underinvestment in key programs exacerbates inequities already present in our communities.

And we inherently know the value of investing in preparedness. In fact, we do it all the time. We invest in public safety infrastructure to quickly respond to 911 calls and help mitigate dangerous situations. The National Weather Service routinely communicates storm warnings to allow local governments and State governments to begin preparations. These are critical efforts. Are we doing enough in these critical efforts, or are we budgeting enough for them?

These types of investments should be prioritized as we think of investments in disaster preparedness as well. As we all know, investments in preparedness cost far less than investments in response measures. And a recent study by the National Institute of

Building Sciences found that for every $1 invested in disaster mitigation measures we ultimately save society $6.

So, while this fundamental budget principle can be applied to the Federal response to many different types of disasters, an examination of the response to COVID–19 is an obvious place to begin.

Almost 2 years since the beginning of the pandemic, this hearing attempts to provide an opportunity to look back and, more importantly, have a conversation about what lessons we have learned and how we can be better prepared for the next pandemic. This type of forward-looking thinking is desperately needed, as lessons learned from previous crises have clearly not been taken to heart.

For example, even after recent public health crises ranging from SARS to Zika, public health agencies continue to be dramatically underfunded. A recent analysis shows that public health spending accounts for just 2.5 percent of all health spending in the United States, which comes to roughly $274 per person.

This past fall, the Biden administration released a pandemic preparedness plan that focused on strengthening public health systems, improving surveillance and monitoring for early threats, increasing stockpiles of PPE, and investing in vaccines and therapeutics.

While I applaud the administration for these efforts and these types of measures that must be enacted, the budget principles behind this plan should be applied to preparedness for other types of disasters as well. From the 2000 to the 2010 decade, spending on FEMA's public assistance programming increased 23 percent. And as the frequency and cost of disasters continues to increase, Congress must consider how to better address disaster preparedness and assistance in the annual appropriations process.

And, finally, coordination between government and private stakeholders can clearly be improved. Although FEMA is the primary agency for disaster assistance, it is important to note that at least 16 other Federal departments and agencies also contribute to disaster relief efforts. And I appreciate, in the testimony submitted by the witnesses, a number have touched on this point.

This response structure becomes even more complex when including State and local government stakeholders, who, along with the private sector and not-for-profit organizations, are often most directly engaged in local communities.

Ensuring that efficient systems are already in place beforehand will dramatically improve the quality of the response, particularly for services where planning and logistics play a significant role. Whether it be allowing food distribution networks and supply chains to operate more efficiently or ensuring that funding for government stimulus programs are able to quickly get to families in need, Congress must examine potential changes to this process.

So I look forward to the discussion today, which I hope will develop policy recommendations on how to use the Federal budget process to build an economy more resilient to future disasters.

And, with that, the Chair now recognizes the ranking member of the subcommittee, Dr. Burgess, for any remarks that he wishes to make.

Dr. BURGESS. I thank the Chair, and I am certainly glad that we are holding this hearing.

I do want to thank our witnesses for being here to testify, and certainly looking forward to hearing from all of you and learning about how our Nation can more efficiently plan our budget to prepare for future pandemics.

You know, I can't help but think I am sitting here in the Rules Committee by myself. This hearing is being done virtually. But it was just a little over 2 years ago that we had one of the first Rules hearings to regard what were the initial stages of this pandemic. And it is hard to believe that not only are we on the second anniversary of that, we are going into the third year of the pandemic. And, certainly, you can recognize a certain amount of pandemic fatigue around the country. And every congressional district is encountering that and recognizing that.

I do hope today's hearing is productive, and I am anxious to see and learn how our budgetary process and our response can improve our pandemic preparedness.

And, Chair Morelle, I just have to point out—and Chairman McGovern—that we are probably—you referenced an appropriations acknowledging that there is going to be future disaster mitigation necessary.

We are actually about, what, 3 weeks away from the lapse of—an appropriation lapse in our governmental funding. Unfortunately, because of where we are in the process, we are very likely to see additional continuing resolutions.

And, as you both know, it is impossible to plan for or to budget money for future disasters if you are only using a continuing resolution process, because, by its very nature, that is a process where you only look back and fund the activities of the previous year or years, not what is going to be happening in the future.

So, I certainly hope that we—and I am sensitive to the fact that our ranking member of the full Rules Committee is an appropriator, so I want to be careful what I say. But, at the same time, we really do depend upon the appropriations process to do their work, and then, of course, we will do our work in the Rules Committee when they finish their product.

But here we are. We are in the largest and most devastating pandemic in—certainly in my lifetime. In fact, I serve on another committee that has jurisdiction over pandemic preparedness; that is the Committee on Energy and Commerce. And I have been asking our committee, the Committee on Energy and Commerce, to hold just such a hearing for certainly longer than a year, probably almost 2 years.

And recently I sent a letter to Chairman Pallone of the Committee on Energy and Commerce expressing my frustration and disappointment with the lack of response from the Energy and Commerce Committee, which is one of the primary committees that should deal with public health.

I think we have much to learn from the experience that we have all been through the past 2 years. But our committee has been—the Energy and Commerce Committee has been eerily silent. And it is a point of personal frustration to me that the Energy and Commerce Committee, which has a responsibility in this area, really has not shouldered that responsibility.

And this is not just a criticism of the majority Democrats. I think that criticism actually applies to both sides of the dais. I cannot believe how passive we have been on the Committee on Energy and Commerce as far as asking the hard questions and providing information as an authorizing committee to our appropriators and then ultimately to the Rules Committee before a process comes to the floor.

It has been extremely frustrating to be in the minority during this pandemic, but it is also extremely frustrating to be part of a committee that should be in the vanguard, should be in the lead, and, in fact, has not even shown up.

So, the Energy and Commerce Committee reauthorized a bill; it was called the Pandemic and All Hazards Preparedness Act of 2018. And this very situation is what we were aiming to prevent and for which we were attempting to be prepared. And I believe we can all agree that we have had many successful accomplishments from the Pandemic and All Hazards Preparedness Act. The one thing that it should have done, which was prepare us for this pandemic, it did not do.

And, again, going to my previous frustration, we had no real-time—no actual hearings, as an authorizing committee, on the Committee on Energy and Commerce looking at this in real-time while the drama was unfolding around us. We had the Pandemic and All Hazards Preparedness Act signed into law in June of 2019, 6 months later to be visited by this pandemic. And we never asked a single question: Did we get it right? What could we have done better? What should we learn for next time?

So, it is not often that we have a real, live case study to intricately examine the effectiveness of the policies that we just passed. And many of us, those of us who are witnesses today and those of us on the legislative side, we have had some experience with this over the years.

One significant success that did occur during the first year of the pandemic—it was a significant milestone of the previous administration, the Trump administration—was that of Operation Warp Speed. Because of this program, we have access to vaccines, we have access to effective therapeutics. And the very existence of those vaccines and therapeutics begs the question, what made Operation Warp Speed so successful, and are there ways that we can apply these successes to our government's regular duties so that we don't just have to respond at the time of an emergency?

It is critically important that we take the time to examine the program while we still have an opportunity to speak with those who developed and deployed it, those who were on the front lines, those who lived it. And so, for that reason, we are so very fortunate to have Dr. Kadlec at our witness table today.

Additionally, it is an opportune time to compare our Nation's response to the novel coronavirus to other pandemics that we have encountered—for example, while on different scales, the Ebola outbreak that ravaged western Africa in 2014 and 2015 and in fact, made its way to this country and ended up in my backyard in Dallas, Texas.

It took 5½ years for an Ebola vaccine to be developed and produced and receive emergency use authorization. That is why the

stunning success of Operation Warp Speed stands in stark contrast, where, over a 9-month period we had the streamlining of the process, the emergency use authorization process, at the FDA and got that vaccine in the hands of our constituents.

Furthermore, I think it is pertinent to learn about what we are currently doing in the current administration to further the progress, the success, of the previous administration's pandemic response.

We also must determine exactly where the almost $5.5 trillion that Congress has appropriated for these efforts, where are those dollars today? Which have been spent, and what remains unspent?

And when we talk about further activities, we really can't authorize new spending—we can't appropriate new spending until we know where the last dollars have gone. Effective oversight is going to be a key component of any successful pandemic preparedness and response effort. And, in fact, we really can't talk about how we budget for future problems if we don't understand where the dollars went, where the successes and the missteps were in the last effort.

Plain and simple, we really can't plan for future pandemic preparedness unless we have a strong understanding of what has worked and what has not worked.

We find ourselves in a unique and really a historic position. While these past 2 years have been exhausting for Americans, now is not the time to just sit back and hope that we won't find ourselves in a similar crisis in the future. This will be our best opportunity to create strategic and smart policy that will help ensure that, the next time this occurs, the country is properly prepared and that preparation can be properly executed.

Thanks, Mr. Chairman, for holding the hearing. Thanks to our witnesses. And I will yield back.

Mr. MORELLE. Thank you, Mr. Burgess. I appreciate your comments about Energy and Commerce.

I do want to note, though, that, while the pandemic is, you know, in the center here in terms of our thinking, that more broadly I also want to deal with the notion of other natural disasters which may be regional, whether it is wildfires, et cetera, and whether or not our budget process is prepared to deal with that.

So I appreciate your comments.

I also want to thank Chairman McGovern, who has been working with our subcommittee to host this hearing, and so, appreciate them.

As for the appropriations process, I don't have the privilege of serving on the Appropriations Committee, but I would note that the House has, I think, done a great deal and we are waiting for our brothers and sisters across the Capitol, as we do on many issues.

So, with that, I would like to introduce our witnesses.

Let me begin with Dr. Helene Gayle, who has been president and CEO of the Chicago Community Trust, one of the Nation's oldest and largest community foundations, since October 2017. Under her leadership, the Trust has adopted a new strategic focus on closing the racial and ethnic wealth gap of the Chicago region.

For almost a decade, Dr. Gayle was president and CEO of CARE, a leading international humanitarian organization. An expert on global development, humanitarian, and health issues, she spent 20 years with the Centers for Disease Control, working primarily on HIV/AIDS. She worked at the Bill and Melinda Gates Foundation, directing programs on HIV/AIDS and other global health issues.

Dr. Gayle was born and raised in Buffalo, New York, which, as a upstate New Yorker, I have special pride in knowing that. She earned a B.A. in psychology at Barnard College, an M.D. at the University of Pennsylvania, and an MPH at Johns Hopkins University.

We are also joined by Julia Tedesco, who is the president and CEO of Foodlink, a not-for-profit dedicated to ending hunger and building healthier communities in the greater Rochester/Finger Lakes region of New York.

Over the past decade, she has led the organization's evolution from one of the country's oldest food banks to an innovative food resource center and public health organization focused on addressing the root causes of food insecurity, including chronic poverty and systemic racism. Ms. Tedesco began at Foodlink in 2008 and has served in numerous roles for the organization. She was named executive director in 2014.

Ms. Tedesco holds a master's degree from Syracuse University's Maxwell School of Citizenship and Public Affairs and a bachelor's degree from Fairfield University. And I have had the privilege of working with her on a number of issues back in my hometown.

Jeff Schlegelmilch is the director for the National Center for Disaster Preparedness at Columbia Climate School at Columbia University. In this role, he oversees the operations and strategic planning for the Center. He also oversees projects relating to the practice and policy of disaster preparedness. His areas of expertise include public health preparedness, community resiliency, and the integration of private- and public-sector capabilities.

Prior to his role at Columbia, he was the manager for the International and Non-Healthcare Business Sector for the Yale New Haven Health System Center for Emergency Preparedness and Disaster Response. He was also previously an epidemiologist and emergency planner for the Boston Public Health Commission.

And, finally, Dr. Robert Kadlec previously served as Assistant Secretary of Preparedness and Response at the U.S. Department of Health and Human Services from August of 2017 through January of 2021. Dr. Kadlec spent more than 20 years as a career officer and physician in the United States Air Force before retiring as a colonel. Over the course of his career, he has held senior positions in the White House, the United States Senate, and the Department of Defense.

So thank you all again for joining us today.

And we will begin with Dr. Gayle. You are recognized to share your testimony with us.

STATEMENTS OF HELENE GAYLE, M.D., CEO, CHICAGO COMMUNITY TRUST; JULIA TEDESCO, PRESIDENT AND CEO, FOODLINK, INC.; JEFF SCHLEGELMILCH, DIRECTOR, NATIONAL CENTER FOR DISASTER PREPAREDNESS, COLUMBIA CLIMATE SCHOOL; AND THE HONORABLE ROBERT KADLEC, M.D., FORMER ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF HELENE GAYLE, M.D.

Dr. GAYLE. Great. Good morning, and thank you, Chairman and the other members of the committee and the subcommittee, for the opportunity to address you on this incredibly important issue.

I won't go over a lot of the statistics around this COVID pandemic. I think we know them well. And while the health and economic consequences of COVID–19 are unlike any that any of us have seen in our recent memory, it is likely that this is not going to be a once-in-a-generation pandemic. We know that more than 40 new infectious diseases in humans have emerged in the past decades. You have mentioned some of them: SARS, MERS, Ebola, Zika, et cetera. So we know that we are at a time when we will continue to see new infections that can lead to global pandemics as we are seeing now.

Clearly, we have to take the lessons that we have learned and think about how we apply those not only to this current crisis but in ways to make us better prepared. And while we know that we will continue to have these new infectious diseases emerging and pandemics, how we respond to them will really determine whether or not we see the kinds of severe health and economic consequences that we are seeing today.

So let me just lead off with five points.

First, pandemics do play on social fault lines and will always impact the most vulnerable in our societies. COVID–19 has highlighted how the social determinants of health and underlying root causes that make one vulnerable to poor health also further amplify health and economic inequity. Pandemic preparedness means focusing on how we prepare for economic stability and resiliency not just in the face of a crisis but also in normal times.

This requires us to think about how we address issues like affordable housing, the social supports we provide to individuals and family over the long term, like paid sick leave; family leave; living wages; affordable, accessible high-speed internet; and comprehensive, affordable health insurance.

Pandemic preparedness can and should help us to reimagine how we deliver social and economic support to make sure that we are all, as a society, resilient in times of crisis.

Number two, we must work with communities that are most impacted, establishing links to organizations and people who are trusted.

Another important lesson we learned during COVID, as we have during other crises, is that, to address the public health needs of people, we must work with the communities that are most impacted, who often have less access to services and less faith in medical systems that have failed them in the past.

It is critical that public health institutions develop relationships with trusted messengers in order to deliver life-saving measures like vaccines. These organizations and people who have been with communities and have stood the test of time are the ones who are going to be most effective, particularly when residents are grappling with the impacts of crises like this pandemic.

Third, pandemics do not know geographic and political boundaries. A go-it-alone approach is ineffective and counterproductive to preventing and addressing a global pandemic. While, clearly, preparing for future pandemics at home and strengthening our own health safety network are immediate priorities, we cannot afford to ignore global health security vulnerabilities. There are no boundaries to global pandemics, and attempts to isolate populations, like closing boundaries, are not only ineffective but counterproductive as we work to look at a collaborative and cooperative way that is critical in addressing global pandemics.

And we have seen time and time again in this pandemic that no one is safe unless we are all safe. As the richest nation in the world and the leader in global health and development assistance, we must provide international assistance to address pandemic prevention and control globally, especially for under-resourced nations.

This is not a matter of charity but of strategic investment in U.S. and global health security. We need to think about models like PEPFAR and global health security and control and prevention of diseases in the ways that we have in the past, because it is critical to our strategic health diplomacy, our investment in foreign policy, our national security, and our economic interests.

Fourth, pandemic preparedness is as important but underfunded as compared to investments in other major threats—as an example, our preparedness in military readiness. Knowing that future pandemics are a serious security and economic threat, the government must commit to investing in prevention, detection, and response to protect vulnerable populations from future infectious disease outbreaks.

And if you compare our spending, our military spending, as an example, $750 billion—compare that to $447 million that we use for preparing for global health security threats like COVID. And while those aren't exact comparisons, if we think about the fact that our future threats are more likely to be in the cyber arena and the biologic arena, we need to think about the magnitude of spending that we commit to health and health security, and particularly thinking about making sure that the organizations like the CDC, the NIH, the FDA, State Department, and USAID are adequately funded in advance to be able to be ready and have systems in place when the next crisis does occur.

And, finally, five, maintaining public health infrastructure, including a well-trained and robust workforce, surveillance systems, laboratory systems, information systems—all of these things are key. And we should have learned this from the HIV pandemic, Ebola, SARS, et cetera.

We know that the public health workforce has been shrinking and is estimated to shrink dramatically. Leading up to the pandemic, there were approximately only 56,000 public health workers due to funding issues. Access to the Public Health Workforce Inter-

ests and Needs Survey shows that a large proportion of workers are considering leaving their job in the next year due to inadequate pay.

We must make sure that we don't continue to lose the critical infrastructure of people, surveillance system, and laboratory capacity that is necessary and needs to be in place in order to be prepared.

The budget for the Hospital Preparedness Program, the major source of Federal funding to help regional healthcare systems prepare for emergency, was only $275 million in fiscal year 2020. That is just half over what it was in 2004 of $515 million. So, you know, we have almost halved the dollars that were available for hospital preparedness over the course of the last few years.

These are just a few examples of how the decline in funding has led to us being caught off guard for this pandemic, not prepared and not having the infrastructure in place. And so, you know, my overall message is that we need to make sure that we have in place the important systems, people, relationships, and commitment to be able to be prepared the next time.

We have learned these—we should have learned these lessons. We have a lot of blueprint to go on, lots of information and lots of lessons learned from the past couple of decades of fighting global pandemics. We need to learn these lessons. We need to keep the infrastructure in place. We need to be prepared so that we don't have to suffer the consequences that we have during this global pandemic.

Thank you.

[The statement of Dr. Gayle follows:]

Helene D. Gayle, MD, MPH
President & Chief Executive Officer
The Chicago Community Trust

House Rules Subcommittee on Legislative and Budget Process
Wednesday, January 19, 2022

As we enter the third year of the COVID pandemic, I would like to thank Chairman Morelle and the members of the subcommittee on Legislative and Budget Process for the opportunity to brief you on the importance of planning for the *next* pandemic. We know the emergence of the next crisis is a matter of when, not if. We must prepare by devoting resources to preventing the devastating health and economic consequences we see today.

My name is Helene Gayle. I am the president and CEO of The Chicago Community Trust, a community foundation focused on the most pressing needs of the Chicago region. I come to this role after almost 40 years of public health and global and local economic development at the Centers for Disease Control and Prevention, the Bill and Melinda Gates Foundation, and the international humanitarian organization CARE. During the current pandemic, I served as the co-chair of the National Academies of Science, Engineering & Medicine's Committee on Equitable Allocation of Vaccine for the Novel Coronavirus, which released a framework of recommendations for distributing the COVID19 vaccines equitably. I also served on a Council on Foreign Relations Task Force to Improve Pandemic Preparedness by drawing lessons from COVID-19. In addition, the Chicago Community Trust has been at the forefront of the pandemic response in Chicago, leading philanthropic efforts to respond to the COVID 19 crisis, and more recently on efforts to ensure that the recovery from the pandemic is equitable and inclusive and does not leave those disproportionately harmed by the crisis farther behind.

Since March 2020, COVID-19 has infected at least 307 million people around the world, killing nearly 5.5 million. In the United States, 60 million people have contracted COVID and over 800,000 have died. Sadly, with the recent surge of the Omicron variant, these numbers continue to grow. Beyond the health consequences, the pandemic has triggered an economic collapse. Today, employment remains below pre-pandemic levels, and millions still do not have enough to eat, are behind on rent payments, and struggle to meet household expenses.

COVID-19 has also exacerbated preexisting disparities. Low-wage workers are less likely to have paid sick leave or savings to pay for food, housing, and health care. Black, Latinx, and other people of color are more likely to be frontline workers, live in overcrowded housing, suffer from chronic diseases, and struggle to access testing, treatment, and vaccines.

While the health and economic consequences of COVID-19 have been unlike anything we've seen in recent memory, it may not be a once-in-a-generation pandemic. Future pandemic threats are inevitable and predictable. More than forty new infectious diseases in humans have emerged in the past few decades, including SARS (2003), H5N1 flu (2007), the H1N1 flu (2009), MERS (2012), the Ebola virus in West Africa (2013–16), and Zika in the Americas (2015–16) before COVID-19.

I am pleased to provide testimony and be in conversation with the Chair and members of the House Rules Committee on this consequential matter. We must take the lessons from prior global pandemics, and those of the current crisis to better prepare the U.S. and invigorate our leadership in preparation for the next pandemic that is sure to come.

In my testimony, I offer 5 key points and accompanying recommendations for how I think we can be better prepared for future pandemics and prevent the disproportionate burden borne by the most vulnerable and under-resourced communities, here and abroad.

1. Pandemics play on the social fault lines and will always disproportionately impact the most vulnerable. Our preparation must be equal to the task.

2. We must work with communities that are most impacted, establishing links to organizations and people who are trusted.

3. A pandemic knows no geographic and political boundaries. A go-it-alone approach is ineffective and counter-productive to preventing and addressing a global pandemic.

4. The fall-out from a pandemic can, as we have seen, be as devastating—if not more so—than an act of war or terrorism. Yet, pandemic preparedness is under-funded as compared to the investments we make in military readiness.

5. Maintaining public health infrastructure, including a well-trained and robust workforce, surveillance systems, laboratory systems, and information systems are all key lessons we should have learned from the HIV/AIDS pandemic, Ebola, SARS, etc.

Below, I provide more detail on each of these points and clear examples of where we can do better in preparation for the next pandemic, even as we learn from and navigate our way through the current one.

1. Pandemics play on social fault lines and will always impact the most vulnerable in our societies.

COVID19 has highlighted how the social determinants of health and the underlying root causes that make one vulnerable to poor health along with lack of information (or disinformation) further amplify social inequity.

During this pandemic, infection and mortality rates have been highest among nursing home residents and Black, Indigenous, and Latinx communities. The virus causes the most severe illnesses in people with preexisting medical conditions such as high blood pressure, diabetes, obesity, and cardiovascular diseases. These underlying conditions are more prevalent among vulnerable groups with inadequate access to nutrition, health care, and a clean environment. The economic fallout also remains prevalent among Black adults, Latino adults, and other people of color who struggle getting enough food, paying rent, or covering household expenses. These disproportionate impacts reflect long-standing inequities in education, employment, housing, and health care that the current crisis has exacerbated. Black, Latinx, and other people of color are

more likely to be frontline workers, live in overcrowded housing, suffer from chronic diseases, and struggle to access testing, treatment, and vaccines. Low-wage workers are less likely to have paid sick leave or savings to pay for food, housing, and health care.

Pandemic preparedness means focusing on how we provide for economic stability and resiliency, not just in the face of a crisis, but in normal times. This requires us to think about how we address root causes and the social determinants of health, like decent, safe affordable housing, and the social supports we provide to individuals and families over the long term, like paid sick and family leave; living wages; affordable, accessible high-speed internet; and comprehensive, affordable insurance.

For example, it became clear early during this pandemic that families did not have enough savings to weather the disruption to their income that came from the loss of employment during stay-at-home orders. Many families quickly faced food insecurity or fell behind on rent payments. Unfortunately, our social safety net currently centers around very specific needs, and there are many hurdles to qualifying for assistance, often preventing families with limited resources from navigating a complex system to access support. When the pandemic struck, what many families urgently needed—and we were able to provide through our Covid Relief funding in Chicago and the federal government provided through Economic Impact Payments—was cash. This unrestricted support was a significant departure from how the federal government offers other social supports through programs like Temporary Assistance to Needy Families or supplemental nutrition assistance. The pandemic required us to trust in families to know their own needs and how to best direct resources to support their families through a pandemic.

Pandemic preparedness can and should include a reimaging of how we deliver social and economic supports to allow for resiliency in good times and in crisis. We might think about how we provide affordable housing to act as an investment in pandemic preparedness by ensuring that individuals and families have a decent, safe place to live when a crisis strikes. Or how guaranteed paid sick and family leave would have allowed individuals to care for children or family members without worrying about loss of income. We know resources like housing and paid leave have important implications for an array of health outcomes, whether heart disease, asthma or weathering a COVID storm.

2. We must work with communities that are most impacted, establishing links to organizations and people who are trusted.

An important lesson we learned during COVID, as we have during other crises, is that to address the public health needs of people, we must work with the communities that are most impacted, who often have less access to services and less faith in medical systems that have failed them in the past. It is critical that public health institutions develop relationships with trusted messengers— organizations and people—in order to deliver lifesaving measures like vaccines. The people and organizations that are based in community, and have been there in good times and during crises, are more often better equipped than the government, scientists, or the news media to provide resources, information and support to residents grappling with impact of a pandemic.

As The Chicago Community Trust has been involved in getting the word out and supporting vaccination efforts across the Chicagoland area, we wanted to understand the status, intentions, and characteristics among both vaccinated and unvaccinated residents. We partnered with local public health partners and researchers to conduct a survey to better understand the issues surrounding the vaccine.

While nearly all unvaccinated respondents know where they can go to get a vaccine or info about scheduling a vaccine appointment, many unvaccinated respondents worried about getting sick or experiencing side effects from the vaccine. Two-thirds of the unvaccinated respondents would prefer to have more time to wait and see if the vaccine works. Most unvaccinated respondents believed the vaccine was developed too quickly compared to other vaccines, and only about a quarter agreed that the vaccine was safe or effective. Many unvaccinated respondents reported trusting their doctor or healthcare provider, but overall, this group was not very trusting of other sources of information about the COVID-19 vaccine, such as the CDC, scientists, religious leaders, news media, or government officials.

We must develop messaging that describes how the vaccine testing and production process was safely compressed into a shorter timeframe while still validating and supporting people who want more time to wait and see. For them, we can focus on other risk-reduction behaviors like masks and testing. Finally, we must talk to the community about who they *do* trust when it comes to information about COVID-19 and vaccines.

3. Pandemics do not know geographic and political boundaries. A go-it-alone approach is ineffective and counter-productive to preventing and addressing a global pandemic.

Given modern increases in global trade, easy travel, and rapid urbanization, infectious diseases easily cross borders. Diseases that may once have died out in rural communities now reach crowded cities—almost 5.5 billion people live in urbanized areas—that act as incubators for outbreaks. And as we have seen with COVID, these diseases are transmissible before people exhibit symptoms and can spread without the knowledge of the infected person. The resulting deaths, illness, and public health restrictions reduce the size of labor forces, lead to absenteeism, and reduce productivity. And treatment and mitigation measures to stop the spread of the virus strain already burdened health-care systems.

While preparing for future pandemics at home and strengthening our own health safety net are immediate priorities, we cannot afford to ignore global health security vulnerabilities. There are no boundaries to global pandemics, and attempts to isolate populations (e.g., by closing boundaries) are not only ineffective but are counterproductive as they lead to lack of cooperation that is critical for addressing global pandemics.

We must provide international assistance to address the impact of the current pandemic and adopt measures to improve pandemic preparedness and response in the future. These commitments are not a matter of charity but a strategic investment in U.S. and global health security. The United States should approach foreign aid to fight COVID-19 the same way it has treated AIDS Relief and other global health programs: as strategic health diplomacy and an investment in U.S. foreign policy, national security, and economic interests.

4. Pandemic preparedness is as important but under-funded, as compared to the investments we make in military readiness.

Knowing that future pandemics are a very real threat, the federal government must commit to investing in prevention, detection, and response to protect vulnerable populations from future infectious disease outbreaks. However, our current priorities are clear in the federal budget, which allocated $750 billion to the U.S. military in fiscal year 2020, but only $547 million to prepare for global health security threats like COVID. The reality is that pandemic diseases like COVID-19 pose risks to Americans on a level comparable to or beyond international terrorism.

When COVID arrived in the U.S., lack of adequate preparedness funding made us reactive, forcing the government to rely on supplementary appropriations for pandemic response. Having now witnessed firsthand the devastating health and economic consequences of a pandemic like COVID, we must proactively appropriate funds for a comprehensive health security budget which would include increased funding for the pandemic preparedness programs, projects, and activities of relevant U.S. agencies, including the CDC, the National Institutes of Health, the Food and Drug Administration (FDA), the State Department, and USAID.

Important components of the nation's health security budget would include increased funding for state and local hospitals, scientific research on emerging diseases, epidemiological surveillance, the Strategic National Stockpile, vulnerable countries around the world, WHO, and other essential multilateral agencies.

As part of increased preparedness funding, we must also commit to improving living conditions and removing barriers to health in good times. Strengthening the U.S. health and social safety net will lead to better, more equitable outcomes during future pandemics and recessions. This will require sizable investments from all levels of government and parts of the federal budget. But like many other developed countries, we can ensure that our residents have paid sick and family leave; living wages; affordable, accessible, high-speed internet; and comprehensive, affordable health insurance. And when the next pandemic does arrive, emergency health, economic, and social supports should be available to all residents regardless of work or immigration status. Such supports should automatically trigger based on predefined criteria and continue for the duration of the pandemic or related recession.

5. Maintaining public health infrastructure, including a well-trained and robust workforce, surveillance systems, laboratory systems, and information systems are all key lessons we should have learned from the HIV/AIDS pandemic, Ebola, SARS etc.

The public health workforce is estimated to have shrunk dramatically leading up to the pandemic, by approximately 56,000, primarily due to funding issues. According to the Public Health Workforce Interest and Needs Survey, a large proportion of workers are considering leaving their job in the next year, in part due to inadequate pay. State health officials estimate that 25 percent of their workforce were eligible for retirement just last year. This is more concerning than ever as we hear about fatigue and burnout setting in amongst health care workers right as cases spike from the Omicron variant's spread.

Inadequate public health funding has devastating health consequences. The Trust for America's Health estimates that the United States spends an estimated $3.6 trillion annually on health care, less than 3 percent of that amount is directed toward public health and prevention. The proportion of total health spending on public health has been decreasing since 2000 and falling in inflation-adjusted terms since the Great Recession.

The budget for the Hospital Preparedness Program—the single source of federal funding to help regional healthcare systems prepare for emergencies funded through the Office of the Assistant Secretary for Preparedness and Response in the U.S. Department of Health and Human Services—was $275.5 million in FY 2020, slightly more than half of what it was in FY 2004 at $515 million.

These are just a few examples of how a decline in funding in the years leading up to the pandemic led to the United States being caught flat-footed when citizens needed a robust public health infrastructure more than ever.

The inevitability and health and economic consequences of future pandemics make investments in preventive measures both sensible and cost effective. We must commit to better preparation and increased funding for future pandemics to prevent the disproportionate impact on the most vulnerable and under-resourced communities, here and abroad.

Mr. MORELLE. Thank you, Dr. Gayle. I appreciate your comments, and I am sure people will have a number of questions.

And, with that, Ms. Tedesco, you are recognized for your testimony.

STATEMENT OF JULIA TEDESCO

Ms. TEDESCO. Thank you, Chairman Morelle, Ranking Member Dr. Burgess, and members of the Rules Committee. Good morning, and thank you for the opportunity to speak with you today.

My name is Julia Tedesco, and I have the great privilege of serving as the president and CEO of Foodlink, a nonprofit organization in Rochester, New York, that serves as the regional food bank.

Congressman Morelle likely recalls attending Foodlink's very first COVID emergency response food distribution on March 20, 2020, in his hometown of Irondequoit. There was a lot we didn't know about COVID then, but, as an emergency response organization, we knew that families were already struggling with hunger and access to food, as they do in the face of any crisis.

That day, a collaboration between the nonprofit and government sectors enabled us to safely get food to more than 300 households. In the 2 years since, we have organized more than 900 similar drive-through emergency food distributions across our region.

In the next few minutes, I would like to first share details about Foodlink's response during this pandemic. And, second, I would like to talk about the critical role that nonprofits play and why investment in this sector will help prepare us for any future emergency response. In doing so, I will do my best to represent the 200-plus Feeding America food banks across the Nation that have responded to COVID–19 and countless other disasters.

Much attention has been given to the pandemic's devastating impact on the food security of millions of families and just how many Americans were one crisis away from not having enough food to eat. We saw this firsthand in the city of Rochester and in the suburban and rural communities throughout our service area.

We saw that as many as 40 percent of the people seeking support from the emergency food system were doing so for the very first time. But we also saw firsthand how this pandemic disproportionately impacted the vulnerable—the elderly with limited incomes, low-income parents, people of color, and so on—individuals who were already facing difficult choices like paying for rent or paying for food, individuals for whom panic-shopping in bulk for groceries was simply not an option.

At the same time, schools closed indefinitely. The city of Rochester has one of the highest child poverty rates in the Nation. Every student in the district is categorically eligible for free school meals. With schools closed, parents were left wondering how to account for two extra meals per child per day, a looming financial and public health crisis of its own.

Foodlink sprang into action on both fronts. In response to the need, we within a matter of weeks established a temporary alternate off-site warehouse to safely store and pack emergency provisions. When most of our network of direct-service partners—think of food pantries in community centers and meal programs in church basements—were forced to shut down, we designed and co-

ordinated no-touch drive-through distributions in centralized locations across 7,000 square miles.

When government and community partners had critical information or supplies they needed to get to the public, we utilized these distributions to disseminate them.

We became a central hub for everything from suicide prevention and mental health resources to U. S. Census data collection.

When a nurse from our regional healthcare system called us to frantically figure out how to get food to an elderly, quarantined, immunocompromised patient, we for the first time in our 40-plus-year history made a home delivery and continued doing so, thanks to partnerships with other nonprofits.

We sat with leaders from our local city school district to brainstorm and coordinate the logistics of 17 grab-and-go meal sites for kids and their families. Understanding that barriers still existed for food access, we repurposed some of our smaller box trucks and, thanks to waivers issued by the USDA, we implemented ice-cream-truck-style neighborhood meal distributions to complement our Summer Meals program.

Foodlink distributed more than 50 million pounds of food in the last 22 months, and our kitchen produced more than 1.5 million healthy meals and snacks. Our fellow food banks in New York State and around the Nation all did similar work, distributing unprecedented amounts of nutritious food, leveraging our relationships in the communities we serve, our expertise in food distribution, and our infrastructure, including distribution centers, industrial freezers and coolers, commercial kitchens, and fleets of trucks.

Significant government intervention, such as child tax credits and boosts in SNAP benefits, helped quell what surely would have been devastating poverty levels. Still, food insecurity remains approximately 10 percent higher than levels recorded in 2019. That is more than 7 million people across our Nation who are food-insecure. And in our region, that equates to about 152,000 people who have limited access to food, 152,000 people who might not know when or from where their next meal will come.

As a food bank, we are proud of our response to this pandemic, but it is important to emphasize that, for every one meal that a Feeding America food bank like Foodlink provides, SNAP provides nine. If we are to make a meaningful reduction to hunger in America and address a compounding factor in any disaster or crisis, the Federal Government must continue to increase investments in antipoverty programs like SNAP and to think of this, in its own way, as a form of disaster preparedness.

In addition to investing in the social safety net, the Federal Government should more significantly invest in the nonprofit sector's ability to respond to crises. Nonprofits are not merely a group of small charities trying to do good; we are oftentimes the engine that generates innovative solutions to complex problems in our society. When the government needed to find ways to distribute food, PPE, vaccines, and information into underserved communities, it relied on the infrastructure expertise and flexibility of community-based nonprofit organizations.

Far too often, though, nonprofits like Foodlink are asked to execute on programs that we did not have an opportunity to weigh in

on. Issues with the Coronavirus Food Assistance Program have already been well-documented, and I won't go into all of them here in the interest of time. But I do hope a major lesson from CFAP is that, when the Federal Government needs to find ways to help feed people, it should include or perhaps begin with the nonprofit sector, and specifically the expertise of the Feeding America network, rather than to recreate the wheel.

This Nation already has a centralized hub for emergency food assistance with spokes across every State, county, and local community in America that could have helped to ensure smoother logistics and more equitable access to these food boxes. If food banks were included from the start and leveraged for their expertise, we could have significantly reduced staff time spent on coordination, saved dollars, and fed millions more Americans.

I hope that a critical lesson to come out of the pandemic is the importance of investing in nonprofit infrastructure and technical capacity. Over the last couple of years, we often found ourselves with a strong food supply but insufficient cold storage and refrigerated vehicles. Foodlink has rented tractor trailers stationed in our parking lot running 24/7 for 2 years to provide additional cold storage.

Community-based nonprofits do not have the resources to do R&D and invest in innovation the way that the private sector does, and when we do, it rarely, if ever, is funded by the Federal Government. We are encouraged by the USDA's promised investments in strengthening our food system and hope these investments extend beyond farmers, producers, and for-profit distributors to include the nonprofit sector.

To summarize, we first and foremost believe that our Nation's social safety net must be strengthened to better prepare us for the next disaster, but the pandemic has also shown us that the Federal Government has a real stake in the operational efficiency, infrastructure, capacity and innovation of the nonprofit sector, especially when responding to disasters. This sector should be invested in, and nonprofits should be counted on not only to receive support and deliver interventions or services decided on by government but to take part in the very design of those services.

Thank you for your time today.

[The statement of Ms. Tedesco follows:]

United States House Committee on Rules

Subcommittee on Legislative and Budget Process

Using Budget Principles to Prepare for Future Pandemics and Other Disasters

January 19, 2021

WRITTEN TESTIMONY

JULIA TEDESCO

PRESIDENT AND CEO OF FOODLINK (ROCHESTER, NY)

Chairman Morelle, Ranking Member Cole and members of the Rules Committee: good morning, and thank you for the opportunity to testify today. My name is Julia Tedesco and I am the president & CEO of Foodlink, a nonprofit organization in Rochester, NY, that serves as the regional food bank for 10 counties.

Congressman Morelle likely recalls attending Foodlink's very first COVID emergency response food distribution on March 20, 2020, in his hometown of Irondequoit. There was a lot we didn't know about COVID then, but as an emergency response organization, we knew that families were already struggling to access food, as they do in the face of any crisis. That day, a collaboration between the nonprofit and government sector enabled us to safely get food to more than 300 households. In the two years since, we've organized more than 900 similar drive-thru emergency food distributions.

In the next few minutes, I'd like to accomplish two things.

- **First**, I'll share details about Foodlink's response during the pandemic – what we saw and experienced as one of many first responders called upon to meet the rising demand of hunger.
- **Second**, I'd like to talk about the critical role that nonprofits play and why deepening partnership and investment in this sector will help prepare us for any future emergency response. In doing so, I will do my best to represent the 200+ Feeding America food banks – Foodlink's sister organizations across the nation - that have responded to the COVID-19 crisis and countless other disasters.

Much attention has been given to the pandemic's devastating impact on the food security of millions of families. Long food lines started to form as the nation caught a glimpse – usually with drone footage thousands of feet above – of just how many Americans were one crisis away from not having enough food to eat.

We saw this firsthand in the City of Rochester, and in the suburban and rural communities throughout our service area. As many as 40% of the people seeking support from the emergency food system were doing so for the very first time. We heard their stories. Some were told to us through a hotline we set up early in the pandemic. Some via social media, from people who wanted to know where and when we'd be distributing food. Some told us their stories while waiting in line, tears in their eyes as they thanked us for basic food items.

At the same time, schools closed indefinitely. The City of Rochester owns one of the highest child poverty rates in the nation. Every student in the district is categorically eligible for free school meals. With schools closed, parents were left wondering how to account for two extra meals, per child, per day—a looming financial and health crisis of its own.

Foodlink sprang into action on both fronts.

In response to the need, we—within a matter of weeks -- established temporary alternate warehousing facilities to safely store and pack emergency provisions. When a majority of our direct service partners – think of food pantries in community centers and church basements--were forced to shut down, we designed and coordinated no-touch, drive through distributions in centralized locations across a 7,000-square-mile region.

When government and community partners had critical information or supplies they needed to get to the public, we utilized these distributions to disseminate them. We became a central hub for everything from suicide prevention and mental health resources, to U.S. Census data collection.

When a nurse from our regional health care system called us frantically to figure out how to get food to an elderly, quarantined, immuno-compromised patient, we – for the first time in our 40+ year history – made a home delivery, triggering a partnership with a local nonprofit partner to continue home deliveries to our elderly population.

We sat with leaders from our local City school district to brainstorm and coordinate the logistics of 17 grab-and-go meal sites for kids and their families. Understanding that barriers still existed for food access, we repurposed some of our smaller trucks and – due to waivers issued by the USDA - implemented ice cream truck-style neighborhood meal distributions to complement our Summer Meals program.

Foodlink distributed more than 50 million pounds of food in the last 22 months, and our kitchen produced more than 1.5 million healthy meals and snacks. Our fellow food banks in New York State and around the nation all did similar work. We distributed unprecedented amounts of nutritious food, leveraging our relationships in the communities we serve, expertise in logistics and food distribution, and our infrastructure which includes billions of dollars of food-related assets – including distribution centers, industrial freezers and coolers, commercial kitchens and fleets of trucks.

Significant government interventions, such as child tax credits, boosts in SNAP benefits or “P-EBT” and more, helped quell what surely would have been devastating poverty levels. Still, food insecurity remains approximately 10% higher than the levels recorded in 2019. In our region, that equates to about 150,000 people who have limited access to food. 150,000 people who, on any given day, might not know when or from where their next meal will come.

By now you should know this stat all too well – but it is important to emphasize that for every one meal that a Feeding America food bank provides, SNAP provides *nine* meals. If we are to make a meaningful reduction to hunger in America and address a compounding factor in any crisis, the federal government must continue to increase investments in the best anti-poverty program we know of –SNAP -- as well as WIC and child tax credits. We also encourage the federal government to continue to improve flexibility when administering meal programs by making many of the USDA waivers permanent.

But in addition to investing in the social safety net, I am strongly advocating for the federal government to more significantly invest in the non-profit sector’s ability to respond to crises.

Nonprofits are not merely a group of small charities trying to do good. We are oftentimes the engine that generates innovative solutions to complex problems in our society. When the government needed to find ways to distribute food, PPE, vaccines and information into underserved communities, it relied on the infrastructure, expertise and flexibility of nonprofit organizations.

Far too often, though, nonprofits like Foodlink are asked to execute on programs that we did not have an opportunity to develop or weigh in on. Issues with the Coronavirus Food Assistance Program have already been well-documented, and I won’t go into all of them here for the interest of time. But I hope a major lesson from CFAP is that when the federal government needs to find ways to help feed people, it should include the expertise of the Feeding America network, rather than recreate the wheel. This nation already has a centralized hub for emergency food assistance – with spokes across every state, county and local community in America, that could have helped to ensure smoother logistics and equitable access to these food boxes. If food banks were included from the start – and leveraged for their expertise in this area, we could have significantly reduced staff time spent on coordination, saved dollars, and fed more Americans.

Moreover, I also hope that a critical lesson to come out of the pandemic is the importance of investing in nonprofit infrastructure. There were times in the last few years where we had adequate food, but

insufficient cold storage and refrigerated vehicles. Foodlink has stationed rented tractor trailers in our parking lot running 24/7 for 2 years, providing additional cold storage. We are still seeking the right technological solutions to help us improve our inventory management and delivery processes. Nonprofits don't have the resources to do R&D and invest in innovation the way that the private sector does, and when we do it rarely, if ever, is funded by the federal government. We are encouraged by the USDA's promised investments in strengthening our food system, and hope that those investments extend beyond farmers, producers and for-profit distributors to include the non-profit sector.

To summarize: the pandemic has shown us that the federal government has a real stake in the operational efficiency, infrastructure and capacity, and innovation of the nonprofit sector, especially when responding to disasters. To be better prepared for the next crisis, we at Foodlink believe that the social safety net – and SNAP in particular, should be strengthened. We also believe that a partnership between the federal government and nonprofit sector should be strengthened in two ways: first, through investments in nonprofit sector infrastructure needs including technology, facilities, transportation and people. And second, by inviting nonprofits to not only receive support and deliver services decided on by government, but to take part in the very design of those services – even, and *especially*, during public health crises or other disasters.

Thank you for your time today, and I'm happy to answer questions.

Mr. MORELLE. Thank you very much for your testimony.

And now, Mr. Schlegelmilch, you are recognized for your testimony, sir.

STATEMENT OF JEFF SCHLEGELMILCH

Mr. SCHLEGELMILCH. Thank you. Thank you, Chairman, and thank you to all of the members of the committee for the opportunity to speak with you today.

To complement my written testimony, I want to talk about a few experiences in the field that sort of illuminate what these larger challenges look like.

So, to start, actually, after Hurricane Harvey, my colleague and then-director of the Center, Irwin Redlener, and I were in Texas assisting some celebrity donors to identify where their money could do the most good. And we saw a range of things, from really emergent community organizations that never envisioned themselves being part of disaster response and were meeting unmet needs—needs that weren't being met by larger, sort of, external groups or maybe that the funding couldn't reach.

But, in particular, what stands out is a faith-based group that was doing what we would call "disaster case management. "So there were a number of people who were being denied assistance through various programs. And, a lot of times, they were actually eligible but had filled out their paperwork wrong or misunderstood a definition or something like that. And so what most of them did, well, they gave up. And so they went to these nonprofits, and they actually helped them reapply and get access to those resources.

In other cases, maybe they weren't eligible but they were eligible for another program they weren't aware of and wouldn't have though to look, like the Small Business Administration.

You know, zooming out a little bit, I was talking to a State mitigation officer on some of the new mitigation funding that was coming in, and he was lamenting about how a lot of the smaller, more marginalized communities just had no way of accessing and putting together the application for these, that the opportunity to waive Federal cost-share was great for the communities that had capacity but not resources for cost-share, but a lot of the most marginalized groups really lacked the administrative capacity.

And for folks like you and I that are mired in paperwork day in and day out, the idea of another grant may not seem too daunting, but a mitigation grant is quite a daunting task and requires a high level of administrative sophistication that many simply don't have.

So we see a pattern here with the increased complexity, that it sort of pushes out those who are already the most marginalized. I tend to say, those who have access to the benefits of civil society before a disaster have access after. Those who don't have lawyers and accountants and access to high-quality administrative frameworks often don't have access to what are otherwise deemed fair and open accessibility. Fair and open in theory does not actually equate to fair and equal in practice with these barriers in place.

So, thinking about root causes and something I talk about in my written testimony—so I had a call a couple of months ago with a congressional office. And it is the same call I get from various offices on all sides of the aisle from time to time after there is a

major disaster. And they say, you know, "We want to know how to do a better job with response. What are some things we can do?"

So I start going down my list, which is suspiciously similar to my written testimony when talking about consolidating and simplifying and really looking at, sort of, larger, sort of, muscle movements in our whole-of-government disaster response.

And I am typically met with, "Yeah, we can't do that. Yeah, that is not going to fly. No, there is no way we can get that approved. In the current climate, we would love to but we can't." And it settles in on this comment: "We are looking for a quick win." "We are looking for a quick win." And then the comment kind of gets cleaned up with "something that can lead to more, something that can be a starting point in all of these things."

In the opening comments from the chairman, I know we talked about the complexity of disaster response and the sheer number of programs and agencies. It is important to note, these quick wins are quite literally killing us. They are creating layers upon layers of complexity to the disaster response. And it requires more and more workarounds with emergency supplementals and budgetary workarounds, which creates a cacophony of data and assistance that leaves the survivors—the only ones who can access it are the ones with the highest capacity and are likely to be less vulnerable to begin with.

So, to close, I want to reiterate a couple of the key recommendations I had in my written testimony.

One is, I know it is pretty on-brand as an academic to say we need better data and more analysis, but we need better data and we need more analysis. We know enough to know in broad strokes that preparedness saves, and some of these specific programs we know. But to really look at this across whole of government and look at what is going into preparedness through the true definition and what is going in response, we actually don't have enough information to get from this concept and general direction to be pointed in to start answering questions: How much? What are the details? What are the investments, and what is the value of those investments? And what are the payoffs in terms of equity, social good, financial good? We have rough ideas but not necessarily to the level of granularity to integrate into a lot of decisionmaking.

We need enhanced guardrails, quite frankly, to prevent electoral incentives that are contrary to the public interest from dominating legislative and budget processes. The political science points towards faster and very voluminous relief and recovery funding. Relief and recovery funding is necessary, but the signals for preparedness funding are virtually nonexistent. But in disaster science, of course, we know those are the most valuable, and that is how you prevent loss of life and livelihoods in the event of a disaster.

We desperately need to simplify disaster funding and assistance and the bureaucratic landscape for all of this. It is a very unappealing and complicated topic, but I think it is probably the single most important thing that could be done to set a landscape that is more conducive towards disaster assistance benefit and equity.

And, finally, I haven't mentioned this yet in my verbal comments, but we need to look hard at the public servants who are carrying out these policies and make sure we are making invest-

ments in their development. The world is changing. We know this. We know that our structures need to change. But these structures ultimately translate into institutions and people. The investment in professional and organizational development often gets thought of as overhead. It needs to be an essential part of the cost of doing business to ensure that those that are engaged in the design, development, and implementation of these strategies have the support that they need to accomplish that which they are already working so tirelessly and admirably at every day.

So, with that, I want to thank you for your time, for the opportunity to speak, and I look forward to any questions and the opportunity to discuss further. Thank you.

[The statement of Mr. Schlegelmilch follows:]

Testimony to the House of Representatives Committee on Rules' Subcommittee on Legislative and Budget Process for the Hearing: Using Budget Principles to Prepare for Future Pandemics and Other Disasters

Testimony Submitted January 16, 2022

By: Jeff Schlegelmilch, MPH, MBA

Thank you for the opportunity to testify before the Subcommittee today. In my role leading the National Center for Disaster Preparedness at Columbia University's Climate School, as well as through other positions, I have dedicated my career to fostering the impact of disaster research in the fields of policy and practice. As everyone is well aware, the challenges we face from disasters are increasing in both severity and frequency. This is driven in part by human-caused climate change, as well as aging infrastructure, and a world that is growing smaller and more connected, virtually and physically. We are now entering an era in which disasters are the norm, and overlapping disasters such as hurricanes and wildfires during a pandemic are transpiring.

As we struggle with this evolving reality, our disaster readiness and response systems are working incredibly hard to meet this challenge, and the work of agency personnel, legislators, non-profits, academics and the private sector to this end should be lauded. But we find ourselves in a changing world, being pulled in different directions by different incentive structures, and seem to be chronically behind the accelerating curve of disaster impacts and their long tails of recovery.

We have forward-looking actions across government, such as FEMA's Strategic Plan. In its latest iteration it focuses on issues of climate change and equity among others. The prior iteration also included critical focuses like creating a culture of preparedness and simplifying bureaucracy as important nods to basic challenges in disaster management. Expansion of pre-disaster mitigation funding such as through the Building Resilient Infrastructure and Communities program, and new funding for infrastructure resilience embedded in the bi-partisan Infrastructure Investment and Jobs Act are also steps in the right direction.

At the same time, we see widening inequalities in who has access to recovery resources, and disparities in vulnerability that are too often predictable by socioeconomic status, race and ethnicity. We have a cacophony of roughly 90 assistance programs that can come from as many as 20 different agencies, with different triggers and rules. And that is just the federal programs. We also find ourselves pulled by incentives to focus on the most immediate assistance to the most visible, when in fact the investments in preparedness and mitigation are dramatically more impactful in diminishing the need for response and recovery funds.

Preparedness funding has ebbed and flowed over the years, peaking a few years after 9/11 and gradually decreasing with health security grant programs decreasing by a third to as much as half from their peaks, with similar reductions across all-hazards emergency management grant programs. The Bipartisan Commission on Biodefense (formerly the Blue Ribbon Study Panel on Biodefense) indicated the need for a more coordinated biodefense budgeting process, to avoid the fits and starts of our bio-security funding.[1]

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[1] https://biodefensecommission.org/reports/budget-reform-for-biodefense/

At the same time, response spending has increased through the use of emergency supplemental expenditures, and later discretionary spending.

In researching the use of emergency spending for disaster response I have been working with two colleagues, Dr. Ellen Carlin, an Assistant Research Professor at the Center for Global Health Science and Security at Georgetown University and Ryan Remmel, an undergraduate researcher based in the same center. In the decade after 9/11, we found that the Congress gradually increased funding for emergencies and disasters, but relied largely on irregular supplemental appropriations bills hastily passed in the immediate aftermath of a crisis, with much of the enacted funding only tangentially related to disasters/emergencies they were meant to address. The framework changed with the Budget Control Act in 2011, which led to the emergence of a more focused and proactive funding model from 2012-2020, and a lessened reliance on reactive supplemental appropriations. During this era, though, there were multiple years where the limited disaster relief spending enabled as part of the annual appropriations process under the Budget Control Act simply wasn't enough to meet the need. Examples include 2013 with Hurricane Sandy, and FY 2018 had the California wildfires following a difficult hurricane season (Harvey, Irma and Maria). Thus, in 2013 and 2018, and to a lesser extent 2017 and 2019, Congress returned to its old approach, passing reactive supplemental appropriations bills funding "emergency requirements" to respond to these unforeseen disasters. And of course COVID-19 spending breaks the charts (see supplemental material for charts and methodology from this research). The question is whether these are exceptions to an otherwise stable need, and the current approach is working. Or if they are indicative of future events, and these are harbingers of more stressors to come. The answer is unequivocally the latter.

Those that say we could not have seen COVID-19 coming, are simply wrong. The severity, the disruptions, the politicization of the response, the inequities, and the pandemics persistence were all predicted in various reports, studies and historical records of prior pandemics. The shortage of ventilators, personal protective equipment and healthcare system capacity were the subject of numerous reports, including from the federal government, including congressional and oversight agencies after the first SARS outbreak in 2003, the emergence of a highly pathogenic avian influenza with pandemic potential in Asia in 2005, and after the emergence of a novel strain of influenza H1N1 in 2009. We didn't want to spend the money on what was needed, so we are dealing with the consequences now. And our response is a lot more expensive and a lot less effective as a result. There were some investments made of course. And there has been benefit from those investments, but it is pennies on the dollar for what was called for, and what will undoubtedly come to be articulated in great detail in many reports and analyses to come.

As the impacts of climate change continue to grow, and more and more people are understanding it through the lens of disasters, we are again confronted with the ghosts of warnings ignored. These disasters will grow in intensity and frequency. They will cost more lives and livelihoods, and they will create new pressures on our economies, infrastructure and even our national security as parts of the world become increasingly unlivable in the coming generations. While quibbling over precise estimates of when, where and exactly how much climate change is to blame, we are missing the greater truth that in broad strokes disasters will unequivocally be more frequent, affecting more places, and with greater intensity.

Amidst all of this, we are overly dependent on a shadow budget for disaster response and relief that no one is planning. This budget is an ad hoc and non-strategic multi-billion, and with COVID-19, a multi-trillion dollar reaction to disasters. It aligns with the electoral incentives to provide relief funding as fast and as

plentiful as possible, and it also supports the immediate needs that can't go unmet. But it fails to create lasting and strategic investments that can drastically reduce the cost to taxpayers, as well as the impacts to lives and livelihoods. And while it shows some leveling off in recent years, the spike in spending from COVID-19 and other disasters shows that any lull is temporary, and we need a better way ahead.

Resolving these issues will require rules that help to offset the incentives that steer us away from resilience, and satisfy our immediate and base concerns while leaving wide open the vulnerabilities for the next disaster. With that in mind, I submit to you the following areas of action:

- First and foremost, we need better data on the vast mosaic of disaster spending. What is the relationship between preparedness and response spending? What is the right balance? In my field, we often lament the enormous costs of disasters compared to the value of preparedness spending, knowing that preparedness saves money and ultimately lives. But there will always be a need for response and recovery spending. It may very well be that we will always need to spend more on response, because it costs more. We don't know what the right balance is, in part because we don't know what is being spent on either. A commission of reports from the Congressional Research Service, or other government oversight and analysis organization will go a long way to methodically tracking disaster spending at all phases, and bringing together the disparate data sets to help frame and understand the problem in a more cohesive and data driven way. This should further inform a larger process for considering a re-look at our whole of government response.
- The electoral incentives for immediate spending is a powerful force, that is not going to be resolved through a rules process. However, rules can be designed to counterbalance these incentives. We have seen how structural changes like the Budget Control Act helped to create some space for proactive, rather than reactive, disaster spending. Further, creating mechanism for scoring proposed legislation for resilience and equity benefits can help to create greater transparency of the value being proposed.
- In an era of threats and vulnerabilities that are increasing in complexity we need to simplify the process. 90 programs across 20 agencies is simply too many. A friend and colleague once described the recovery process as the a "Jenga of federal assistance" that is layered on the recovering community. The administrative burdens of applying, receiving, tracking, reporting and de-conflicting with other programs leads administrative processes to drive response rather than need. I have seen this first hand in many disaster settings, where survivors are waiting weeks and then months for assistance for bureaucratic reasons. Such delays have an enormous negative impact on residents' financial well-being and health. In areas where there is no functional equivalent to the disaster relief fund, such as in public health response, money is often pushed through preparedness vehicles, with competing demands on state and local governments to reconcile preparedness with response aims under grant structures that were not designed for response.
- Finally, we need to look at our human resources in disaster resilience. My first full time job in this field was in the early days of post-9/11 health and homeland security funding, and I recall my boss lamenting the pressure to spend money on stuff. "Preparedness is people", he would say. Today, our people are exhausted. Even before COVID-19, but especially now. The world is changing, and our disaster staff, no matter how you define them, are working tirelessly. But as agencies and organisations need to evolve to meet the challenge of 21st century disasters, so too must the people who define, design and execute these efforts. Investment in agency organizational development, employee growth and development, and mentoring for the next generation often falls into overhead budget categories, and is thus frowned upon. Any investment in structures must also include

investment in the people who are to carry that forward, and to make sure that their hard work and dedication has the wind of the federal government at their backs.

Thank you again for the opportunity to share these thoughts. I hope that they are useful to your deliberations and I look forward to any questions you may have along with any follow-on discussions.

Supplemental Materials

Figure 1: Supplemental appropriations by fiscal year, FY 2000–2021. We obtained data from CBO[2] for all supplemental appropriations enacted from FY 2000 through October 5, 2018—that is, appropriations passed outside of the annual appropriations cycle. Using this data, we summed the enacted budget authority for supplemental appropriations by year. To then gather data for FY 2018–2021, we reviewed all appropriations bills listed in the CRS Appropriations Status Table[3] that became law. For each supplemental appropriations bill, we quantified the bill's enacted budget authority using the CBO's most recent published cost estimate. For all other bills (i.e. continuing resolutions, annual appropriations bills, and omnibuses), we reviewed the final bill text from Congress.gov and summed all supplemental provisions (i.e. provisions containing the clause "for an additional amount"). We excluded provisions funding Overseas Contingency Operations in annual appropriations bills, to maintain consistency with CBO's methodology for tracking supplemental appropriations from FY 2000–2018.

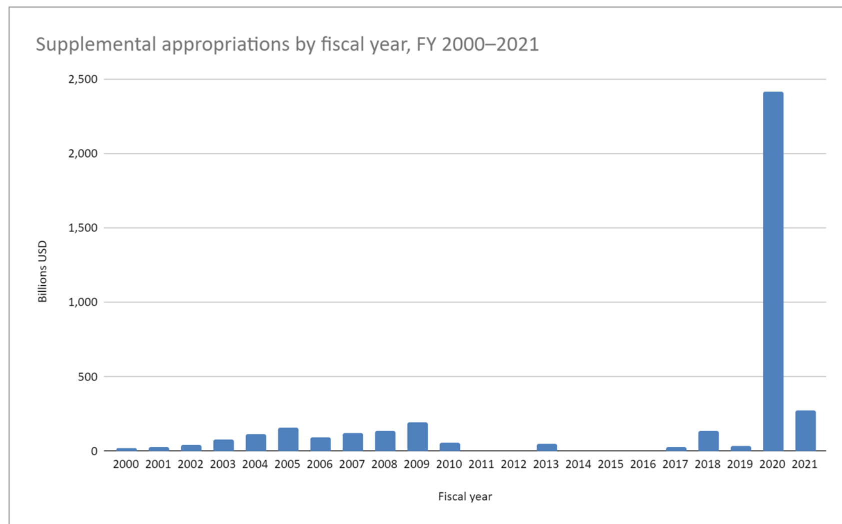
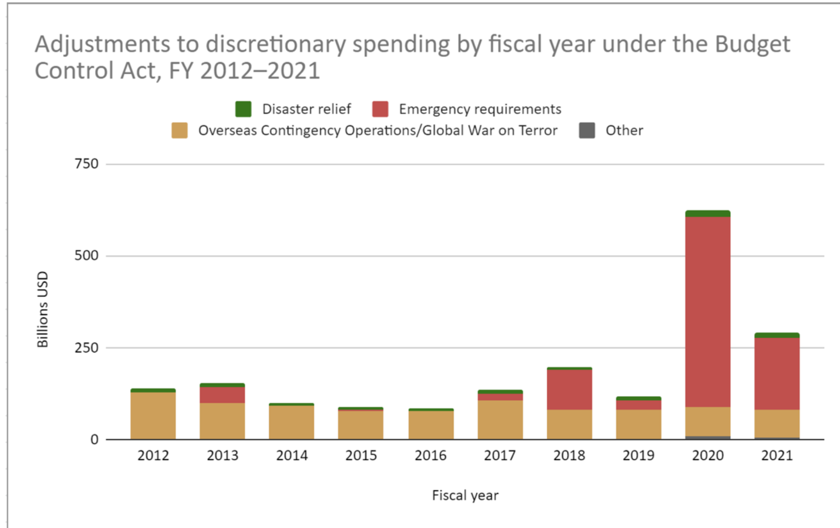


Figure 2: Adjustments to discretionary spending by fiscal year under the Budget Control Act, FY 2012–2021. The Budget Control Act of 2011 (BCA; P.L. 112-25) instated annual limits on discretionary spending for FY 2012–2021. Using "budget adjustments" relating to major disasters, emergencies, war, and limited other purposes, however, Congress was permitted to enact discretionary spending in excess of the BCA's

[2] https://web.archive.org/web/20181209004116/https:/www.cbo.gov/system/files?file=2018-10/Supplementalappropriations-2018-10-5.pdf

[3] https://crsreports.congress.gov/AppropriationsStatusTable

annual limits. We obtained data from OMB[4] on the total enacted adjustments under each BCA adjustment category for FY 2012–2021 and present the sums here. While the "disaster relief" adjustments are subject to statutory limitations and must be used to pay for the costs of declared major disasters, adjustments for "emergency requirements" or "Overseas Contingency Operations" are not subject to statutory limitations and can be used in unlimited amounts and for purposes unrelated to disasters.



[4] https://www.whitehouse.gov/wp-content/uploads/2021/01/sequestration_final_January_2021_speaker.pdf

Mr. MORELLE. Thank you so much for your testimony.

And I would like to ask Dr. Kadlec to provide his testimony now, sir.

STATEMENT OF THE HONORABLE ROBERT KADLEC, M.D.

Dr. KADLEC. Thank you, Chairman Morelle and Ranking Member Burgess and other members on the line today. Thank you for the privilege and the opportunity to appear before you.

Now as a private citizen, as the HHS Assistant Secretary for Preparedness and Response at the start of the pandemic, I lived, breathed, and bled the experience. I certainly want to acknowledge the incredible work, service, and sacrifice of the Federal, State, local, Tribal, and territorial civil servants and professionals from the private health sector that served as the first responders during this pandemic response. The whole-of-Nation response has been vital to preserving our Nation, society and saving lives.

I also want to commend you and your colleagues for your strategic vision and foresight in having this subcommittee consider budgetary approaches that Congress should take to prepare the country for the next pandemic or major public health emergency.

I am convinced, by these collective commitments to learning from the COVID response and to future congressional action we can better prepare to mitigate unnecessary loss of life, negative economic impacts, and societal disruptions that another pandemic will bring.

There are several historical and contemporary budget approaches that worked, did not work, and could work better. There are some prospective ideas that are innovative and I think would work to improve future pandemic preparedness. Whatever approach is taken must address a range of potential health security threats, to your point, Mr. Chairman, and ensure congressional accountability and sustainability of critical response capabilities.

What worked? Project BioShield Act that was created by Congress in 2004 after the events of 9/11 was an effective tool. It created a 10-year advance appropriation to incentivize the development and procurement of chemical, biological, and radio-nuclear medical countermeasures that did not have a commercial market.

The program was successful, but the special reserve fund created by legislation was not replenished when the original 10-year appropriation ended.

Advance appropriations could be useful in developing pandemic and antimicrobial medical countermeasures as well as CBRN ones. The dilemma becomes renewing such advance appropriations and the potential that Congress may later choose not to do so. The original BioShield concept called for obligatory, nondiscretionary funding.

What didn't work? Funding preparedness with periodic disaster supplementals.

Funding to sustain improvements in preparedness are not particularly useful tools. And, quite frankly, with the mainstay at ASPR, I have a chart of ASPR's budgetary history that indicate that the majority of funding that we received for our role was often times through supplemental Congressional funding from disasters.

While they have been significant enablers for preparedness, when those funds basically expire, as they did with influenza and

Ebola, our ability to sustain programmatic funding for pandemic preparedness and particularly countermeasure development and some of our practical capabilities, operational capabilities, such as NDMS, national disaster medical teams, were jeopardized.

For example, when I arrived at ASPR, our NDMS teams had not received any sustainment or specialized training for several years. Now, fortunately, but unfortunately, because of the hurricane supplemental generated after Hurricane Harvey, Irma, and Maria, we were able to fund highly infectious disease training for our NDMS teams before the pandemic.

Looking ahead, periodic pandemic or disaster supplemental funding will not support the desired long-term countermeasure development, medical response or hospital preparedness, or similar programmatic preparedness initiatives that the Nation needs.

What worked but could work better? Well, the CARES Act worked fabulously. The Coronavirus Aid, Relief, and Economic Security Act worked. But the delay in securing the funding through the supplemental process slowed our ability to respond and, quite frankly, delayed our ability to procure personal protective equipment at a time when cash in hand was the only way to buy available limited PPE supplies. It also delayed our ability to contract with pharmaceutical companies for the development of COVID-related vaccines, therapeutics, and diagnostics.

What could work with the right safeguards and provisions? Appropriating funds into the existing Public Health Emergency Fund found in 42 U.S. Code, section 247(d), that enumerate powers and authorities of the Secretary of Health and Human Services. This cannot be a generalized public health emergency slush fund. It would be used by the Secretary specifically to address the risks of a pandemic or catastrophic national public health emergency such as a large-scale cyber attack affecting public health or healthcare or a large-scale CBRN event.

The last area that I would identify is things that have been identified as prospective ideas, and that is really the idea of somehow circumventing or exempting designated preparedness funding from budget caps, which I believe is an excellent idea and is an idea supported by the Bipartisan Policy Center.

And I think that the idea of creating a permanent budget designation for programs deemed highest priority to prevent, detect, and address infectious disease threats outside the annual 302 allocations and outside the overall budget limitations would be something that would be extraordinarily beneficial.

And, finally, with time running out, I would just say that there needs to be some kind of mechanism to support the Strategic National Stockpile, and that should be studied and evaluated. The SNS has consistently been tasked to meet more hazards than its funding has allowed. Congress should specifically identify which hazards the SNS should be prepared to encounter over the next 5 to 10 years and authorize an appropriate commensurate budget to meet those requirements; when it makes economic sense, to permit the SNS to rotate certain stock before expiry, possibly through vendor-managed inventory, to save the government and American taxpayers significant funds.

And, ideally, Congress should identify a mechanism to enable better preparedness not only for the Federal level but the opportunity to procure personal protective equipment by our non-Federal partners at the State, local, Tribal, and territorial levels.

With that, sir, I will end my comments and look forward to your questions.

Thank you very much.

[The statement of Dr. Kadlec follows:]

Written Testimony of Dr. Robert P. Kadlec
House Rules Subcommittee on Legislative and Budget Procedures of the House Rules Committee
10:00 AM January 19, 2021

Chairman Morelle and Ranking Member Burgess thank you for the privilege and opportunity to appear before you today. I am appearing as a private citizen and not in my capacity as a Senate professional staffer. As the former Assistant Secretary of Preparedness and Response at the start of the pandemic, I lived breathed and bled the experience. I certainly want to acknowledge the incredible work, service and sacrifice of the federal, state, local, tribal and territorial civil servants and professionals from the private health sectors that served as the backbone of the past and current pandemic response. The whole-of-nation response has been vital to the preserving our society and lives saved. I also want to commend you and your colleagues for your strategic vision and foresight in having this Subcommittee consider budgetary approaches that Congress could take to prepare the country for the next pandemic.

I am fortunate to know an individual, Senator Richard Burr, who shares your urgency and necessity to learn from the successes and mistakes of the COVID response to better prepare for the next pandemic. I am convinced because of your collective commitments to future congressional action that we as a government and nation can be better prepared to mitigate the unnecessary loss of life, economic impacts and societal disruptions that another pandemic would bring.

A Context for Future Preparedness

The risk of focusing exclusively on the current crisis to define future preparedness will hopefully be a lesson learned from this pandemic. Before COVID, our pandemic preparedness was exclusively focused on influenza. The precedence of previous influenza pandemics resulted in a form of target fixation: excluding from consideration other potential pandemic pathogens like coronaviruses, Hendra (e.g. Nipah) and other viruses. It would be a similar mistake to exclude other potentially catastrophic events that could have a national impact on public health and health care provision. For example, a large scale chemical, biological, radiological or nuclear (CBRN) cyber- or critical infrastructure attacks on the homeland would have severe effects on Americans health and welfare.

The 2021 US State Department Arms Control compliance report raised concern about the compliance of China, Iran, North Korea and Russia adherence with the Biological Weapons Convention (BWC). Our limited preparedness and faulty response to COVID could only validate and encourage them and potentially others about the utility of biological agents against the United States. We have witnessed a number of state sponsored targeted killings using advanced chemical and radiological agents. We also watched these adversarial nations to develop advance hypersonic missiles that could deliver unconventional warheads against our homeland.

We have also witnessed the occurrence of large scale cyberattacks on health care systems. The United Kingdom's National Health System and several US health care systems were adversely effected by ransomware attacks. These attacks emanated from both state sponsors and criminal

elements. Such effects does not exclude incidents caused by disturbed individuals. My 2020 Christmas Day holiday was interrupted by a deliberate detonation of a vehicle borne improvised explosive device in Nashville that killed the perpetrator. The explosion severely damaged a critical telecommunications facility. The interruption of telephone and internet services impacted three major regional health care systems and 911 call service across several states.

You cannot dismiss the risk of major weather events either. Early in my tenure, we were confronted by three consecutive major hurricanes, Harvey, Irma and Maria. The December 2021 deadly tornadoes that effected 8 states is a more recent example. The challenges and documented incidents I encountered during my ASPR tenure, including a novel coronavirus pandemic, could be considered the new normal. I would also suggest they should be considered the likely future we must be prepared for.

Three Policy Imperatives for Future Whole of Nation Preparedness

These potential challenges require the same "whole of nation" response we saw attempted with varying success during this pandemic. It is apparent that the successes achieved during COVID required collaboration between the federal state, local, tribal and territorial governments, the private sector, academia and the general public. Nowhere was that most effective than during Operation Warp Speed. The Warp Speed approach for medical countermeasure development, if effectively applied, could have improved our efforts in disease surveillance, testing, supply chain management and health care provision. The core elements of Warp Speed can be described by three elements.

1. Promoting Strong, Effective Leadership and Coordination. There is a need for clear and effective leadership emanating from the White House and HHS working with FEMA to promote better all-hazard preparedness and operational response coordination across federal interagency, state and local governments, academia and the private sector.

2. Strengthening Public-Private Partnerships. Much progress has been made in creating public private partnerships with a variety of entities in the U.S. health care enterprise. Notably, Operation Warp Speed (OWS) defied the pundits and the odds by creating vaccines and therapeutics in record time. OWS was built on a public-private partnership created by BARDA, which leveraged pre-existing relationships between the federal government, the private sector, and academia.

   Similar partnerships were created with manufactures, suppliers and distributors in the medical supply chain. They were created with entities in diagnostics through partnerships with testing developers, companies and a variety of health care providers, health care systems, and retail pharmacies. Besides enabling the advancement of specific lines of effort addressing the pandemic, the information provided, created a transformational data set as part of *HHS Protect*. These partnerships, however, are still nascent and need to be preserved, improved upon and made enduring for the next public health emergency.

3. Capacity, and Capability Improvements, Innovation and Exercises. Health care systems must expand their limited surge capacity, and there is a need to better coordinate and rapidly surge

personnel and staffed medical beds to meet future contingencies. Capacity must also reflect specialized capabilities that may be needed in future public health emergencies.

There were significant pre-pandemic capabilities that provided significant yet insufficient levels of capacity. The National Emerging Special Pathogens Training and Education Center and the 10 Regional Ebola and Special Pathogen Treatment Centers managed and supported care of highly infectious patients. Prior to the pandemic they provided specialized training to affiliated hospitals and health care systems. The National Disaster Medical System effectively coordinated with participating civilian health care systems and the Department of Defense and the Veteran Affairs health system. The coordination maximized the limited capabilities and capacity that DoD and VA could offer supported by the NDMS Disaster Medical Assistance Teams.

There is also an opportunity and imperative to leverage innovation to expand medical preparedness and response capacity and capabilities, including those of the Strategic National Stockpile and the medical countermeasures enterprise.

Understanding our capabilities and capacities has come through painful experiences such as COVID. According to a July 2021 CRS report, there were no National Level Exercises (a term FEMA utilized that is scenario playing among the interagency, often in partnership with states and localities). The only pandemic exercise was a TOPOFF exercise conducted by HHS known as Crimson Contagion (looking at a pandemic influenza event with state, local, tribal, and territorial partners). Crimson Contagion was one exercise I was particularly adamant about having as there hadn't been a pandemic related exercise since the 2009 pandemic. Such exercises help to identify critical assumptions, shortfalls, and provide rubrics for timely response. While the bureaucratic process behind these exercises takes many months to reach consensus through After-Action Reports, it takes even longer to inform the policy and budget processes to address the identified challenges.

In the case of Crimson Contagion, we identified many challenges, including the importance of financial access in a timely measure. Given my previous role, I didn't await the drawn-out processes to perhaps inform changes years down the road. Following a hot wash (immediate debrief), I instructed staff to immediately attempt to integrate Congressional staff into the shortfalls that may hinder such a response. In fact, barely over a month later, they hosted several dozen staff to relive the exercise and tour a Strategic National Stockpile facility. These bipartisan and bicameral staff expressed their thoughts in the roundtable format where they primarily honed on concerns about the speed by which Congress could appropriate funds necessary to address that theoretical pandemic and how vulnerable to disruption and just-in-time the supply chain was.

Potential Budget Principles to Prepare for Future Pandemics

There are several historical and contemporary budget approaches that worked and didn't work. There some prospective ideas that are innovative and I think would work improve future pandemic preparedness. Whatever approach taken must be evaluated on the basis of

responsiveness to the health security threat contemplated, and ensure congressional accountability and sustainability.

The Project BioShield Act that was created by Congress in 2004 after the events of 911 was an effective tool. It created a ten year advanced appropriation to incentivize the development and procurement of CBRN medical countermeasures that did not have a commercial market. The program was successful but the Special Reserve Fund created by the legislation was not replenished when the original ten year appropriation ended. Advanced appropriations could be useful in developing potential pandemic medical and antimicrobial countermeasures. The dilemma becomes renewing such advanced appropriations and the potential that Congress may later choose not to do so. The original BioShield concept called for obligatory nondiscretionary funding.

The second potential budgetary approach could be adopting a similar funding mechanism represented by FEMA's Disaster Relief Fund (DRF) to create a Health Security Emergency Fund. This is a concept also supported by the Bipartisan Policy Center.

Congress periodically replenishes the FEMA DRF in response to large natural disasters. While the DRF can provide access to such funds for public health emergencies it is usually available later than Congressional supplemental funding. DRF allocations are subject to reimbursement of mission assignments. This approach is not conducive to large-scale pharmacologic research and development, material stockpiling, or related spending necessary to health security emergencies.

The frequency of health security events is not annual. Were Congress to establish careful guardrails to limit expenditures to true health security threats and provide an annual appropriation into a Health Security Emergency Fund (HSEF), a response that bridges the gap from potential pandemic threat emergency to true pandemic could be addressed.

The guardrails needed to define temporal health security threats include:

- Existential health security threats can and should be addressed by agencies through the normal
- Appropriations and Authorizing processes.
- Consistent and timely obligation reporting to key Congressional Committees would help Congress to more accurately forecast threat potential and related authority or financial needs. Such oversight also helps to ensure guardrail compliance.
- Given medical and public health expertise, such a fund should reside at a cross-cutting level within the agency with principal responsibilities, HHS. While interagency partnership should encouraged in an advisory manner, it should not be a hindrance to the rapid decision-making necessary for such actions.

Upon fund maturation, a required set aside for health security-specific NLEs should occur on a rotating basis to encompass the major threat areas of pandemic, large scale CBRN incidents, and national health care disruptions (cyber or supply chain).

This iterative cycle of health-specific threats would provide for the bureaucratic processes to play out and to inform the policy and budgetary processes. Such a cycle also permits officials to see if recommendations hold up across the threat spectrum or the relative degree of insularity. Key hot wash highlights and eventual After-Action Reports should be provided to key Congressional Committees along with interpretive debriefs.

What didn't work particularly for ASPR was periodic pandemic or disaster supplemental funding to sustain improvements in preparedness. Disaster and pandemic supplemental funding were significant enablers of preparedness but when the funds from that funding (e.g. influenza, and ebola) ran out, ASPR's ability to sustain programmatic funding for pandemic influenza countermeasure development and training of our NDMS Disaster Medical Assistance Teams were jeopardized for example. When I arrived at ASPR, our NDMS teams had not received any sustainment or specialized training for several years. Fortunately, because of the hurricane supplemental funding after Harvey, Irma and Maria, we were able to fund highly infectious disease training of our NDMS personnel before the pandemic.

The Coronavirus Aid Relief Economic Security (CARES) Act worked but the delay in securing the funding through the supplemental process slowed our ability to respond. Delays impacted our ability to procure personal protective equipment at a time when those with cash in hand were buying the available limited PPE supplies. It also delayed our ability to contract with pharmaceutical companies for the development of COVID related vaccines, therapeutics and diagnostics. Congress was and remains generous in allocating funds for pandemic response. The benefit of these dollars, however, is greater in lower amounts before the crisis or outbreak happens. The ounces of prevention and preparedness are greater than the pounds of response.

I am strongly supportive of some prospective budget ideas whose time has come. I think the notion of designating preparedness funding exempt from budget caps is an excellent idea. I understand members of this Committee are supportive of the idea of put forth by the Bipartisan Policy Center. The concept Biodefense Interagency Operations creates a permanent budget designation for programs deemed highest priority to prevent, detect, and address infectious disease threats outside annual 302(a) allocations, and outside overall budget limitations. I think this would be an indispensable addition and tool for future pandemics and other potential catastrophic health security threats too.

Finally a new mechanism specific to the Strategic National Stockpile has also been proposed. Permitting the creation of a working capital fund specifically for the SNS is viewed as a potentially beneficial authority to ensure the long term sustainability of certain dual-use commercial products such as personal protective equipment (PPE). Permitting the ASPR and SNS to rotate stock before expiry could save the government and American taxpayer significant funds that could be reused for pandemic preparedness. It could be a tool that could enable better preparedness not only at the federal level but the opportunity to procure PPE and other medical supplies jointly non-federal partners (e.g. state, local tribal and territorial governments).

Mr. MORELLE. Thank you, Doctor. And thank you for your service to our country in the number of different capacities you have held, and we appreciate that very, very much.

I am going to just, if I can, ask just a handful of questions in the first round, and then I want to make sure my colleagues all have an opportunity to ask questions. And I may come back for a second round, if that is acceptable to folks.

I want to start with Dr. Gayle and Ms. Tedesco, both of you representing the not-for-profit sector that did so much over the last 2 years and continues to do so much. And perhaps, Dr. Gayle, if you could respond, and then Ms. Tedesco.

But I sort of think about three things. First of all, is there enough local planning and coordination being done in Chicago and Rochester? And I will take those two data points to sort of reflect on what it is like in the country.

So, in Chicago, for instance, are you routinely going through with other community partners and local government a planning process, a coordination on what would happen if? And the same thing I would ask of Ms. Tedesco.

Second, if not, if we are not doing enough, how could we help incentivize that local coordination—drills, planning process, et cetera?

And, finally—and I think Ms. Gayle mentioned this in your testimony, the idea of not enough money for not-for-profits prior to—and maybe it was Ms. Tedesco, actually, who mentioned this.

So, if there were additional dollars, what would not-for-profits do with those dollars in pursuit of greater resiliency? How would those—would they be technical? How would you actually use those things?

So those are sort of just initial questions. If perhaps Dr. Gayle first, and then Ms. Tedesco?

Dr. GAYLE. Great. Thanks so much.

So your first question around the coordination, I mean, I think that, clearly, much more coordination needs to occur. And, you know, I think the link is from the Federal to the State to the local and then working at the local level with nonprofits that work directly with communities.

And I would say, you know, if I look at the situation here in Chicago, Chicago local public health department had done a lot of preparedness and had, in fact, been, you know, doing drills and looking at tabletop exercises and other things, understanding that, you know, preparedness for the next pandemic was critical.

That said, that isn't necessarily going on across the country. And the resources that need to flow from Federal to State to local have not been there historically for preparedness so that, when something occurs, those systems are in place.

And I think we saw in the beginning of this pandemic a real disconnect between, for instance, our surveillance system, our ability to even know what was going on—because we weren't adequately funding it so that those dollars did flow from Federal to State to local.

You know, at the local level, you know, I go back to a lot of the experience I had when we were focusing on the HIV/AIDS pandemic. We funded at the Federal level directly community-based or-

ganizations that really built the kind of infrastructure to reach communities that were at greatest risk. But a lot of that funding dried up, and it didn't maintain some of the kinds of networks that were necessary at the community-based level.

So we have seen, through this pandemic, a rebuilding of a lot of that. You know, we are working here at Chicago—we are helping to coordinate a Chicago vaccine partnership that is really looking to—with the organizations that can reach the hardest-to-reach communities, particularly Black and Latinx here in Chicago, but that has all had to be rebuilt.

And, you know, these are the kinds of things that could stay in place, because these are the same community organizations that are meeting people's needs in different ways. And they can be ready and ready to be mobilized, but we had to do a lot of rebuilding to put those community partners in place and to make sure that the health department and community-based organizations were working in tandem.

And so, you know, I think the message over and over again is that we know how to do it and we know the organizations that can be incredibly effective at the grassroots and the community level but we don't continue to resource them so that, you know, we have this functioning, seamless system that flows from Federal to community-based level.

Ms. TEDESCO. Thank you——

Mr. MORELLE. Thanks for that.

Ms. TEDESCO [continuing]. For the question, Chairman. And I agree with Dr. Gayle's response. I think there is a disconnect between emergency planning and disaster preparedness at the government level and then at the local and community-based level.

On, you know, Foodlink's part, we have been involved at various times with VOAD, Voluntary Organizations Active in Disaster, but what we have seen is that there has been fits and starts with that. And at the State level, when you look at who manages disaster preparedness and how that flows, it is incredibly complex, and it does not translate to how we work at the ground level and does not, sort of, honor the knowledge that we have and the relationships we have in the community.

So I don't know if this is a recommendation per se, but I think what needs to happen is that we need to begin to speak the same language, that the government needs to come to the table with community-based organizations who end up delivering those disaster response services and come to the table as equals in terms of planning.

Because what exists at the government level, what we have seen, is a series of flowcharts and complexities. And what exists, you know, at the local level is just an understanding of what people need and what our peer nonprofits can offer.

And communications is key. We saw that in Rochester, is simply having the structure—we immediately, thanks in part to you, Chairman, were able to have these weekly emergency response calls with government entities and nonprofits and the for-profit sector. That made all of the difference. It made us nimble; it made us be able to respond quickly. So, more than anything, having the communications structure in place.

But to answer the second part of your question, yeah, it is truly capacity-building. Someone else touched on this earlier, but—and I am sure you have all heard this before, but, far too often, non-profits have the opportunity to apply for Federal grants for, you know, really prescriptive programs, or even from private funders. You know, they want to fund a feeding program for children over and over, and I certainly understand why, but what they don't want to fund is the technical capacity-building, the staffing.

And, certainly, I think what is lacking is thinking about all of that in the context of planning for a disaster. Food banks know how to distribute food. Do they all have generators?Do they all have the cold storage that is required?Right now, we are facing supply-chain issues with trucks. We have a truck shortage; we have a truck driver shortage. So that type of investment is what could make a huge difference for us.

Mr. MORELLE. Thank you.

I do want to—and I will just editorialize, because, in Rochester, as Ms. Tedesco is pointing out, at the beginning I think we organized twice-a-day phone calls with groups that included Foodlink and others, but we were really making it up as we went along.

And I am just sort of thinking about how we might better incent local communities to do that on an ongoing basis so that they are basically—you know, I used to say there is no real manual, locally, on what we do in the middle of this, so we are just making it up, sort of building the airplane as we are flying it. But it would be interesting to me whether there is a way, in partnership with the Federal Government, to start incenting local communities to go through that process and that exercise in advance of having a real, live event.

I just want to switch—you know, Mr. Schlegelmilch, you said something that has been the bane of my public existence, which is, whenever I am at a table and people say "let's get some quick wins," to me, in my brain, what that says is "let's do the easiest thing so we can show everybody that we are doing things," but rarely have I ever seen quick wins turn into any lasting value. In fact, I think it almost undercuts.

So I would ask it this way: What kinds of things should we do to develop some slow wins or some wins that are lasting?

You started to touch on it a little bit, but—and maybe even use the frame of making this easier for people. I thought your comments also about how difficult it is—if you are already, in a sense, disenfranchised prior to a crisis, you are not going to be any better able or better equipped to deal with it during the crisis.

So if you could just expand on that a little more. I thought that was very interesting. What should we be doing to think about that differently?

Mr. SCHLEGELMILCH. Absolutely. Thank you for the question. I think—so I will answer it two ways, sort of the from the bottom up, I think the first thing we have to think about is really, what are the transactions that we are asking people to engage within in order to access different kinds of assistance, if you are a survivor at the individual level, if you are an nonprofit within a community? And what are the strings attached to that? Now, obviously, it runs through filters at the State and local level that this committee

might not necessarily have direct oversight of but certainly originating from the Federal level.

And so that is where there is an obvious answer but not an easy one to implement, which is simplification, that is sort of these quick wins layering on top of each other I reference in my written comment, and there is a Federal colleague who calls it the Jenga of Federal assistance, topping one block on top of the other in random arrangements, and seeing how that really affects those and what capacities are required to access that and who has them and who doesn't.

Honestly, in the meantime, a stopgap may be to provide technical assistance to communities to put grants in place or to increase funding for disaster case management until the larger paradigm can be simplified. And that leads to sort of broader topics, which is that really taking a step back holistically and looking at this—you know, I mentioned the data. So a couple years ago—the conversation is still going on, but it sort of broke through in my world where a number of former senior Federal officials were talking about how States need to do more to invest in preparedness, and rules should be changed to really—really putting a lot of the burden on this is because States aren't investing in preparedness, and they are—the Stafford Act incentivizes not investing because you are can get 70 percent, 75 percent of Federal cost share through a disaster declaration.

There is probably a bit of truth to that, but I am bringing this up because the Pew Charitable Trusts, through their fiscal federalism initiative, did a survey of States on their investments in preparedness, and it turned out there was no standard metric for measuring preparedness. States didn't have a standard way of doing this, and so the self-reported data ranged from very little to a whole lot to nonrespondents because they were responding to active disasters.

So I think, also, as a consequence of quick wins, we have information that is spread out across many different points that can be neatly pulled together to form a narrative for an argument but are really short of systemic analysis.

With my colleagues at Georgetown, we put together some analyses on some very specific elements of emergency supplementals, and even there we have—admittedly, there are things that there are blind spots to with different changes in rules and things like that.

So I hope that is somewhat helpful, but I guess, at the ground level, really be very sympathetic to the transactions we are asking people to engage in to access resources and recognizing that can be a critical barrier and, in the formulation of these, really looking at whether or not this complexity ultimately serves or hides a lot of actions that are ultimately detrimental to the broader goals of resilience building.

Mr. MORELLE. Well, and I won't bore you with my long seminar on how we should better integrate social, health, and educational, and governmental services just in general, absent a natural disaster, but—and Ms. Tedesco and I are part of an effort back in Rochester to integrate those services. But, at some point, I may come back and talk to you more about that subject.

Just if I can, to Dr. Kadlec, so we are hearing from local community organizations about what they experience in terms of coordination. I am just curious, and this is—you know, I am not someone who is very interested in the past except what we can learn from it, but from your vantage point, the notion that there was so many different agencies involved in this, did you feel frustrations, and is there a way to better organize and coordinate at the high level, at the Federal level our response in times of either natural disaster or things like the pandemic?

Dr. KADLEC. Sir, there is a mechanism that exists through FEMA with the use of the VOADs. I think Ms. Tedesco kind of raised that up as one thing, and that is through the FEMA regional offices where they collect them. Now, I think, practically speaking, in the nature of a pandemic, which really required a different set of players to work in different contexts, you know, that is, I think, one of the issues that I think that was brought up by Dr. Gayle that there is this need to really drill and exercise.

In my testimony, I have a piece that says, whatever we do, we need to commit to that at a Federal level, and we did do that at Crimson Contagion. We actually did do a local/State—we worked with a number of different States—Illinois being one, Chicago being a city—where we looked at the ability for pandemic preparedness, but that was the first time it was ever done.

And this is something that has to be drilled regularly, you know, in some kind of regular basis, ideally like every third year, so every administration gets a chance to go through that experience but, more importantly, to do it with different parts of the country and really get down to the community level and exercise it so that we can get people like Ms. Tedesco talking about the food bank; we can get other elements of the local community outreach programs to make sure that those who are not easily reachable or who have challenges in being reached or the equity issues can be identified and effectively addressed.

We did do that in our efforts with Warp Speed working with the Warp Speed team, the logistical team and with CDC and State and locals, but that is something that has to be done, I think, drilled regularly to make sure that not only the muscle memory but the people who are actually holding those positions, which oftentimes changes every couple years, are refreshed and, again, trained and educated.

Mr. MORELLE. Thanks for those comments. I am going to reserve more of my questions, but I want to give my colleagues an opportunity, and they have very demanding schedules.

So I am going to go first to you, Dr. Burgess, for any questions you might have, sir.

Dr. BURGESS. Great. Thank you, Chairman Morelle.

And, like you, I will probably divide my questions up into two sections to give other colleagues an opportunity to talk to our excellent panel this morning.

Dr. Kadlec, I do want to reference one thing. You mentioned in your written testimony in speaking with Crimson—about Crimson Contagion, the exercise that you did. You have a statement here, in fact: Barely a month later, we hosted several dozen congres-

sional staff to relive the exercise and tour a Strategic National Stockpile facility.

Chairman McGovern, Chairman Morelle, maybe the Rules Committee could visit a Strategic National Stockpile facility so that we could learn better for ourselves firsthand. I dare say, it is probably an exercise that most Members of Congress have not taken.

And we speak about a Strategic National Stockpile, but we have never actually been to the warehouse and seen for ourselves what is involved. So I just simply offer that as an observation. If the Rules Committee would like to organize a visit to a Strategic National Stockpile, this member would be interested in attending.

So, Dr. Kadlec, let me just ask you, on the Operation Warp Speed and on your team on Operation Warp Speed, you successfully were able to accelerate the advancement of some of the monoclonal antibiotic treatments and the antiviral agents. And your ASPR team led the allocations of distributions of these products in an unprecedented way.

You know, my understanding is, with the change of administrations, there was at least the existence of the opportunity for procurement that your administration and ASPR had left for the incoming administration in February of 2021, that those could have been extended but, in fact, weren't. And I just ask you, is that understanding correct, and do you have a sense if—if it is correct, do you have a sense as to why it was not executed?

Dr. KADLEC. Sir, it is correct, and we made deliberate efforts, particularly when we were setting up Warp Speed and not knowing the nature of the election but was trying to, if you will, make sure that whatever we did would be in doing at least through the first couple of months of either the second term of Trump or the first term of Biden's administration to give them some time to get their feet underneath them and recognize that they would need to make decisions as it would relate to the conditions on the ground that they encountered.

So we had turned over, I think in the sense of the vaccine issues, vaccine procurement that was to the 300 million dose level and the antiviral immunoglobulins at least at that time to at least give them some cushion of time and opportunity to evaluate as well as knowing that there would be additional products coming through the pipeline.

Now, two things happened, is—and so I can't speak for the other team, but one was they had the Delta variant surge, and then clearly there were some of the monoclonals, truly the monoclonals, the single cocktail, single monoclonal cocktail made by Lilly that had to be reconfigured into a cocktail to ensure that it could have the coverage.

So there was some challenges that were encountered that were anticipated, some that were not. But we did try to put them in the best position so that they could figure out what to do going forward. And, frankly, I don't know why, maybe there were decisions not to make further procurements at that time, but clearly they have adjusted to the realities on the ground and have expanded their monoclonals.

But here is the dilemma that we have, we have—not that we have a thinking enemy, but the virus is a wily adversary and has

circumvented the two main stays of our monoclonal therapies, the Regeneron product and the Lilly product, and now we are left with GSK. So, you know, again, this is a very dynamic, fluid environment, and you just can't rest on your laurels, for sure.

Dr. BURGESS. Yeah, as we have learned. And, you know, one of the successful aspects of Operation Warp Speed was the suspension of the normal Federal procurement rules, that if you had a product in development that showed significant promise, there was an ability to prefund the purchase prior to approval so that the government would assume a significant amount of the risk and not the private sector.

So do you have a sense that that continues today? I know when we had an opportunity to just have a general HHS call with the administration's COVID team, they talked about Operation Warp Speed and Operation Warp Speed being used to develop the Pfizer antiviral, but it didn't seem like they followed through with the advance procurement, which seems to me to be a critical part of Operation Warp Speed. Do you have any knowledge about that?

Dr. KADLEC. No, not directly. But I think, to your point, there was a package of things that were done that were really trying to aggressively, you know, advance the development of these—a variety of different products, vaccines and therapeutics. And the kind of panoply of things that were done were we use the Defense Production Act, which were aggressively kind of assisted companies, either expand capacity or obtain a priority for supplies, needed supplies so they could manufacture or develop their potential product.

We did do advance procurement activities, particularly with the vaccines and with the therapeutics with the idea that that would just give them some assurance that if the product worked, whether it worked or not, we bought it. And as we would joke a little bit—there was no joking a lot in that experience, but it would—that we would take a product that didn't work and just accept that that was a lost investment and move to the next product and move forward.

So there was an element of what I would say risk-taking on the part of the government, risk mitigation on the benefit of the company, and then really very focused product and portfolio management. And we had an extraordinary team, the public/private partnership that existed with Dr. Slaoui, Dr. Carlo De Notaristefani were an exceptional group of experts that would kind of help us stay on track.

Dr. BURGESS. Well, thank you. And, again, let me just echo Chairman Morelle in thanking you for your incredible service to our Nation.

Dr. Gayle, I appreciate so much you mentioning PEPFAR in your discussion. That is a model that it seems like we perhaps have lost sight of recently, but was enormously effective in the early part of the 2000s, at a time where it seemed like all could be lost in the fight against HIV and AIDS in Africa, and that a generation would have to be—would face coming into adulthood without their parents because the disease was so devastating.

And because of actions of then the Bush administration and, yes, the United States Congress to participate in PEPFAR, which was really an extraordinary effort, and I don't know that we talk about

it enough, that there—I don't know that before or since if there has been that sort of effort that one nation has made on behalf of multiple other nations. So, when we think about the global investments that need to be made for future preparedness, learning some of the lessons from PEPFAR, I think, are going to be extremely important.

Dr. GAYLE. Yeah, I would wholeheartedly agree. You know, it has been an incredibly important program. It was comprehensive. It was global. It really built infrastructure. And, in fact, the infrastructure that PEPFAR built was in large part the reason why future pandemics were able to build on that infrastructure.

And so, you know, I think being able to mount something similar to that, and as you noted, it was started by President Bush, but it was continued on for other—all the next administrations no matter what the political party was, and I think it is just one example of how global health is a bipartisan issue and one that I think people can rally behind.

And in a pandemic like this, you know, again none of us is safe unless all of us are safe, and I would love to see the same sort of coordinated effort that really, you know, made sure that we were thinking about this in a very holistic way in the way that we did with PEPFAR and the AIDS pandemic. So I think there is a lot of lessons to be learned there, and I think it is a very important model.

Dr. BURGESS. So immediately prior to being distracted by the pandemic of the century, there was some discussion of utilizing the infrastructure that had been built during the—during PEPFAR to provide a platform for improved maternal care, maternal mortality in other locations. And, unfortunately, that is going to, I guess, go down in history as one of the unintended consequences or victims of the pandemic. I haven't heard recently any discussion of that, because clearly everyone has been focused on the more immediate danger of the coronavirus.

Ms. Tedesco, it is really not fair to ask you this, but I am going to. Was Mr. Morelle helpful to you in getting the school districts to reprogram their funding that they should have been using to provide free and reduced lunches, to get those funds to your nonprofit so that you could appropriately take care of the people who now weren't being fed in their school lunchrooms?

Ms. TEDESCO. I can honestly answer, Congressman Morelle was incredibly instrumental in, you know, maybe not precisely what you just said but exactly the spirit of that, which was coordination between the sectors.

And Foodlink, you know, even prior to this disaster is the largest nonmunicipal provider of meals in our region, so we have a community kitchen. Prior to the pandemic, we were doing 3,000 meals a day. We can came in—the first case in Rochester was on a Friday. We came in on a Sunday and started preparing meals and figuring out in conjunction with the city school district how we could get those meals to kids.

And if I could connect this to the question I was asked prior, in just continuing to think about that, in any disaster preparedness that I have been involved with—and, Dr. Kadlec, you sort of said this as well—never did a global pandemic come up. You know,

when we were talking with the Red Cross and State FEMA reps and whatever, we didn't talk about global pandemics, nor did we talk ever specifically about the crises of children being out of school. And that became the number one crisis that we addressed, not public health instantly but kids being out of school and what we instantly knew that meant for our community and for families.

And so, yes—I hope I answered your question. Yes, Congressman Morelle was incredibly helpful, but it was truly a collaborative process and I think paves the way for what it needs to be for school districts, especially in impoverished areas like the city of Rochester, that they really need sustainable, collaborative models with the nonprofit sector in order to fully meet the needs of their student body during a pandemic and during, quote/unquote, normal times. I hope that answered your question.

Dr. BURGESS. It almost did. And you used the word "nimble" earlier, and I think that is perhaps something we should all bear in mind when we are faced with the existential crisis that this was and the ability to be nimble in our funding. And just as the virus doesn't respect any political party, it also doesn't respect political jurisdictions. And whether it is school district, county funding, State funding or Federal funding, we need to be nimble in our response.

Mr. Chairman, I am going to reserve the balance of my time and allow you to go to other members.

Mr. MORELLE. Thank you, Dr. Burgess.

And I do note, as it related to the schools, that one of the first requests we got from one of the school districts was to allow them to receive funding even though they weren't providing lunches anymore. And we held a pretty robust discussion that included Foodlink because they wanted to step up and help and certainly did. But it did raise the question of how difficult it is to coordinate in the middle of an emergency, because there were existing rules, there were existing requirements you have to meet. So we went through a long process to try to work that out. But I appreciate your comments. I want to now call on——

Ms. TEDESCO. Chairman, may I add one thing to that?

Mr. MORELLE. Yes, of course.

Ms. TEDESCO. I just—I want to say that I think one of the most successful things that happened during this pandemic in terms of government response was the USDA waivers that were put into place fairly rapidly, and I would truly advocate for those being extended or put in permanently.

But reducing barriers to access for kids by allowing grab-and-go meals, by increasing reimbursement rates so we can get more nutritious and higher quality food out to folks, by doing away with what was formerly required congregate meal settings that enabled caretakers and children to eat together, to take food home to their families together, all of those things, and there is more to add to that, I believe, should always be in place.

They honor the dignity of the individuals receiving those services. They meet people where they are. They enable us to get better food to more people. So I applaud the USDA, the government for those waivers. Thank you.

Mr. MORELLE. Well, I appreciate those comments. And I am sure Chairman McGovern, who is leading the national effort on a White House conference on hunger, is thinking about those things, and I appreciate your comments.

I now want to turn to my colleague and friend, Ms. Ross, for questions.

Ms. ROSS. Thank you, Mr. Chair.

And thank you to the folks who have testified today. I am juggling a Science, Space, and Technology markup, but I would argue that maybe we should get Science, Space, and Technology to take up this issue as well since so much of their jurisdiction has to do with things that might involve research and planning for the future.

As we know, the COVID pandemic has exposed how unprepared the United States and the rest of the world are for large-scale public health emergencies. And it is critical that we learn from these experiences and use our knowledge and resources to prepare for and prevent similar disasters in the future.

For years, before the onset of the current pandemic, academic, scientific, and policy institutions warned of the potentially devastating impacts of a global pandemic, so did Hollywood. And as recently as 2012, the Rand Corporation concluded that pandemics were capable of destroying the American way of life.

In the years following, the U.S. intelligence community cautioned in their Annual Worldwide Threat Assessment that pandemics can cause political and economic upheaval, as we can attest.

Our goal today should be to address the systemic gaps that left us vulnerable to this crisis in the first place and to ensure that science is not politicized, especially when it concerns the health of millions, not only in our Nation but around the world. We must ensure that we take basic steps to protect our own citizens first, and there are ways that we simply have not.

For example, in my home State of North Carolina, the State has refused to expand Medicaid, leaving hundreds of thousands of North Carolinians without health insurance and more vulnerable to this pandemic. And I spoke with all the hospital CEOs in my district yesterday, and they continue to say that, had we expanded Medicaid, things would be much better in the State of North Carolina.

In addition, our public health infrastructure has been affected by staffing shortages, which some of you have mentioned, among frontline healthcare professionals. And it is critical that we in Congress provide support to our healthcare institutions to continue serving our Nation as we deal with the resurgence of cases caused by Omicron and the variants that I am sure will come even on the heels of Omicron.

I have also heard from educators in my district about the challenges of teaching when schools lack essential health resources. And I know we have talked about food issues, but right now what the schools are looking for are KN95 masks and COVID tests.

And we know that the administration is sending them out, but, clearly, it would have been great if they had them all throughout the pandemic. And providing these tools should be a top priority to ensure that our children can continue to be educated and our

teachers and school professionals can be protected as they serve our communities.

This brings me to the importance, as Dr. Burgess raised, of continuing our effort to provide COVID resources around the world, from vaccine tests to personal protective equipment. We can't defeat the pandemic and expect to protect ourselves without coordination and support with the international community. And, without investments in global health, including vaccines, therapeutics, and more, we will continue to face new variants that develop in other countries with fewer health resources that we have.

My question to all of the witnesses, and Dr. Burgess started this by bringing up the success of PEPFAR, is, what strategy should we use to ensure that our Federal budget accounts for the global nature of pandemics and other public health crises in a recurring fashion and not just as a reaction?

Dr. KADLEC. Representative Ross, I will take a first swing at this, if you don't mind.

Ms. ROSS. Thank you.

Dr. KADLEC. In specifically focusing on I think the medical aspects that I think were highlighted by PEPFAR, and that is, clearly it was a U.S. initiative, but in managing a pandemic—and obviously we—there are things called CEPI, and I applaud what the current administration is trying to do to expand, if you will, the participation of other countries to donate vaccine—there really has to be an established mechanism that builds capacity here domestically that is likely excessive to our national needs but yet is contributable to the global needs in the event of a pandemic. And I think that is one thing that, quite frankly, that has to be kind of considered and sized.

There was discussion late in the Trump administration about creating a Marshall Plan, the idea of doing something similar to what was done in Europe following World War II to basically enlist support of willing countries to donate vaccine globally. And then I think that, you know, transitions are disruptive, but I think now that you can see that our country is kind of moving into that role.

But I think there has to be a dedicated effort to build that. There has been a discussion about an international treaty to deal with pandemics, and it would seem that that would be an appropriate, you know, consideration to be part of that, amongst other things. But, with that, I will stop and turn to the other witnesses for their comments.

Mr. SCHLEGELMILCH. I can add a few thoughts, and thank you. And I appreciate the—also the callout to the series of warnings that have come from the scientific community, from the policy community, from the government itself on the challenges of the pandemic. And it is something that I am sure will be the subject of many committees, commissions, blue-ribbon panels, whatever the case may be for years to come.

Yeah, the data was there; the incentives were not. And so I think that there—you know, complexity—we are entering into a more complex world. This pandemic may very well not be the last one we see in our lifetime, and with the growing impacts of climate change, it is going to get worse before it gets better.

And I think that one of the key components there is we have a very distributed set of responsibilities, both throughout Congress and through the various committees. I know a few other committees have been mentioned today as potentially ones to also take this up as well as across our government, which we have talked about.

And so, in a sense, almost what we need to do is to decomplexify—I am not sure if that is a word, but to reduce the complexity of this to afford more flexibility towards a range of scenarios that we are facing that can be implemented as they are needed.

I think it is also worth noting that the science provides a range of different options for managing different disaster threats, but we tend to focus on certain kinds of science over others. So, up until fairly recently, a lot of mitigation efforts were focused on the built environment and engineering options, when increasingly we are seeing from the social science how social determinants can be an even greater predictor of how a community does before, during, and after a disaster. The relationships of social programs to disaster resilience after the fact is becoming increasingly clear.

And we have had sort of the politics, the behavioral science. You know, why is it easier to ask people to wear masks and get vaccinated in some parts of the world than the other? The behavioral science illuminates a lot in terms of the landscape you have to work with these policies. And more individualistic societies are going to require different approaches or different levels of investment than for certain approaches than we are seeing overseas.

So we do need more data, we do need more research, but there is also a lot of research that isn't really being pulled together in part because of the distributed nature and ownership of all of this. So unifying, simplifying, I know these are overly simplistic answers, but ultimately to create capacities to harness the complexity of these situations and create vehicles that have the flexibility to meet needs that we know the outer boundaries of but won't know the details of until they are occurring.

Dr. GAYLE. Yeah, and I would just add, I was going to say something similar. I mean I think, you know, in situations like this, the knee-jerk response is to try to create something different and something new and a new infrastructure. And I think there is a lot of things that are already in place that we need to figure out how are they better connected, how are they better coordinated, and are we giving systems incentives to work together.

And so, you know, there are agencies that already have mandates, but we didn't do a good job in the beginning of this pandemic to actually make sure that agencies were working together and that there was a coordinated approach to it, you know. And some of the structures that we had had in place for disaster preparedness, which really were coordinating structures to a large degree, had been dismantled.

So I think we have to think about, you know, not looking at recreating the wheel, but really are we doing the best job we can. And I like the notion of simplification, but, you know, really looking at how we have the right systems for coordination.

I think the other thing that, you know, has come out in many ways as we have talked about this today is that, you know, we were dealing with two different aspects of the crisis. We had a public health crisis that precipitated an economic crisis, and in both of those situations, we did not have in place the things to make us more resilient.

And so we have talked about how could we make some of the social safety net issues in place and better so that, you know, populations don't get knocked so far down every time something happens. If communities that are financially insecure had greater security going into this, they wouldn't have been as harmed as they were.

And so we need to think about—you know, a lot of the things that I think we did on an emergency basis showed what we could do on a longer term basis to put in place not only the health preparedness but also the social and economic preparedness, and how can we weave that together so that whenever this next occurs we are resilient, both from a public health standpoint but also from a social and economic standpoint.

Ms. ROSS. Thank you, all, for your responses. I am happy to take information from this hearing to the Science, Space, and Technology Committee.

And, Mr. Chairman, I yield back.

Mr. MORELLE. Thank you, Ms. Ross.

I am now going to call on Mr. McGovern, who has the distinction of being the chair of the entire Rules Committee. And we appreciate him being here and for all of his help to get to the hearing today.

Mr. MCGOVERN. Well, let me thank Chairman Morelle and Dr. Burgess and Ms. Ross for their comments and questions. This has been a really interesting conversation on a very, very important topic.

And as I was listening to the testimony, listening to the questions, I kept on thinking about the reality that we are not particularly good at things like planning, which is essential, or coordination. We are not very good at coordination between the House and the Senate, never mind the Federal Government, the State and local governments, and others that need to be part of it.

There is an issue here of funding in order to prepare for these disasters—potential disasters, and then there's the issue of leadership, which is important. You know, we have Members of Congress when it comes to natural disasters, whether it is wildfires or tornados or, you know, you name it, floods, that routinely balk at responding to them after they happen except if it happens in their own State. So there is this hypocrisy that exists. And I think part of it is that we have some people who just don't think government is part of any solution unless it affects them directly.

We heard about all the incredible work that went in to combating HIV/AIDS and the response that Congress actually acted—by the way, after years of inaction, Congress actually began to act. And the response included things like the Ryan White Act, and then the PEPFAR program that Dr. Burgess referenced, which was a bipartisan effort and, you know, I think is something that we could be proud of. But this was kind of a healthcare-plus approach.

And here Congress also recognized how much housing and food matter to potential healthcare outcomes. So I think that is an important point.

On the COVID–19 issue and the response, international efforts to speed up pharmaceutical response and review process I think was very, very important. It led to the rapid creation of a lifesaving vaccine, which I think is a fantastic feat. But the bad news, of course, is that misinformation has limited our Nation's ability to get shots in the arms.

So the issue now is we have the vaccine, and I think I speak for all of us on this panel: I go home; I am still trying to convince people to make sure they get the vaccine. And we have a political system here in which some go out and actively say, you know, don't do the vaccine.

You know, Dr. Burgess wax nostalgic about the previous administration. I look back on the early days of this crisis with with a lot of shock that scientists were telling us that we had to take this pandemic seriously, and we had leaders, including the President of the United States, saying, you know, it is no big deal. It is not real. The first couple of months we were in denial.

And Dr. Burgess, if you don't believe me, just go read the President's statements. But the bottom line is we were being told to wear masks, and we had people actively discouraging people from wearing masks. This was before the vaccine was developed. And so you look back on that, and you say—you know, I am hearing now from medical experts, maybe we could have saved a lot more lives if we had taken it more seriously at the beginning.

You know, I am trying to get the White House to start focusing in on, you know, on the issue of hunger and food insecurity in this country, trying to get more to the White House Conference on food, nutrition, health, and hunger, one, to plan; two, to understand that we have to connect the dots, that when we talk about, you know, issues of hunger, it is also a healthcare issue. It is also an issue of kids being able to learn in school. It is a whole bunch of things. We need to look at need things more holistically.

But we don't have a plan in this country. We haven't had a plan to end hunger. We have had a plan to try to manage it but not to end it. And we talk about resiliency and all those other important concepts; I mean, quite frankly, we just haven't—we don't coordinate very well up here because, if you are going to prepare and solve some of these problems, it is not just one committee; it is multiple committees. It is not one agency; it is multiple agencies. It is not just the Federal Government; it is the State and local government; it is the provider. I mean, everybody has a role in all of this.

So, you know—look, so I think what we have heard here today is some things that have gone well and that we ought to, you know, replicate or we ought to use as a model, some things that haven't gone so well. So let me just ask this question for each of the witnesses, any thoughts that you may have as it relates to pandemic or disaster preparedness in general. What is something that we have done that we should consider continuing beyond the pandemic to ensure better preparedness, and what is something that you believe we could or should have done, again, as we think toward the

future to ensure better community, State, and national preparedness? I will just open this up to whoever wants to respond.

Mr. SCHLEGELMILCH. I will go ahead and start. You know, I think one of the things that has been done well, as much as we lament, myself included, really quite extensively the lack of funding for preparedness and the ebbs and flows in the annual appropriations process, we were better for having those resources over the last 20 years than not having them.

The relationships that were fostered that are frustratingly not as robust as they could be within communities are where they are because of the capacities that have been invested in into emergency management structures and into a whole-of-community sort of paradigm of thinking of these things. So I think that as—at least coming from me, while I am critical of funding levels and lack of predictability across a lot of this, having what we have is better than not having it.

Now, on the flip side, in terms of what we could do better with—you know, I think we really do have to look at the disaster science is increasingly going into the social services arena and illuminating where social services predict outcomes in disasters. And this is only going to grow stronger as there is more data and there is more evidence with all of this.

And I think one of the most important things to consider going forward is that investments in resilience aren't necessarily the bills that say "disaster" in front of them. They may be investments in food security. They may be investments in healthcare to make sure more people are insured and we have a financed national health continuum of public and private deliveries that are used to serving the whole population and not just the insured population, that is built for the kind of demand, that we are financing public health and not just taking for granted the value of that.

And the other, as I do want to point out, there has been a lot of talk about structures, of sort of wrangling these Federal processes that are distributed. One of the big criticisms of the past administration was dismantling the—or moving to a point of functionally dismantling the Global Health Security Team and the Pandemic Response Unit in the National Security Council.

I think there is some merit to that argument, but I also want to add that it was created because there was not a legislated solution to this, so it was executive action that created a Band-Aid approach. And as the political wind shifted, that Band-Aid was removed, and the pandemic hit, and we were left bare from a coordinated mechanism for doing this, and now that is being rebuilt.

But I would be careful to not—it is a bipartisan issue, and it is one that ultimately we need some stability in the legislated groundwork for these things so that we are not completely reliant on executive action, which can be undone as easily as it can be implemented. So I hope some of that is marginally useful to you——

Mr. MCGOVERN. It is helpful, very helpful.

Mr. SCHLEGELMILCH [continuing]. And appreciate the opportunity.

Mr. MCGOVERN. Anybody else want to——

Dr. GAYLE. Yeah, I would say, you know, I think a couple things that we did well, and this was mentioned earlier, I think the co-

ordination with the private sector was critically important and the ability to develop vaccines in record time, you know, which built on a lot of important science that was being worked on already. So, you know, I think that our investments in new science and discovery and then the working with the private sector, you know, I think was really critical and a model that we need to think about how do we do that in the future.

I do also think that the speed with which emergency support and the level of emergency support that was mobilized was incredible and the willingness to do some things that we had not ever, you know, done before, like give people cash who needed cash to pay their bills and, you know, some of the things that, you know, I think could be models for how we think about building resiliency in the future.

You know, things that I think we didn't do as well, the coordination, which we have talked about multiple times and the communication. I think the fact that we had mixed messages, the fact that we sowed, you know, seeds of doubt and confusion is not what you need at a time like this. At a time like this, you need clear communication, you need strong leadership, and you need consistency. And so I think that was one of the things that, you know, was a real challenge.

And I would say the other is that we were pulling out of global collaboration at a time when we most needed global collaboration, the idea that we were going to pull out of the World Health Organization at a time when we needed to come together as the world community more than ever. So, anyway, those are some of the things that I think we did right and some of the things that I think we could do differently next time.

Mr. McGovern. Thank you.

Anybody else?

Ms. Tedesco. I would just add, you know, a lot has been said about strengthening the social safety net. So I would, you know, just in my final remarks here say that what we were—it is something we did well during the pandemic, and it is something that, if we were willing to do during that type of crisis, I think we need to consider why we are not willing to do it all the time.

We had an unprecedented level of investment in food and recognition of the issue of hunger, partially because hunger is tangible but it really in our Nation is another word for poverty. It is not a matter of food; it is a matter of a tradeoff because of limited economic resources for families. So we need to continue to invest in antihunger and put the infrastructure behind it, and as I argued, invest in nonprofits as partners.

But, in the broader sense, we now know and it was said multiple times on this call, that pandemics, disasters disproportionately affect those who are economically disadvantaged, Black and LatinX communities. And so, for the long term investing in the social safety net is, to me, the best preparation for any future disaster.

Mr. McGovern. No, and I appreciate that. I always tell people that, you know, we had a hunger problem and a crisis before the pandemic; we just weren't coordinating an effort to respond to it appropriately. We had close to 38 million people in this country who didn't know where their next meal was going to come from,

and the pandemic just highlighted the disparities that already existed. And so, I mean, you know, but it is more than just responding to an immediate crisis. We have got to solve the problem.

I don't know whether, Mr. Kadlec, do you have anything you want to——

Dr. KADLEC. Yes, so I do, Mr. Chairman. And that is, it was mentioned already about the public/private partnerships and particularly around medical countermeasures. You know, that model quite frankly can be used in a much broader context, whether it be about surveillance of diseases, whether it be about testing, whether it be about supply chain, whether it be about healthcare provision; it would seem that that is a model, and, quite frankly, to your point about how do you manage, you know, hunger in America, it really does require a whole-of-nation approach. And, quite frankly, that model, to work against these very troubling problems, whether it be during a pandemic or not, I think is a model that can effectively be mobilized in a way that, quite frankly, is demonstrated by things like Warp Speed.

The second area is—and this gets to more public health or not public health but healthcare provision, and that is, even right now during Omicron with the availability of vaccines and other things, we are finding not only are we having problems managing cases of COVID but non-COVID emergencies, non-COVID chronic cases, both in rural and urban environments, and it affects all access groups and particularly those who are have difficulty getting access to healthcare. And I think that is one area that has to take maybe some kind of priority view.

Public health has been defined as one of the critical gaps in our pandemic preparedness, and I would argue that our ability to provide healthcare across the range of conditions that we need to in a pandemic or not was severely challenged during this crisis and could be similarly challenged through other crises that are not necessarily infectious disease related. And I think that that is one thing that has to be evaluated.

Mr. MCGOVERN. I think that is an excellent point.

I just—again, I want to thank Chairman Morelle for putting this hearing together, but I think you challenge us to think bigger and more holistically, which is something that is always very difficult to do, you know. And I mentioned that we—I talked about hunger at the beginning, but I also sit on the Agriculture Committee. So, when we talk about combating hunger on the Agriculture Committee, we talk about SNAP. Well, that is not the whole answer, right. If you want to talk about school feeding, you have got to go to the Education and Labor Committee. You know, if you want to talk about food is medicine, you have to go to Ways and Means or Energy and Commerce, and, you know, the same within our agencies. And I think there needs to be a better coordinated effort to look at things more holistically.

I think it would enable us to be better prepared for upcoming disasters, whether they are climate related or whether they are pandemic related, or, you know, who knows what related. But anyway, I really appreciate the expertise of this panel and, again, I thank you for your comments.

Mr. MORELLE. Thank you, Mr. Chairman, not only for being here but the incredible work you are doing on addressing hunger in America.

Just a couple of quick followups, because I am mindful of the time and appreciate all of your—the time and expertise you shared with us this morning. And I want to give Dr. Burgess a chance to ask any additional questions he has as well.

But, Mr. Schlegelmilch, you mentioned the value of investments in mitigation in comparison to funding for disaster response. And I wonder if you could—first of all, before you even talk about your research showing the benefits of proactively investing in disaster mitigation measures, could you describe for me what those disaster mitigation measures are in sort of a tangible way? I would be interested to hear that.

Mr. SCHLEGELMILCH. Yeah, yeah. And so it is—I appreciate that. So the research has been conducted by some other groups, so FEMA has commissioned from the National Institute of Building Sciences, a look at some of the more specific mitigation measures. So that is where you get this term $1 in preparedness saves $6, it comes from sort of specific kind of physical mitigation measures, but then you see benefits downstream.

There was a group of political scientists that did some research that found that number anywhere from $1 saves $12 to $1 saves $15. They were looking at more catalog of Federal direct assistance numbers and sort of categorizations and things like that. So we definitely see this trend. There have been other analyses for pandemics by the World Bank and others. The number varies, but the message is always the same.

So what we have seen primarily in these investments, decisions have been more on the physical and administrative side, putting in planning processes and things like that. The social science research is getting more and more into sort of the value of these things. And I think we are going to start seeing more of that in the valuations going forward as well too.

Mr. MORELLE. Gotcha. And you also—I think you talked about this, but in November of 2020, FEMA released a report finding recovery programs often provide an additional boost to wealthy homeowners and others with less needs while lower income individuals and others sink further into poverty after disasters.

And a number of people have talked about this, but from your perspective, what accountability and transparency mechanisms are available to ensure any increases in disaster preparedness and assistance funding is spread equitably among low-income and minority communities? And do you have any specific recommendations for how Congress could improve those mechanisms, any suggestions or thoughts?

Mr. SCHLEGELMILCH. Yeah, absolutely. And there has also been some independent research looking at the various Federal assistance programs as well too and similarly disparities among socioeconomic status and racial categories. And so, in terms of that, I think first and foremost, is data transparency in reporting to have demographic breakdowns to know where the money is going, who is getting what, what these are. It sounds like a simple thing, but often it is not immediately available.

The other would be, you know, we saw with some of the COVID funds a nod to using the Social Vulnerability Index from the CDC, and there are plenty of tools that are out there to help kind of identify and steer resources towards areas that are in higher need, in higher states of vulnerability and higher states of social vulnerability.

We see this built in with FEMA's National Risk Index, and so we are increasingly seeing this. But there isn't much accountability, so there is a lot of lamenting of various officials on the inequity but not necessarily a mechanism for accountability.

And then the final piece, actually a colleague had brought the idea to me, is to have a scoring mechanism much like the Congressional Budget Office will score financially different bills, is to have an equity score and to bring together a panel of experts who can actually look at the equity implications as well as broader resilience implications of various bills, various traps, and actually provide more specific guidance on a case-by-case basis.

Mr. MORELLE. Thank you. That is very helpful.

Dr. Gayle, do you have any thoughts on that, how that impacts either your agency or Chicago writ large and any thoughts about that—or nationally, but I am just curious about your experience.

Dr. GAYLE. Yeah. I would just in some ways echo some of the previous comments because, you know, what we saw in the beginning of this pandemic is we didn't have data to even know who was being impacted, you know, by demographic groups and particularly race/ethnicity. Chicago was one of the first cities to actually look at COVID cases by race and ethnicity, and it was a critically important piece to then putting in place systems to address the disparities accordingly.

You know, to have talked to and been in discussions with people about coming up with some of those scores, if equity really is—if we are going to be accountable for thinking about equity, are there ways that we can build those into just like we do environmental scores that are built in to new development projects, could we do the same sort of thing of building something that kind of built on the social vulnerabilities index or other things to allow us to be able to have that accountability in there. But I think, first and foremost, is we have got to collect the data.

Mr. MORELLE. Yeah. And actually, Ms. Tedesco, from your perspective, have you been tracking that data on who you serve? Could you report back or have demographic information on who you served in the last 2 years?

Ms. TEDESCO. It would be difficult. We have a number of households served, and we have some demographic information, and then obviously we have other data that we are pulling from census data. But because of how food banks operate, we rely on a network of providers. Many of those, you know, these are small, grassroots, community-based organizations who are required to track the number of households they are serving, required in some cases to get attestations of need from those families but not always required to do demographic information.

So we know partially just by looking at our geographic region and understanding the demographics there and looking at need

and service levels in those areas but don't have hard data associated with it.

Mr. MORELLE. Gotcha. No, that is certainly understandable. Last—I think this is——

Dr. GAYLE. Could I add just one thing to that?

Mr. MORELLE. Yes.

Dr. GAYLE. You know, earlier we talked about building community-based organizations capacity, and I do think that by building capacity at the local and community level that is helping to build an accountability mechanism as well. And I think that the more we have strength from our civil society sector, you know, it does build in an accountability, because I think when people are able and capable of looking at how dollars flow, able and capable of applying for those dollars, and also, you know, being able to ask for what is rightfully their community because of where their needs are, I think we do build in accountability. I mean, that is what democracy, after all, is all about.

Mr. MORELLE. No, I very much appreciate that. I was—I did want to get into the issue of long-term funding, stable funding that didn't rely on emergency appropriations. I wonder, Dr. Kadlec, if you could just comment on the advisability of that. There has been a lot of conversation about it, but from the point of view, again, of having worked in an administration, how important is that, and how should Congress be thinking about that in terms of long-term funding the appropriations process rather than supplemental or emergency appropriations?

Dr. KADLEC. Well, first of all, I just want to acknowledge that the funding that you provided, Congress provided, during the course of the pandemic during my tenure was very generous.

However—however—you know, there is this issue of an ounce of preparedness is worth a pound of response dollars and that the fact of being able to be a good steward of the taxpayer dollars in a response—and I will just give you one example, and it had to do with ventilators, for example, and the fact that we bought 243,000 ventilators that, quite frankly, we didn't need. In fact, we bought types of ventilators that, quite frankly, were problematic.

Because, as we learned very early in the pandemic—I mean, this is how you have to learn and get back to the data issue and how vital it is to have quality data. We didn't have quality data early.

And yet, based on, you know, a little bit of serendipity and focus, we were able to recognize that certain techniques to manage people with the severe cases of COVID that in some parts of the country were resulting in people being on mechanical ventilation and was the thing that scared everybody to buy 243,000 ventilators at $3. 5 billion—it was recognized that that was actually resulting in higher mortality, upwards over 80, close to 90 percent mortality.

Whereas, in other parts of the country—and this is a great story. And a lot of credit goes to the State health officer in Louisiana and a pulmonologist that he worked with to create a State system where they used proning and high-flow nasal cannula, which is a noninterventional way of managing somebody's ventilation so you don't need all the specialized drugs and paralytics and paralyzed people and a lot of intensive-care nursing staffing.

And so, by just that virtue thing alone, based on recognizing that, we were able to do a couple of critical things to, first of all, not need the ventilators. And that was just an example of where you had to make big purchases because it took a long lead time to get those devices in there.

And so I only use that as an example of saying, you know, if we kind of fund the needs based on requirements, based on exercises and working with State and local localities on what the needs would be in the event of a crisis, we can be a better steward of the taxpayer money. So you pay $1 today or $100 tomorrow during the response is, I think, the tradeoff.

And it really is something that you can't just invest in, you know, buying stuff. You have to, you know, invest in training people and exercising capabilities, which is the combination of people and stuff, to make sure all this stuff works.

To Chairman McGovern's comments about coordination and planning, those are all critical elements of the preparedness quotient that are, you know, low dollar value but high response impact.

And so I will just stop there and just say, you know, it is really— you want to spend a little now or you want to spend a lot later, and knowing that, well, when you spend a lot later, you are going to be less efficient and likely wasteful in your efforts.

Mr. MORELLE. I think there was an old TV commercial, "You can pay me now or pay me later." So I appreciate that.

Dr. Burgess, let me turn to you for any additional questions you might have.

Dr. BURGESS. Thank you, Chairman Morelle.

I am going to submit some additional questions for the record, but I have two unanimous consent requests, one from Research America, a letter that they submitted. I will ask that be made part of the record. And then, earlier in my testimony, I referenced a letter that I wrote to Chairman Pallone, and I would ask that that be made part of today's record for this hearing.

And I will yield back.

Mr. MORELLE. Without objection.

Let me just thank everyone.

I do note that a lot of the conversation has been about planning and coordination, resiliency, communication—trusted communication—and funding. And I am thoughtful, back many years ago when I was in the State legislature, I was chairman of the insurance committee. And I remember, you know, people don't want to pay insurance premiums, let's face it. It is the last thing any of us really wants to do. But, in a moment of crisis, having prepared and thought about it in advance really takes that moment of crisis and makes it hopefully more manageable. And I think, in some ways, that is what we need to do, is provide those insurance premiums so that in a moment of crisis, such as we are facing now, we are really in a much better position.

And, finally, I even think of—I serve on the House Armed Services Committee. You know, the amount of planning that the military does for potential threats is virtually unlimited. I mean, we are constantly training.

Colonel, I know you would attest to that.

And yet we do so little of it when it comes to domestic challenges like natural disasters or the pandemic which we are going through. And so we might want to take a page out of the military's book as it relates at least to training people, capabilities, threats, and really make that part of our national dialogue.

So, with that, I want to thank all the witnesses. You have been incredibly helpful to us as we go through our deliberations about how to move forward. And I want to thank you all for the incredible work that you have done to keep safe and help protect people in your communities and across the country.

And, with that, I will officially declare this hearing ended. Thanks so much.

[Whereupon, at 12:06 p.m., the subcommittee was adjourned.]

Rep. Michael C. Burgess, M.D.
Rules Hearing: Using Budget Principles to Prepare for Future Pandemics and Other Disasters
January 19, 2022

QFRs

Dr. Kadlec, the Operation Warp Speed team, under your leadership, was able to accelerate the advancement of COVID-19 monoclonal antibody treatments and antivirals. The ASPR team also led the allocations and distributions of the products in an unprecedented way. I understand that the Biden Administration had the opportunity for procurement that ASPR left them for February of 2021 that may have been extended but was later rescinded.

Is this correct, and do you have a sense of why that was not executed? Did you have a transition conversation about this plan?

Yes, we did make plans to enable the Biden Administration to leverage procurements we had secured as well as others that we had initiated negotiations for. We did not, however, have a formal transition discussion on either areas before Inauguration Day.

Dr. Kadlec, one successful aspect of Operation Warp Speed was the allowance for the prefunding of product development. This transferred risk from the manufacturing company to the government and allowed researchers and manufacturers to invest time and resources into high-risk product development.

Are you aware of any therapeutics that started to show promising results while you served as the Assistant Secretary for Preparedness and Response?

Yes, there were several monoclonal and polyclonal antibody therapeutics produced by Regeneron and Eli Lilly for example. Also, Merck's Molnupiravir was one.

Did the government help prefund and procure the materials needed to manufacture these therapeutics?

Yes, in the case of Regeneron and Lilly, there were arrangements to provide funding support and purchase guarantees.

Dr. Kadlec, while successful at preventing hospitalization and death, the COVID-19 vaccines do not seem to be preventing all disease transmission, and we have yet to have a strategy on how to efficiently treat this disease. Though testing can indicate to an individual that they are contagious, tracking and tracing efforts are not proving to be successful.

Can you expand upon how can we better incentivize a quicker development of therapeutics in the future?

To you point therapeutic are a vital adjunct to the role of testing and vaccination. Two issues could be addressed to improve therapeutic development. The first is more effective pre-crisis establishment of clinical trial sites for therapeutic clinical trials. While NIH made effective use of existing HIV clinical trial sites for vaccination, similar stand by sites were not available for therapeutic testing. Second, the prefuding of therapeutics was limited to principally antibody therapies

and not small molecule products. In the case of EID-2801, BARDA made a conscious decision not to fund development that had a delaying effect on getting that product through development and clinical testing.

Dr. Kadlec, I mentioned earlier the need to incorporate accelerated practices into the development of therapeutics and vaccines.

As a founder of Operation Warp Speed, are there any specific concepts or provisions from that we can incorporate into regular practice outside of the Public Health Emergency?

One issue is establishing a standing task force between HHS and DOD to maintain the organization and practices of WARP SPEED going forward. It should be possible and beneficial to keep the muscle memory of how we achieved OWS successes between pandemics to accelerate medical countermeasures for priority CBRN and potential pandemic threats.

Dr. Kadlec, time and again we hear of issues with domestic manufacturing and production.

> **Reflecting on the past two years, would access to more domestically manufactured goods have helped our preparedness?**
>
> **What are some of the things we should be considering to ensure our Strategic National Stockpile is adequately prepared for the future?**

To you first question yes. Domestic manufacturing of finished goods and access to non-foreign (China) raw materials and US active pharmaceutical ingredients are essential preparedness prerequisites. To your second question, clearly identifying what should be part of the SNS (requirements) and funding to meet those requirements is essential.

Dr. Kadlec, the Strategic National Stockpile has been evaluating new ways to achieve efficient distribution and acquisition of supplies using Vendor Managed Inventory and other mechanisms.

Can you talk more about this and what tools the Strategic National Stockpile may need to accomplish this goal?

Dr. Kadlec, while we continue to fight COVID-19 and its variants, we need to be prepared for the next pathogen that could cause a pandemic.

Should the federal government look to public-private-academic partnerships to research pathogen families that are likely targets for the next pandemic and that can promptly be treated with therapeutic treatments such as monoclonal antibodies?
Yes that is an essential component of future pandemic preparedness. So should supporting development by the same partnerships for vaccines and diagnostics for potential pandemic pathogens.

Rep. Joe Morelle
Chairman
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Subcommittee on Legislative and Budget Process
H-312 The Capitol
Washington, D.C. 20515

Rep. Michael Burgess
Ranking Member
House Committee on Rules
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Dear Chairman Morelle and Ranking Member Burgess:

On behalf of the undersigned organizations and our millions of supporters, thank you for the opportunity to submit materials for the hearing, "Using Budget Principles to Prepare for Future Pandemics and Other Disasters". We appreciate the Committee's interest in these critical issues and are writing to highlight the role of healthy biodiversity – the natural variety of plant and animal life – in both preventing and mitigating disasters.

Healthy ecosystems act as a critical buffer against natural disasters. For instance, as we see an increase in flooding from severe storms, nature can help us to manage stormwater and reduce flooding. A single acre of wetlands can hold up to 1.5 million gallons of rain or melting snow,[1] preventing that water from flooding nearby communities. Just one mature, 100-foot tree can absorb 11,000 gallons of stormwater each year.[2] Preserving natural features, such as floodplains with a natural vegetation buffer along streams can slow, filter, and store polluted runoff, again protecting human populations from flooding and pollutants.

At the other end of the spectrum, landscapes with higher levels of biodiversity are better able to abate extreme temperatures, withstand the effects of drought, and are more resilient in the face of wildfires.[3] Loss of tree cover and vegetation through development, as an example, can lead to a "heat island" effect, the reason that city temperatures are higher than the surrounding areas. Indeed, an unshaded surface may be as much as 45°F hotter than a shaded one,[4] and forested neighborhoods may enjoy ambient temperatures up to 50°F cooler than those without green spaces in the same region.[5]

These critical natural protections cannot exist without healthy levels of biodiversity, however. Biodiversity is the foundation of healthy ecosystems. Each plant, animal, and insect species plays its role in the system, and removing one will change the whole. In some cases, the loss of a single, keystone, species (species like the saguaro cactus, beavers, wolves, whales, bees, or elephants, for example) can cause the entire system to unravel. Conserving and restoring biodiversity, therefore, provides a front line of defense against natural disasters, and can serve to protect human life, wellbeing, and property.

Conversely, if the present rate of biodiversity loss continues, it will leave communities across the United States and around the globe increasingly vulnerable to catastrophic damage from disasters. Here, as in the rest of the world, the loss of biodiversity and its associate benefits falls disproportionately on communities of color and poor communities, as wealthier and historically whiter neighborhoods are repeatedly shown to have better tree cover.[6]

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[1] https://www.ayresassociates.com/why-are-wetlands-critical-think-flood-control-clean-water/
[2] https://www.fs.usda.gov/Internet/FSE_DOCUMENTS/stelprdb5269813.pdf
[3] https://www.sciencedaily.com/releases/2018/09/180919133028.htm
[4] https://www.epa.gov/heatislands/using-trees-and-vegetation-reduce-heat-islands
[5] https://www.fs.usda.gov/ccrc/topics/urban-forests
[6] https://www.americanforests.org/our-programs/tree-equity/

Biodiversity does more than mitigate the effects of disasters; the varied web of plants and animals, both on land and at sea, work together to remove carbon from the atmosphere and sequester it in a variety of helpful ways.[7,8] Not only do native trees and grasslands sequester carbon, animals do as well. One great whale, for instance, will absorb an average of 33 tons of carbon dioxide during its lifetime, and keep it sequestered on the ocean floor long after its death.[9] Furthermore, whale dung fertilizes phytoplankton, which goes on to remove 10 gigatons of carbon from the atmosphere each year.[10]

The interplay between species – both plant and animal – is important to the long-term success of efforts to fight climate change.[11] Some nature-based proposals to address climate change contemplate planting huge tree plantations as climate sinks. That approach would be counterproductive in the longer term, however, as these large-scale plantings would harm biodiversity. Indeed, scientists from the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services (IPBES) and the Intergovernmental Panel on Climate Change (IPCC) recently collaborated to produce a joint report (attached here) warning that the biodiversity and climate crises are intricately linked and cannot be addressed separately if they are to be tackled successfully.[12] That is to say that efforts to mitigate climate change must also support biodiversity or they are doomed to fail.

By conserving ecosystems and protecting the rich diversity of animal and plant species within them, we can mitigate climate change and protect ourselves against damage from future natural disasters. We thank you for holding a hearing to explore these important issues, and stand ready to work with you to use budget principles to advance biodiversity protection.

Sincerely,

International Fund for Animal Welfare

Humane Society Legislative Fund

Endangered Species Coalition

Save Animals Facing Extinction

Jane Goodall Institute USA

FOUR PAWS USA

Earthjustice

World Animal Protection

The Humane Society of the United States

Humane Society International

Bonobo Conservation Initiative

OneNature

Wildlife Conservation Society

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[7] https://environment-review.yale.edu/animals-carbon-cycle-mediators-0
[8] https://www.oneearth.org/five-animals-and-how-they-fight-climate-change/
[9] https://docs.google.com/forms/d/e/1FAIpQLSeXvr5xm3-Vjwsw4-iyB0-6qyre_MXazFATqs6MLn_xurDaSQ/viewform?usp=sf_link
[10] https://www.oneearth.org/five-animals-and-how-they-fight-climate-change/
[11] https://environment-review.yale.edu/animals-carbon-cycle-mediators-0
[12] https://ipbes.net/sites/default/files/2021-06/20210609_workshop_report_embargo_3pm_CEST_10_june_0.pdf

November 2021
CURRICULUM VITAE

HELENE D. GAYLE, M.D., M.P.H.
President and CEO
The Chicago Community Trust

OFFICE ADDRESS: The Chicago Community Trust
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Chicago, IL 60601
(312) 565-2836
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UNDERGRADUATE EDUCATION:

1976 Barnard College, Columbia University, New York, New York, B.A., Psychology, Cum Laude

GRADUATE EDUCATION:

1981 University of Pennsylvania School of Medicine, M.D.,
1981 Johns Hopkins University School of Hygiene and Public Health, M.P.H.,

RESIDENCY TRAINING:

1981-1984 Pediatric Internship and Residency, Children's Hospital National Medical Center, Washington, DC.

1985-1987 Preventive Medicine Residency, Centers for Disease Control and Prevention, Atlanta, Georgia

TRAINING EXPERIENCE:

1984-1986 Epidemic Intelligence Service (EIS): Center for Health Promotion and Education, Division of Nutrition, Epidemiology Branch,
Atlanta, Georgia 1984-1986.

PROFESSIONAL POSITIONS:

October 2017 – current
President and CEO
The Chicago Community Trust
Chicago, IL

Responsible for establishing the priorities of The Chicago Community Trust and building positive engagement with the Trust's diverse family of stakeholders in ways that advance the mission and goals. As one of the nation's leading community foundations, the Trust works with donors, nonprofits, community leaders and residents to lead and inspire philanthropic efforts to improve the quality of life for the residents of the Chicago region.

July 2015 – September 2017
CEO
McKinsey Social Initiative
Washington, DC

Responsible for implementing programs that bring together varied stakeholders to address complex global social challenges, setting direction and building the organization. Build its first program, Generation, addressing the problem of youth unemployment, with programs in five countries—India, Kenya, Mexico, Spain, and the United States—and a goal of connecting one million young people with skills and jobs in five years.

April 2006 – June 2015
President and CEO
CARE – USA
Atlanta, Georgia

Responsible for one of the largest international humanitarian organizations with approximately 11,000 staff whose poverty fighting programs reached 82 million people in 2010 in 87 countries. Lead efforts to reinforce CARE's commitment to empowering girls and women to bring lasting change to poor communities. Strengthen its focus on long term impact, increase policy and advocacy efforts and deepen connections between poverty and the environment.

September 2001 - March 2006
Director, HIV, TB and Reproductive Health
Bill & Melinda Gates Foundation
Seattle, Washington

Responsible for research, policy and program issues on HIV/AIDS and related issues such as sexually transmitted diseases (STDs), tuberculosis (TB) and reproductive health in resource poor countries. Responsible for the development and management of the overall HIV/AIDS, STD, TB and reproductive health strategy and programs for the foundation whose activities include addressing issues such as vaccine, diagnostic tests, contraceptive technology and microbicide development; HIV, STD, TB prevention and control and improved reproductive health; and policy and advocacy for these issues. Served as the foundation's chief representative on these matters at relevant national and international forums.

PROFESSIONAL POSITIONS (cont):

September 1995 - August 2001 Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia
(Acting Director, February 1995-September 1995)

Responsible for providing scientific, managerial and policy leadership for surveillance, research and interventions related to the prevention and control of HIV, STDs and TB. The Center consisted of approximately 1,400 staff members including 500 field staff located in state and local health departments and international settings. It had an annual budget of over $1 billion. The Center is the lead organization within the Department of Health and Human Services for HIV, STD and TB national and international prevention efforts and collaborates with a diverse group of public and private partners to accomplish its mission.

October 1995 - October 1996 Acting Director
Division of HIV/AIDS Prevention
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia

Served as Acting Director of the largest division within the National Center for HIV, STD, & TB Prevention, providing overall management and policy direction for scientific and programmatic activities in HIV surveillance, research and prevention, and supervision of HIV/AIDS staff. Served as CDC's primary representative on HIV/AIDS and related issues and primary liaison with other federal, international, and non-governmental organizations on HIV/AIDS policies.

June 1994 - September 1995 Associate Director/Washington
Centers for Disease Control and Prevention
Washington, DC

Represented the Director of CDC on legislative, policy, program management, and intergovernmental matters in Washington, DC. Played a key role in shaping and implementing CDC policies, especially as they relate to the Department of Health and Human Services liaison and legislative activities, serving as the primary advisor to the Director, CDC and other senior CDC officials on such issues. Functioned as a core member of the Office of the Director, CDC.

PROFESSIONAL POSITIONS (cont):

May 1992 - June 1994 — Agency AIDS Coordinator and Chief, HIV/AIDS Division, United States Agency for International Development (USAID), Washington, DC

Responsible for providing technical managerial and policy guidance for programs funded by the HIV/AIDS Division, United States Agency for International Development (USAID) and supervision to HIV/AIDS Division staff and projects. As the Agency AIDS Coordinator, coordinated all HIV/AIDS activities and provided technical and policy leadership on HIV/AIDS for USAID, and served as the Agency's Chief Representative on HIV/AIDS, and related health issues. Responsible for coordination with other US Government, non-governmental, bilateral, and international organization on HIV/AIDS policies and activities.

August 1990 - May 1992 — Chief, International Activity Branch
Division of HIV/AIDS Prevention
National Center for HIV, STD, & TB Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia

Developed, implemented and supervised international epidemiologic research projects on HIV/AIDS. Included providing technical and managerial supervision for CDC's HIV/AIDS research projects in Zaire, Cote d'Ivoire and Thailand. Represented CDC in international meetings on HIV/AIDS, and was the principle liaison with other CDC units, other U.S. Public Health Service Agencies, Department of Defense, international organizations including: World Health Organization (WHO), US Agency for International Development (USAID), and other organizations that are involved in international HIV/AIDS activities.

September 1989 - August 1990 — Assistant Chief for Science International Activity
Division of HIV/AIDS Prevention
National Center for HIV, STD, & TB Prevention
Centers for Disease Control and Prevention

Assisted the Chief, International Activity in developing epidemiologic studies on HIV/AIDS in international settings and providing overall scientific for the Activity. Had a major responsibility for liaison and consultation with other CDC organizational units, other US Government and international agencies. Assisted in the design and implementation of selected HIV/AIDS research projects, including dissemination of research results and related policy formation.

PROFESSIONAL POSITIONS (cont):

October 1988 - September 1989 — Acting Special Assistant for Minority HIV Policy Coordination
Office of the Deputy Director (HIV)
Centers for Disease Control and Prevention
Atlanta, Georgia

Responsible for coordination of CDC's HIV prevention activities for US racial and ethnic minority populations and related policy formation. Served to facilitate effective communication between CDC, and groups representing racial and ethnic populations on issues related to HIV/AIDS prevention and provide for greater minority input into the design and implementation of CDC's prevention activities.

July 1987 - August 1989 — Medical Epidemiologist
Pediatric and Family Studies Section
AIDS Program
Centers for Disease Control and Prevention
Atlanta, Georgia

Designed and conducted original research related to the investigation of HIV/AIDS in children, adolescents, and women. Responsible for the analysis and publication of research findings. Included collaboration with other CDC and outside investigators, supervising CDC-funded research projects, contributing to program and policy formation relevant to research findings.

July 1986 - June 1987 — Medical Epidemiologist (Preventive Medicine Resident)
Division of Evaluation and Research
International Health Program Office (IHPO)
Centers for Disease Control and Prevention
Atlanta, Georgia

Responsible for epidemiologic research and program implementation with the Combating Childhood Communicable Disease program in Africa. This project was a USAID-funded
child survival program implemented by CDC. Primary responsibilities included developing country programs for the control of diarrheal diseases in African children and research to evaluate the effectiveness of these programs.

July 1984 - June 1986 — Epidemic Intelligence Service Officer
Epidemiology Branch
Division of Nutrition
Centers for Disease Control and Prevention
Atlanta, Georgia

Participated in research and training activities to develop expertise in the practice of epidemiology and public health. Research responsibilities focused on malnutrition, low birth weight, and poor growth in children in the United States and Africa.

AWARDS AND HONORS:

Alpha Omega Alpha Medical Honor Society, University of Pennsylvania, 2021
Mayor's Medal of Honor, City of Chicago, 2021
Peace Corps, Director Franklin H. Williams for Lifelong Service, 2021
Crain's Chicago Business, Top 25 Power Players, 2020
CARE IMPACT Award for Global Health & Visionary Leadership, 2020
YWCA Metropolitan Chicago Racial Justice Award, 2020
Chicago Council on Global Affairs, Advancing Equity in Global Health and Safety National Award, 2020
Chicago Magazine, The 50 Most Powerful Women in Chicago, 2020
Black Girl Magic!, Illinois' 2020 African American Women Trailblazers, 2020
UNICEF Chicago Humanitarian Award 2019
Elizabeth Kirk Rose Women in Medicine Award Pereleman School of Medicine, University of Pennsylvania, 2019
Make It Better Magazine, 25 Most Powerful Women in Chicago, 2018
Teachers College, Columbia University, Medal for Distinguished Service – 2018
John Hopkins University Society of Scholars – Inducted 2017
APHA – Presidential Citation Award - 2015
WNBA – Inspiring Women Award - 2015
GABWA – Zenith Award of Distinction, 2015
BET Black Girls Rock, Social Humanitarian Award, 2015
Congressional Black Caucus Foundation, Sojourner Truth "Woman of Truth" Award, 2014
Georgia State University – Robinson College of Business, Hall of Fame Award, 2014
Atlanta Business League, Millennium Pacesetter Award, 2014
Atlanta Business Chronicle, Most Admired CEO Award, 2014
Northwest Georgia Chapter, NCBW 100, Woman of Impact Health Award, 2014
Bloodwater: Water Mission – Shujaa Award, 2013
Clark Atlanta, Pathway to Excellence Award, 2013
National Association for Female Executives, Woman of Achievement Award, 2012
Atlanta Business Chronicle Health Care Heroes, Lifetime Achievement Award, 2012
Barnard Medal of Distinction, 2012
Rotary Club of Atlanta, Bert Adams International Service Award, 2012
Jimmy and Rosalynn Carter Humanitarian Award, 2012
World Chamber of Commerce International Hero Award, 2012
Forbes Magazine 100 Most Powerful Women, 2011
The NonProfit Times Power and Influence Top 50, 2010, 2011, 2018, 2019, 2020
Global Action Women's, Global Action Award, 2011
Bryn Mawr College, Katherine Hepburn Award, 2011
AARP Inspire Award, 2010
Bennett High Alumni Honor Roll, 2010
SCLC Women Inc, Humanitarian Award, 2010
Georgia State University, Ethics Advocate Award, 2009
Business to Business, Women of Excellence Award, 2009

InterAction, Governance Service Award, 2009
Spelman College, National Community Service Award, 2009
100 Most Influential Atlantans Award, 2009, 2010, 2011
Ivan Allen College, Georgia Institute of Technology, Ivan Allen Jr. Prize for Progress and Service, 2009
South African Partners, Desmond Tutu Award, 2009
Georgia Trend's 100 Most Influential Georgians Award, 2009, 2010, 2013
Morehouse College, Coca-Cola Leadership Award, 2008
American for Informed Democracy, Innovator in International Development Award, 2008
Cable Positive, Humanitarian of the Year Award, 2008
High Heels in High Places Award, 2008
Golden H.E.R.O. Award, 2007
Women's Leadership Exchange Compass Award, 2007
Public Health Service, Commissioned Officers Association, Health Leader of the Year Award, 2007
National Council for Research on Women, Women Who Make a Difference Award, 2007
Southern Christian Leadership Conference (SCLC) Community Service Award, 2007
Wall Street Journal, "50 Women to Watch", 2006
Society for Public Health Education Honorary Fellow Award, 2006
Eleanor Roosevelt Val-Kill Medal, 2006
Helen H. Jackson, Woman of Valor Award, 2006
Arthur Ashe Institute for Urban Health, Leadership in Global Medicine Award, 2005
Blacks Educating Blacks About Sexual Health Issues, Eighth Annual John Allen Blue Award, 2004
National Medical Fellowship, Distinguished Service Award, 2003
Johns Hopkins University, Distinguished Alumnus Award, 2002
Women of Color, Health Science & Technology Awards: Medical Leadership in Industry, 2002
Bennett High School Outstanding Alumni Award, 2001
Barnard College, Columbia University, Barnard Woman of Achievement, 2001
Constituency for Africa, Constituent of the Year, 2001
Friends of Morehouse School of Medicine, Salute to Excellence Award, 2001
Heroes in the Struggle Award, 2001
U.S. Department of Health and Human Services, Secretary's Award for Distinguished Service, 2001
National Medical Association, Scroll of Merit Award, 2000
Women Looking Ahead, Inc., The Women Looking Ahead (WLA) 100s List Award, 1999
100 Black Men of America, Inc., Woman of the Year Award, 1999
Brooklyn Perinatal Network, Inc., Board of Directors Special Recognition Award, 1999
U.S. Department of Health and Human Services, Secretary's Award for Distinguished Service, 1999
Atlanta Business League, Women of Influence Award, 1998
U.S. Public Service Foreign Duty Service Award, 1997
U.S. Public Health Meritorious Service Medal, 1996
Columbia University Medal of Excellence, 1996
U.S. Public Health Service, Poindexter Award, 1996
National Coalition of 100 Black Women, Inc., Serwa Award, 1995
Honor Award for Program Operations Management, 1992
U.S. Public Health Service Unit Commendation Medal, 1992

U.S. Public Health Service Outstanding Service Medal, 1992
Colgate-Palmolive Company, Model of Excellence, 1992
U.S. Public Health Service Commendation Medal, 1991
U.S. Public Health Service Outstanding Unit Citation, 1990
U.S. Office of Personnel Management Celebration of Public Service Award, 1990
U.S. Public Health Service Outstanding Unit Citation, 1989
Who's Who Among Black Americans, 1990, 1993 and 1994
U.S. Public Health Service Achievement Medal, 1989
Henry J. Kaiser Family Foundation Merit Scholar, (National Merit Scholar Fellowship Award), 1981
Outstanding Young Woman of America, 1981 and 1985
Henrietta & Jacob Lowenburg Prize, (Pediatric Excellence), 1981
Joel Gorden Miller Award, (Outstanding Class Contribution), 1981
University of Pennsylvania, Administrators and Black Faculty Merit Award (Outstanding Academic Achievement and Community Service Award), 1981
Who's Who in America Colleges, 1972

HONORARY_DEGREES:

Emory University, Doctor of Humane Letters, 2019
Rensselaer Polytechnic Institute, Doctor of Science 2019
American University, Doctor of Science, 2018
Xavier University, Doctor of Science, 2016
University of Buffalo, Doctor of Science, 2016
University of Miami, Doctor of Science, 2013
Oberlin College, Doctor of Science, 2011
Colby College, Doctor of Humane Letters, 2010
Columbia University, Doctor of Laws, 2009
Agnes Scott College, Doctor of Science, 2009
Brandeis University, Doctor of Humane Letters, 2008
Morehouse School of Medicine, Doctor of Science, 2008
Mount Sinai School of Medicine of New York University, Doctor of Humane Letters, 2008
Duke University, Doctor of Science, 2008
Meharry Medical College, Doctor of Science, 2007
Smith College, Doctorate, 2007
Pennsylvania State University, Doctor of Science, 2004
Jackson State University, Doctor of Humane Letters, 2004

FACULTY APPOINTMENTS:

Adjunct Professor, Hubert Department of Global Health, Emory University, Rollins School of Public Health, Atlanta, GA, 2009 -Present
Clinical Associate Professor, Department of Global Health, University of Washington, School of Public Health, Seattle, WA, 2008 – Present

Clinical Associate Professor, Department of Health Services, University of Washington, School of Public Health, Seattle, WA, 2002 – 2008
Clinical Assistant Professor of Community Medicine, Emory University School of Medicine, Atlanta, Georgia, 2006 – Present

BOARDS:

Public Company:
Palo Alto Networks, 2021-present
Go Health, 2020-present
Organon & Co., 2020-present
The Coca-Cola Company, 2013-Present
Colgate-Palmolive Board, 2010-2021

Non-profit and other:
Chatauqua Institution, 2020-present
Y Analytics, 2019-present
The Federal Reserve Bank of Chicago, 2019-present
The Economic Club of Chicago, 2019-present
Brookings Institution, 2015-present
The New America, 2013-Present
Rockefeller Foundation, 2009-2019
Center for Strategic and International Studies, Board of Trustees, 2007-Present
ONE, 2006-Present

PROFESSIONAL SOCIETY MEMBERSHIP:

American Academy of Arst and Sciences
Council on Foreign Relations
National Academy of Medicine (formerly Institute of Medicine)
Delta Omega Society (Public Health)
American Public Health Association
National Medical Association
American Medical Women's Association
Society for Public Health Education

MEDICAL LICENSE:

District of Columbia

BOARD CERTIFICATION:

Pediatrics, September 1985

BOARD ELIGIBILITY:

Preventive Medicine

SECOND LANGUAGE:

French, good speaking, writing, and reading skills
Spanish, good comprehension, some speaking and reading

JOURNAL PUBLICATIONS:

1. Gayle HD, Dibley MJ, Marks JS, Trowbridge FL. Malnutrition in the first two years of life. AJDC, 141: 531-4, 1987.

2. Gayle HD, Yip YX, Franks MJ, Nieburg P, Binkin NJ. Validation of maternally reported birth weights among 46,637 Tennessee WIC program participants.
Public Health Reports, 1998, 103(2): 143-6.

3. Gayle HD, Binkin NJ, Staehling N, Trowbridge FL. Arm Circumference vs. weight-for height in nutritional emergencies: Are the findings comparable? Journal of Tropical Pediatrics, 1988, 34:213-7.

4. Gayle HD, AIDS: Specific concerns for the center setting. Child Care Center, 1988, 3:39-40.

5. Manoff SB, Gayle HD, Mays M, Rogers MF. AIDS in the Adolescent population: A review of the epidemiology, prevention and public health issues. Pediatric Infectious Disease Journal, 1989, 8:309-14.

6. Vermund SH, Hein K, Gayle HD, Cary JM, Thomas PA Drucker E. Acquired Immunodeficiency Syndrome (AIDS) among adolescents: Case surveillance profiles in New York City and the rest of the United States. AJDC, 1989; 143:1220-5.

7. Gnoare E, DeCock, KM. Gayle HD, Porter A, Coulibaly R, Timite M, Assi-Adou J, Heyward WL. Prevalence of an mortality from HIV type 2 in Guinea Bissau, West Africa. Lancet 1989; II; 513.

8. Schoenbaum EE, Weber M., Vermund S, Gayle HD. HIV antibody in persons screened for syphilis: prevalence in New York City emergency room and general medical clinic. Sexually Transmitted Diseases 1990; 17:190-3.

9. Gayle HD, Keeling RP, Garcia-Tunon M, Kilbourne BW, Narkunas JP, Ingram FR, Rogers MF, Curran JW. Prevalence of human immunodeficiency virus among college and university students. N Eng J Med 1990; 323:1538-41.

10. Harrison L, DeSilva APJ, Gayle HD, Albino P, Del Castillo F, George R, Lee-Thomas S, Heyward WL. Risk Factors for HIV-2 infection in Guinea-Bissau.
Journal of Acquired Deficiency Syndrome 1991;11:1155-1160.

11. Fau C-F, Granade, TC, Parekh B, Schochetmam, G DeCock, KM, Gayle HD, Cernescuc, George Jr. Mis-identification of HIV-2 proteins on commercial Western blots: A need for standard procedure and re-examination of the interpretive criteria for HIV-2 Western blot. Lancet, 1991; 337:616-7.

JOURNAL PUBLICATIONS (cont):

12. Gayle HD, D'Angelo LJ. The epidemiology of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection in adolescents. Pediatric Infection Disease Journal, 1991; 10:322-8.

13. Gayle HD, D'Angelo LJ. The epidemiology of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection in adolescents. Pediatric Infection Disease Journal, 1991; 10:322-8.

14. D'Angelo LJ, Getson PR, Luban NLC, Gayle HD. Human Immunodeficiency Virus infection in urban adolescents: can we predict who is at risk? Pediatric, 1991; 5:982-6.

15. DeCock KM, Selik RM, Soro B, Gayle HD, Colebunders RL. AIDS surveillance in Africa: A reappraisal of case definition. BMJ, 1991' 303:1185-8.

16. Hersh BS, Popovici F, Zolotusca L, Beldscu N, Oxtoby MJ, Gayle HD. The epidemiology of HIV and AIDS in Romania. AIDS 1991; 5(suppl 2):S87-S92.

17. Qu C-Y, Takebe Y, Weninger BG, Luo C-C, Kalish M, Auwanit W, Bandea C, de la Torre N, Moore JL, Schocetman G, Yamazaki S, Gayle HD, Young NL, Weninger BG. Wide distribution of two sub-types of HIV-1 in Thailand. AIDS Research and Human Retroviruses. 1991;8:1471-1472.

18. Gayle HD, Gnoare E, Adjorlolo G, Ekpini E, Porter A, Braun MM, DeCock KM. Human Immunodeficiency Virus in children, Abidjan, Cote D'Ivoire. Journal of Acquired Immunodeficiency Syndrome 1992;5:513-517.

19. Kestens L, Brattegaard K, Adjorlolo G, Ekpini E, Sibailly T, Diallo K, Gigase PL, Gayle HD, DeCock KM. Immunological comparison of HIV-1 and Hiv-2 and dually-reactive women delivering in Abidjan, Cote d'Ivoire. AIDS 1992;6:803-807.

20. Gayle HD, Coutinho R. The global epidemiology of HIV infection including HIV infection in Pregnancy and childhood and among intravenous drug users.
Curr Opin Infectious Disease 1993; 6:300-204.

21. Pau C-P, Lee-Thomas, S. Auwanit, W, George JR, OuC-Y, Parekh B, Granade, T, Holloman D, Phillips, S. Schochetman G, Young NL, Takebe Y, Gayle HD, Weninger BG. Highly specific V-3 peptide enzyme immunoassay for serotyping HIV-1 specimens from Thailand, AIDS 1993; 7:337-340.

22. Nopkesorn T, Mastro TD, Sangkharomya S, Sweat M, Singharaj P, Limpakarnjanarat K, Gayle HD, Weninger BG. HIV-1 infection in young men in northern Thailand. AIDS 1993; 7:1233-123

JOURNAL PUBLICATIONS (cont):

23. Ou C-Y, Takebe Y, Weninger BG, Luo C-C, Kalish M, Auwanit W, Yamazaki S, Gayle HD, Young ML, Schochetman G, Laboratory Investigation Group. Independent introduction of two major HIV-1 genotypes into distinct high risk populations in Thailand. Lancet 1993 341-:1171-1174.

24. Hersh BS, Popovici F, Jezek Z, Satten GA, Apetrei RC, Beldsescu N, George JR, Shapiro CN, Gayle HD, Heyman DL. Risk Factors for HIV infection among abandoned Romanian children. AIDS 1993;270-1617-1624.

25. DeCock, KM, Adjorlolo G, Ekpini E, Sibailly T, Kouadio J, Maran M, Brattegard K, Vetter K, Doorly R, Gayle HD. Epidemiology and transmission of HIV-2: Why there is no HIV 2 pandemic. JAMA 1993; 270:2083-2086.

26. DeCock, KM, Lucas SB, Lucas S, Kadio A, Gayle HD. Clinical research, prophylaxis, therapy and care for HIV disease in Africa. AJPH 1993;83:1385-1389.

27. DeCock, KM, Ekpini E, Gnaore E, Kadio A, Gayle HD. The public health implications AIDS research in Africa. JAMA 1994; 272:481-486.

28. DeCock, KM, Zadi F, Diallo MO, Sassan-Morokro M, Adjorlolo G, Ekpini E, Sibailly T, Doorly R, Batter V, Brattegard K, Gayle HD. Retrospective study of maternal HIV-1 and HIV-2 infections and child survival in Abidjan, Cote D'Ivoire.
BMJ 1994;308:441-443.

29. Kimball A, Berkley S, Ngugi, E, Gayle HD. International aspects of the HIV/AIDS epidemic. Ann Rev Pub Health 1995;16:253-285.

30. Richards SB, St. Louis ME, Nieburg, P, Coulibaly IM, Coulibaly D, Abouya L, Gayle HD, DeCock, KM. Impact of the HIV epidemic on trends in tuberculosis in Abidjan, Cote D'Ivorie. Tubecle and Lung Disease 1995; 76:11-16.

31. Munkolenkole CK, DeCock, KM, St Louis, ME, Toure CK, Zakaria S, Ngbichi, JM, Ghys PD, Holmes, KK, Eschenbach DA, Gayle HD, Kreiss JK. The impact of Human Immunodeficiency Virus (HIV) infection on Pelvic Inflammatory Disease (PID): A case-control study in Abidjan, Ivory Coast. Am J Obstet Gynecol 1995; 172:919-25.

32. Ngbichi JM, DeCock, KM, Batter V, Yeboue K, Ackah A, Zadi F, Diallo MO, Kadio A, Gayle HD. HIV status of female sex partners of men reactive to HIV-1, HIV-2 or both viruses in Abidjan, Cote D' Ivoire. AIDS 1995;951-954.

JOURNAL PUBLICATIONS (cont):

33. Lillie-Blanton M, Parsons P E, Gayle HD, Dievler A. Racial Differences in Health: Not Just Black and White, But Shades of Gray. Annual Review of Public Health. 1996;17:411-48.

34. St. Louis, ME, Wasserheit JN, Gayle HD. Editorial: Janus Considers the HIV Pandemic-Harnessing Recent Advances to Enhance AIDS Prevention. American Journal of Public Health. 1997;87:10-12.

35. Edlin BR, Keeling RP, Gayle HD, Holmberg SD. Prevalence of Human Immunodeficiency Virus type 1 (HIV-1) in U.S. College and University students, 1988-1990. Journal of Acquired Immune Deficiency Syndrome Human Retro-Viruses (In Press).

36. Sumartojo, E, Carey JW, Doll LS, Gayle, HD. Targeted and general population interventions for HIV prevention: towards a comprehensive approach. AIDS 1997, 11:1201-1209.

37. Simons, RJ, Dondero TJ, DeCock KM, Gayle HD. Ethics and HIV Trials (Letter). AJPH, 1999;89:255-6.

38. Gayle, HD, Counts, GW. Syphilis Elimination: A Unique Time in History (editorial) JAMWA, Vol. 56, No. 1

38. Gayle, HD. An overview of the global HIV/AIDS epidemic, with a focus on the United States. AIDS 2000, 14(suppl 2):S8-S17

39. Gayle, HD, Hill, GL. Global Impact of Human Immunodeficiency Virus and AIDS. Clinical Microbiology Reviews, Apr. 2001, p. 327-335, Vol. 14, No. 2

40. Gayle, HD. Curbing the Global AIDS Epidemic. N Eng J Med 2003; 348:1802-1805.

41. Klausner RD, Fauci AS, Corey L, Nabel GJ, Gayle HD, Berkley S, Haynes BF, Baltimore D, Collins C, Douglas RG, Esparza J, Francis DJ, Ganguly NK, Gerberding JL, Johnston MI, Katachkine MD, McMichael AJ, Makgoba MW, Pantaleo G, Piot P, Shao Y, Tramont E, Varmus H, Wasserheit JN. Editorial: The Need for a Global HIV Vaccine Enterprise. Science Magazine. 2003; 300:2036-2039

42. Shelton JD, Halperin DT, Nantulya V, Potts M, Gayle HD, Holmes KK. Partner Reduction is Crucial for Balanced "ABC" Approach to HIV Prevention. British Medical Journal, 10 April 2004, p. 891-893, Vol. 328

43. Gayle HD, Lange JMA. Seizing the Opportunity to Capitalize on the Growing Access to HIV Treatment to Expand HIV Prevention. The Lancet, July 3, 2004; pages 6-7

JOURNAL PUBLICATIONS (cont):

44. Hill Carl V., Neighbors HW, Gayle HD. The Relationship Between Racial Discrimination and Health for Black Americans: Measurement Challenges and the Realities of Coping. African American Research Perspectives, 2004, Vol. 9, No. 2

45. Halperin DT, Steiner MJ, Cassell MM, Green EC, Hearst N, Kirby D, Gayle, HD, Cates, W. The Time Has Come for Common Ground on Preventing Sexual Transmission of HIV. The Lancet, November 2004, Vol. 364, pages 1913-15

46. Coordinating Committee of the Global HIV/AIDS Vaccine Enterprise, Bhan MK, Berkley S, DeWilde M, Esparza J, Fauci AS, Gayle HD, Johnston MI, Kaleebu P, Kazatchkine MD, Klauser RD, Lander ES, Makgoba MW, Mocumbi P, Piot P, Quintana-Trias O, Snow W, Walport MJ, Wigzell H. The Global HIV/AIDS Vaccine Enterprise: Scientific Strategic Plan. Public Library of Science (PLoS) – Medicine, February 2005, Volume 2, Issue 2, e25

47. Dean HD, Steele CB, Cagle MC, Gayle HD, editors. HIV/AIDS in Racial Ethnic Minorities. Journal of the National Medical Association 2005;97(7 supplement):1S-63S

48. Gayle HD, Daulaire N. A Better Future for Women and Children. The Lancet, October 2007, Vol. 370, pages 1297-1298

49. Gayle HD, Wainberg MA: Impact of the 16th International Conference on AIDS: can these conferences lead to policy change? Retrovirology; 2007;4:13

50. Gayle HD, Childress J. Race, Racism, and Structural Injustice: Equitable Allocation and Distribution of Vaccines for the COVID-19, The American Journal of Bioethics; 2021; 21:3, 4-7

BOOKS & BOOK CHAPTERS:

1. Gayle, HD, D'Angelo L.J. The epidemiology of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection in adolescents. In: Pizzo PI, Wifert CM, eds. The Challenge of HIV Infection in Infants, Children and Adolescents. 1991:38-50.

2. Mastro TD, Gayle HD, Heyward WL. Epidemiology of HIV infection and AIDS outside of the United States. In: Wormser GP ed. AIDS and other Manifestations of HIV Infection, Second Edition. 1992:25-35.

3. Gayle HD, Nzila, N, Heyward Wl. HIV and AIDS in Central Africa. In: Essex M, Mboup S, Kanki PJ, Kalengayi MR ed. AIDS in Africa 1994:51-667.

4. Buzy JM, Gayle HD. The epidemiology of HIV and AIDS in Women. In: Long LD, Ankrah EM ed. AIDS and Women's experience. 1996: 181-204Epidemiology of HIV, chapter from AIDS and Other Manifestations of HIV Infection. Third Edition. Edited by Wormser GP. New York: Raven Press, Ltd., 1998

BOOKS & BOOK CHAPTERS (cont):

5. Lamptey PR, Gayle HD, (eds.) HIV/AIDS Prevention and Care in Resource-Constrained Settings: A Handbook for the Design and Management of Programs. Arlington, VA: Family Health International AIDS Institute, 2001.

6. Esparza J, Gayle HD. Consideraciones en relacion con el desarrollo de una vacuna contra el VIH/SIDA. In: "Manual de SIDA" (6a edicion). Eds. Soriano V, Gonzalez-Lahoz J, Publicaciones Permayer, Barcelona, Spain. (in press)

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2. Impact of oral re-hydration on hospital admission and case-fatality rates for diarrheal disease: results from 11 countries. WHO Weekly Epidemiology Report, 1988, 63;49-52.

3. Oxtoby MJ, Gayle HD. AIDS in Women in Children. Outlook 1990;8:2-6.

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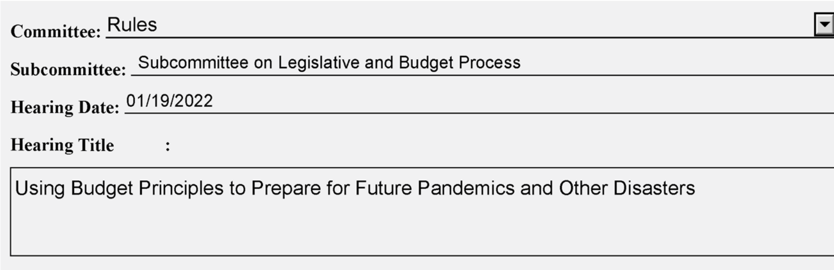
REFERENCES PROVIDED UPON REQUEST.

Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)* of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.



Committee: Rules

Subcommittee: Subcommittee on Legislative and Budget Process

Hearing Date: 01/19/2022

Hearing Title:

Using Budget Principles to Prepare for Future Pandemics and Other Disasters

Witness Name: Helene D. Gayle

Position/Title: President & CEO, Chicago Community Trust

Witness Type: ○ Governmental ◉ Non-governmental

Are you representing yourself or an organization? ○ Self ◉ Organization

If you are representing an organization, please list what entity or entities you are representing:

FOR WITNESSES APPEARING IN A NON-GOVERNMENTAL CAPACITY

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

Are you a fiduciary—including, but not limited to, a director, officer, advisor, or resident agent—of any organization or entity that has an interest in the subject matter of the hearing? If so, please list the name of the organization(s) or entities.

n/a

Please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the source and amount of each grant or contract.

n/a

Please list any contracts, grants, or payments originating with a foreign government and related to the hearing's subject that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the amount and country of origin of each contract or payment.

n/a

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

☑ I have attached a written statement of proposed testimony.

☑ I have attached my curriculum vitae or biography.

*Rule XI, clause 2(g)(5), of the U.S. House of Representatives provides:

(5)(A) Each committee shall, to the greatest extent practicable, require witnesses who appear before it to submit in advance written statements of proposed testimony and to limit their initial presentations to the committee to brief summaries thereof.

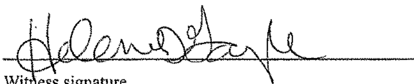
(B) In the case of a witness appearing in a non-governmental capacity, a written statement of proposed testimony shall include— (i) a curriculum vitae; (ii) a disclosure of any Federal grants or contracts, or contracts, grants, or payments originating with a foreign government, received during the past 36 months by the witness or by an entity represented by the witness and related to the subject matter of the hearing; and (iii) a disclosure of whether the witness is a fiduciary (including, but not limited to, a director, officer, advisor, or resident agent) of any organization or entity that has an interest in the subject matter of the hearing.

(C) The disclosure referred to in subdivision (B)(ii) shall include— (i) the amount and source of each Federal grant (or subgrant thereof) or contract (or subcontract thereof) related to the subject matter of the hearing; and (ii) the amount and country of origin of any payment or contract related to the subject matter of the hearing originating with a foreign government.

(D) Such statements, with appropriate redactions to protect the privacy or security of the witness, shall be made publicly available in electronic form 24 hours before the witness appears to the extent practicable, but not later than one day after the witness appears.

False Statements Certification

Knowingly providing material false information to this committee/subcommittee, or knowingly concealing material information from this committee/subcommittee, is a crime (18 U.S.C. § 1001). This form will be made part of the hearing record.



Witness signature

1/12/22

Date

Rules

01/19/2022 — Using Budget Principles to Prepare for Future Pandemics and Other Disasters

Julia Tedesco, President & CEO

Julia Tedesco is the president and CEO of Foodlink, a nonprofit dedicated to ending hunger and building healthier communities in the Greater Rochester/Finger Lakes region of New York. Over the past decade, she has led the organization's evolution from one of the country's oldest food banks, to an innovative food resource center and public health organization focused on addressing the root causes of food insecurity, including chronic poverty and systemic racism.

Tedesco began at Foodlink in 2008,and has served in numerous roles for the organization. She helped to launch food-related programs that nourish communities and foster economic development, including the Curbside Market – a farmers' market on wheels- and the Foodlink Career Fellowship, a one-of-a-kind workforce development program. She oversaw the growth of a marketing, communications and development team, serving as Foodlink's first Chief Development and Communications Officer. She was named executive director in 2014.

During her tenure at Foodlink, Tedesco also played a key role in the relocation of Foodlink's facility in 2012, the expansion of its Community Kitchen in 2016, and Foodlink's response to the COVID-19 pandemic in 2020-22. Foodlink has won numerous awards locally for its service to the Rochester area, and is widely recognized as one of the more innovative food banks in the Feeding America network, boasting an array of programs and social enterprises that address both the systems and root causes of food insecurity.

Tedesco holds a master's degree from Syracuse University's Maxwell School of Citizenship and Public Affairs, and a bachelor's degree from Fairfield University. She currently serves on the Board of Directors for Feeding New York State, Rochester Regional Health, and Rochester Health Reach (Healthcare for the Homeless), and as an Editorial Advisory Board member of Food Bank News. She lives in Rochester, New York with her husband and three children.

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Committee: Rules

Subcommittee: Subcommittee on Legislative and Budget Process

Hearing Date: 01/19/2022

Hearing Title:

Using Budget Principles to Prepare for Future Pandemics and Other Disasters

Witness Name: Julia Tedesco

Position/Title: President & CEO, Foodlink

Witness Type: ○ Governmental ● Non-governmental

Are you representing yourself or an organization? ○ Self ● Organization

If you are representing an organization, please list what entity or entities you are representing:

Foodlink, Inc. (Rochester, NY)

FOR WITNESSES APPEARING IN A NON-GOVERNMENTAL CAPACITY

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

Are you a fiduciary—including, but not limited to, a director, officer, advisor, or resident agent—of any organization or entity that has an interest in the subject matter of the hearing? If so, please list the name of the organization(s) or entities.

N/A

Please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the source and amount of each grant or contract.

USDA -- $537,803 (The Emergency Food Assistance Program/CARES Act 2020)
FEMA -- $75,599 (CARES Act, 2020-21)
USDA -- $3,093,967 (Summer Food Service Program, 2020-21)
USDA -- $167,325 (Child and Adult Care Food Program, 2020-21)

Please list any contracts, grants, or payments originating with a foreign government and related to the hearing's subject that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the amount and country of origin of each contract or payment.

N/A

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

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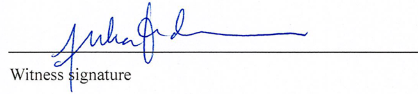

Witness signature

1/13/22

Date

Jeff Schlegelmilch, MPH, MBA

EMPLOYMENT HISTORY

Director, National Center for Disaster Preparedness at Columbia University | Earth Institute (6/2020 - present); Research Scholar, National Center for Disaster Preparedness at Columbia University | Earth Institute (2/2020 - present)

Executive Advisor, Quanta Technology LLC (5/2021 – Present)

Owner/Proprietor, Schlegelmilch Advisers LLC (9/2020 – Present)

Deputy Director, (promoted from Managing Director for Strategic Planning & Operations, 11/2015)
National Center for Disaster Preparedness at Columbia University | Earth Institute (8/2014 – 6/2020)

Manager, Emergency Management Services / International and Non-Healthcare Business Sector
Yale New Haven Health System Center for Emergency Preparedness and Disaster Response (2/2011 – 8/2014)

Program Manager, Emergency Management Planning Services
Yale New Haven Health System Center for Emergency Preparedness and Disaster Response (11/2008 – 02/2011)

Drills and Exercise Specialist
Yale New Haven Health System Center for Emergency Preparedness and Disaster Response (12/2007 – 11/2008)

Epidemiologist
Communicable Disease Control Division, Boston Public Health Commission (10/2006 – 12/2007)

Project Manager
Office of Public Health Preparedness, Boston Public Health Commission (1/2005 - 10/2006)

BOARDS AND VOLUNTEER POSITIONS

Advisory Board Member
Meishan California Smart City Institute Advisory Board (MCSC-I) (2/2021 – present)

Defy:Disaster Advisory Council Member
Entertainment Industry Foundation (2/2021 – present)

Advisory Council Member

Center for Disaster Philanthropy – (8/2020 – present)

Commissioner
Sustainability Commission, Manchester, CT (8/2020 – present)

Deputy Editor
Journal of Disaster Medicine and Public Health Preparedness (8/2019 – 4/2021)

Advisor – Community Resilience and Health & Safety Sectors
Westchester County Climate Change Task Force (December 2019 – present)

Member
Sustainability Task Force Manchester, CT (3/2019 – 2/2020)

Well Concept Advisor - Community
International Well Building Institute (Appointment term 7/2018 – 12/2019)

Associate Editor
International Journal of Disaster Response and Emergency Management (1/2018 – present)

Guest Editor – Serial Hurricanes Special Issue
Journal of Disaster Medicine and Public Health Preparedness (10/2017 – 7/2019)

Content Expert Panel - National Healthcare Disaster
American Nurses Credentialing Center (Appointment term 8/2016 – 12/2019)

Resilient Partner Network – Communications Advisory Board
Federal Emergency Management Agency (3/2016 – 12/2019)

Senior Advisor and Technical Advisory Board Member
Trek Medics International (7/2014 – Present)

EDUCATION

Master of Business Administration (Awarded 8/2014)
Quinnipiac University

Master of Public Health - Health Policy and Management (Awarded 5/2005)
University of Massachusetts Amherst

Bachelor of Fine Arts - Theatre Studies with minor in Sociology (Awarded 6/2002 with High Honors)
DePaul University

REPORTS, PEER REVIEWED PUBLICATIONS, ABSTRACTS, ACADEMIC BLOGS

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Ratner, **Schlegelmilch,** Samur, Sury, Esposito, Tolsdorf, Marquez, Kamidola. RCRC Issue Briefs: Why Children Should be the #1 Disaster Priority. *National Center for Disaster Preparedness at Columbia University's Earth Institute, Issue Briefs.* April 2021

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White, **Schlegelmilch,** Ratner, Saxena, Wongsodirdjo, Aguilar, Kushner, Ortega, Paaso, Bahramirad. Current Data Gaps in Modelling Essential Worker Absenteeism due to COVID-19. *Disaster Medicine and Public Health Preparedness*. 2020, 1-4.

Schlegelmilch. Rethinking Readiness: A Brief Guide to Twenty-First Century Mega Disasters (Book). *Columbia University Press*. July 2020.

Schlegelmilch, Douglas. Initial COVID-19 closure strategies adopted by a convenience sample of U.S. school districts: Directions for future research. *Disaster Medicine and Public Health Preparedness*. 2020, 14 (3) e17-e18.

Schlegelmilch, Ratner, Bahramirad, Paaso. 2020. Lives on the Line: The Big Benefits of Microgrids in Disaster. *Research Counts*. Natural Hazards Center, University of Colorado Boulder. 3(2). 2020

Schlegelmilch, Sury. From the Ground Up: Building Child-Focused Community Resilience. *Research Counts, Special Collection on Children and Disasters, Natural Hazards Center*, University of Colorado Boulder. 3 (SC18). 2019.

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Suneja, Chandler, **Schlegelmilch**, May, Redlener. Chronic Disease After Natural Disasters: Public Health, Policy, and Provider Perspectives. *National Center for Disaster Preparedness at Columbia University's Earth Institute, Project Report,* 2018

Jacobs-Wingo, **Schlegelmilch**, Berliner, Airall-Simon, Lang. Emergency Preparedness Training for Hospital Nursing Staff, New York City, 2012–2016, *Journal of Nursing Scholarship*, 2018

Kirsch, **Schlegelmilch**, Strauss-Riggs, Chandler, Redlener. Regions Respond to Catastrophes. *Disaster Medicine and Public Health Preparedness*, 2017, 11(4), 399-401.

Schlegelmilch, Petkova, Martinez, Redlener. Acts of Terrorism and Mass Violence Targeting Schools: Analysis and Implications for Preparedness in the United States. *Journal of Business Continuity and Emergency Planning*, 2017; 10 (3) 280-289

Petkova, Martinez, **Schlegelmilch**, Redlener. Schools and Terrorism: Global Trends, Impacts and Lessons for Resilience. *Studies in Conflict & Terrorism*, 2016

Sury, **Schlegelmilch**, Redlener. Anger Versus Fear: Perceptions of Terrorism Among the American Public. *National Center for Disaster Preparedness at Columbia University's Earth Institute, Polling Brief* 2016; 1

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Margevicius, **et al**. The Biosurveillance Analytics Resource Directory (BARD): Facilitating the Use of Epidemiological Models for Infectious Disease Surveillance. *PloS ONE* 2016; 11 (1) 1 - 17.

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Akselrod, Risoe, Mercon, **Schlegelmilch**, McGovern, Bogucki. Creating a process for incorporating epidemiological modeling into outbreak management decisions. *Journal of Business Continuity and Emergency Planning 2012*; 6(1); 68-83.

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Centers for Disease Control and Prevention. Norovirus Activity -- United States, 2006 – 2007. *MMWR* 2007;56 (33); 842-846.

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National Association of County and City Health Officials. Pandemic Influenza Tabletop Exercise Template. *NACCHO* 2007.

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https://smartcities.ieee.org/newsletter/september-2021/us-cities-and-climate-change-status-and-roadmap-for-the-future

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Bahramirad, **Schlegelmilch.** The electric grid of the future requires major upgrades – we must start today. *The Hill: Contributors;* published 5/18/21, available at: https://thehill.com/opinion/technology/554122-the-electric-grid-of-the-future-requires-major-upgrades-we-must-start

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Schlegelmilch. Deadly extreme weather is the new normal. *The Hill: Contributors*; published 5/23/19, available at: https://thehill.com/opinion/energy-environment/445230-deadly-extreme-weather-is-the-new-normal

Schlegelmilch, Alter. Financing catastrophe: 4 ways we pay for disasters. *The Hill: Contributors*; published 1/28/18, available at https://thehill.com/opinion/energy-environment/427205-financing-catastrophe-4-ways-we-pay-for-disasters

Schlegelmilch. 3 reasons Trump is wrong about California's deadly fires, and one reason he may be right. *The Hill: Contributors*; published 11/13/18, available at: https://thehill.com/opinion/energy-environment/416523-3-reasons-trump-is-wrong-about-californias-deadly-fires-and-one

Schlegelmilch, Sury, Redlener. As Hurricane Michael moves inland, public data can help the most vulnerable. *The Hill: Contributors;* published10/11/18, available at:

https://thehill.com/opinion/energy-environment/410986-as-hurricane-michael-moves-inland-public-data-can-help-the-most

Schlegelmilch, Redlener. Five reasons not to underestimate Hurricane Florence. *The Hill: Contributors*; published 9/12/18, available at: http://thehill.com/opinion/energy-environment/406207-five-reasons-not-to-underestimate-hurricane-florence

Schlegelmilch. Emergency management is having a #MeToo moment. *The Hill: Contributors*; published 9/6/18, available at: http://thehill.com/opinion/energy-environment/405366-emergency-management-is-having-a-metoo-moment

Schlegelmilch. The 2018 Hurricane Season Is Here. We Can't Just Rely on the Federal Government to Help Us Prepare. *Fortune Commentary*; published 5/30/18, available at: http://fortune.com/2018/05/30/2018-hurricane-season-fema/

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Committee: Rules

Subcommittee: Subcommittee on Legislative and Budget Process

Hearing Date: 01/19/2022

Hearing Title :

Using Budget Principles to Prepare for Future Pandemics and Other Disasters

Witness Name: Helene D. Gayle

Position/Title: President & CEO, Chicago Community Trust

Witness Type: ◎ Governmental ◎ Non-governmental

Are you representing yourself or an organization? ◎ Self ◎ Organization

If you are representing an organization, please list what entity or entities you are representing:

FOR WITNESSES APPEARING IN A NON-GOVERNMENTAL CAPACITY

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

Are you a fiduciary—including, but not limited to, a director, officer, advisor, or resident agent—of any organization or entity that has an interest in the subject matter of the hearing? If so, please list the name of the organization(s) or entities.

n/a

Please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the source and amount of each grant or contract.

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False Statements Certification

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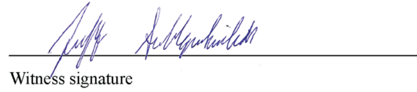

Witness signature

1/15/22

Date

Robert P. Kadlec, M.D., Colonel (retired) U.S.A.F.

Summary

Served in a range of senior policy, legislative & joint operational, & medical positions concerning intelligence homeland security, all hazards medical preparedness, WMD counter-proliferation & counterterrorism.

Professional Experience & Accomplishments:

Assistant Secretary of Preparedness and Response (ASPR) HHS (Aug 2017-Jan2021) : Presidentially appointed and Senate connfirmed position. Led a response organization of over 800 personnel and managed a budget in excess of $2.6B.

Majority Deputy Staff Director, Senate Select Committee on Intelligence (SSCI) (Jan15 to present): Oversees and manages 35 person professional staff conducting U.S. Intelligence Community oversight

Managed portfolio of intelligence priorities & issues for SSCI hearings, roundtables & briefings

Managing Director, RPK Consulting LLC (Sep 2011 to Jan 15) Consultant to the Office of Secretary of Defense on chemical & biological defense matters;

Advisor to Director National Intelligence Biological Science Experts Group & DoD Threat Reduction Agency Advisory Committee & Co-chairman of Institute of Medicine Medical Preparedness Forum.

Vice President Biodefense & Public Health Practice, PRTM Management Consultants LLC (May 2009 – Aug 2011) Consulted on all hazard programs in the Departments of Defense & Health & Human Services.

Special Assistant to the President & Senior Director for Biodefense Policy, Homeland Security Council (Dec 2007 – Jan 2009): Advised President George W. Bush & senior White House officials on a range of issues pertaining to all hazards, bioterrorism & pandemic influenza preparedness.

Director for Biodefense & Public Health PRTM Management Consultants LLC (Aug 2006 – Nov 2007): Biodefense consultant to the Departments of Homeland Security & Health & Human Services.

Staff Director, U. S. Senate Subcommittee on Bioterrorism & Public Health Preparedness (April 2005 – August 2007): Conducted oversight of US Government bioterrorism preparedness programs and drafted all-hazards legislation for the Senate Health Education Labor & Pension Committee.

Drafted the Pandemic & All-Hazard Act (PL109-417) signed into law during the 109th Congress.

Director for Biodefense Preparedness & Response, **Homeland Security Council**, (Feb 2002-Feb 2005): Provided guidance to senior White House officials & developed policy on Homeland Security & WMD threats.

Co-authored National Biodefense Strategy: Homeland Security Presidential Directive (HSPD) 10.

Participated in Iraqi Survey Group field evaluations of Iraqi BW Program (Apr 2003-Aug 2004).

Special Advisor for Counterproliferation Policy, **Office of Secretary of Defense (OSD)** (Sep 2001-Jan 2002**):**

Assisted in DOD efforts to counter WMD threat following 9-11 & FBI investigation of anthrax letter attacks.

Professor, Department of Military Strategy & Operations, National War College, DC (Jan 2000-Sep 2001): First physician on faculty, taught security implications of WMD proliferation & homeland security.

Organized seminar with recognized terrorism experts on psychological consequences of WMD terrorism.

Targeting Officer Counter-proliferation Division (CPD), Central Intelligence Agency (Nov 1996-Jan 2000**):** Provided medical, technical, policy, & special operations military expertise to the Directorate of Operations.

Senior Assistant for Counterproliferation Policy to the Assistant Secretary of Defense for International Security Policy, (Oct 1993-Nov 1996**):** Provided policy oversight & guidance to senior U.S. Defense officials on a wide range of WMD non-proliferation & counter-proliferation issues.

Secretary of Defense Representative to the Biological Weapons & Toxin Convention, Geneva, Switzerland.

UN Special Commission (UNSCOM) Weapons Inspector in Iraq (Aug 1994, Sep 1996, Jun 1998).

Surgeon, 24th Special Tactics Squadron; Special Assistant to J-2 for Chemical & Biological Warfare, Joint Special Operations Command (JSOC) (Aug 1990-Oct 1993): Created WMD medical training standard for JSOC medical personnel & all hazards paramedic training for USAF Pararescue personnel.

JSOC J-2 intelligence analyst for Chemical Biological warfare issues during first Gulf War.

Member Interagency Intelligence Working Group on Iraqi Biological Warfare Threat.

Flight Surgeon 16th Special Operations Wing, Hurlburt Field, FL, (Sep 1984-Jul 1988):

Participated in sensitive counter-terrorism operations; 1986 USAF Flight Surgeon of the Year.

Education & Professional Training: Bachelor of Science, Distinguished Graduate USAF Academy, 1979; Doctor of Medicine, Uniformed Services University of the Health Sciences (USUHS), 1983; Masters in Tropical Medicine & Hygiene, USUHS, 1989; Masters in National Security Studies, Georgetown University, 1995; Board Certified in General Preventive Medicine & Aerospace Medicine; Member of the Council on Foreign Relations.

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Robert P Kadlec 1/15/22

Witness signature Date