

LESSONS FROM THE FRONTLINE: COVID-19'S IMPACT ON AMERICAN HEALTHCARE

HYBRID HEARING

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
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C O N T E N T S

	Page
Hon. Diane DeGette, a Representative in Congress from the State of Colorado, opening statement	2
Prepared statement	5
Hon. H. Morgan Griffith, a Representative in Congress from the Commonwealth of Virginia, opening statement	8
Prepared statement	10
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	14
Prepared statement	16
Hon. Cathy McMorris Rodgers, a Representative in Congress from the State of Washington, opening statement	18
Prepared statement	20

WITNESSES

Megan Ranney, M.D., M.P.H., Emergency Physician, Rhode Island Hospital ¹	
Prepared statement	25
Answer to submitted questions	94
Tawanda Austin, M.S.N., R.N., N.E.B.C., Chief Nursing Officer, Emory University Hospital Midtown	27
Prepared statement	29
Answer to submitted questions	101
Daniel Calac, M.D., Chief Medical Officer, Indian Health Council, Pauma Band of Luiseno Indians, INC.	34
Prepared statement	36
Answer to submitted questions ²	
Laura E. Riley, M.D., Obstetrician And Gynecologist-In-Chief, New York Presbyterian Hospital	39
Prepared statement	41
Answer to submitted questions	104
Lucy McBride, M.D., Internist, Private Practice	46
Prepared statement	48
Answer to submitted questions	107

SUBMITTED MATERIAL

Report “Protecting Our Front Line, Ending the Shortage of Good Nursing Jobs and the Industry-created Unsafe Staffing Crisis,” National Nurses United, December 2021, submitted by Ms. Schakowsky ³	
Article “The C.D.C. Isn’t Publishing Large Portions of the Covid Data It Collects,” by Apoorva Mandavilli, New York Times, February 20, 2022, submitted by Mr. Dunn	88

¹ The information has been retained in committee files and also is available at <https://docs.house.gov/meetings/IF/IF02/20220302/114450/HHRG-117-IF02-Wstate-RanneyM-20220302.pdf>.

² Dr. Calac questions were not answered by the time of publications <https://docs.house.gov/meetings/IF/IF02/20220302/114450/HHRG-117-IF02-Wstate-CalacD-20220302-SD021.pdf>.

³ The information has been retained in committee files and also is available at <https://docs.house.gov/meetings/IF/IF02/20220302/114450/HHRG-117-IF02-20220302-SD003.pdf>.

LESSONS FROM THE FRONTLINE: COVID-19'S IMPACT ON AMERICAN HEALTHCARE

WEDNESDAY, MARCH 2, 2022

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:36 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, and remotely via Cisco Webex online video conferencing, Hon. Diana DeGette, (chair of the subcommittee) presiding.

Members present: Representatives DeGette, Kuster, Rice, Schakowsky, Tonko, Ruiz, Peters, Schrier, Trahan, O'Halleran, Pallone (ex officio); Griffith (subcommittee ranking member), Burgess, McKinley, Palmer, Dunn, Joyce, and Rodgers (ex officio).

Also present: Representatives Sarbanes and Carter.

Staff present: Jesseca Boyer, Professional Staff Member; Austin Flack, Junior Professional Staff Member; Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry Hamilton, Clerk; Fabrizio Herrera, Staff Assistant; Rebekah Jones, Oversight Counsel; Zach Kahan, Deputy Director Outreach and Member Service; Mackenzie Kuhl, Digital Assistant; Kaitlyn Peel, Digital Director; Caroline Rinker, Press Assistant; Chloe Rodriguez, Clerk; Andrew Souvall, Director of Communications, Outreach, and Member Services; Xiaoyi Huang, GAO Detailee; Kate Arey, Minority Content Manager and Digital Assistant; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Marissa Gervasi, Minority Counsel, Oversight and Investigations; Grace Graham, Minority Chief Counsel, Health; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, Oversight and Investigations Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

Ms. DEGETTE. The Subcommittee on Oversight and Investigations hearing will now come to order.

Today the Subcommittee on Oversight and Investigations is holding a hearing entitled, "Lessons from the Frontline: COVID-19's Impact on American healthcare." Today's hearing will examine the

COVID-19 pandemic's impacts, and how providers, the healthcare system, and patients can better prepare for future variants and future public health emergencies.

Due to the COVID-19 public health emergency, members can participate in today's hearing either in person or remotely, via online video conferencing.

In accordance with the updated guidance issued by the Attending Physician, members, staff, and members of the press present in the hearing room are not required to wear a mask.

For members participating remotely, your microphones will be set on mute for the purpose of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you wish to speak. Please note that, once you unmute your microphone, anything that is said in Webex will be heard over the loudspeakers in the committee room, and subject to be heard by the livestream and C-SPAN.

Because members are participating from different locations at today's hearing, all recognition of members, such as for questions, will be in order of subcommittee seniority.

If at any time during the hearing I am unable to chair the hearing, the vice chair of the subcommittee, Mr. Peters, will serve as chair until I am able to return.

Documents for the record can be sent to Austin Flack at the email address we provided to staff. All documents will be entered into the record at the conclusion of the hearing.

The Chair will now recognize herself for purposes of an opening statement.

OPENING STATEMENT OF HON. DIANE DeGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Over the past two years, this subcommittee has held eight hearings examining the COVID-19 response, covering everything from vaccine development and deployment to the impacts of the pandemic on children. Today this subcommittee continues the examination. They—building on its long history of pandemic preparedness oversight.

We will hear from the on-the-ground providers about how the pandemic has impacted their own lives, the healthcare systems they work in, and the patients that they serve. Their frontline perspectives will provide insight into how we can better protect the health and safety of our communities throughout the remainder of this pandemic, and help us better prepare for future public health emergencies.

While our witnesses today represent an array of experiences, there are many other types of healthcare providers serving a range of communities that have felt similar impacts from this pandemic: emergency medical technicians, nursing home and in-home healthcare providers, and physical and occupational therapists, to name a few.

As we all know, the COVID-19 pandemic has impacted nearly every aspect of American life. The healthcare system is no exception, which has faced these impacts head on. Resource constraints and workforce shortages existed long before the pandemic started,

but have been exacerbated to alarming degrees over the last two years.

A recent poll found that nearly one in five healthcare workers quit their jobs during the pandemic, and nearly one-third of those remaining have seriously considered finding new jobs. And we have heard the reasons for some of this from the mental health experts who testified before this subcommittee two weeks ago. I have heard similar experiences during a recent visit with some of Colorado's healthcare workers, and I know many of you can attest that the feelings of burnout, exhaustion, and unmanageable stress are echoed in hospitals and healthcare settings throughout the country.

We must find a way to ensure these critical workers have the support they need. Of course, the cascading impacts of COVID-19 do not stop with the workforce alone. The COVID-19 surges due to new variant waves have led to significant capacity constraints within hospitals. And when hospitals are overwhelmed, patient care can suffer. Heart attacks, car accidents, and other emergencies don't stop for COVID-19. Routine preventative care and so-called elective procedures, often involving lifesaving treatment, have been delayed due to surges in the pandemic.

But the end of a COVID-19 surge does not necessarily bring the relief we hope for, as patients seeking backlogged services flood facilities. Moreover, the combination of workforce strains and capacity challenges further compound historical inequities of health disparities, presenting further barriers to care for people of color and other under-served communities.

There is no single solution to these challenges, but we do have the tools to help alleviate some of these concerns today. The most effective way to fight the pandemic and lessen the burden on our healthcare system is for eligible Americans who have not gotten the COVID-19 vaccine to get vaccinated. CDC data shows that unvaccinated adults are 16 times more likely to be hospitalized, and 14 times more likely to die from COVID-19 than fully vaccinated adults.

Further, unvaccinated adults are an astounding 41 times more likely to die from COVID-19 than those who have been fully vaccinated and boosted. The science is clear: vaccines are safe and effective, and they are our best shot, literally, at alleviating the impacts of future surges of COVID-19 on our healthcare system.

But vaccines alone will not help us prepare for future public health emergencies. We must identify what steps we can take now to rebuild and strengthen the healthcare workforce so the burnout, trauma, and resulting impacts on patient care can be avoided. And critically, we must ensure that future public health emergencies do not inflame existing disparities in access to care and health outcomes for vulnerable populations and marginalized communities.

Congress and the Biden Administration have begun to address some of these concerns through investments in prevention measures and healthcare workforce and systems support, but more must be done.

As a Nation, we have relied on healthcare workers to bear a significant burden these last two years, working long hours and extra shifts, often at great risk to their own health and that of their families. We owe a debt of gratitude for their leadership and their sac-

rifices. I look forward to hearing all of their insights and recommendations for how we can work to keep America safe and healthy for the remainder of this pandemic and for the future.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Committee on Energy and Commerce

Opening Statement as Prepared for Delivery
of

Subcommittee on Oversight and Investigations Chair Diana DeGette

Hearing on “Lessons from the Frontline: COVID-19’s Impact on American Health Care”

March 2, 2022

Over the past two years, this Subcommittee has held eight hearings examining the COVID-19 response—covering everything from vaccine development and deployment to the impacts of the pandemic on children.

Today, this Subcommittee continues this examination, building on its long history of pandemic preparedness oversight. We’ll hear from on-the-ground health care providers how the pandemic has impacted their own lives, the health care systems they work in, and the patients they serve.

Their frontline perspectives will provide insight into how we can better protect the safety and health of our communities throughout the remainder of this pandemic and help us better prepare for future public health emergencies.

While our witnesses today represent an array of experiences, there are many other types of health care providers serving a range of communities that have felt similar impacts from this pandemic—emergency medical technicians, nursing home and in-home health care providers, and physical and occupational therapists, to name a few.

As we all know, the COVID-19 pandemic has impacted nearly every aspect of American life. The health care system is no exception, which has faced these impacts head-on.

Resource constraints and workforce shortages existed long before the pandemic started but have been exacerbated to alarming degrees over the last two years. A recent poll found that nearly 1 in 5 health care workers quit their jobs during the pandemic and nearly one-third of those remaining have seriously considered finding new jobs.

We heard some of the reasons for this from the mental health experts who testified before the Subcommittee two weeks ago. I’ve heard similar experiences during a recent visit with some of Colorado’s hospital workers. As I know many of you can attest, their feelings of burnout, exhaustion, and unmanageable stress are echoed in hospitals and health care settings throughout the country.

We must find a way to ensure these critical workers have the support they need.

March 2, 2022
Page 2

Of course, the cascading impacts of COVID-19 do not stop with the workforce alone. The COVID-19 surges due to new variant waves have led to significant capacity constraints within hospitals.

And when hospitals are overwhelmed, patient care can suffer. Heart attacks, car accidents, and other emergencies don't stop for COVID-19.

Routine preventive care and so-called "elective" procedures—often involving life-saving treatment—have been delayed due to surges in the pandemic.

But the end of a COVID-19 surge does not necessarily bring the relief we hope for, as patients seeking backlogged services flood facilities.

Moreover, the combination of workforce strains and capacity challenges further compound historical inequities and health disparities—presenting further barriers to care for people of color and other underserved communities.

There is no single solution to these challenges, but we do have the tools to help alleviate some of these concerns today. The most effective way to fight the pandemic and lessen the burden on our healthcare system is for eligible Americans who have not yet gotten the COVID-19 vaccine to get vaccinated.

CDC data shows that unvaccinated adults are 16 times more likely to be hospitalized and 14 times more likely to die from COVID-19 than fully vaccinated adults. Further, unvaccinated adults are an astounding 41 times more likely to die from COVID-19 than those who have been fully vaccinated *and* boosted.

The science is clear. Vaccines are safe and effective, and they are our best shot at alleviating the impacts of future surges of COVID-19 on our health care system.

But vaccines alone will not help us prepare for future public health emergencies. We must identify what steps we can take now to rebuild and strengthen the health care workforce so that burnout, trauma, and resulting impacts on patient care can be avoided.

And, critically, we must ensure that future public health emergencies do not inflame existing disparities in access to care and health outcomes for vulnerable populations and marginalized communities.

Congress and the Biden Administration have begun to address some of these concerns through investments in prevention measures and health care workforce and systems support, but more must be done.

As a nation, we have relied on health care workers to bear a significant burden these last two years—working long hours and extra shifts, often at great risk to their own health and that of their families. We owe a debt of gratitude for their leadership and sacrifices.

March 2, 2022
Page 3

I look forward to their insights and recommendations for how we can work to keep America safe and healthy throughout the remainder of this pandemic and for the future.

Ms. DEGETTE. And I am now very pleased to recognize the ranking member, Mr. Griffith, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. H. MORGAN GRIFFITH, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF VIRGINIA

Mr. GRIFFITH. Thank you, Madam Chair, and I appreciate you holding this hearing. Understanding the lessons learned from the COVID-19 pandemic is crucial for future decisionmaking.

Americans need to learn to live with COVID-19, and the Federal Government needs to learn to better prepare for and handle future pandemics. It is our duty on this subcommittee to oversee the Federal Government's COVID-19 response, to examine what worked and what did not. I have heard from frontline workers in my district about both successes and failures experienced over the course of the last two years.

One of the best things to come out of this pandemic for rural areas like my district is increased use of telehealth. Thanks to flexibilities from the Centers for Medicaid and Medicare Services and others, residents who were shuttered into isolation could connect to their doctors and nurses virtually. From mental health appointments to cardiology checkups, doctors and patients alike were appreciative for the ability to use at-home equipment to monitor and assess.

Other emergency flexibilities implemented by Federal and State governments also helped to increase patient access to healthcare, such as allowing pharmacists to deliver vaccines, and allowing hospitals to compound medications that were in short supply. As we move forward, this committee should examine which of these flexibilities should be available on a permanent basis.

During COVID-19 surges, many hospitals across the country had to think fast, often surprising even themselves with creative solutions. Ballad Health, a healthcare system that serves much of southwest Virginia, created a Safe at Home program. This program helped healthcare workers monitor COVID-19 patients at home by providing kits with a thermometer and a pulse oximeter. Nurses called patients to help monitor them from home, and helped schedule followup appointments for further care when necessary, based on patient self-monitoring.

The Ballad health system cared for thousands of patients this way. By screening patients at home, and preserving precious resources in the hospital for the sickest of patients, this program reduced hospital admittance rates, keeping beds open for those who needed them most.

Despite these successes, certain policies and mandates implemented throughout the course of the pandemic resulted in setbacks in my district. The decision to delay elective procedures eventually backfired for some patients and hospitals. The delay of treatment and preventative screenings resulted in worsened conditions for patients. People often think of an elective surgery as—think of elective surgery as referring to something cosmetic or optional. However, the term is broad, covering many critical procedures, including cancer screenings, hip replacements, hernia repairs, or the removal of kidney stones or an appendix.

We saw a temporary fix to manage staff shortages and the influx of COVID-19 cases ultimately leave patients frustrated, nervous, and in weakened health. And in some cases, like that of our friend, Congressman Andy Barr's wife, the delay in care became fatal.

Other challenges to our Nation's healthcare systems were a result of over-burdensome Federal mandates. Vaccine mandates made people choose between personal choice or their livelihood, which we know made existing problems in recruiting and retaining healthcare workers in rural areas worse. Amid Federal COVID-19 vaccination mandates for healthcare facilities, healthcare workers have been fired for non-compliance, and some have resigned or quit. In a rural hospital the loss of staff is not only noticeable, but very damaging. Any loss of staff is detrimental to rural hospitals.

Through this pandemic, our Nation's healthcare workforce has learned that it is possible to be resilient in a crisis. Even the smallest changes to care can have the biggest impact on patient health, staffing, and hospitalization rates. This is especially true in rural districts with smaller staffs, where each person plays an important role in keeping the hospitals running. The mandate didn't work.

Now that being said, I agree with Chairwoman DeGette. I have been vaccinated. I think it is an effective tool. But making it a mandate has forced people to choose whether they continue to work in our local hospitals or in healthcare systems, or give up their jobs. It is critical that we take a closer look at the experiences of frontline workers and examine lessons learned as we discuss solutions to face the next pandemic.

I look forward to hearing from our witnesses, what they experienced on the front lines, and what we can do to incorporate their lessons that they learned as we prepare for the next pandemic.

[The prepared statement of Mr. Griffith follows:]

PREPARED STATEMENT OF HON. H. MORGAN GRIFFITH

Opening Statement of Ranking Member Morgan Griffith
Subcommittee on Oversight & Investigations Hearing
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”
March 2, 2022
As Prepared for Delivery

Thank you, Chair DeGette, for holding this hearing.

Understanding the lessons learned from the COVID-19 pandemic is crucial for future decision making. Americans will need to learn to live with COVID-19, and the federal government will need to learn to better prepare and handle future pandemics.

It is our duty in Congress to oversee the federal government’s COVID-19 response—to examine what worked and what did not. From listening to the frontline workers in my district, I have heard about both the successes and the failures we have experienced. Today, I’m going to tell you a little about both.

One of the best things to come out of the pandemic for my district is telehealth. As residents were shuttered into isolation during the pandemic, doctors and nurses used telehealth to reach their communities and provide care. From mental health appointments to cardiology checkups, doctors and patients alike were appreciative for the ability to use at-home equipment for monitoring and testing.

During COVID-19 surges, many hospitals across the country had to think on their feet—often surprising themselves on what solutions they had created. For example, Ballad Health, a health care system that serves the Tri-Cities, Eastern Tennessee, and Southwest Virginia, created a “Safe-at-Home” program. This program helped health care workers monitor COVID-19 patients at home by providing kits with a thermometer and a pulse oximeter. Nurses called patients to help monitor them from home and helped schedule follow-up appointments for further care when necessary based on patients’ self-monitoring. The Ballad Health system cared for thousands of patients this way. By screening patients at home and preserving precious resources in the hospital for the sickest patients, this program helped keep patients out of hospitals and decrease the strain put on hospitals during the pandemic.

Despite the advancements of telehealth, there were also setbacks in my district. The decision to delay elective procedures eventually backfired for hospitals. On the surface, the decision to divert resources and care for COVID-19 patients seemed like a good idea. But the delay of treatment resulted in patients arriving to hospitals in worse conditions due to postponed care. People often think an “elective” surgery means cosmetic surgery. However, the term is broad, covering many critical procedures, including cancer screening, hip replacements, hernia repair, or removing kidney stones or an appendix. Over time, health care

systems saw the negative impacts from delaying surgeries. A temporary fix to manage staff shortages and the influx of COVID-19 cases ultimately left patients frustrated, nervous, and in weakening health.

Other challenges to our nation's health care systems were self-inflicted. Vaccine mandates made people choose between personal choice or their livelihood, which may have made existing problems in recruiting and retaining health care workers in rural areas. Amid federal COVID-19 vaccination mandates for health care facilities, health care workers have been fired for noncompliance, and some have resigned or quit. In a rural hospital, this loss of staff is not only noticeable, but damaging. No matter the total number of resignations, any loss of staff is detrimental to rural hospitals.

Furthermore, according to a survey by AMN Healthcare, a health care staffing company, 95 percent of health care facilities reported hiring staff from contract labor firms, with respiratory therapists being the primary need for many hospitals.¹ Contract nurse positions often receive higher pay than that of hospital staff positions. Thus, nurses left staff position jobs to apply for contract nurse

¹ *Data Brief: Workforce Issues Remain at the Forefront of Pandemic-related Challenges for Hospitals*, American Hospital Association, available at <https://www.aha.org/issue-brief/2022-01-25-data-brief-workforce-issues-remain-forefront-pandemic-related-challenges>.

positions. This further diminished the nurse supply and increased the demand for contract nurses.

Through this pandemic, our nation's health care workforce has learned that it is possible to be resilient in a crisis. Even the smallest changes to care can have the biggest impact on keeping a hospital running and continuing to care for patients. This is especially true in rural districts with smaller staffs, where each person plays an important role in keeping hospitals running.

It is critical that we take a close look at the experiences of frontline workers and examine lessons learned as we discuss solutions to face the next pandemic. I look forward to hearing from our witnesses discuss today on what they experienced on the frontlines, and what we can do to incorporate their voice as we make changes to the U.S. health care systems.

Thank you. I yield back.

Mr. GRIFFITH. Thank you very much, Madam Chair, and I yield back.

Ms. DEGETTE. The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

TMr PALLONE. Thank you, Chairwoman DeGette.

Today the committee will continue our oversight of the ongoing COVID-19 response by hearing from frontline healthcare workers who have served their communities throughout the pandemic. Their experiences offer valuable insights into our current response, and ways we can better be prepared for future public health emergencies.

And nearly four-and-a-half million Americans have been hospitalized due to COVID-19, and more than 930,000 Americans have lost their lives. No one has been unaffected by the pandemic, though seniors have been particularly vulnerable to the disease, and communities of color have faced disproportionate impacts.

Essential workers and frontline responders, such as the healthcare workers joining us today, have faced additional risk and burdens. Over the last 2 months the Omicron variant ripped through our communities, spreading quicker than prior variants. While Omicron appears to have peaked, the experience has shown that we must remain vigilant as new variants emerge, and we have to continue to use the tools available to us to prevent transmission of COVID-19, and protect the most vulnerable among us.

Now, evidence shows that being fully vaccinated and boosted is the most effective way to fight COVID-19 and its impacts on our community. This remained true, even during the spread of the Omicron variant, where unvaccinated Americans continue to face a greater risk of severe disease and death than those fully vaccinated. Yet today in the United States, only 69 percent of eligible Americans are fully vaccinated, and just 45 percent have gotten a booster dose.

So I look forward to hearing from our witnesses about the efforts they found successful in encouraging people to get the vaccine and the booster dose because, unfortunately, despite all the available tools, the pandemic continues to substantially strain our Nation's healthcare system.

The pandemic is exacerbating longstanding workforce shortages, capacity issues, and barriers to access for people of color and other under-served communities. As COVID-19 surges caused patients to overwhelm hospitals and medical facilities, healthcare workers have faced both mental and physical challenges. They are experiencing work overload, burnout, and increased anxiety or depression with women, Black, and Hispanic healthcare workers reporting higher stress. And as different variants have emerged, hospital capacity has at times surpassed the number of staff beds available.

So this week, more than 75 percent of ICU beds in hospitals across the United States remain occupied, despite the fact that the Omicron wave has crested. And this strain not only adds to

healthcare workers' burden, but can affect patient care and, potentially, their health.

Capacity constraints, fear of contracting COVID-19, and other barriers to healthcare led to 4 in 10 adults delaying or avoiding medical care in the early days of the pandemic. One in eight adults, and an even higher rate for Black and Hispanic adults, postponed emergency care. And delayed preventative care and diagnosis can lead to chronic, life-threatening illnesses. As the pandemic continues, we must contend with these broader and longer-term impacts on Americans' health.

Fortunately, Congress and the Biden Administration have taken action to support America's healthcare workforce, and protect the health and safety of all Americans. The American Rescue Plan and the CARES Act provided billions of dollars in funding to address worker retention and wellness, and resources for healthcare providers serving children, low-income individuals, and seniors.

And then, last November, this committee passed legislation that would provide support to the healthcare workforce and expand access to important preventative services. The House-passed Build Back Better Act also included key provisions to invest in public health infrastructure and the healthcare workforce.

The Biden Administration has also made hundreds of millions of tests and masks and COVID-19 vaccines and therapies available to Americans at no cost. The President talked even more about what he plans to do in the future last night, and these are critical steps to supporting the Nation's healthcare system and the public's health. But more must be done to ease the burden on healthcare workers, and boost—and booster—and I say also bolster capacity.

So I just wanted to say, Madam Chair, I am grateful for the tireless commitment our Nation's healthcare workers have shown for the last two years, and I look forward to hearing from our witnesses about their experiences on the front lines. Together we can strengthen America's continued response to the COVID-19 crisis.

If I could just say, Chairwoman DeGette, I know that many times you have approached me and talked about how we have to be better prepared. And I know that, even before the pandemic, when it started a couple of years ago, you were talking to me about, you know, long-term preparedness for viruses and other healthcare emergencies. And I appreciate the fact that you and the members of the committee, in general, you know, want us to think about the future.

You know, right now everybody is saying, "Oh, everything is great," right? I mean, it is not. We still have a lot of problems. But more important—and this is what you have always stressed, Diana—we have to think about, you know, the next pandemic, or the next wave. And this is a very important part of this committee's function. So thank you.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Committee on Energy and Commerce

Opening Statement as Prepared for Delivery
of
Chairman Frank Pallone, Jr.

Hearing on “Lessons from the Frontline: COVID-19’s Impact on American Health Care”

March 2, 2022

Today, the Committee will continue our oversight of the ongoing COVID-19 response by hearing from frontline health care workers who have served their communities throughout the pandemic. Their experiences offer valuable insights into our current response and ways we can be better prepared for future public health emergencies.

Nearly four-and-a-half million Americans have been hospitalized due to COVID-19 and more than 930,000 Americans have lost their lives.

No one has been unaffected by the pandemic, though seniors have been particularly vulnerable to the disease and communities of color have faced disproportionate impacts. Essential workers and frontline responders—such as the health care workers joining us today—have faced additional risks and burdens.

Over the last two months, the Omicron variant ripped through our communities, spreading quicker than prior variants. While Omicron appears to have peaked, this experience has shown that we must remain vigilant as new variants emerge.

We must continue to use the tools available to us to prevent transmission of COVID-19 and protect the most vulnerable among us.

Evidence shows that being fully vaccinated and boosted is the most effective way to fight COVID-19 and its impacts on our community. This remained true even during the spread of the Omicron variant, where unvaccinated Americans continued to face a greater risk of severe disease and death than those fully vaccinated.

Yet today in the United States, only 69 percent of eligible Americans are fully vaccinated and just 45 percent have gotten a booster dose. I look forward to hearing from our witnesses about the efforts they’ve found successful in encouraging people to get the vaccine and the booster dose.

Because unfortunately, despite all the available tools, the pandemic continues to substantially strain our nation’s health care system. The pandemic is exacerbating long-standing workforce shortages, capacity issues, and barriers to access for people of color and other underserved communities.

March 2, 2022

Page 2

As COVID-19 surges caused patients to overwhelm hospitals and medical facilities, health care workers have faced both mental and physical challenges. They are experiencing work overload, burnout, and increased anxiety or depression—with women, Black, and Hispanic health care workers reporting higher stressors.

And, as different variants have emerged, hospital capacity has, at times, surpassed the number of staffed beds available. This week, more than 75 percent of ICU beds in hospitals across the United States remain occupied despite the fact that the Omicron wave has crested.

This strain not only adds to health care worker burden but can affect patient care and potentially their health. Capacity constraints, fear of contracting COVID-19, and other barriers to health care led to four in ten adults delaying or avoiding medical care in the early days of the pandemic. One in eight adults—and an even higher rate for Black and Hispanic adults—postponed emergency care.

Delayed preventive care and diagnoses can lead to chronic, life-threatening illnesses. As the pandemic continues, we must contend with these broader and longer-term impacts on Americans' health.

Fortunately, Congress and the Biden Administration have taken action to support America's health care workforce and protect the health and safety of all Americans. The American Rescue Plan and the CARES Act provided billions of dollars in funding to address worker retention and wellness, and resources for health care providers serving children, low-income individuals, and seniors.

Then, last November, this Committee passed legislation that would provide support to the health care workforce and expand access to important preventative services. The House-passed Build Back Better Act also included key provisions to invest in public health infrastructure and the health care workforce.

The Biden Administration has also made hundreds of millions of tests and masks and COVID-19 vaccines and therapies available to Americans at no cost.

These are critical steps to supporting the nation's health care system and the public's health, but more must be done to ease the burden on health care workers and bolster capacity.

I am grateful for the tireless commitment our nation's health care workers have shown for the last two years, and look forward to hearing from our witnesses about their experiences on the frontlines. Together we can strengthen America's continued response to the COVID-19 crisis.

Ms. DEGETTE. I thank the Chair. The Chair now recognizes the ranking member of the full committee, Mrs. Rodgers, for 5 minutes.

**OPENING STATEMENT OF HON. CATHY McMORRIS RODGERS,
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF
WASHINGTON**

Mrs. RODGERS. Thank you, Chair DeGette, Republican Leader Griffith.

We owe it to today's witnesses and all our frontline heroes to listen to them, to understand their perspectives, and to provide solutions. The families who lost loved ones—about 947,000 in the United States—and those who have suffered and sacrificed during the pandemic are owed answers to many questions.

The first question, how did the pandemic start? Republicans on this committee have been leading a comprehensive investigation into the COVID-19 origins, and we continue to urge our colleagues on the other side of the aisle to join us in this pursuit. Understanding how this pandemic started is one of the most important public health questions of our time, and it is necessary to answer, hopefully, to prevent future pandemics.

Second, why weren't we better prepared? The Federal Government could have provided more resources to healthcare responders. For years, the Republicans on this committee have raised concerns about the wisdom of not funding frontline healthcare preparedness, instead of spending more than 80 million a year on the BioWatch program that started in 2004. In a report to the bipartisan leadership on this committee, the GAO found this program doesn't have the science to show that it even works.

We have also raised concerns about relying on China and other foreign countries for critical medical supplies, which we all know we must address.

Third question: Why is CDC mixing politics with science? Lockdowns, distancing, and masking were almost exclusively emphasized by the CDC, while concerns about the effects on mental health and social and economic costs have been ignored. Fortunately, the Trump Administration led public-private efforts to expedite the development of effective vaccines and therapeutics.

The vaccines vastly reduced the risk of death and hospitalization, and now we have data on what many of us have known from the beginning: natural immunity protects robust protection, or provides robust protection. But even with the effect of vaccines and better understanding of who is most at risk, the Biden Administration has continued an unbalanced response, uninformed by these advances. There is far too much fear, and far too much confusion.

The CDC led from behind on the issue of school closures. Several countries in Europe never closed their schools. Some localities in the U.S., and even CDC Director Walensky herself, before she came to CDC, saw no difference in safety between three feet and the CDC-recommended six feet distancing that was keeping schools closed. Yet when her agency put out the school guidance, she required six feet of distance. Why? Because she gave the teachers' union a policy pin.

As a direct result of CDC's guidelines, children have paid a significant price in mental health harms, lagging education, and lost

time for social development. Even when schools were mostly reopened, CDC continued to force masking requirements, even for young children, in a departure from World Health Organization and UNICEF recommendations.

And the CDC continues to rely on discredited studies to force their masking agenda on kids. The CDC is supposed to—suppressed a large study it funded that showed little benefit to masking in schools. It cherry-picked data by highlighting a discredited study, and suppressing another one.

But there is more. The CDC also collected data on vaccine and booster effectiveness, breakthrough infections, and wastewater analysis, but released very little of it. The CDC deprived hospitals and frontline workers of data that would have better informed mitigation and treatment efforts. All of these moves of the CDC have undermined trust in public health when it is needed most.

The fourth question: Why did the Biden Administration take actions that made it harder on frontline healthcare workers?

Many hospitals struggled with staffing shortages, but vaccine mandates may have further worsened the staffing situation at hospitals. During the height of the Omicron surge, the Biden Administration took nearly \$7 billion from the Provider Relief Fund, meant to help hospitals and clinics affected by the pandemic, and used it to buy COVID-19 vaccines and therapeutics. Congress has set aside that money to help providers pay for pandemic-related expenses, including staffing, personal protective equipment, care for the uninsured, and vaccine distribution. This relief was badly needed by rural hospitals that were competing to hire temporary contract staff.

These are just a few of the questions that this committee needs to pursue. We must get answers to ensure the frontline heroes, like all of you, have trust and confidence in public health.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY McMORRIS RODGERS

Republican Leader Cathy McMorris Rodgers
Oversight & Investigations Hearing
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”
March 2, 2022
As Prepared for Delivery

Thank you, Chair DeGette and Republican Leader Griffith.

We owe it to today’s witnesses and all our frontline heroes to listen to them, to understand their perspectives, and to provide solutions.

THEY ARE OWED ANSWERS

The families who lost loved ones – about 947,000 in the U.S. -- and those who suffered and sacrificed during this pandemic--- are owed answers to many questions.

First question: how did this pandemic start?

Republicans on this committee have been leading a comprehensive investigation into the origins of COVID-19 and we continue to urge our Democrat colleagues to join us in our pursuit for the truth.

Understanding how this pandemic started is one of the most important public health questions of our time – and it is necessary to answer to hopefully prevent future pandemics.

BETTER PREPARATION

Second: why weren’t we better prepared?

The federal government could have provided more resources to the healthcare responders.

For years, the Republicans on this committee have raised concerns about the wisdom of not funding frontline healthcare preparedness instead of spending more than \$80 million a year on the BioWatch program that started in 2004.

In a report to the bipartisan leadership of this committee, the GAO found this program doesn't have the science to show that it even works.

We've also raised concerns about relying on China and other foreign countries for critical medical supplies. – which we know we must address.

THE CDC MIXING OF POLITICS WITH SCIENCE

Third question: why is the CDC mixing politics with science?

Lockdowns, distancing, and masking were almost exclusively emphasized by the CDC, while concerns about the effects on mental health and social and economic costs have been ignored.

Fortunately, the Trump administration led public-private efforts to expedite development of effective vaccines and therapeutics.

The vaccines vastly reduce the risk of death and hospitalization AND we now have data on what many of us have known from the beginning – natural immunity provides robust protection.

But even with the effective vaccines and better understanding of who is most at risk, the Biden administration has continued an unbalanced response... uninformed by these advances.

There is FAR too much fear and FAR too much confusion.

CDC – LEADING FROM BEHIND ON SCHOOLS AND MASKING

The CDC led from behind on the issue of school closures.

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Some localities in the U.S., and even CDC Director Walensky herself before she came to the CDC, saw no difference in safety between three feet and the CDC-recommended six feet distancing that was keeping schools closed – yet when her agency put out school guidance, she required six feet of distance.

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As a direct result of CDC's guidance, children have paid a significant price in mental health harms, lagging education, and lost time for social development.

Even when schools were mostly reopened, CDC continued to force masking requirements, even for young children in a departure from the WHO and UNICEF recommendations.

CDC CHERRY PICKING AND WITHHOLDING DATA

And CDC continues to rely on discredited studies to force their masking agenda on kids.

The CDC suppressed a large study it funded that showed little benefit to masking in schools.

It cherry picked data by highlighting a discredited study and suppressing another one.

But there is more to the politics at the CDC.

The CDC has collected data on vaccine and booster effectiveness, breakthrough infections, and wastewater analysis but released very little of it. The CDC deprived hospitals and frontline workers of data that would have better informed mitigation and treatment efforts.

All these moves of the CDC have undermined trust in public trust when it was needed most.

OTHER ACTIONS ALSO MADE IT HARDER

Fourth question: why did the Biden administration take actions that made it harder on frontline health care workers?

Many hospitals struggled with staffing shortages, but vaccine mandates may have further worsened the staffing situation at some hospitals.

During the height of the Omicron surge, the Biden administration took nearly \$7 billion from the Provider Relief Fund meant to help hospitals and clinics affected by the pandemic and used it to buy Covid-19 vaccines and therapeutics.

Congress had set aside that money to help providers pay for pandemic-related expenses including staffing, personal protective equipment, care for uninsured patients, and vaccine distribution.

This relief was badly needed by rural hospitals that were competing to hire temporary contract staff.

These are just a few of the questions that this committee needs to pursue.

We must get answers to ensure the ensure front line heroes like all of you have trust and confidence in your government and public health.

Mrs. RODGERS. Thank you, Madam Chair. I yield back.

Ms. DEGETTE. I thank the gentlelady.

I ask—I now ask unanimous consent that members' written opening statements be made part of the record.

And without objection, so ordered.

I would now like to introduce our witnesses for today's hearing: Dr. Megan Ranney, an emergency physician at Rhode Island Hospital; Tawanda Austin, chief nursing officer at Emory University Hospital Midtown; Dr. Daniel Calac, chief medical officer for the Indian Health Council, Inc.; Dr. Laura E. Riley, obstetrician and gynecologist in chief at New York Presbyterian Hospital, all appearing on Webex. And then in person we have Dr. Lucy McBride, a private practice internist.

I want to thank all of the witnesses for appearing before the subcommittee today.

I know all of you are aware that the committee is holding an investigative hearing. And when we do so, we have the practice of taking testimony under oath. Does anyone have an objection to testifying under oath?

Let the record reflect the witnesses have responded no.

The Chair then advises you, under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Does any of you wish to be accompanied by counsel?

Let the record reflect the witnesses have responded no.

And so would our witness in the room please rise, and everybody else please raise your hand, so you may be sworn in?

[Witnesses sworn.]

Ms. DEGETTE. And let the record reflect that the witnesses have responded affirmatively, and you are now under oath and subject to the penalties set forth in title 18, section 1001 of the United States Code.

Now, at this time, the Chair will recognize each witness for 5 minutes to provide their opening statement.

Before we begin, I would like to explain the lighting system for the witness testifying in person.

That would be you, Dr. McBride. In front of you is a series of lights. The light will initially be green. The light will turn yellow when you have 1-minute remaining, and so start to wrap up at that point. The light will turn red when the time expires.

Now, for the witnesses who are testifying remotely, there is a timer on the screen that counts down to the remaining time.

And so, first of all, I would like to introduce Dr. Ranney for 5 minutes.

Doctor?

STATEMENTS OF MEGAN RANNEY, M.D., M.P.H., EMERGENCY PHYSICIAN, RHODE ISLAND HOSPITAL; TAWANDA AUSTIN, M.S.N., R.N., N.E.-B.C., CHIEF NURSING OFFICER, EMORY UNIVERSITY HOSPITAL MIDTOWN; DANIEL CALAC, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH COUNCIL, INC.; LAURA E. RILEY, M.D.; OBSTETRICIAN AND GYNECOLOGIST-IN-CHIEF; NEW YORK PRESBYTERIAN HOSPITAL; AND LUCY MCBRIDE, M.D., INTERNIST, PRIVATE PRACTICE

STATEMENT OF MEGAN RANNEY, M.D., M.P.H.

Dr. RANNEY. Thank you so much. I appreciate the invitation to testify, Chair Pallone, Ranking Member Rodgers, Madam Chair, and members of the committee.

Monday marks three years since our first COVID case in Rhode Island. I was working in the emergency department that night, and I had continued to work on the frontlines of the COVID-19 response throughout the pandemic. I therefore testify today as a practicing, board-certified emergency physician, public health researcher, academic dean of the School of Public Health at Brown University, and mother of two school-aged children.

Let me start by recognizing that, in so many ways, we are in a better place than we were two months ago, much less two years ago. We have had quick development and rollout of vaccines, therapeutics, and use of masking, testing, and ventilation during surges. Omicron cases are plummeting. But despite this progress, the situation in healthcare facilities has deteriorated to new lows.

Only a few weeks ago, a nurse in charge of my emergency department told me she was ten nurses short for the [inaudible], and therefore forced to reduce services. She said, "I have been begging people to stay all day long, offering double time and double incentives, but the nursing staff is too burnt out."

So today I will highlight challenges ahead, and then propose ways to leverage this fleeting window of opportunity we have to protect the health of America.

I also respectfully ask the members to read my written testimony, which contains many firsthand accounts of the challenges we face.

Let me start by discussing the profound impact of COVID on accelerating staff shortages and hospital overcrowding, particularly in emergency departments, the only place in our system that provides care to all, 24/7/365.

Some have reported that as many as one in five healthcare workers—not just docs and nurses, but home health aides, EMTs, social workers, and more—have left bedside care during the pandemic. These staff shortages are a problem across the Nation, although rural communities are disproportionately hurt.

During COVID surges, due to these shortages, many hospitals have had to resort to extreme measures, calling in the National Guard, shutting down so-called elective procedures to try to save space for true emergencies like strokes and traumas. But even with these steps, we have been unable to care for patients in a timely manner.

One nurse recently told me that every day in the ER feels like she is going before the firing squad due to her inability to provide

adequate care. Surgeons have shared their anguish at watching patients lose vital functions due to delays, which highlights the most significant reason for the staffing shortages: the mental and emotional effect of repeated COVID-19 surges on our healthcare providers. We keep showing up, but our work keeps getting tougher, and there are no reinforcements in sight.

In my own specialty, the proportion of emergency physicians experiencing burnout has increased from 43 to 60 percent during the pandemic. We also report increased

[inaudible] injury, depression, PTSD, and workplace violence. We must fix these core issues to save healthcare.

Second, COVID has exposed weaknesses in our healthcare data information systems. We need good data, timely, accurate, transparent, and complete to make good decisions about what is needed, where, when, and for whom. Thanks to the CARES Act and the ARP, the CDC and HHS temporarily have access to many important data streams, making earlier citizen-led data efforts unnecessary.

But important pieces of data are still missing, things like actual numbers of staff beds in hospitals. Lack of data related to race and ethnicity are particularly glaring. And it is unclear what will happen to even these preliminary data sources, once the public health emergency is over. I and others deeply fear the loss of hard-won data gains.

Third, we have continued problems with the healthcare system's supply chain. Although early PPE shortages have resolved, we face new and worsening problems with key tests, therapeutics, and equipment for both COVID and non-COVID-related care. The life-saving work of folks like myself is heavily affected by these swings in supply. We are forced to substitute one preferred medication or treatment for another, and sometimes there is no substitute. This directly hurts patients.

Finally, the increasing politicization, misinformation, and public mistrust around COVID has had a deep impact on healthcare workers, public health, and the quality of care provided. Three-quarters of healthcare workers say that misinformation has negatively influenced both patients' decisions to get vaccinated and patient care.

But all of this can be fixed. As Americans, we have a long history of transforming public health crisis into opportunity. In my written testimony I provide specific examples. Some were highlighted by President Biden last night, including systemic fixes to the healthcare delivery system; support for healthcare workers; investing in training and retaining all types of healthcare workers; treating the medical supply chain not as any other part of the U.S. economy, but rather as a concern of national security and health; and finally, rebuilding trust.

In close, every American wants to be able to show up in an emergency department and get timely, appropriate care for their emergency. Right now they can't. Throughout the pandemic we have relied too heavily on stopgap solutions, instead of addressing the underlying issues. I urge you, please think bigger and do more.

Thank you for your time.

[The prepared statement of Dr. Ranney follows:]

[The prepared statement of appears at the conclusion of the hearing.]

Ms. DEGETTE. Thank you so much, Doctor.

I am now pleased to recognize Ms. Austin for 5 minutes.

STATEMENT OF TAWANDA AUSTIN, M.S.N., R.N., N.E.B.C.

Ms. AUSTIN. Good morning, Subcommittee Chairwoman Diana DeGette, Subcommittee Ranking Member Morgan Griffith, members of the committee, and my fellow witnesses. Thank you for inviting me to participate in today's hearing. The views that I express today are my own views, and do not necessarily reflect the views of my employer.

My name is Tawanda Austin, and I serve as the chief nursing officer and vice president of patient care services at Emory University Hospital Midtown. I have been a nurse for over 20 years, and the COVID-19 pandemic presented the biggest challenge to the healthcare workforce in decades. Today I am going to talk about the multi-year mental and physical strain on nurses, hospital capacity challenges, and the worsening workforce shortage that Congress must address.

I recall rounding in our COVID ICU at the end of 2020, and I will never forget the exhaustion and despair that I saw on the nurses' faces. This is an ICU team that are innovators, and they are highly engaged, a team that proudly received a third Beacon Award during the pandemic. So it was not customary to see them look so defeated. As I walked around getting a pulse check on the nurses, one nurse says to me, "Walk with me. I want to show you something."

She took me to four patients' rooms. We stood on the outside of each of those rooms, peering through the glass windows, as she explained to me how severely ill each of those patients were, and she outlined the numerous medications and complex therapies they each were receiving. She paused and said, in her best clinical estimation, that not a single one of those patients would survive.

I believe her mission was purposeful. She wanted me to experience in just those few minutes what it was like to be on the front line, how devastating it was to do everything possible to save a patient's life, only to lose them in the end. I remember feeling deflated because, as a leader, it is my duty to support, to help find solutions to problems, to offer comfort when it is needed. But I didn't feel that that was enough in that moment.

As I continued to make rounds in the ICU, I stopped to check on another nurse, who appeared to be the most exhausted of all the nurses that I had encountered that day, and I asked how she was doing. She explained to me that she was caring for two patients that day, although one really required intensive one-to-one care. She was extremely overwhelmed, and stretched too thin. She had spent most of her day in this one patient's room, and had not been able to check in on the other patient as often as she wanted. On this day, like many others, the unit was short-staffed. But fortunately, the nurse in charge was able to support her with the care of her second patient.

These are just a few of the all-too-common stories that have emerged from hospitals during the COVID-19 pandemic. I share

these stories with you today because they illustrate the incredible pressure on our staff, who have been caring for COVID patients for nearly 750 days.

In addition to the physical strain, there is the mental stress that is plaguing our workforce. The morale of nurses has declined over time, as they continue to care for patients who are extremely ill and who are suffering and dying.

Additionally, nurses have shared stories of being verbally attacked for implementing COVID-19 safety restrictions. Patients' families have become frustrated and distressed, taking their emotions out on nurses, and workplace violence is at an all-time high.

The COVID-19 pandemic has tested the capacity of all hospitals. We are facing extremely long wait times in our emergency departments. And at the beginning of COVID, Emory paused our elective procedures, and providers were redistributed to our COVID units to support testing and to support our vaccine clinics. But now that we are back at regular operations, we again feel the immense shortage of nurses.

Early in the pandemic we saw nurses leave. Now we are experiencing additional staffing issues, as support staff have also fled the industry, adding to the nurses' daily burden. While we face challenges, Emory nurses have stepped up. The COVID-19 pandemic forced our nurses to find new and innovative solutions to the challenges brought on by this public health crisis. Emory nurses placed baby monitors in the COVID rooms, and this allowed them an additional way to communicate with patients quickly, and make patients feel less isolated. It also saved on PPE, by consolidating the nurse's visits into the room. So instead of donning PPE to go in and hear the patient's request, the nurses received the request over the baby monitor, and entered the room once to deliver the needed care.

As we emerge from this pandemic, various lessons can be learned from the experiences of healthcare professionals.

First, we need a far more robust workforce to combat burnout and overall shortage of providers. I urge Congress to fund pathways for more young people to enter the nursing field, and programs to retain our staff.

Second, we need to address issues surrounding travel nursing agencies. While these businesses offer the chance for hospitals to bolster their workforce during surges, their costs have risen to unsustainable levels. Congress should take action so that hospitals remain financially viable, and avoid the risk of having to reduce services or, even worse, avoid the risk of shutting their doors.

Finally, I urge Congress to take a deeper look into the rising trend of violence toward healthcare workers, and find steps to mitigate this trend.

I look forward to your questions. Thank you.

[The prepared statement of Ms. Austin follows:]

**Congressional Testimony of Tawanda Austin for the Energy and Commerce's
Subcommittee on Oversight and Investigations "Lessons from the Frontline:
COVID-19's Impact on American Health Care"**

Good morning, Subcommittee Chairwoman Diana DeGette, Subcommittee Ranking Member Morgan Griffith, members of the Committee, and my fellow witnesses. Thank you for inviting me to participate in today's hearing.

My name is Tawanda Austin, and I currently serve as the Chief Nursing Officer and Vice President of Patient Care Services at Emory University Hospital Midtown. I began my nursing career with Emory Healthcare back in 1999 and have held numerous roles within the Emory Healthcare system.

As my role with Emory has grown and evolved, I have seen the various problems that members of the healthcare community face. While there had been issues within our workforce long before the COVID-19 pandemic, the public health crisis brought new light to these glaring faults. COVID-19 presented the biggest challenge to the healthcare workforce in decades. Nurses, doctors, and other providers have felt an impact on both their mental and physical health for nearly two years, as this crisis has dragged on.

Today, I'm going to talk about the mental and physical strain on nurses, hospital capacity challenges, and the worsening workforce shortage that Congress must address.

I remember rounding in our COVID ICU around the end of the first year of the COVID-19 pandemic, and I will never forget the exhaustion and despair that I saw on many of the nurses' faces. This is an ICU team that is constantly innovating. A team that has a highly engaged leader and highly engaged care team members. And a team that proudly

received a third Beacon Award during the pandemic, so it was not customary to see this team look so defeated.

As I walked around getting a pulse check on the nurses, one of the nurses on the unit said, “walk with me. I want to show you something.” She gave me a tour around various ICU rooms until we had visited about four patients’ rooms. We stood on the outside of the rooms peering through the glass window of each one, and she told me how severely ill they were. She paused and told me that, in her best clinical estimation, not a single one of these four patients would survive.

I believe her mission was purposeful. She wanted me to experience what it was like on the frontlines for just those few minutes. I remember feeling deflated. As a leader, it’s my duty to support and to help find solutions to problems, but I had very little to offer at that moment.

As I continued to make my rounds, I stopped to check in on another nurse sitting at a computer, appearing to be the most exhausted of all the nurses I encountered in the ICU that day. I stood on the other side of the desk, immediately across from her, and asked how she was doing. She explained that she was caring for two patients that day, although one required intensive one-on-one care. She was extremely disappointed that, due to staffing shortages, she was stretched too thin. She had spent most of her day in this one patient’s room and had not been able to check in on her other patient as much as she had liked to. Fortunately, on this day, the charge nurse was able to support the care of her second patient.

These are just a few of the all-too-common stories that emerged from hospitals during the COVID-19 pandemic. I share these stories with you today because they illustrate the incredible pressure on our staff – and this is just one of the surges that has affected our hospital over the last

two years. Nurses work incredibly long hours dealing with overwhelming waves of patients coming through the door. Despite the frequency of these extended shifts, many nurses continue to pick up extra rotations to help their colleagues who may not be able to work.

In addition to the crushing workload, nurses are under additional strain due to the complex care that treating patients with COVID-19 requires. Often this care requires one-on-one support, which is difficult to provide when you are tired and short-staffed.

The pandemic has also forced our nurses to wear personal protective equipment (PPE) that is cumbersome to put on and take off, especially when done multiple times a day. As a result of PPE, many caregivers have complained of overheating or being uncomfortable due to the additional restrictions PPE places on their ability to move and adequately breathe.

In addition to the physical strain, there is the mental stress that is plaguing our workforce. As we deal with patients becoming sicker and dying, we see nurses' morale suffer. Additionally, at times patients' families have become frustrated and distressed, taking their emotions out on our employees.

Nurses have shared stories of being verbally attacked for implementing COVID-19 safety restrictions. Families are not the only ones suffering from the limitations brought on by social distancing. As nurses, our roles are not only to care for patients but educate them and their families on how to take care of themselves. The social distancing guidelines have forced us to interact with patients and their families through virtual means, which is far less personal. Finally, our nurses had their own families to worry about. Many expressed fear that they could infect their loved ones with the virus and chose to isolate themselves in their own homes.

The COVID-19 pandemic has tested the capacity of all hospitals. We are facing extremely long emergency department wait times. This creates significant safety risks for patients and may lead to bad outcomes. Doctors and nurses have shared that the demands of patient care have increased from pre-pandemic times. Patients are sicker and require more time and resources from caregivers. Compounding this issue, we don't have the staff to deal with surges of patients. We paused elective procedures early in the pandemic, and providers were redistributed to support COVID units. Now that these operations have resumed, we again feel the immense shortage of nurses. Earlier on in the pandemic, we began to see nurses leave. Now we are experiencing additional staffing issues as support staff have also fled the industry.

While we have faced challenges, Emory nurses have stepped up. The COVID-19 pandemic forced our nursing workforce to find new and innovative solutions to the challenges brought on by this public health crisis. Our nurses found creative ways to save PPE while keeping staff safe.

During the early months of the pandemic, nurses at Emory hospitals placed baby monitors in the rooms of COVID-positive patients. This allowed healthcare staff and loved ones an additional way to communicate with patients while avoiding direct exposure to the virus. The baby monitors allowed for patient interaction without using precious PPE. This serves as another example of how frontline workers adapted to the pandemic's problems.

As we emerge from this pandemic, various lessons can be learned from the experiences of our healthcare professionals. First, we need a far more robust workforce to combat burnout and the overall shortage of providers. I urge Congress to fund pathways for more young people to enter the medical and nursing fields.

Second, we need to address issues surrounding travel-nursing agencies. While these businesses offer the chance for hospitals to bolster their workforce during times of surging patient loads, they have benefited from unprecedented profits during the COVID-19 pandemic. I urge Congress to take action to help rein in the predatory practices of these agencies so that America's hospitals remain financially viable and aren't at risk of having to reduce services, or even worse, at risk of shutting their doors.

I look forward to your questions. Thank you.

Ms. DEGETTE. Thank you so much.
Dr. Calac, now I recognize you for 5 minutes.

STATEMENT OF DANIEL CALAC, M.D.

Dr. CALAC. Good day to Chairwoman DeGette, Chair Congressman Pallone, Congressman Rodgers, and Republican Leader Griffith. Thank you so much. My thanks to all the healthcare workers' hard work over the last two years.

The testimony provided today is not necessarily reflective of my corporation. I would like to provide a brief description of the effect and response to COVID during the period of March 2020 to 2022, January.

So the context of this response is based in the Southern California area. My primary role at the facility is chief medical officer at this facility for the past 19 years. I serve as the primary care provider for the panel of patients that services nine American Indian tribes in these areas.

We currently operate out of a 30,000-square-foot facility that is located approximately 40 miles northeast of San Diego. There is an additional 12,000-square-foot facility about 25 additional miles from the main site, in the mountainous areas. We provide a multidisciplinary, ambulatory care facility that provides care to approximately 20,000 American Indian clients in the surrounding area. However, about 5,000 of those are active patients.

The organization provides multiple disciplines, including internal medicine, family practice, pediatrics, general dentistry, behavioral health, public health outreach. We also provide additional subspecialties, including orthodontics, endodontics, orthopedics, acupuncture, optometry, OB/GYN, substance use disorder management, marriage and family therapy, pharmacy services, and podiatry.

The organization also contracts with outside agencies that are in neighboring cities 20 or 30 miles away.

I provide care, as a primary care physician, as I mentioned, in internal medicine. I am also pediatrician-trained, and also provide hospice care services to our community.

So our COVID response in that time is spread over the northern half of San Diego County. And so, just for references, the area covers about 10,000 square miles. Of note, the southern California area is home to over 30 different tribal entities with different cultures, different dialects, and, hence, the need to be culturally appropriate in these types of primary care delivery. One can, obviously, see the issues regarding delivering COVID-sensitive response care to these communities.

In this setting a pandemic has not been seen to this magnitude since the early 1900's. In a community where the average lifespan is 10 to 15 years less than the average American, the tribes in the surrounding area were required to mount a response that was replete with challenges, including dealing with the geographic diversity, the economic issues that have been persistent over the past 100 years.

Considering the limited resources from which to work, the tribes provided a boots-on-the-ground workforce by—and spreading information by word of mouth, fliers, social media, when appropriate.

It is important to acknowledge that, in the area that I work, only half of the tribes have access to the—to internet or any type of significant social media because of the geographic diversity and the limits of providing telehealth in these areas.

Additionally, challenges exacerbated by health literacy makes receiving, processing, and disseminating true and accurate information a monumental challenge, especially in our older demographics, 60 to 70 years of age.

From a corporate standpoint, we managed to provide a unified approach, despite the closure of our internal services. The services that we provided, including preventive health services, were deferred because of the limitations of providing access in-house. We were required to provide most of our service out in a setting that consisted of our parking lot.

So I wanted to leave the committee with recommendations on this experience, and recommending a persistent and consistent outlook and perspective, and continued funding in dealing with the issues of long-term COVID, and the effects of COVID in communities such as the rural one that I serve, looking at providing additional perspectives in infrastructure on telehealth for the delivery of healthcare to these outlying communities, and especially to look at the effects the pandemic has had on the pediatric population, in terms of delayed delivery of healthcare services, the issues of specialty services for the community, and also to address workplace shortages that persist in the communities that are served by Indian Health Services under Health and Human Services. Thank you.

[The prepared statement of Dr. Calac follows:]

House Energy and Commerce Oversight and Investigations Subcommittee
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”

Testimony

Daniel J. Calac, MD

Chief Medical Officer

Indian Health Council

Pauma Band of Luiseno Indians

The following is a brief description of the effect and response to COVID during the period of March 2020 to January 2022. The context of this response is based in the Southern California area. My primary role at the facility is the Chief Medical Officer at this facility for the past 19 years. I serve as the primary care provider for a panel of patients that services 9 American Indian tribes. The 50,000 square foot facility is located approximately 40 miles northeast of San Diego. There is an additional 12,000 square foot facility that is an 25 additional miles that services tribes in those areas. The organization is a multidisciplinary ambulatory care facility that provides care to approximately 20,000 clients in the surrounding area. Approximately 5000 of these American Indian clients are active patients meaning that they have had a visit in the last 18 months for one of the services at the facilities. The organization provides multiple disciplines including Internal Medicine, Family Practice, Pediatrics, General Dentistry, Behavioral Health guidance, and Public Health Outreach. Additional specialty services include orthodontics, endodontics orthopedics, acupuncture, chiropractic, optometry, obstetric/gynecology, substance use disorder mgt, marriage/family therapy, pharmacy services, and podiatry. The organization also contracts for specialty services in neighboring cities that are approximately 20-30 miles away.

- I. COVID Response
 - a. Community- The community that is serviced by the organization is spread over ¼ of Northern San Diego County. From the Pacific Ocean to the Salton Sea (118 miles) and ¼ the distance from the Salton Sea to the Mexico border (180 miles), the service area for the clinic is just under 10,000 square miles. Of note, California is home to over 110 American Indian tribes and the region south of Los Angeles has the most American Indian tribes per capita across the United States. Although other areas have more individuals in mass, the concentration of differing dialects and cultures in the San Diego county area is unique to this region.
 In is in this setting that the community must respond to a pandemic not seen since the beginning to the 1900s. In a community where the average life span is 10-15 years less than the average American, the tribes from Indian Health Council’s service area were required to mount a response replete with challenges that have been exacerbated by decades of underfunding by Health and Human Services in partner with Indian Health Service. According to the NIHB recent analysis for Indian Health Service budget, requests for FY 2020 for 7 billion and phasing in an additional 36 billion over 12 years to

support shortfalls in providing comparable health care for American Indian tribes over the 12 Service sites across the US.

Considering the limited resources from which to work, tribes provided a cogent “boots-on-the-ground” approach by spreading word by traditional means of word of mouth, flyers, and social media. It is important to acknowledge that due to the geographic variation in Southern California, internet services are only available to ½ of the tribes in Indian Health Council’s Service area. Additionally, the challenge of health literacy further makes receiving, processing and disseminating true and accurate information a monumental challenge; especially if you are over 50 years of age. This is not to discredit the analytical capacity of tribes, but as we have seen in the last 2 yrs, misinformation can have a powerful effect on communities; especially those with large health disparities.

- b. Corporate – Effectively managing a pandemic is not in a typical job description though it should be for American Indian tribes and the staff that support the health care facilities that provide care to these communities. Ravaged by fires in 2003 (Cedar Fire), in 2007 (Witch Creek Fire), and 2014 San Diego County fires, Indian Health Council is adept at coordinating Emergency Response Actions due to these experiences. In response to yet another emergency, the Pandemic initiated Incident Command Team (ICT) immediate activation and spawned events producing effective and redundant failsafe interventions that provided staff and the partnering tribes a strong mechanism for communication and health care delivery. Examples include regular telephone communications with Tribal Councils. This was coupled with regular emails from the CEO that provided fresh and up to date detail on hours, testing, vaccine access, and available services. The ICT provided regular and culturally appropriate posts on social media aimed at population segments at most risk. Videos, live Web Casts, and Instagram accounts were posted and shared by staff and subscribers to make the audience aware of any and all changes. Lastly, the Governance Board led by 2 representatives from each consortia tribe provided sage guidance and direction as voices for the community.
- c. Cultural – The tribes in these areas have thrived for tens of thousands of years. They have survived fires, drought, rain torrents, plague, invasion and contemporary persecution. This is a credit to their resilience as a people and the bond they share in their culture. The pandemic has ravaged the world and its heaviest effects have been felt in under represented communities with little to now depth in their age demographics. When documenting the number of elders over 60 years of age who have been vaccinated, it is thrilling to see that those numbers reached peaks of 80-90 percent. This is based on the context that in some of those age groups there were only 20-30 people over 60-69, and 70-79 years of age. Coupled with high levels of morbidity due to limited access to health care, low health literacy, and limited access to transportation, the death of these persons providing care to young children, guiding the very board that governs the health facility and providing guidance to the tribal governments themselves manifests as a heavy burden to carry.

- II. Effect on Children – Having served as the Chief Medical Officer and resident Pediatrician for the clinic, it has been a privilege to guide these young people over the past two decades. I am not shamed by confessing that since 2003 when I began at Indian Health Council, that I have been whispering in those young ears that they should become physicians. These are the same children that I have seen born, attend kindergarten and then off to college. COVID has yet to determine the full effects on this group. Whether long terms risks for pulmonary disease/asthma, unknown complications from MIS-C, or the effects of increased ACE (Adverse Childhood Event) scores, the pandemic will certainly be remembered by those over 5 as when their grandparent died or when their young father died.

- III. Long Term Effects on American Indian Community – Recognizing the protracted effects on the psyche is an important touchstone to recognize. The intergenerational trauma that has persisted over the last five hundred years is punctuated by the significant “blip” of the pandemic. By no means is the pandemic insignificant and to be sure that the lives lost and those affected are no less important than those American Indian lives lost and affected, but in a community devastated like the AI/AN community, there is an important lesson to be taught. In this testimony, I want the remembrance of those lost and affected not to be a “blip”, but a turning point with an opportunity to make an effective and long lasting change for a people that have suffered long enough.

Ms. DEGETTE. Thank you so much, Doctor.
 Dr. Riley, I am now recognizing you for 5 minutes.

STATEMENT OF LAURA E. RILEY, M.D.

Dr. RILEY. Thank you, Chairs DeGette, Pallone, and Ranking Members for inviting me to speak with you today. My name is Dr. Laura Riley, and I am an obstetrician, gynecologist in chief at New York Presbyterian Hospital/Weill Cornell Medicine.

As a maternal fetal medicine specialist and expert on obstetric infectious disease, I have dedicated my career to ensuring patients have healthy pregnancies. I am a member of the advisory committee on immunization practices workgroup on COVID vaccines, and I currently serve as the chair of the American College of Obstetricians and Gynecologists' immunization, infectious disease, and public health preparedness expert workgroup.

While many of my colleagues in other specialties were forced to delay non-emergency services during COVID surges, our labor and delivery unit remained operational at full speed, caring at great personal risk for our laboring patients.

The ongoing pandemic has placed an incredible strain on our healthcare system and its workforce. Many labor and delivery units, including my own, are struggling with these mounting shortages. Obstetrics is practiced in a team. And when members of the team are missing, that can negatively impact patient care.

While there is no one solution to these workforce challenges, greater investment in and training of healthcare professionals, from physicians and nurses to technicians, as well as efforts to diversify our healthcare workforce, are absolutely critical.

The early days of the pandemic were a time of extreme anxiety and confusion, especially for our pregnant patients. Many were left wondering if they should attend their prenatal appointments, and if it was safe to deliver at the hospital. During that time it was essential to reiterate to my patients that it was safe to deliver, and that their entire maternity team is committed to making sure that they get the support they need to birth confidently, safely, and respectfully.

One of the most important healthcare system shifts during the pandemic was to increase the utilization and coverage of telemedicine. Remote visits have become an expectation of patients, and I strongly urge their continued coverage, including extending flexibilities such as audio-only to meet patient needs.

Additionally, an ongoing and urgent concern is our health system's failing of historically marginalized communities, who are disproportionately impacted by the pandemic. A key lesson learned is that equity must be a focus of pandemic preparedness and response.

The impact of COVID-19 on the patients I serve is significant and ongoing. When the pandemic first began, we worried, based on our experience with flu, that COVID-19 may be worse in pregnant individuals. Those fears were confirmed, as we found that they are at increased risk of severe illness and death. Despite this evidence, and urgent calls from the medical community, pregnant and lac-

tating individuals were initially excluded from COVID-19 vaccine trials, and continue to be excluded from therapeutic trials. That meant that, when the vaccines became available, we had very little data on their safety in pregnancy, resulting in confusion and fueling misinformation.

While ACOG and the CDC were finally able to make an affirmative recommendation for vaccination during pregnancy last summer, the long delay contributed to low vaccination rates among pregnant individuals and the rise of adverse outcomes.

The COVID-19 pandemic is exacerbating the maternal mortality crisis. In September 2021, the CDC released an advisory following the record-breaking COVID-19-related deaths among pregnant individuals in a single month. Of note, their primary recommendation was to increase efforts to protect pregnant and lactating individuals through accelerated vaccine—vaccination effort. Unfortunately, vaccine hesitancy remains today, and I continue to counsel my unvaccinated pregnant patients on the vaccine's protection of their health and their newborn's health.

These routine exclusions of pregnant and lactating individuals from research, presumably for their protection, leaves them disproportionately vulnerable, and may have, in this instance, contributed to avoidable loss of life. As we reflect on the pandemic and lessons learned, it is past time to shift the narrative on research in this population. Instead of protecting them from research, we should be protecting them through research.

Thank you for the opportunity to share my experiences and expertise with you today. I look forward to your questions.

[The prepared statement of Dr. Riley follows:]

41

WRITTEN TESTIMONY OF

LAURA E. RILEY, MD, FACOG

BEFORE THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

REGARDING THE HEARING

LESSONS FROM THE FRONTLINE: COVID-19'S IMPACT ON AMERICAN HEALTH CARE

MARCH 2, 2022

Chair Pallone, Chair DeGette, Ranking Member McMorris Rodgers, Ranking Member Griffith, and Members of the House Energy and Commerce Subcommittee on Oversight and Investigations, thank you for inviting me to speak with you today at this important hearing entitled “Lessons from the Frontline: COVID-19’s Impact on American Health Care.” It is an honor to be here today to testify and discuss the deep impact of the pandemic on obstetrician-gynecologists, the systems in which we work, and the patients we serve.

My name is Dr. Laura Riley and I am the Obstetrician and Gynecologist-in-Chief at New York-Presbyterian/Weill Cornell Medical Center and Chair of the Department of Obstetrics and Gynecology at Weill Cornell Medicine. As a maternal-fetal medicine specialist, expert on obstetric infectious disease, and a physician-researcher, I have dedicated my career of more than 30 years to ensuring patients have healthy pregnancies, especially those whose pregnancies are high-risk because of chronic illness or infectious disease. I am also a member of the Advisory Committee on Immunization Practices’ workgroup on COVID vaccines as well as the COVID vaccine safety technical work group at the Centers for Disease Control and Prevention (CDC). I have worked extensively with the CDC to develop practice guidelines for pregnancy care for those with Group B strep, Ebola, Zika, H1N1, influenza, and COVID-19. I currently serve as the chair of the American College of Obstetricians and Gynecologists’ (ACOG) Immunization, Infectious Disease, and Public Health Preparedness Expert Work Group and am a member of ACOG’s COVID-19 Expert Work Group, where I coauthored ACOG’s clinical guidance on care for patients with COVID-19 and COVID-19 vaccine considerations for obstetric and gynecologic patients.ⁱ

My testimony will focus on three main areas, through the lens of obstetrics and gynecology: the impact of the pandemic on the health care workforce, the impact on systems of care, and the impact on the patients we serve.

Impact on the Health Care Workforce

Obstetrician-gynecologists are on the frontline of this pandemic. While many of my colleagues in other specialties were forced to delay preventive and non-emergent services during COVID-19 surges, our labor and delivery unit remained operational at full speed, caring for our laboring patients for whom care cannot be delayed. Early in the pandemic, when we knew very little about COVID-19 infection and experienced shortages of personal protective equipment meant that we worked at great personal risk.

The strain that this ongoing pandemic has placed on our already stressed health care system – and its workforce – cannot be overstated. According to the Association of American Medical Colleges, the pandemic is exacerbating workforce shortages, as physician labor supply is impacted by the “morbidity, mortality, and stress caused by COVID-19, both directly and indirectly.”ⁱⁱ These strains are, as in the general population, felt most acutely by people of color and women physicians, who bear a disproportionate amount of childcare burdens.ⁱⁱⁱ As a specialty that is now majority female, the field of obstetrics and gynecology has been particularly impacted.

The COVID-19 pandemic has revealed and intensified pre-existing workforce challenges. Many labor and delivery units, including my own, are struggling with the mounting health care workforce shortage, particularly among our nursing colleagues and technicians. Obstetrics is practiced in a team-based care model, with each team member playing an important role and bringing their own expertise, to optimize clinical outcomes and enhance the patient experience.^{iv} When staffing levels drop, and members of the team are missing, that can have a negative impact on patient care. These stressors are being felt across the board, from urban academic medical centers to critical access hospitals in rural communities. While there is no one solution to these workforce challenges, greater investment in and training of health care professionals, and efforts to diversify our health care workforce, are critical.

One aspect of the pandemic response that has given me hope for the health care workforce is the coordinated effort behind the safe development of the vaccines, as well as the policies of many health care institutions to require vaccination of health care workers in order to help ensure that those life-saving vaccines are deployed. When the vaccines first became available to health care workers, the collective sigh of relief was palpable among my colleagues. Having contracted the COVID-19 virus myself early in the pandemic, and continuing to serve patients once I recovered, I was personally grateful to receive the vaccine and do my part to keep my patients, colleagues, and family safe.

Finally, I would be remiss if I didn't also mention the mental health impact of the pandemic on the health care workforce. Recent surveys on physician burnout are incredibly alarming, with 20 percent of respondents reporting depression and 13 percent reporting suicidal thoughts.^v This issue is not new, but it has been dramatically worsened by the pandemic and the current trend of anti-science, anti-medicine vaccine opposition, and it must be urgently addressed. I appreciate that the Energy and Commerce Committee recognized this urgency when it advanced the Dr. Lorna Breen Health Care Provider Protection Act and I am relieved that the bill is to be signed into law. It will save lives.

Impact on the Health Care System

The early days of the pandemic were a time of extreme anxiety and confusion for many of us, and especially our pregnant patients who were preparing to give birth. As the media was reporting on intensive care units (ICUs) with no available beds and overburdened emergency departments, many of our pregnant patients were left wondering if they should still attend their prenatal care appointments, if it was safe to deliver at the hospital, and if their hospital even had space for them.

Part of my work as a member of ACOG's COVID-19 Expert Work Group was to help develop guidance for obstetrician-gynecologists and other health professionals caring for pregnant and lactating patients. Practicing in what was an early COVID-19 "hot spot," I know my patients felt the uncertainty around safe access to care particularly acutely. Especially during those early days, and during subsequent COVID-19 surges, it was essential to reiterate to my patients that their entire maternity care team is committed to making sure they get the support they need to birth confidently, safely and respectfully.^{vi}

One of the most important health care system shifts during the pandemic was to increase the utilization – and health insurance coverage – of telemedicine. Increased access to telemedicine has enabled my patients, especially those who are low income or are the primary caretakers of their children, to access the care they need without having to find childcare or make arrangements to travel to in-person appointments. Remote visits have become an expectation of patients, and I strongly urge its continued coverage, including extending flexibilities that enable utilization of the most appropriate modality of care, which in some cases may be audio-only, to meet patient needs.

Finally, an ongoing and urgent concern is our health system's failing of historically marginalized communities, who experience disproportionate rates of COVID-19 infection, severe morbidity and mortality, and have persistently lower COVID-19 vaccination rates. Social determinants of health, current and historic inequities in access to health care and other resources, and structural racism and the resultant distrust of the medical system, contribute to these disparate outcomes.^{vii} A key lesson learned from the pandemic should be the need to center equity concerns in all of our pandemic decision-making. For instance, it is critical that protocols and policies for testing, visitation, triage, treatment, vaccine distribution, and resource allocation are intentionally reaching and meeting the needs of historically marginalized communities, and that policies and processes designed to mitigate virus transmission are closely monitored to ensure that their implementation does not worsen inequities.^{viii}

Impact on Patients

As a specialist in high-risk pregnancy and infectious disease, I can say unequivocally that the impact of the COVID-19 pandemic on the patients I serve is significant and ongoing. When the pandemic first began, and we knew very little about the virus, we worried – based on our experience with other viruses like flu – that COVID-19 may be worse in pregnant individuals. Those fears were confirmed as we began to collect and report data, finding that pregnant individuals are at increased risk of severe illness, including ICU admission, mechanical ventilation, and extracorporeal membrane oxygenation, and death from COVID-19 infection.^{ix}

Despite the growing body of evidence that pregnant individuals are at increased risk for adverse outcomes, and urgent calls from the medical and public health community, pregnant and lactating individuals were and continue to be excluded from COVID-19 vaccine and therapeutic trials.^x That exclusion meant that when the vaccines became available, we had very little data on their safety in pregnancy, resulting in an initial permissive recommendation from ACOG, the Society for Maternal-Fetal Medicine (SMFM), and the CDC that pregnant individuals should have access to the vaccines and not be denied vaccination. This led to confusion among patients and clinicians and fueled the proliferation of misinformation on the safety of the vaccines in pregnancy. While ACOG and SMFM, and subsequently the CDC, were finally able to make an affirmative recommendation for vaccination during pregnancy in July and August of 2021, respectively, the long delay contributed to persistently low vaccination rates among pregnant individuals and the rise of adverse outcomes. Finally, the lack of inclusion of pregnant and lactating individuals in clinical trials for COVID-19 therapeutics once again leaves pregnant patients and their clinicians with unanswered questions around safety and efficacy of medical interventions, and puts our patients at a further disadvantage, limiting their access to potentially life-saving treatment.

The United States is in the midst of a maternal mortality crisis that, according to data released by the CDC last week, continues to be on the rise, and disproportionately impacts Black and Indigenous birthing people.^{xli,xlii} The COVID-19 pandemic is exacerbating this crisis, leading the CDC to release a health advisory in September 2021 following the recording of the highest number of COVID-19-related deaths among pregnant individuals in a single month.^{xlii} Of note, the primary recommendation in the CDC health advisory was to increase efforts to protect pregnant and lactating individuals through accelerated vaccination efforts, consistent with the strong medical consensus of the nation's leading organizations representing maternal and public health experts.^{xiv} Unfortunately, vaccine hesitancy among pregnant and lactating individuals remains today and I continue to routinely counsel my unvaccinated pregnant patients on the science and evidence behind the COVID-19 vaccines, dispelling disproven myths and sharing the growing body of data confirming the safety and efficacy of the vaccines to protect their health and their newborns' health.^{xv,xvi}

These routine exclusions of pregnant and lactating individuals from research, presumably for their protection, leaves them disproportionately vulnerable and may have in this instance contributed to avoidable loss of life. As we reflect on the pandemic and lessons learned, one that I hope we come away with is that it is past time to shift the narrative on research in pregnant and lactating individuals: instead of protecting them *from* research, we should be protecting them *through* research.^{xvii} Specifically, federal agencies should prioritize the safe inclusion of pregnant and lactating individuals in the development of vaccines and therapeutics and ensure that industry includes this population in their study plans from the outset.

Thank you for the opportunity to share my experiences and expertise with you today as you evaluate the impact of the COVID-19 pandemic on American health care and consider lessons learned from the

frontline. I hope you will consider me a trusted resource as the Subcommittee continues its important work in this area.

ⁱ Practice Advisory: COVID-19 Vaccination Considerations for Obstetric–Gynecologic Care. American College of Obstetricians and Gynecologists. December 2020 (last updated February 8, 2022). Available at <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care>.

ⁱⁱ IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: AAMC; 2021. Available at <https://www.aamc.org/media/54681/download?attachment>.

ⁱⁱⁱ Ibid.

^{iv} Executive summary: Collaboration in practice: implementing team-based care. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:612-7.

^v Kane L. ‘Death by 1000 Cuts’: Medscape National Physician Burnout & Suicide Report 2021. Medscape. January 2021. Available at <https://www.medscape.com/slideshow/2021-lifestyle-burnout-6013456#1>.

^{vi} Patient-Centered Care for Pregnant Patients During the COVID-19 Pandemic. American College of Obstetricians and Gynecologists. March 30, 2020. Available at <https://www.acog.org/news/news-releases/2020/03/patient-centered-care-for-pregnant-patients-during-the-covid-19-pandemic>.

^{vii} Position Statement: Addressing Health Equity During the COVID-19 Pandemic. American College of Obstetricians and Gynecologists. May 11, 2020. Available at <https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2020/addressing-health-equity-during-the-covid-19-pandemic>.

^{viii} Ibid.

^{ix} Zambrano LD, Ellington S, Strid P, et al. Update: Characteristics of Symptomatic Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–October 3, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1641–1647. DOI: <http://dx.doi.org/10.15585/mmwr.mm6944e3>.

^x Letter from the Coalition to Advance Maternal Therapeutics to the National Institutes of Health and Food and Drug Administration. March 18, 2020. Available at <https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/letters/letter-to-nih-and-fda-on-covid-19-camt.pdf?la=en&hash=696162B7BEC34A9F3998E3AE2CE99F93>.

^{xi} Hoyert DL. Maternal mortality rates in the United States, 2020. *NCHS Health E-Stats*. 2022. DOI: <https://dx.doi.org/10.15620/cdc.113967>.

^{xii} Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: <http://dx.doi.org/10.15585/mmwr.mm6835a3>.

^{xiii} CDC Health Alert Network. COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19. Sept 2019. Available at <https://emergency.cdc.gov/han/2021/han00453.asp>.

^{xiv} Statement of Strong Medical Consensus for Vaccination of Pregnant Individuals Against COVID-19. American College of Obstetricians and Gynecologists. August 9, 2021. Available at <https://www.acog.org/news/news-releases/2021/08/statement-of-strong-medical-consensus-for-vaccination-of-pregnant-individuals-against-covid-19>.

^{xv} Halasa NB, Olson SM, Staat MA, et al. Effectiveness of Maternal Vaccination with mRNA COVID-19 Vaccine During Pregnancy Against COVID-19–Associated Hospitalization in Infants Aged <6 Months — 17 States, July 2021–January 2022. *MMWR Morb Mortal Wkly Rep* 2022;71:264–270. DOI: <http://dx.doi.org/10.15585/mmwr.mm7107e3>.

^{xvi} COVID-19 Vaccination During Pregnancy Is Key to Saving Lives, Medical Experts Urge. American College of Obstetricians and Gynecologists. December 6, 2021. Available at <https://www.acog.org/news/news-releases/2021/12/covid-19-vaccination-during-pregnancy-is-key-to-saving-lives-statement>.

^{xvii} Ethical considerations for including women as research participants. Committee Opinion No. 646. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e100–7.

Ms. DEGETTE. Thank you so much, Doctor.

And now, Dr. McBride, I am very pleased to recognize you for 5 minutes.

STATEMENT OF LUCY McBRIDE, M.D.

Dr. McBRIDE. Good morning, and thank you to Chairs DeGette and Pallone, and to Ranking Members Rodgers and Griffin (sic) for inviting me today.

My name is Dr. Lucy McBride. I am here as a board certified primary care physician in Washington, DC. I have been practicing medicine for 20 years. I have dedicated my life and my career to helping people understand the inseparability of mental and physical health, whether it is my teenage patients or my octogenarian patients. I trained at the Harvard Medical School and at Johns Hopkins Hospital.

I am not here today to be clear with any political agenda whatsoever, but rather to share my perspective on the pandemic as someone who has seen patients every day, patients who are on the receiving end of complex and often confusing public health information, and who are trying to make sense of the news.

This is a watershed moment of the pandemic. We have learned enormous amounts about the virus over the last two years. We have learned exactly who is most susceptible to the severe consequences from COVID-19, and we have now incredibly safe and effective vaccines and therapeutics. But we are not done. COVID continues to cause widespread death and destruction. We have a lot of work to do to increase vaccine uptake.

We have also unmasked major problems in our healthcare system—in particular, the erosion of trust in public health and the lack of access to needed medical care just when people need it most. As a result, we are dealing with a parallel pandemic of mental health and crisis and surging rates of underlying conditions like obesity, and people just don't know where to go for advice.

I have seen everything over the course of the pandemic. I have had patients hospitalized from COVID. I have had patients die from COVID. I have patients with long COVID. I have patients with COVID right now. I have also witnessed the social, emotional, and mental health toll of the pandemic itself, and from all of the losses that come along with losing friends and families—family members to the virus, but also from lost jobs, sense of normalcy, social disruptions, isolation, and loneliness, and just from navigating the deluge of information coming at people every day, and the politicization of science.

I see the emotional distress and the very real physical manifestations of stacked stressors, from insomnia to stress eating to substance use disorder, and the accompanying surging levels of medical conditions like diabetes, obesity, and depression. What I see in my patients every day is mirrored in the medical data.

Take, for example, my patient from earlier this week, a single mother with two children, one a middle schooler with special needs, and the other who is a college student suffering from depression. Stressed to the max, my patient finds herself drinking too much, eating, not exercising. And as a result, her blood pressure and her

weight have soared during the pandemic. Naturally, she worries about COVID-19, but that is only one of the myriad health issues that she and I are working on together.

So I am here to bring my firsthand appreciation for what I am seeing, and for what I see people needing most. And that is access to a trusted primary care provider, something that 80 million Americans do not have, particularly in rural and poverty-stricken urban areas. Of course, I am a little biased, because I am a primary care doctor myself. But really, COVID-19 is an outpatient disease. The ERs and ICUs have, obviously, been critical for our most sick patients, and are certainly where the news focus is, and where doctors like Megan Ranney have been doing heroic and essential work.

But the fact is that the vast majority of patients with COVID-19 are out in the world, and not in the ICUs. ERs were flooded not only because people were severely and sometimes critically and fatally ill, but also because they were scared and sick, and navigating the pandemic alone without access to a guide. So there are three unmet needs that I see in the community that we need to face.

One is all the information—misinformation we are seeing. More than ever, people need a trusted medical provider to receive fact-based, nuanced medical advice. Just last month a study in JAMA showed that the COVID vaccine uptake increases with the number of PCPs per capita.

No. 2 is a place to manage underlying conditions. We know that, in addition to age, one of the biggest risk factors for severe outcomes from COVID is underlying conditions. And we manage those, not with ER visits, but rather with longitudinal relationships with a primary care doctor for guidance on things like nutrition, sleep, exercise, stress management.

And three, people need a place to help apply broad public health advice to their unique lived experience and situation. I spent countless hours on the phone over the last two years helping people manage everyday questions: which COVID test? Which vaccine? Do I need a booster? And people need help navigating these everyday decisions, and balancing risks.

There is no better role for primary care than in a global health crisis. My hope is that our children grow up in an America where they have unfettered access to primary care, a hub for problem-solving, a place where mental and behavioral health and physical health meet, where people can be fully seen and heard, and where they don't have to worry about who to trust. They don't land in Dr. Ranney's ER because they have underlying health conditions that aren't managed. And when they are short of breath, they don't have to wonder, is this COVID or is this a panic attack? Or they can get their COVID test and talk about their anxiety, and navigate that mental health condition that is so common.

As we dig through the rubble of the pandemic and prepare for the next one, we must invest proactively in medical systems founded on relationships, rapport, and reason. Investing in primary care is the way we invest in our health and our collective well-being. Thank you very much.

[The prepared statement of Dr. McBride follows:]

Subcommittee on Oversight and Investigations on Energy and Commerce

Hybrid Hearing

**Wednesday, March 2, 2022, at 10:30 a.m. (EST)
John D. Dingell Room
2123 Rayburn House Office Building**

“Lessons from the Frontline: COVID-19’s Impact on American Health Care.”

Witness: Lucy McBride, MD

Title: Internal medicine physician in private practice, Washington, DC

Thank you to Chairs Degette and Pallone and Ranking Members Rodgers and Griffith for inviting me today. My name is Dr. Lucy McBride. I'm a primary care physician here in Washington, DC.

I trained at Harvard Medical School and the Johns Hopkins Hospital. I hold a degree in pharmacology from the University of Cambridge in the UK. I have been practicing medicine for 20 years and have a large panel of patients, from ages 15-92.

I am here today to share my perspective on the pandemic, from a somewhat different vantage point than is often highlighted—someone who has seen patients every day on the receiving end of public health guidance.

As a primary care doctor, I have witnessed a lot of suffering—much of it preventable.

As you know, more than 950,000 Americans have died. More people have been hospitalized. Many are suffering from a long tail of the infection (like we see with many other viruses.) And COVID continues to cause widespread death and destruction.

I have cared for adults and teens who have experienced serious illness and loss from COVID-19, and also those who have suffered from isolation, educational loss, economic hardship, delayed medical care, and decreased physical activity.

I've also witnessed my patients' stress over getting crucial information, facts, and trusted guidance on testing, quarantine, isolation, vaccines, therapeutics, and managing COVID risks. Navigating the deluge of information to make everyday decisions about school, work, caregiving, and simply being human during a pandemic has posed its own set of challenges.

Despite their necessity at various times along the last two years, the mitigation measures themselves have had unintended harms on our economy, our social fabric, and our physical and mental health. Remote schooling has hampered learning and now affected three school years. School closures and disruptions to normal school and

activities have promoted learning loss, widening educational gaps along racial lines. Kids with learning disabilities, speech and language delay, English as a second language, and autism for example have suffered disproportionately from school mask mandates.

Not to mention the social-emotional toll—particularly for kids—of living through a pandemic and not being able to appropriately connect with peers, teachers, coaches, and mentors. The country's mental health has taken a toll. The US Surgeon General declared a mental health emergency in kids and teens; the American Academy of Pediatrics and other expert groups also [has declared a mental health emergency](#) in children. As the Surgeon General recently highlighted, combined [analyses of 80,000 children found](#) that symptoms of depression and anxiety have doubled among young people during the pandemic, with 1 in 4 showing depressive symptoms and 1 in 5 showing anxiety.

Medically, we will be seeing the effects of the pandemic for a long time. Elective procedures were suspended. Preventive care and screenings were postponed because of fear and sometimes undue anxiety, thereby exacerbating people's underlying conditions. Obesity rates, for example, soared during COVID due to relative inactivity, poor nutritional choices, lack of access to nutritious foods, stress, missing medical appointments and preventative care. Every day, I witness the effect of stacked stressors on people's physical and mental health and their medical outcomes.

In focusing solely on COVID we have lost sight of the other risks to our health and well-being and our policies haven't always reflected a broader definition of health. To me and my medical colleagues, *health is about more than the absence of COVID-19*. And good health comes from reducing *total* harms and balancing risks—not trying to eliminate something that we cannot eliminate.

Like we do with everyday threats to our health and well-being—from COVID-19 to driving a car to intimate relationships—we must manage risk, understand our unique medical vulnerabilities, and calibrate our thoughts and behaviors to match our *actual* risk. Public policy must do the same. Like primary care providers do, public health's job is to arm people with tools and nuanced information to navigate the everyday risks people face—with compassionate (and not fear- or shame-based) messaging.

COVID-19 is an outpatient disease. Even before the vaccines (which beautifully reduce the risk of needing hospital level care), most patients infected with SARSCoV2 didn't require being admitted to the ER or ICU. But without a primary care provider, too many people landed in the ER—for lack of anywhere else to go—and because they needed help managing symptoms and anxieties and navigating testing etc.

Public health guidance is crucial, however policy lives downstream of society. These policies are not self-executing. There must be societal understanding and internalization for there to be widespread compliance. There is nowhere better for this to happen than a trusted primary care home.

Role of Primary Care

According to a study from 12/2019 in [JAMA Internal Medicine](#), about 25% of Americans don't have a PCP. There has been a shortfall of U.S. primary care doctors for a long time, with much of the problem concentrated in rural and poverty-stricken urban areas. A new 3/2021 study in [Annals of Internal Medicine](#) by Sanjay Basu MD PHD projects that the United States could save thousands of lives each year by addressing its lack of primary care providers, particularly in underserved U.S. counties. The shortfall is directly responsible for the U.S. having some of the worst COVID outcomes in the world.

This was a **pandemic of underlying conditions**, making Americans uniquely vulnerable. PCPs are best positioned to treat—and prevent—them. The role of outpatient medicine and primary care in general is prevention—to prevent disease and to keep people out of the ER and ICU, where doctors like Dr. Ranney work so tirelessly. The biggest risk factors for poor outcomes from COVID (other than age) are obesity, diabetes, heart disease—all of which are managed best in PCP offices.

As the pandemic evolved, Americans didn't know who to trust. Fighting **misinformation** has become a part time job for PCPs, not to mention sorting through the deluge of data and confusing public health messaging. And this is limited to those with access to a PCP. People without access look to the internet salesmen, media personalities, and get easily tangled in webs of harmful medical advice. Primary care providers fill vacuums of trust. We are well positioned to help get people to vaccinate, balance risks, etc.

Our job is to marry broad public health advice with the unique patient in front of us and dispense nuanced advice to help people make everyday decisions — which, in a pandemic, includes delivering real-time, fact-based information and guidance on COVID symptom management, isolation, quarantine, testing vaccine information.

[When asked](#) if Americans trusted Anthony Fauci's advice about COVID-19, only 30.8% said yes. That number decreased to 15.5% when asked about President Biden. Out of desperation, many have sought advice from those whose interests don't always align with protecting the public. Conversely, 63% of Americans trust their primary medical providers, many of whom are members of their own communities. Their children attend the same schools, they root for the same football team, and attend the same places of worship. During regular check-ups, patients engage with their physician in face-to-face conversations where empathy and reason can reign—an impossible feat in 240 characters or less.

We provide safe, non-judgmental spaces. We ensure the dissemination of accurate medical information and marry broad medical evidence with the patient in front of us. We build relationships to promote health and well-being. We meet people where they are—whether they're vaccine hesitant or want a fifth booster. Understanding patients' lived experiences is the ground game of improved health.

Time with a trusted physician has been proven to improve vaccine uptake and patients' overall health. Establishing rapport with a PCP can save lives. For example, [data show](#). A study in JAMA last month showed that COVID vaccine uptake increases with the number of PCPs per capita. The common thread between countries who successfully navigated the pandemic was not GDP; It was trust. A [Lancet study](#) published last month concluded that higher levels of trust in public health measures were the most predictive factors of lower COVID infection rates. Where else better to translate government-issued health guidance than the primary care office?

Invest in Primary Care

With an endemic virus like SARSCoV2 that will be woven into the fabric of our lives—just like the other four coronaviruses and the flu—we need to work to limit the severe consequences—through vaccination, boosting as needed, scaling up therapeutics, and giving people access to a medical “hub”—where they can care for their underlying health, get fact-based information, understand how broad public health advice applies to them, and feel fully seen and heard.

Primary care medical providers, if well-funded and scaled up, are the best line of defense against our most insidious health problems, the harms of misinformation, and misallocated hospital resources. To prepare for the next pandemic, we must invest proactively in medical systems founded on relationships, rapport, and reason.

We can protect the vulnerable, while returning to defining health as more than the absence of COVID, but rather a state that incorporates physical, mental, social and spiritual well-being. This will be essential for our community to heal in the months and years ahead

We have a lot of healing to do—physically, emotionally, socially—to restore our collective wellbeing. We can also expect another wave of COVID and/or another pandemic. To build back better, we cannot afford to make the same mistakes twice.

Investing in primary care is investing in our nation's health. Primary care isn't just about getting an annual physical, it's about building a relationship with a medical professional, so that when you do get sick that doctor knows everything about you.

Without more PCPs in the next pandemic, we can expect the merry-go-round of overwhelmed emergency rooms, increased wait times, staff burnout, and diminished quality of care.

The COVID-19 pandemic exposed the ailing condition of crucial American infrastructure. We tossed over \$5 trillion at the problem through three necessary, but reactive, spending bills. If we hope to truly protect the health of our communities moving forward, we must fortify the frontline of the American healthcare system: primary care providers.

Debates about masking children are becoming a distraction from fixing the structural problems that have made the pandemic so deadly. We should instead be uniting around equitable, evidence-based policies that invest in long-ignored healthcare infrastructure that have exacerbated the worst effects of the pandemic.

Ms. DEGETTE. Thank you so much, Doctor, and thank you for your work on the front lines.

Thanks to all of our witnesses for their hard work.

It is now time for members to have the opportunity to ask you questions, and so the Chair will recognize herself for 5 minutes.

You know, when we hear the testimony today from all of our witnesses, and when we hear from our constituents in our districts, we know that this crisis is impacting healthcare workers across all levels, from primary care physicians to nursing to emergency care, and on and on. And only when we understand where we fell short can we better understand what we need to do for the future. As the chairman said, I am all about recognizing the positives and the challenges, and seeing what we need to do. And so what I want to do with our witnesses today is drill down in what the witnesses feel are the critical steps for Congress and the Federal Government to take to prepare for tomorrow's challenges.

So, Dr. Ranney, I am going to start with you first. Your testimony mentions needing a "culture of preparedness" to effectively manage national disasters. What action do you think would be key to being better prepared in the future?

Dr. RANNEY. Thank you for the question. So I will note that organizations like ASPR have previously outlined good preparedness plans, ways to set up healthcare systems that have adequate resiliency with staff, with supply, with real-time data to be able to respond, identify surges when they start, respond appropriately from stop—to stop them from getting worse, and then to deploy healthcare workers across the country, as needed.

Right now, though, we need to shore up our workforce. So that is both about retaining current healthcare workers, helping them individually manage their burnout—distress, stopping or reducing the impact of workplace violence, and creating those systemic fixes so that we have, particularly for our nurses, having adequate nursing staffing ratios, and about training up new healthcare providers, so that we can refill the ranks from all the folks that have left.

And then the third part is working on creating new models of access to care. I do appreciate Dr. McBride's points about primary care providers, the minority chair's—Minority Griffith Member's comments about telehealth. Also, new digital health modalities, as well, can make a big difference.

And then, at the bottom of it, setting up a better data infrastructure. So the wastewater monitoring that CDC is now beginning to implement into its data systems are critical. Setting up other data systems that we have accurate information not just on race, ethnicity, and age of cases, but also hospitalizations, so that we have real-time data on staffed hospital beds, so that we have real-time data on supply shortages. Again, personal protective equipment was—

Ms. DEGETTE. Doctor, I am going to—I am sorry, I am going to need to interrupt you, so I can—

Dr. RANNEY. No problem.

Ms. DEGETTE [continuing]. Get to the rest of my questions.

Dr. RANNEY. Go ahead.

Ms. DEGETTE. I want to ask you, Ms. Austin, the same question. What do you think we need to do to support nurses and address the challenges in the future?

[No response.]

Ms. DEGETTE. OK, I will come back to you, Ms. Austin, I think we are having a technical issue.

I want to ask you, Dr. Riley. You have noted the availability of vaccines and treatments that were instrumental in supporting the health and well-being of your patients, but there was a delay in the evidence necessary to assure safety and efficacy among pregnant and lactating women. Briefly, what can we do to recommend—to address this in the future?

Dr. RILEY. I think—thank you for the question. I think it is really important that we figure out how we are going to involve pregnant and lactating women in research earlier in the process.

Research could have been done on the vaccine, giving us information about safety that would have allowed us to vaccinate even more women. The long delay allowed us to then fill that in with the mistrust and, you know, all sorts of things on the social

[inaudible], which have led to fewer pregnant women being vaccinated than we would hope.

I think the other

[inaudible] that we need to really focus on is the surveillance systems which, in the past, did not include information on pregnancy and lactating women. And those surveillance systems, which have now been stood up for COVID-19, need to remain in place. So not only do we need surveillance of disease, we also need surveillance of vaccine use and vaccine safety, which are absolutely critical. Thank you.

Ms. DEGETTE. Ms. Austin, do we have you back?

Ms. AUSTIN. Yes, I apologize. I lost audio for just a few minutes there. Thank you so much—

Ms. DEGETTE. Technology is our friend.

Ms. AUSTIN [continuing]. The question.

Ms. DEGETTE. Go ahead. Go ahead. The question was what steps do you think that we can take to support nurses and address the challenges we found with COVID?

Ms. AUSTIN. Yes, I think the biggest opportunity for our nurses, I hear all the time, is our staffing shortages. I think, if there is anything at all that could be done, it is just investing in our accredited nursing residency programs.

Emory has one of only two nursing residency programs in the State of Georgia, and it is truly a pipeline for us. Over the last couple of years we have brought in about 500 new nurses, new graduate nurses, and our goal this year is to bring in over 700. So I think that anything that could be done to help partner with the Federal Government to grow our program would be really helpful.

Ms. DEGETTE. Thank you so much.

Dr. McBride, I am out of time, but I—you know, my daughter is a primary care doctor in San Francisco, and I know the work that all of you do. I would be interested if you could just very briefly tell us what Congress can do to help support primary care doctors going forward, because there is a severe shortage, as you say.

Dr. MCBRIDE. So right. Before the pandemic we had an enormous shortage of primary care physicians, particularly as patients age, and if you have Baby Boomers, and people are living longer. So here's my advice.

First, we have a supply problem. We need to incentivize people coming out of medical school to come into primary care professions. Right now the incentives are to go into specialties that are more procedural-based, and we need to—in my opinion, I am biased, obviously—make primary care the kind of crown jewel of medicine, because it is the place—it is the ground game, it is where trust is born, it is where relationships and rapport are born, to be able to dispense trust and nuanced information. And if we have better primary care, particularly with behavioral health and mental health services woven in with PAs, NPs, doctors, and extensions of us, then we can do better to prevent mental health despair, physical health problems.

And so it is about getting more people in medical school to go into primary care. It is also about—

Ms. DEGETTE. I am sorry to interrupt you, but my time is way expired, and I appreciate the ranking member. I know—I am sure we can get more from you. Thank you.

And I am going to recognize Mr. Griffith for 5 minutes.

Mr. GRIFFITH. Thank you very much. I am going to ask for a little indulgence, too, because I want us to go back to Dr. Riley for just a second on one of your questions, because part of our duty is not only to get information for ourselves, but to make sure people back home that might be watching on C-SPAN have an opportunity, too.

And Dr. Riley, you mentioned surveillance systems. Define that for us. You were talking about nursing and so forth.

Dr. RILEY. So I was talking about having information on COVID infection specifically for pregnant women and lactating women. So that surveillance system that the CDC, you know, ultimately stood up allowed us to then figure out that, in fact, COVID infection was worse for pregnant women.

Mr. GRIFFITH. I got that. But the problem is, I am not sure folks back home understand what you mean by “surveillance system” that the CDC stood up. That is what I am trying to get at—

Dr. RILEY. Oh, I am sorry.

Mr. GRIFFITH [continuing]. Just a definition.

Dr. RILEY. OK.

Mr. GRIFFITH. That is all right.

Dr. RILEY. So a way of counting cases of—you know, being able to recognize that the patients coming into the hospital are pregnant or not pregnant, lactating/not lactating, race ethnicity, so getting more information on patients as they come into the hospital or as they leave the intensive care unit, so that you can figure out exactly who is getting sickest.

Mr. GRIFFITH. Thank you very much. That is very helpful.

Dr. McBride, at the beginning of the pandemic the Centers for Medicare and Medicaid Services announced that all elective, non-essential procedures should be delayed during COVID-19 outbreak. CMS also stated that the decision to proceed with these procedures would be made by the clinician, patient hospitals, State and local

health departments, et cetera. But as a result of that, patients and doctors across the U.S. postponed procedures. More recently, during the Omicron outbreak, some states and hospital systems continue to grapple with the decision to delay elective, or so-called elective, procedures to manage care for COVID-19 patients.

Looking back on the decisions to postpone procedures, were there any options besides across-the-board postponements that we could have made?

Dr. MCBRIDE. So, as we all know, hindsight is 20/20.

Mr. GRIFFITH. Yes, ma'am.

Dr. MCBRIDE. But I do think it is important to realize, moving forward—because we will have another wave of COVID-19, we will have another pandemic, whether it is in six years, six months, or six decades—to recognize that COVID is only one threat to our health and well-being. It is enormous, right? We have lost almost 950,000 American lives. People are suffering from long COVID and other sequela from the virus. But I think it is also important to realize that elective surgeries, for example, are essential for people to keep people healthy, to prevent the underlying conditions that then put them at higher risk for poor outcomes.

So I don't claim to have the solution, but I think we need to make sure that we gather as much information now on the virus, who exactly it affects, so that we tailor our mitigation measures more appropriately to the actual risk, and that we don't do more harm than good with mitigations.

Mr. GRIFFITH. And I appreciate that, because there are situations where harm was done because, as I said in my opening, most people, when they hear elective, they think you are talking about something that doesn't need to be done, or cosmetic surgery, or something like that, when in often cases it is the diagnosis phase, where you are trying to figure out what is wrong. And it may not appear to be an emergency today, but, as we know, unfortunately, sometimes it is actually an emergency, or the test would have turned up something that needed to be dealt with right away.

All right. Also Dr. McBride, and then also Dr. Riley, during the COVID-19 pandemic healthcare providers had to adopt remote methods to care for their patients by using telemedicine. This is especially important in under-served and isolated communities, where it is more difficult to access care. We know that telemedicine can save lives, and I am glad that the healthcare facilities in my district have taken advantage of the Federal grant funds to enhance their capabilities.

Did you use telehealth during the pandemic? And if so, what type of equipment did you need to use to monitor patients from home?

We will start with you, Dr. McBride, then we will go to you, Dr. Riley.

Dr. MCBRIDE. Thank you for that question. So telehealth was a lifeline during the pandemic. I actually wrote an opinion piece in The Washington Post in the spring of 2020 with the former FCC Chairman Reed Hundt about the urgent need to get universal broadband access to all Americans, particularly, as you said, for those in rural communities and marginalized communities, who

don't have access to internet service, which right now is a beautiful adjunct to, for example, primary care.

Particularly with mental healthcare, which, as you know, is a surging and crisis in this country, you know, in-person therapy, in-person Alcoholics Anonymous is probably better than virtual, but virtual therapy and virtual AA is better than no therapy and no AA. So if we can get people the access to the internet services they need, then we can reach the far corners of—

Mr. GRIFFITH. And I agree with that. What did you use in your practice, or what did you need to update or improve in your practice to make that happen?

Dr. MCBRIDE. We had to do a control/alt/delete on how we practice medicine, if you will.

[Laughter.]

Dr. MCBRIDE. We—so basically, Zoom and Microsoft Teams, we had to—you know, I remember the days of getting my 92-year-old patient, for example, to log in to Zoom, and do the passwords. I became a tech support, in addition to a doctor, trying to help her manage her sore throat. Is it COVID? Is it something else? On Zoom.

So, you know, we need better tech capabilities. We need better tech support, not just doctors—

Mr. GRIFFITH. All right.

Dr. MCBRIDE [continuing]. And we need [inaudible]—

Mr. GRIFFITH. And I have—

Dr. MCBRIDE [continuing]. Access.

Mr. GRIFFITH. I have to cut you off, because my time is up.

And Dr. Riley, I will probably ask that as a written question. If you could give me your answer in writing to those questions, I would greatly appreciate it.

[The information appears at the conclusion of the hearing.]

Mr. GRIFFITH. But I must yield back.

Ms. DEGETTE. I thank the gentleman.

All the Members of Congress also became tech support experts, as well, Doctor.

The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Chairwoman DeGette. I wanted to ask Ms. Austin, initially.

You state in your testimony—and I quote—“The COVID-19 pandemic forced our nursing workforce to find new and innovative solutions to the challenges brought on by this public health crisis.” So if I could ask you, do you think the availability of new tools, such as the COVID-19 vaccines and treatments, has helped your team and other nurses in the country keep these challenges from being worse in the United States? And, if so, how?

Ms. AUSTIN. I would say yes to that. You know, our nurses really appreciated the opportunity—when our vaccines came out, they appreciated the opportunity to take the vaccine. They appreciated the opportunity that there were patients, family members that were taking the vaccine. Because again, you know, what nurses are fearful of, most of them, is being exposed and having to take, you

know, the virus home to their family members. So I think that vaccination is, for most nurses, is appreciated.

And I do think it helps with

[inaudible], and all the other things that they are doing. It is one less thing to worry about while they are trying to take great care of patients.

Mr. PALLONE. Thank you.

Dr. Riley, your patients have had specific needs in thinking about their own safety and health, and that of their families for the past two years. What is the availability well what has the availability of COVID-19 vaccines meant to your patients, Dr. Riley?

Dr. RILEY. It has been tremendously helpful to patients. I think, for those who have availed themselves of the vaccine, I think that there is good data to suggest that it certainly has helped them, personally. So women are less likely to become ill and land in the ICU if, in fact, they are vaccinated, pregnant and vaccinated.

I think also we now have good data that suggests that the antibodies that those women make after vaccination are transmitted to the newborn, and can be protective through newborns, who can sometimes get sick.

So I think that, you know, patients who are unvaccinated are the ones that we are really trying to target now, so that they can protect their own health, as well as the health of their babies.

Mr. PALLONE. The committee has supported a range of legislation intended to support healthcare workers and the broader health infrastructure, including 48 million in funding recently made available by the American Rescue Plan for community-based organizations in rural and tribal communities to expand public health capacity. So, Dr. Calac, I wanted to ask you, how critical are the investments such as those in the communities you serve with the Indian Health Council?

Dr. CALAC. Thank you for your question. Those needs are critical.

I would like to segue off of Ms. Austin's question, in terms of nursing, the importance of nursing not only in facilities and in hospitals, but also in public health settings, where you send out nurses to these rural communities to support the needs of patients that cannot come in, or cannot have access to a telehealth platform and receive the care that they need.

So in terms of the continued funding supports for healthcare workers, it is critical that we not only look at nursing, but also other forms of healthcare providers, including physicians. I might just support and recommend programs like Indians Into Medicine, which is a 5-year program looking at providing funding for Indians going into medicine. And quoting the 2017 Association of American Medical Colleges data, where we had, between 2012 and 2017, 93,000 medical graduates, and only 131 of those were identified as American Indian and Alaska Native. So 93,000, and only 131 physicians that would potentially go back to the communities to serve those rural areas that we just spoke of.

Mr. PALLONE. Let me just—one more question of Dr. Ranney about—you know, we have a number of—we had passed legislation to address behavioral health, and how that impacts health providers.

Dr. Ranney, how do these targeted investments in behavioral health, or the behavioral health needs of healthcare professionals, you know, how important are they? If you just would comment on that.

Dr. RANNEY. So briefly, they are just tremendously important.

The Lorna Breen Act, which, obviously, was named for one of my fellow emergency physicians who killed herself after taking care of COVID patients and then catching COVID herself in the early days of the pandemic, is just a tremendous step forwards.

In the face of burnout, PTSD, depression, so many healthcare providers are leaving. And as the other witnesses testified, a teammate's departure isn't just about losing that staff member. It is also about the overall culture of the team. So providing individual-level support, reducing stigma to getting that support, encouraging State medical licensure boards and hospitals to not ask about behavioral health treatment when licensing, those are all critical steps to helping us be healthy, so that we can better take care of our patients.

Mr. PALLONE. Thank you.

And thank you, Chairwoman DeGette.

Ms. DEGETTE. The Chair would like to remind all of the members who are appearing on Webex that they need to mute themselves, both the witnesses and the members. We are getting feedback because people aren't muting themselves. Thank you.

The Chair now recognizes Mrs. Rodgers for 5 minutes.

Mrs. RODGERS. Thank you, Madam Chair. This will not be the last pandemic we face, and I believe that it is critical that we learn from our response to not only prepare us for future pandemics, but to ensure we do not repeat the costly and harmful policies that we have seen over the last couple of years.

To that end, John Hopkins recently published a report that lockdowns had little to no effect on COVID-19 mortality, but certainly brought significant social and economic cost. Dr. McBride, in your—your written testimony you speak to this, and you note that we failed to tailor our mitigation efforts to those highest at risk. Can you please explain how this happened, and why it was especially harmful?

Dr. MCBRIDE. So I think, in the panicked spring of 2020, when we didn't know much, if anything at all, about the novel coronavirus, it arguably made sense to do everything we could, right, to prevent all of the widespread death and destruction. I think the two biggest failures in my mind in the public health response were the closures of schools and the prolonged closures of schools.

We know now that, in a public health emergency, schools should be the last to close and the first to open. And we imposed very strict interventions on children, who we now know face the lowest risk of any age cohort for severe consequences from COVID-19. That is not to dismiss the ongoing suffering of families who have lost children to COVID-19. The death of a child is tragic, regardless of the cause. And we—it is not to dismiss kids with long COVID, with MIS-C. It is not to dismiss any of the devastation. It is simply to say that closing schools has done harm to our youngest generation.

And second, the other major health—public health failure in my mind was that we did not protect our most frail elderly patients as well as we could during the early days of the pandemic. We know that there is an increase in risk of severe consequences and death from COVID that goes with age. And we could have done things like paying home health or nursing home aides to work at one nursing home facility, instead of many, because they were unwittingly spreading the disease, even though they were trying to help protect their patients.

And so I think, you know, as I said earlier, hindsight is 2020. I do not ascribe mal intent to anyone. I simply think that it is really important moving forward—because, again, we will face another pandemic, we will face another COVID wave—that we tailor our mitigations, and we appropriately calibrate the risk mitigation measures to the population at risk, and then arm people with tools and information to use to protect themselves.

Again, I will go back to my main argument in my testimony. This is another reason why we need primary care hubs. We need patients to be able to pair the broad public health advice with their unique lived experience, age, underlying health conditions. We can do a lot better the next time around.

Mrs. RODGERS. As a mom, I really appreciate your voice, your fighting on the front lines to get our kids, our children, back in school.

Just as a followup, do you believe it was foreseeable? You talked about the impact of the prolonged closures of schools. Do you believe it was foreseeable?

Dr. MCBRIDE. I think we know that school is essential, not only for learning. It is also essential for kids who aren't safe at home. Kids don't always come from a happy, healthy home. Kids use school for their food. They use it—they need it for their emotional health. They need it for social bonds. That is where kids get their athletic activities.

We have seen surging rates of obesity and children in part—not fully, but in part—because kids have been relatively inactive and on screens much more than they were pre-pandemic. Although that was—I am a mother, I know the screens are not an easy problem to solve.

But I think it was foreseeable that school closures would cause harm. I think we thought that this was going to be a short-term, 2-week flatten-the-curve proposition.

Mrs. RODGERS. Yes.

Dr. MCBRIDE. But here we are, two years—

Mrs. RODGERS. Yes.

Dr. MCBRIDE [continuing]. Into the pandemic.

Mrs. RODGERS. Yes.

Dr. MCBRIDE. We have so much accumulated data on who is at highest risk.

Mrs. RODGERS. Yes.

Dr. MCBRIDE. And I think we need to really, really—

Mrs. RODGERS. Before I run out of time, would you just speak briefly if you have reviewed the data at CDC around the mask mandate on our kids, and its impact?

Dr. MCBRIDE. Sure. No, I have looked very, very closely at the mask mandate data. And what I would say is that there is no real-world compelling evidence at this moment, in March, 2022, that mask mandates in schools have meaningful effects on the transmission of the virus in the schools.

That is not to say that masks don't work, or can't work. I am not anti-mask. I was wearing a mask all day yesterday in my office, seeing a sick patient. It is simply to say that the burden of proof is on the intervention.

The norm is to see faces in schools, to see the broad range of expression on teachers and coaches and mentors' faces and on peers' faces. It is to say that there are unintended harms of a mandate, for example, on children who are autistic, children who have speech and language delays, children who have English as a second language. And even for neurotypical children, seeing people's faces is the norm.

Mrs. RODGERS. Thank you, thank you.

Dr. MCBRIDE. So any intervention that we impose——

Mrs. RODGERS. Yes.

Dr. MCBRIDE [continuing]. Particularly if it is mandated, needs to have more benefit than harm.

Mrs. RODGERS. Thank you. My time has expired.

I appreciate a little extra time there. I yield back.

Ms. DEGETTE. You bet. The Chair now recognizes Ms. Kuster for 5 minutes.

Ms. KUSTER. Thank you, and I just can't resist going back to the last witness.

We all would like to have the children in schools, and certainly now, and we would all—delighted to get rid of our masks. Do you think, if the previous President had taken the vaccine publicly a year ago, when he chose to take it privately and not tell anyone, that that would have made a difference in vaccine uptake, and would have ended this pandemic earlier?

Dr. MCBRIDE. I think——

Ms. KUSTER. That is to the previous witness.

Dr. MCBRIDE. Is that for me?

Ms. KUSTER. Yes.

Dr. MCBRIDE. Absolutely. I think if the previous President had modeled vaccine confidence, it would have made an—absolutely, a big difference. And one of my jobs in medicine is——

Ms. KUSTER. It would have saved hundreds of thousands of lives, possibly, and certainly would have saved many, many children from harm.

So I will dive back into my remarks, but I can't leave that unsaid.

Like many places throughout the country, my home State of New Hampshire [inaudible] surge caused by Omicron over the last few months. And at one point in December there was not a single available bed in the five-State area in our region.

I spoke with hospital leaders across my district in December, who detailed the serious impact of COVID-19 on workforce bed availability and delays in healthcare. And in my own family, we have had delays in healthcare directly related to the COVID surge.

Like all Americans, I am glad to see that the Omicron surge is largely behind us, but it must be underscored that this surge and the tragic deaths that followed were driven overwhelmingly by unvaccinated Americans.

Throughout the pandemic, hospitals and healthcare providers have had to delay elective procedures to be able to respond to surges in COVID-19 cases and hospitalizations. My own brother's surgery has recently been delayed. Hopefully, it will happen today. But all of us are scrambling in our families to rearrange travel schedules and to try to be there for those who we love.

Dr. Ranney, your testimony mentioned colonoscopies, heart surgeries, and even brain surgeries as the type of surgeries postponed or disrupted. Can you give us a better understanding of the types of services that are considered elective?

And what are some potential implications of delaying these procedures?

Dr. RANNEY. Thank you, Representative. So to be clear, again, these elective surgeries are not cosmetic; they are things that are utterly necessary. It is about removing a pituitary mass, something—a mass in the brain that is threatening your sight. It is about removing cancer. It is about repairing an aorta before it bursts.

And what happens when these surgeries get delayed is that they triage according to what is the most likely to be most life-threatening. Those are the ones that get moved up. So I know of many patients who had their surgeries delayed, ended up with emergent conditions, ended up in my ER, and then we had to make space for them.

The trouble was, though, is that so many of our nurses were re-deployed to take care of COVID patients that we couldn't adequately staff post-surgical ICU beds. And this was true, of course, not just in my own hospital system, but in others across the country, which then created a knock-on effect of having to keep patients in the emergency department longer before they could get the surgeries.

One of my colleagues, actually, in Wisconsin recently told me that he is diagnosing more advanced cancer now and recurrences of cancer than he ever has, because of folks having to put off these procedures, imaging studies and so on, due to COVID, and due to the staffing limitations they are in.

Ms. KUSTER. And in our situation, I am having to fly across the country tomorrow evening because they won't keep my brother in the hospital post-surgery because of COVID. So this is really impacting people's lives.

Studies confirm patients also made the decision to delay medical care, and you have mentioned that. A CDC study earlier in the pandemic found 4 in 10 adults delayed or avoided care, including urgent and emergency care, a trend that is continuing. What is—you have mentioned delaying care and the consequences. But I am wondering, delaying screenings and preventative care, if you could, review the consequences on both patients and the healthcare delivery system.

Dr. RANNEY. Absolutely. So early in the pandemic, when our COVID visits were high, overall number of visits dropped. That has

also happened during the Delta surge and during the Omicron surge. And what we found was actually in parallel: the number of at-home cardiac arrests increased, the number of strokes that we couldn't treat increased, because people stayed out when they really should be coming in to get evaluated.

We are also seeing delays in things like dental care that result in people coming in with major cavities or tooth abscesses. We are seeing delays in diagnoses of cancer, and, of course, we are seeing increases in untreated behavioral health problems, opioid overdoses, and the like, problems that pre-existed before the pandemic, but have worsened over the last two years.

Ms. KUSTER. And we do intend to——

Ms. DEGETTE. Thank you so much.

Ms. KUSTER [continuing]. To that. Thank you, my time——

Ms. DEGETTE. The gentlelady's time has expired.

Ms. KUSTER. I yield back.

Ms. DEGETTE. Mr. Burgess?

Mr. BURGESS. Thank you, and thanks to our witnesses for being here today. This is exactly the type of hearing that we should have been having over these last two years, so I am grateful that we are having it. I hope this is not the last.

I hope we will continue to do this type of work because, as you will recall, the congressional approach to the pandemic were massive supplemental emergency appropriations, but we are an authorizing committee. We are supposed to do the work. We are supposed to take the testimony from the experts and come up with how the money is most correctly to be spent, and then the appropriators write the check. But these last two years, we have written a lot of checks without doing the groundwork ahead of time, so we can do some of it after the fact.

But the Congressional Budget Office was in my personal office earlier this week, and they said there is, I think, around \$350 billion of unspent, unobligated funds in all of the appropriations packages we did as emergency measures over the past two years. So when I hear discussion about we need more money for this, for that, I don't disagree. But that is because this committee has not done the authorization work that it should have done over these last two years.

Now, having said that, let me—Dr. Riley, I will not get through every question that I have got to get through, so I will be submitting some of these questions in writing, and look forward to your responses.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. But Dr. Riley, if I could ask you, we actually have a doctor's caucus here in Congress. The surgeon general came and talked to us a couple of weeks ago. He said, doing his rounds around the country, he was very concerned about physician burn-out, as am I, as all of you.

But one of the things that was sort of left unmentioned is every year we turn around and we start cutting Dr. McBride's pay, and Dr. Riley's pay because of the physician fee schedule in Medicare. So I will just ask you, Dr. Riley. Do you think, if we as a committee, would spend the time addressing issues like provider pay,

that that would help some of the workforce issues and the burnout issues?

Dr. RILEY. Thank you for the question. I suspect yes. I mean, I think that, you know, people want and deserve to be compensated for the work that they do.

I do think that there is also the opportunity to incentivize certain aspects of medicine. I think that we are—you know, we are facing a really important challenge right now, where every aspect of healthcare, whether you are a physician, a nurse, a technician, a genetic counselor, et cetera, all of those people are absolutely critical to what we do, but all need to be compensated. And there is quite a bit of, you know, technical education that needs to go into that.

So yes, I do think that—

Mr. BURGESS. Yes. And I will have to move on because, again, time is so short.

So Dr. Ranney, I had a question for you. I have got a hospital. It is not in my district, it is just outside of my district. As everyone knows, with coronavirus, we do have some things that can be administered as an outpatient. That is a wonderful benefit. Once someone gets sick enough to be in the ICU, once they have had the course of steroids, after they have failed Remdesivir, there is not much on the shelf to be able to administer to those patients to try to save them.

There is work going on. In fact, one of the hospitals just outside of my district is working with a compound called Zyesami that is a vasoactive intestinal peptide, which seems to show a lot of promise, just in general. And this is what has been so frustrating with the FDA through this pandemic. You get something into a phase three trial, so it is more likely than not to be beneficial. You have got nothing else, and a sick patient in the ICU on the ventilator.

So what about the access to late-stage therapeutics in coronavirus patients who are in critical care?

Dr. RANNEY. So I think the emergency use authorization—thank you for the question. I think emergency use authorizations are a critical tool for us to use during a pandemic to improve the speed at which we have access to therapeutics that have good safety data and decent efficacy data.

I don't want to spend any time or money on things that—

Mr. BURGESS. Yes, I have got to interrupt you there, because—

Dr. RANNEY. Yes.

Mr. BURGESS [continuing]. I agree with you. The problem is this particular compound, that application is gummed up in the FDA. They might get to it in September. We have situations where it is not the regulation, but we have personalities that we can't get past, and that is one of the things that needs to change as we go forward in this pandemic.

I thank all of our witnesses for being here. I know how valuable your time is.

I will yield back to the chair.

Ms. DEGETTE. I thank the gentleman. Ms. Schakowsky, you are now recognized for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Chairwoman DeGette, and I appreciate your holding this hearing. We owe our nurses and doctors

and all of the frontline healthcare workers an enormous debt, and the title of this hearing, lessons from the front, really drives home what I believe is the point that we have to listen to our healthcare workers, and give them the supplies and the support and the resources that they are asking for.

And though they are not here at this hearing today. I want to recognize that labor unions that represent frontline healthcare workers have provided a path for critical health and safety protections for workers and for patients. And for this reason I would ask to put into the record a December 2021 report from National Nurses United, the largest national union representing registered nurses from around the country.

Ms. DEGETTE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. SCHAKOWSKY. Thank you. The nurses and healthcare workforce is in crisis, and it has been for, actually, a long time. And we know that there is a shortage of good-paying, permanent nursing jobs, where nurses and—are fully valued, and their work at—for their work at the bedside. And this is exactly why we need to invest in permanent jobs, with good wages, and benefits, and safe staffing standards.

I am very proud that I have introduced legislation, and leading the legislation called Nurse Staffing Standards for Hospital Patient Safety and Quality Care, and I would like to talk to—ask Dr. Ranney.

In reviewing your written testimony, I noted that—I noted and appreciate, actually, that you referenced the dire need to implement minimum nursing standards. And I wondered if you could talk more about the science and the evidence that backs up the need to have minimum nursing staffing ratios.

Dr. RANNEY. Absolutely, and I can share specific studies after the hearing. I don't have all of the exact numbers at my fingertips, but the short version is that there is ample evidence that having low nurse-to-patient ratios improves patient outcomes, decreases patient mortality, decreases staff burnout, not just for nurses, but also for the rest of the team. Asking nurses to take care of more than a certain standard number of patients, with a lower number of patients acceptable in the intensive care unit compared to on hospital floors, but going past that limit increases, again, both patient harm and nurse and others' burnout.

Ms. SCHAKOWSKY. Is that the lack of the—any kind of staffing ratios, and is there a reason for burnout of nurses, that they just feel overwhelmed?

And we do see a flight of nurses. That was mentioned by one of our other witnesses, and that that would help to keep people on the job.

[Pause.]

Ms. SCHAKOWSKY. Dr. Ranney?

Dr. RANNEY. Absolutely. Thank you. That would absolutely help to keep people on the job.

Speaking to nurses that are in states that have nursing staffing ratios versus those without, there is a really big difference in terms of their quality of care provided, their levels of burnout, and their willingness to stay there.

Ms. SCHAKOWSKY. So I really appreciate that, because we are talking not only about the nurses themselves and their ability to stay on the job, but I think the data that you referred to that shows that the outcomes for patients really improves, and I have talked to nurses who are so worried that they have not been able to make sure that the medication is correct, and we know that there are—is a good deal of harm that happens in hospitals that—some of which can be attributed to the fact that the nurses can't spend enough time. So I just thank you for that.

And you know, we want to do everything we can to make sure that both the workers and the patients have what they need, as we go forward.

And so I yield back. Thank you.

Ms. DEGETTE. I thank the gentlelady. Mr. McKinley, you are now recognized for 5 minutes.

Mr. MCKINLEY. Thank you, Madam Chairwoman. Lessons learned from the pandemic. There are several things that I am going to try to get through in a short time.

Several of the hospitals in West Virginia have indicated that they seem to have increased efforts to hack into their hospital records. I don't know whether that is unique to West Virginia. Has it been—for all—anyone of the panel, have they seen that across the country during this pandemic, that people are trying to get access to health records? Can anyone comment about that, just quickly?

Hearing none, let me go to Ms. Austin—

Dr. RANNEY. This is Dr. Ranney—

Mr. MCKINLEY [continuing]. If I could.

Dr. RANNEY [continuing]. Just to say that there—the issue of cyber attacks on healthcare records is an issue that has been going on for a very long time, and I can provide data from Dr.—

Mr. MCKINLEY. Increase. Has there been an increase in this? That is what I am trying to get to.

Dr. RANNEY. That I am not sure. I will find out.

Mr. MCKINLEY. OK. To Austin down in Emory, we have had—my wife was a critical care nurse for 45 years, and we have known about this shortage of nursing care for some time, and—but during the pandemic there was a call or demand for increased nursing care. And so the traveling nurses really took off on this.

And so hospitals like Emory, or the larger hospitals all across America, are paying—I know, we have records of it—as much as \$200 an hour for the first 1,000 hours that they worked. That is exacerbating the shortage that Schakowsky just talked about. Larger hospitals can afford to pay that. But rural hospitals, like we have in West Virginia, and in eastern Ohio or elsewhere, rural areas, can't compete with that. We are—they are being robbed of their nurses.

So I am curious. What is the solution? They can't afford to pay more, or they would have been doing that. How are small hospitals supposed to exist during a pandemic when their nurses are being robbed to go someplace else? Can one of the panelists comment about that?

Ms. AUSTIN. Thank you for that question. I am happy to. I would like to acknowledge and thank your wife for her many years of nursing service.

I think that is—the question that you asked is a question that all hospitals are asking themselves, whether it is a rural hospital, or a larger hospital in a metro city.

One thing I talked about earlier is the ability to bolster any types of training programs to actually increase the nursing pipeline, I think, could be really helpful. That way we can decrease, I think, the dependency on contract labor. Contract labor is not sustainable. In my healthcare organization we are having a lot of conversations about how to mitigate the labor cost for travelers. I mean, it is—in the beginning it is meant to be a very temporary way to supplement, say, nurses that are on leaves of absences. It is not a way that we want to staff our hospitals, because, again, I say it is just not sustainable, financially.

Mr. MCKINLEY. Thank you very much. I may reclaim my time. I am trying to get two quick questions.

During the pandemic also there was this shortage of PPE, and we were seeing companies like Premier that were trying to level out to make sure that it was distributed. But yet this committee, or the Energy and Commerce, has before it a bill that is going to restrict. We know we need more plastics, but yet we have, in this committee, an effort to try to restrict increased plastic production in America. It just doesn't make sense to me.

So what they are talking about under—you know, it was the Clean Future Act. Under section 902 it says, for the next three years, there will be no new plastic manufacturing in America. I think—it just befuddles me as to why we would do this, when we need the plastic.

But Dr. McBride, I want to turn to you at the last of it and say, because of the children with mental health, I am curious to see what we are saying in—for schools. Are we going to continue to depend on our teachers to try to take on the mental health issue?

Can you talk to me a little bit? Because this is very frustrating, when I see, as we come through the pandemic, how we deal with this.

Dr. MCBRIDE. Absolutely. I mean, teachers are some of the unsung heroes of the pandemic.

Mr. MCKINLEY. Yes.

Dr. MCBRIDE. We owe a debt of gratitude for our frontline health workers, our essential workers, our teachers.

We cannot ask teachers to be mental health providers. I mean, I think one of the reasons—at least the teachers I know and care for as patients—go into teaching is to be not only someone who educates children, but also a mentor, and a guide, and provide emotional support.

But in order to help children, you know, recover from the stacked stresses of the pandemic, regardless of their lived experience, and in order to bolster their mental health moving forward, we need to make sure that educators are aware of mental health issues.

And here is an idea that I—one of my friends works in D.C. here. She is a pediatrician, and her clinic is annexed to Anacostia High School. If we can build in primary care, and annex it to schools,

particularly schools in marginalized, under-served, often urban communities, where people can get vaccines, or they can get basic primary care, and they can get access to truthful information right in the school setting, that would do a lot to bolster the mental and, therefore, physical health of children and adolescents. Make it easy to get access to mental healthcare, even at school or annexed to school, because teachers cannot do—they are wonderful, but they can't do everything.

Mr. MCKINLEY. Thank you.

Ms. DEGETTE. Thank you.

Mr. MCKINLEY. I have run out of time——

Ms. DEGETTE. The Chair now recognizes Mr.——

Mr. MCKINLEY. I yield back.

Ms. DEGETTE. Mr. Tonko.

Mr. TONKO. Thank you, Madam Chair. The pandemic has adversely impacted our Nation's healthcare workers, and leading many to experience work overload, burnout, and feelings of anxiety or depression. In addition to what we have heard this morning, a survey of pandemic frontline healthcare workers found a majority experienced worry and stress negatively affecting their mental health, with 3 in 10 needing mental health services as a result of the pandemic.

This is one of the reasons that I have introduced H.R. 1716, the COVID-19 Mental Health Research Act, along with my colleague and friend, Congressman Katko. This bipartisan legislation would fund research to study the effects of COVID-19 as a pandemic, and what effect it has had on the mental health of Americans, including its impact on healthcare providers.

So, Dr. Ranney, as an ER doctor, I imagine that workplace stress is commonplace. Can you describe how the pandemic has impacted the mental health of emergency physicians, and what you mean by—and I quote—"moral injury" that you make mention of in your testimony?

Dr. RANNEY. Thank you for the question, Representative. I have stories in my written testimony around the effects of both treating COVID-positive patients for two years on end, and the effect of the continued staffing shortages on the emotional health of frontline providers. It is things like not being able to care for your patients because you are too busy with others. It is about having patients wait out in the waiting room, who you know are desperately ill, but who you simply can't get to because there aren't staffed beds back in the emergency department.

Moral injury is really a concept that derives from wartime. It is the idea of being exposed to or having to make choices that go against the moral fiber of your being, that go against how you were trained, your faith, your sense of integrity, simply because you have no other options. And that is what healthcare providers have faced over and over during the pandemic. We have been forced to make decisions that we would not normally make, that we know are hurting patients or their families, simply because there is no other choice, because there is no space, because there are no staff, because there are no optimal medications, or sometimes because the equipment that we depend on is not available.

It is, at this point in the pandemic, a totally preventable occurrence if we had adequate staff and adequate supply chains.

Mr. TONKO. So with that being said, Doctor, what can we do to, beyond that, better support healthcare workers during this pandemic and beyond?

Dr. RANNEY. Thank you, Congressman. So there is a combination of individual level support. Again, things like your bill, the Lorna Breen Act, some innovative projects that are being done at hospitals around the country. I highlight in my testimony Project Cobalt, that is being developed by colleagues at Penn to provide digital therapeutic support to healthcare providers. It is about destigmatizing reaching out for mental healthcare and behavioral healthcare.

But most of all, it is about supporting us in our daily jobs. Those individual-level solutions are important for helping those of us that have been there, but what we really need is things like loan repayment programs, increased staffing, improved ability to, honestly, just support our patients, do our jobs, and support their families.

Mr. TONKO. Thank you.

A study by the Occupational Safety and Health Administration found that, prior to the pandemic, healthcare workers were already four times as likely to face workplace violence, such as physical assaults or threats, than workers in private industry. Since the pandemic we have seen disturbing reports about verbal and physical abuse directed toward healthcare workers. Some hospitals have even had to issue panic buttons to their staff.

Ms. Austin, the nurses often bear the brunt of this abuse. In fact, as you mentioned in your testimony, nurses have been verbally attacked for implementing COVID-19 safety restrictions, and patients and families take their emotions out on nurses. Did your nursing team witness an increase in verbal and physical attacks over the last two years? And, if so, how have you and your colleagues coped?

Ms. AUSTIN. Yes, we have. One thing that we have done here at our hospital is we have instituted a workplace violence prevention team. We have encouraged our nurses to report every instance of either verbal or physical abuse. Often times, what we have found is that nurses believe that, you know, this is just what is supposed to happen, and they take on the verbal—usually not the physical, but the verbal abuse they will let go. And so we have done a lot of work to encourage nurses to report every single instance.

Our workplace violence prevention team will respond to every single instance to ensure that our nurses are supported, to make sure that we have had conversations with patients. We have involved our public safety department, if that was necessary. We make sure that our leaders are rallying around our staff, so that they know that they have full support from our hospital around these types of instances.

Mr. TONKO. Thank you very much, and Madam Chair, I yield back.

Ms. DEGETTE. I thank the gentleman. The Chair now recognizes Mr. Palmer for 5 minutes.

Mr. PALMER. I thank the witnesses for being here, and for the chairwoman holding this hearing.

One of the things that I think has been touched on a little bit is the impact of the lockdowns on school children. But I haven't heard anyone talk about this, Dr. McBride, the surge in teen suicides. I mean, we have seen a record number of teen suicides. It got so bad in Las Vegas that it forced the Las Vegas schools to reopen.

I know that the medical community has been overwhelmed with the—treating COVID patients, but added to that are the complications of being locked out of jobs, being locked out of schools, being cutoff socially from peers and friends. Hasn't that added to your workload?

To Dr. McBride, yes, thank you.

Dr. MCBRIDE. Absolutely. I mean, I think it is important to recognize that ER visits for mental health concerns, suicide rates cannot possibly measure the breadth and depth of people's despair, as defined by having depression, anxiety, OCD, PTSD, substance use disorder.

I would also say, to make it clear, that there are many, many routes of people's underlying health conditions in the mental health sphere. In other words, people have lost loved ones to COVID-19. That is a trauma. People have also lost a sense of normalcy in their fourth-grade classroom. That is also a loss.

So I think that the roots of the mental health crisis are broad and varied, but I think it is not a coincidence that the surgeon general—

Mr. PALMER. Let me ask for a little clarification here, because when you start talking about how broad it is, that implies that there are underlying conditions that may have been made worse by the lockdowns. But that is true of physical health, as well.

Dr. MCBRIDE. Sure.

Mr. PALMER. So the bottom line is here—and I am looking at this Johns Hopkins—it is not a report, it is an assessment of existing research, and I just want to read what it said, that "The lockdowns during the initial phase of the COVID-19 pandemic have had devastating effects. They have contributed to reducing economic activity, rising unemployment, reducing schooling, causing political unrest, contributing to domestic violence, undermining liberal democracy. These costs to society must be compared to the benefits of lockdowns, which our meta analysis has shown are marginal, at best." And then it concludes with this, "such a standard benefit cost calculation leads to a strong conclusion: lockdowns should be rejected out of hand as a pandemic policy instrument."

And the thing that bothers me about this is that we knew this before this report came out. And as a consequence, I mean, there is all kinds of research out there and studies that show that we had this surge in teen suicide, particularly among women. We had teachers quitting. We now—you talk about a shortage of healthcare workers, we now have a shortage of teachers. And a lot of it has to do with the lockdowns.

Dr. McBride?

Dr. MCBRIDE. So I think you are absolutely right, that lockdowns have done enormous harm on our social fabric, on our economy, on our physical health. And I think it is not a coincidence that the surgeon general has issued a concerning report about pediatric and

teen mental health. And we know that the AARP, the American Association of Pediatrics, the American Association of Child and Adolescent Psychiatrists, and the Children's Hospital Association issued a very concerning report in October, saying that kids are at high risk, and are experiencing unprecedented levels of anxiety and depression. So it is not a coincidence.

And I think that, moving forward, we need to be better at recognizing that health is about more than the absence of COVID-19, and that people face myriad threats to their health and well-being from depression, diabetes, obesity, substance use disorder, and highly contagious respiratory viruses. That is our job in healthcare, is to think broadly about health.

Mr. PALMER. My—one of my biggest concerns about this, aside from all of the other things that we have just discussed, is this massive loss of public confidence in medicine and science, and in the political leadership of this country. We have to get back to science, we have to get back to medicine, and we have got to figure out a way to restore the public's confidence in those who make these type decisions, that they cannot be political.

With that, Madam Chairman, I yield back.

Ms. DEGETTE. I thank the gentleman, and I agree. The Chair now recognizes Mr. Ruiz for 5 minutes, virtually.

Mr. RUIZ. Thank you, Chairwoman. This is a very special day and hearing for me, not only because of the topic, but because a good old friend is part of the hearing witnesses.

I texted Dr. Dan Calac earlier today, and I said who would have ever imagined, during those long hours of studying at Harvard Medical School for our exams, that one day he would be a witness in a hearing before Congress, and I would be a member of that committee. And we worked tirelessly fighting to reduce disparities and fighting for health equity as medical students, as residents. And now here we are, doing the same work, and I am so proud of the work and his leadership throughout all of this.

So thank you, Doctor, my good friend, Dan Calac, for being here.

The nation's health system relies on a range of professions and people to support the health of all people in all communities. From the public health infrastructure within Federal, State, local, tribal, and territorial health agencies to the networks of non-profits and private healthcare facilities, it takes every entity working together to prepare for and respond to public health emergencies, in addition to preventing disease and promoting Americans' health every day.

Unfortunately, the COVID-19 pandemic has been a stark example of the consequences of failing to support a robust public health infrastructure. According to a Kaiser Health News and Associated Press analysis from August 2020, in the decade prior to the pandemic at least 38,000 State and local public health agency jobs had been eliminated, 38 jobs had been—thousand jobs—had been eliminated in public health. And now, two years into this pandemic, we are continuing to grapple with the consequences of our weakened public health infrastructure.

Dr. Calac, has the weakened public health infrastructure impacted your patients and communities across to public health information and education about COVID-19 and would strengthening

this infrastructure, especially within the IHS system, help address access and health disparities and inequities Native Americans face? And if so, how?

Dr. CALAC. Thank you, Congressman Ruiz. There is, as we all have seen in the past couple of years, a tremendous disparity that has been uncovered by the pandemic in the delivery of healthcare services. And it is no more evident than what we see in health and human services, and especially in providing healthcare to those rural communities, and also those communities with under-represented individuals who are at increased risk for health disparity, whether they exist in rural communities, or they are in urban communities, in impoverished areas.

The placement, as we had spoke about with many of the interviewees and the people on the panel today, is the workforce needs. So it is an interesting predicament we are right now, and I really recognize the fact that we have two American Indian individuals on this subcommittee, which is not typical for Congress.

But the issue of dealing with what we are going to do with the problem moving forward, and so I think we have multiple lessons to garner information from. But what are we going to do, in terms of workforce?

Mr. RUIZ. I am glad you said what do we do moving forward, because in some of the more under-served parts of my district, community health workers, or the promotoras, played a vital role in keeping my constituents safe and healthy. They were the ones educating those communities on how to obtain and use PPE, how to access testing, and the importance of getting vaccinated, and build trust between the community and the healthcare professionals. They became critical liaisons between my constituents and health and community support systems like the county health department, churches, and our healthcare district.

This certainly is not the last pandemic that we will face, and there are lessons that we learned through this one that we can carry into our planning for the future. Dr. Calac, as a provider who cares for a widely under-served population, I know you have seen the unique challenges that those communities face. Do you see an increased role in our use of community health workers, both in future pandemics and in our public health education systems in general?

Dr. CALAC. Community health workers and public health nurses and primary care providers, together, can provide that role for those areas at most risk.

Mr. RUIZ. Thank you.

Dr. CALAC. And looking at options for loan repayment, as one of our panelists had mentioned, I know that the loan repayment through the Indian Health Service is not a tax-deferred loan payment. There is a current bill in Congress looking at providing a tax-deferred option for the loan repayment. I am currently an—I was an Indian Health Service recipient of that scholarship, and I am looking forward to more progress—

Mr. RUIZ. Thank you, Dan. I have about—

Dr. CALAC [continuing]. In the future.

Mr. RUIZ. —10 seconds left. I want to ask Dr. Ranney.

You talked about how healthcare delays caused worsening health outcomes. We have a lack of access in under-served communities. How has those health delays affected the disparities that we see in under-served populations' health?

Dr. RANNEY. Thank you, Representative, and it is a joy to see you, and thank you for representing our specialty in Congress.

Very briefly, we already had wide disparities according to race and ethnicity in health outcomes. Those have only worsened during COVID, both in terms of COVID outcomes and in terms of access to other preventative care and timely treatment. Our safety net hospitals have been the worst affected by the pandemic, by PPE shortages, and, of course, by COVID itself.

Mr. RUIZ. Thank you very much—

Ms. DEGETTE. Thank you so much.

Mr. RUIZ. I yield back.

Ms. DEGETTE. The gentleman's time has expired. The Chair now recognizes Mr. Dunn for 5 minutes.

Mr. DUNN. Thank you very much, Madam Chair and Ranking Member Griffith, for hosting us here today to discuss the impacts of COVID-19 on American healthcare. The impacts across all medical specialties are so wide-ranging that it would be literally impossible to adequately address them in a single hearing. It is my hope, however, that this committee will continue this important work.

Dr. McBride, I greatly appreciate your remarks and ongoing work to raise awareness of the detrimental effects of masking policies and school closures on our Nation's children with no proven benefit. President Biden's COVID response team and public health officials have actually failed our children in this regard. America is behind the curve on in-person schooling and school masking policies, and the most concerning impact that I am hearing about is a sharp uptick in suicidal ideation among children, as well as record numbers of children presenting to emergency rooms having attempted suicide. This is a government-manufactured tragedy.

I am also learning of developmental and learning delays among children, which is concerning in its own right. This Administration's public health policies have been an outright failure, and destroyed the credibility of our public health officials, as my colleague, Mr. Palmer, noted.

The—I would like at this point, if I may, to enter into the record an article published last week in the New York Times: "The CDC Isn't Publishing Large Portions of the COVID Data it Collects." I will submit that for the record, if I may.

Do I have consent, Madam Chair?

[No response.]

Mr. DUNN. Do I have your consent for the—to put that in the record?

Ms. DEGETTE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. DUNN. Thank you so very much.

To make matters worse, the New York Times has just revealed what many of us had been suspecting, that is that the CDC had been cherry-picking its data and its studies to suit their message as a means to a political end. Not—they were controlling people, not disease, controlling people. Americans can't make good deci-

sions for themselves and their families when they have no trust in the public health institutions. CDC has violated that trust, and this subcommittee needs to hear directly from them on that subject.

While the mental health impacts of the pandemic are already apparent, the long-term physical health impacts are only beginning to become apparent. In my specialty, urology, a record number of newly diagnosed prostate cancer cases are presenting as metastatic disease—that is to say too late to cure. We know early screening saves lives, and I can't stress enough how important it will be for people to get back to their doctor's office and make up for the missed opportunities of the last two years.

Dr. McBride, to that end, as you know well, hospitals facing a surge of COVID-19 cases postponed many semi-elective surgeries and medical services. Do you think that the postponements and now rescheduling of those elective and semi-elective procedures could be contributing to the current high case volumes, even as Omicron is subsiding?

Dr. McBRIDE. Thank you very much for that question. Yes, I think that delaying care for underlying health conditions has caused major problems.

Pre-pandemic we had surging rates of obesity, substance use disorder, and under—

Mr. DUNN. Lots of things.

Dr. McBRIDE. And—excuse me?

Mr. DUNN. Lots of things. Let me ask you. In your hospital, would you say it is bed capacity or staffing shortages that are most critical to the hospital's capacity to take new patients?

Dr. McBRIDE. I am sorry, can you repeat the question?

Mr. DUNN. Bedding? Bed—shortage of beds, or shortage of staff? Which is more critical in your hospital?

Dr. McBRIDE. So I am not sure I am the right person to answer that question, because I work mostly in the outpatient setting.

Mr. DUNN. OK, that is fair enough. I have been surveying a lot of hospitals in my district, and they all say it is the staffing.

I would also like to ask you this. We know that the public health agencies failed a lot on the messaging, specifically on natural immunity. Can—they have only recently recognized that. Can you tell us how—what that meant to our COVID response?

And tell me also if there is any disease that we vaccinate for after somebody recovers from that disease. So smallpox, yellow fever, diphtheria. Do we come in behind the disease and vaccinate? I can't think of one.

Dr. McBRIDE. Well, I mean, I can think of one off the top of my head, which is the chickenpox virus that lives latent in our system. If we had chickenpox as a child, we boost people later in life to prevent shingles, which is the reactivation of chicken pox.

Mr. DUNN. That is a different, very different virus—

Dr. McBRIDE. Well, sure.

Mr. DUNN [continuing]. Vaccine.

Dr. McBRIDE. Excuse me?

Mr. DUNN. It is a different vaccine.

Dr. McBRIDE. Yes.

Mr. DUNN. Yes. So, I mean, but you don't reintroduce chickenpox to the——

Dr. MCBRIDE. So let's talk about natural immunity. So I don't love the word "natural immunity," because it——

Mr. DUNN. From infection.

Dr. MCBRIDE. But what I would call—you know, there is vaccine-induced immunity and there is infection-acquired immunity. We all, ultimately, will be——

Mr. DUNN. I see my time is running out. I am just going to say that, when I was in med school, they taught us that mandates undermine public confidence in public health. And——

Ms. DEGETTE. Would the——

Mr. DUNN [continuing]. We didn't do that.

But I yield back, Madam Chair.

Ms. DEGETTE. Dr. McBride, do you want to finish your answer on that?

Dr. MCBRIDE. About the——

Ms. DEGETTE. Natural immunity versus——

Dr. MCBRIDE. Sure. So there is infection-acquired immunity and there is vaccine immunity. We all, ultimately, will be tragically exposed to coronavirus, whether we want to or not. It doesn't mean we will all get infected or get sick.

We would rather be prepared by getting vaccinated when we are ultimately faced with the virus, because the vaccines, as we know, take the claws and the fangs away from the virus, and turn it into a more manageable disease.

At the same time——

Ms. DEGETTE. Thank you.

Dr. MCBRIDE [continuing]. It is important to recognize infection-acquired immunity is real. And in some people and populations it is more durable and superior to vaccine-induced immunity. It is important we recognize that the human immune system is not a political body, that it has basically—that it is the human immune system, and that we need to recognize people's lived experiences, people who have been exposed and infected, and to weave that into decisionmaking in the doctor's office as to whether or not to get a third shot, or a fourth shot, or whatever we may end up doing in our public health guidance.

And also, we need to recognize that that should drive public policy when we are thinking about mandates.

Ms. DEGETTE. Thank you. Thank you so much. It goes back to, as Mr. Palmer said, science.

Let's now recognize Miss Rice for 5 minutes.

Miss RICE. Thank you, Madam Chair.

The public health and healthcare workforce shortages in the United States, obviously, pre-dated the pandemic. But as we all know, it has made an already bad situation rise to the level of a crisis situation over the past two years. Even before COVID-19, public health departments faced a workforce shortage created by limited resources and an exodus of retiring workers. These existing challenges were further amplified under the strains of the pandemic.

But the shortage in health professionals isn't just limited to the public health sector. Estimates by the Health Resources and Serv-

ices Administration predict that, by 2030, the demand for all types of primary care providers, including physicians, nurse practitioners, physician assistants will exceed supply of these workers by more than 15 percent. Demand for nursing occupations in long-term care settings is likewise expected to grow 46 percent by 2030. So it is clear that we need strategies and solutions to address this provider gap.

Ms. Austin, can you share more about your experience in managing Emory Midtown's nursing team through staff shortages during the pandemic?

And let us know what your biggest challenge in keeping your shifts actually staffed—

Ms. AUSTIN. Yes, thank you for the question.

You know, we talked earlier about the cost of travel contracts. What we have done here at Emory is that we have invested in contract labor, one, because we know that, when nurses have the support that they need, when nursing ratios are adequate and are safe, our patients receive better care. That is a big thing that we stand on here at Emory, is quality patient outcomes. We couldn't have done it without contract labor. We want to make sure that, again, our nurses have safe staffing ratios.

And even prior to the pandemic, we had what I would consider probably one of the best nursing staffing ratios in the city, and we get that information from nurses who come to us from other hospitals. So I would say that we have typically done a really good job with that. We are ahead of most health systems in that respect.

But we are not immune to what has happened during this pandemic, where we have seen nurses leave. So we have had to again bolster our staff using contract labor to ensure our patients receive the care and have the outcomes that we would want them to.

Miss RICE. Thank you.

Dr. Riley, you reference in your testimony the Association of American Medical Colleges, the fact that they found that the strains that COVID-19 placed on the health—workforce has been felt most acutely by women, physicians, and physicians of color. And as you stated, the field of obstetrics and gynecology has been particularly impacted.

How have these shortages affected maternity care teams and patients in your practice?

Dr. RILEY. So I think that the concern is that, because we work in a team, when we are missing even one or two people, you know, and their expertise, it is really difficult to give patients the experience that they deserve.

So we, you know, break our necks to be sure it is safe, but being able to take the time to teach breastfeeding, and take the time to, you know, get people ready to go home with this newborn that they don't know what to do with, those are the things that tend to get lost. And so I think that the—you know, unfortunately, I suspect that there are patients who will say, "My experience was not as great as it could have been." And I think that that is really pretty tragic.

I do think also, as we think going forward, it is not going to be a quick fix to—we can't just plug people into the workforce. And so I really think that we need to think way back, and start at

STEM. We need people who are going to be able to, you know, really work on the science, as people have said multiple times during this conversation. And we need to start that as early as, you know, third grade, fourth grade, whatever it is, and get people excited about science, because we just need so much help.

Miss RICE. You know, you make a good point, Doctor, because, you know, if there is one thing that we have seen also, maybe one of the upsides, was that there has been this increased interest in people getting involved in the medical field, whether it is from, you know, EMTs to nursing to doctors. And we should do everything we can to enable people to enter those fields

[inaudible]. Obviously, as we have all been talking about, we need to increase the pool of this workforce.

So thank you all so much for coming and testifying today, and I yield back the balance of my time.

Thank you, Madam Chair.

Ms. DEGETTE. I thank the gentlelady. Mr. Joyce, you are now recognized for 5 minutes.

Mr. JOYCE. Thank you, Chair DeGette, for yielding, and to Ranking Member Griffith for holding this hearing today. I would also like to thank our distinguished panel of physicians and health providers for not only appearing here today, but for all the work that you have done during this pandemic.

Dr. McBride, recently entered into this hearing, a New York Times article reported that the CDC over the last year collected extensive data on vaccine and booster effectiveness, breakthrough infections, and wastewater collection for the presence of virus, but subsequently released very little information of this data.

Even what was released included the CDC Morbidity and Mortality Weekly Report, which was published in late January of this year—showed that during the Delta surge case rates for those with previous infection, what we consider acquired immunity, and no vaccination were substantially lower, almost four to five times lower, than those who were previously vaccinated, four to five times lower with acquired or natural immunity, and hospitalization rates followed a similar pattern.

What is the impact of the CDC withholding data or delaying the release of that data for you, as a healthcare professional on the front line treating those with COVID-19?

Does this withholding data fracture your relationship to utilize CDC information when you are one on one with the patient?

Dr. MCBRIDE. Thank you for that question. Trust is the glue in patient care and in public health. And I do worry that we have seen an erosion of trust in doctors and in public health institutions.

We need our institutions to succeed. I want the CDC to succeed. We need to have broad public health advice. We also need clear communication of truthful, real-time data and information. We need to have—as Dr. Ranney touched on, we need to understand who is in the hospital. Is it an incidental COVID infection, or is it someone who has—is in the hospital for COVID-19? Is that person—you know, we need to know in terms of racial and ethnicity data. We need to know, do they have underlying conditions? We have so much work to do to have the public understand and trust what the CDC is telling us.

One of the parts of my job that has been very, very challenging during the pandemic is helping people make sense of the news and the changing guidance. You know, people don't have the luxury of paying attention to COVID like I have every single day for the last two years. And so they are calling me with just everyday decisions. And I think one of the challenges is that, even people who are paying attention have a hard time making sense of the guidance, and there has been an erosion of trust, because they see the New York Times article, for example, last weekend talking about withholding of information.

Again, I do not ascribe mal intent or ill intent. I simply think we need much more transparency and trust and communication of facts to the general public.

I think another thing is, for people to trust the CDC, the CDC needs to trust people. It needs to trust people with—it needs to trust people that they can handle murky and muddy information. When I have a patient who has a diagnosis, but I am not yet sure what the trajectory is, it doesn't help my patient for me to withhold information or to not tell them the full truth. I want to give them hope when it is rooted in the facts and the science, but I also want to be honest and real with them about what is going on. Same goes for the public.

People are smarter than we give them credit for. The public is paying attention to a lot of the data that is coming out. And I think, if the CDC could more transparently communicate facts and data in real time, then we, as primary care doctors, can act more as the lieutenants for the CDC, and transmit that information to our patients for their everyday lives. Should I go to school? Should I go to work? Which vaccine? How many booster shots do I need?

Mr. JOYCE. Does that—my time is limited, but does that lack of transparency and transfer of information, which you just discussed, does that make your job more difficult—

Dr. MCBRIDE. Absolutely.

Mr. JOYCE [continuing]. As a Johns Hopkins-trained physician, someone who is used to dealing with data, used to dealing with this every day of how you practice, does that lack of transparency from the CDC make your job as a physician more difficult?

Dr. MCBRIDE. It absolutely does. And one of the reasons why I have cut my practice in half in the pandemic, and am donating 50 percent of my time doing advocacy work and pro bono work, is that I am trying to help people—stripped of politics, stripped of ideology, no financial incentive, I am reaching now almost 20,000 people with a weekly newsletter to dispense nuanced, contextualized information to a wide audience. I am reaching people in rural America. I am reaching people in urban areas who don't have access to primary care doctors.

It is hard when the CDC is putting the burden on the general public, and when we don't have access—80 million Americans, as I said earlier, don't have access to a primary care doctor to translate the information—sometimes confusing, and sometimes not the full picture—into everyday decisionmaking.

And so again, we need trust, transparency, first and foremost. We need primary care doctors out there for people to have access

to information that—and we need primary care doctors to be able to trust the CDC.

Again, I believe in the CDC.

Ms. DEGETTE. The gentleman's time has expired—

Dr. MCBRIDE. I trust the CDC in many ways, but we need to do better.

Ms. DEGETTE. The gentleman's time has expired. Thank you.

Mr. JOYCE. Thank you, and I yield.

Ms. DEGETTE. The Chair now recognizes Ms. Schrier for 5 minutes.

Ms. SCHRIER. Thank you very much, Madam Chair. This has been quite a 2-years, and we have learned a ton, and a lot of those topics have been discussed already today. I think that there are questions that are still going to come at us, and that may hit us very hard. My question is going to be directed at Dr. Riley, so I will just give that heads up.

I am a pediatrician, 20 years in practice. I have experienced vaccine hesitancy, which is about one percent of my—of the parents that I would see who would flat-out say, no, not immunizing, no way, no how. Probably around ten percent, 15 percent. Just—questions, they just—very legitimate questions. I just had to meet them where they are, answer some questions, make them feel reassured. And then we moved on, and got everybody vaccinated. I have just been blown away by how politicized this has become, by the extreme misinformation out there, and vaccine—it is not just hesitancy, it is like a rabid sense that is anti-vaccine.

The question I think we may be headed for now is what will this now do to routine childhood vaccinations that—it is not just going to be a question of whether children in school should be required to have a COVID vaccine, it is—I am wondering—perhaps going to be a question of re-examining every routine childhood vaccine, measles, mumps, chickenpox, you name it, and questioning that.

And so, Dr. Riley, I was just wondering if you could comment on any concerns you might have there, or what you thought might be coming our way.

Dr. RILEY. I certainly agree with your thought that vaccine hesitancy is, you know, truly a problem. I think the WHO just recently named vaccine hesitancy as a global health issue to really be grappled with. And I think that we have to recognize that, as people lose confidence in science, which is unfortunate, and as our inability to communicate in all the different ways that we need to, that just fuels the vaccine hesitancy.

I think that we have to get back to the basics, understand, you know, the diseases that we are trying to prevent, let the public understand the diseases and how devastating they can be, and then, you know, re-educate on the benefits of vaccines, not—in addition to the safety, but also the benefits to prevent disease. And I think that that is, you know, sort of where we are going to need to go.

But I share your concern as I try and, you know, explain to pregnant women every day that this is—you know, the COVID vaccine is something that we feel will decrease the likelihood that they themselves will be ill, and that there is evidence now that there is protection for their babies.

Ms. SCHRIER. Thank you, and I share those concerns. In fact, I am even a little bit more concerned now, because even seeing how many people have died in this country, how many people are in the hospital, you know, the vast difference between vaccinated people who are safe from being in the hospital or dying, and those not—even with that data, there is still extreme hesitancy. And so I wonder if conversations about measles and how devastating that can be will even carry.

Speaking of lack of trust, just a quick question for Dr. Ranney: public health. There is tremendous need across the board. We don't have a public health infrastructure, and then distrust grew in our public health system. Do you think that, if we had a baseline public health infrastructure, where in routine cases they would be doing well baby visits at homes, and helping with mental health and substance abuse disorders, if we had that infrastructure already in place, do you think we would have more success rolling out a big public health campaign, come any future pandemic?

Dr. RANNEY. Thank you, Representative. Absolutely. Our investing today adequately in our public health infrastructure is critical for us dealing with future surges of COVID, and whatever comes next.

Community health workers and peer specialists are important. Disciplining physicians who are active purveyors of disinformation is critically important, and our correctly interpreting and sharing those interpretations of data with our patients is important.

And I actually want to take a moment to correct some of the prior information that has been shared. There actually was not a dramatic increase in pediatric suicides during lockdowns. In fact, pediatric suicides dropped dramatically during lockdowns, and we have seen a small increase in adolescent girls' emergency department visits, most significantly over the last couple of months. So I just want to correct the record on that part.

But overall, investing in public health infrastructure, ensuring that they have adequate workforce, adequate tools, adequate ability to get data and then share it nationally, which will speed up the sharing of data by the CDC if they get good data from local departments, is absolutely critical to our meeting the challenges of the future head on.

Ms. SCHRIER. Thank you very much. Thank you for setting the record straight. I yield back.

Ms. DEGETTE. Thank you so much. The Chair now recognizes Mrs. Trahan for 5 minutes.

Mrs. TRAHAN. Thank you, Chairwoman DeGette and Ranking Member Upton, for holding this important hearing.

As many of my colleagues have mentioned today, the COVID-19 pandemic brought healthcare workforce issues to the forefront as it exposed gaps and weaknesses in our Nation's preparedness for public health emergencies. And these workforce issues are present across healthcare workforces, and have highlighted the need for public health, behavioral health, EMS, primary care, and long-term care professionals.

The effects of these shortages are especially felt in under-served communities, which have historically experienced diminished access to healthcare services. Indeed, nearly half of the counties in

Massachusetts have shortages of infectious disease physicians, and our westernmost county has zero. That is why I introduced the Bolstering Infectious Outbreaks Preparedness Workforce Act with Congressman McKinley, which will offer student loan repayment as a major new incentive to recruit more physicians, nurses, and other healthcare professionals to work in infectious diseases

[inaudible] preparedness in communities with the greatest need.

So, Dr. Ranney, why is access to loan forgiveness, especially for medical specialties with lower average annual salaries like ID physicians, important in building up and retaining a robust and diverse healthcare workforce?

Dr. RANNEY. Thank you very much for that question. So the average physician graduates with more than \$200,000 of debt. They go through residency, where their debt continues to grow, and then that can dissuade folks from taking on some of the lower-paid professions. Many folks that do go into primary care actually choose to not take insurance, and to take direct concierge care payments instead, in order to increase their income.

I myself was the benefit of the loan repayment program in order to pay off my medical school loans. I know that Dr. Calac was, as well. It is critical, in terms of getting physicians and other healthcare professionals to be able to work on the front lines in under-served communities, to be able to spend time doing research, and to do other critically important public health functions, and to not take those higher remunerating jobs, to not have to go to areas that pay better.

I will also say that loan repayment would make a big difference for those that have been on the front line for the last couple of years as a small token of gratitude to help retain frontline providers who have been there throughout the pandemic. Having a loan repayment program such as Congresswoman Maloney's would be helpful for those who have served throughout the pandemic.

Mrs. TRAHAN. Absolutely, and I thank you for flagging Chairwoman Maloney's bill, because I couldn't agree more.

I am going to switch gears because the President mentioned last night in his State of the Union address the importance of Congress conquering other public health crises, such as rising substance use disorder rates that require specialized healthcare professionals.

And I would like to just ask you one more question, Dr. Ranney. As you noted, the importance of American Rescue Plan workforce investments, including for substance use disorder treatment and recovery programs, you know, I was encouraged to see that Brown University's Warren Alpert Medical School class of 2020 graduates were the first in the Nation to graduate with training that allows them to prescribe medications to treat opioid use disorder in any U.S. State.

So as a trained emergency physician, you interact with patients seeking treatment for a range of physical and mental health issues, and often have opportunities to provide effective interventions for individuals with an opioid or other substance use disorder. In your experience, do you agree that more patients with OUD could be helped if comprehensive training on how to identify, treat, and manage patients with a substance use disorder was the standard?

Dr. RANNEY. One hundred percent I agree. In my emergency department, thanks to the leadership of our former director of health, Dr. Alexander Scott, as well as our former Governor, now Secretary of Commerce Raimondo, we actually have standard screening—we have standard protocols for every patient that comes in with opioid use disorder.

We prescribe Suboxone at the bedside during an emergency department visit for folks who have overdosed on opioids. That has been shown over and over again by my fellow emergency physicians, as well as addiction medicine specialists, to be the best way to help prevent overdose deaths.

Surrounding that with a suite of pre-recovery supports is also critical, whether in-person or remote. This is one of the most important things that we can do to help folks who are subject to opioid use disorder.

And I will strongly urge that we actually get rid of the X waiver requirement, which is a huge barrier to prescribing a medication that is no more dangerous—and perhaps more helpful—than many of the medications that we prescribe every day for many other disorders.

Mrs. TRAHAN. Well, thank you. I appreciate both of those answers.

And to all the other witnesses, thank you for your testimony today.

I yield back. Thank you, Madam Chair.

Ms. DEGETTE. I thank the gentlelady. The Chair now recognizes Mr. O'Halleran for 5 minutes.

Mr. O'HALLERAN. Thank you, Madam Chair and Ranking Member, for holding this meeting. Thank you to the panelists for their presentations today.

The issues that we have heard from today's witnesses are not new. The pandemic has strained our health systems and exposed our doctors, nurses, and frontline workers to overwhelming conditions and a constant struggle to treat patients and save lives.

I was happy to spend the last two weeks touring my district and talking to healthcare providers and administrators. These are rural and tribal providers, and they are struggling. Some of these struggles are not new. Payment models continue to discriminate against rural providers, and healthcare systems continue to incentivize doctors and providers to settle in urban and suburban areas and practice medicine in well-resourced settings.

But what is new are incredible staffing challenges. Hospitals, community health centers, our doctors' offices, paramedics, EMTs, and ambulatory services, among others, are all suffering from the same staffing issues, and it is harming access to care in rural and tribal areas. This is an area that is—this committee needs to be focused on, and I look forward to working with anyone who is interested in actually addressing the issues that rural and tribal communities are facing.

Just as a side issue, you know, a lot of people will say, "Well, why don't they just move into urban areas?" Well, we need them out in rural areas for producing the food, bringing water in, making sure our transportation systems work, on and on and on. This is a combination that is needed critically in our future.

So, Dr. Calac, thank you for joining us today. Your testimony highlights this longstanding lack of investment in Indian Health Services facilities. Can you elaborate on some of the challenges the Indian Health Council faced in providing quality medical services within your community before the pandemic?

Dr. CALAC. Thank you for the question. Just a couple of comments regarding the workforce that currently exists now.

So I am one of only two pediatricians in the area surrounding a 50-square—or 50-mile radius from our site. So that poses a challenge to provide that pediatric care.

But also, with the same concern for the demographic, the need to have kids enter STEM programs such as the Native American Research Centers for Health, which is a NIH-funded program to retain and recruit Native Americans to go into medical school and/or research, is an important program that actually highlights your concerns and the needs for promoting recruitment and retention for this workforce.

And I would also like to comment on the fact that my son is actually one of—actually, the only M.D./Ph.D. who will be at University of California San Diego, providing—or finishing up his studies there over the last four years. But he will be the only Native American from this area to accomplish that feat.

So I think just examples of those wide disparities show a need to have a continued workforce, and some of the challenges that tribes and rural areas as a whole across the country are facing.

Mr. O'HALLERAN. Well, thank you, Doctor. And this is another question for you.

Since my time in Congress I have focused on addressing longstanding failures of the Federal Government to provide support to tribal communities and, for that matter, rural communities throughout our country.

However, since the pandemic, Congress has taken several actions to support tribal communities, including increasing funding through the CARES Act, the American Rescue Plan, and the bipartisan Infrastructure Investment Jobs Act. Which programs have been most effective throughout the pandemic?

And, should we rework—and should be reworked to provide additional support to tribal healthcare?

And if you can, comment also to rural healthcare.

Dr. CALAC. Yes, thank you. The funds that have been provided through the CARES Act and through several different funding mechanisms to support the tribal missions in the area have been phenomenal. And without those funds we would not have been providing the care that we have done so with testing, tracing, treatment for those individuals afflicted with COVID, and providing the supportive care for the preventive healthcare measures that we have had to catch up on.

It is said that pediatrics are almost a year and a half back, in terms of preventive health exams. So I think looking at Indian Health Service funding and other public health service programs, since the budgets have been relatively flat over the last ten years, is an important first step.

Mr. O'HALLERAN. Well—and thank you, Doctor. Thank you, Madam Chair, and I yield.

Ms. DEGETTE. I thank the gentleman.

We have several members of the full committee who have asked to waive on, and we are always pleased to accommodate them. So first I will recognize Mr. Carter for 5 minutes.

Mr. CARTER. Thank you, Madam Chair, and thank all of you for participating in this. It is extremely important.

I want to ask kind of a general question, and I will start with you, Dr. Ranney. What data do you think the CDC should be collecting at this time that it hasn't collected?

Dr. RANNEY. Thank you for that question. You know, the big challenge that the CDC faces is that there is very little mandated data from local or State health departments that is required to be reported to the CDC.

There is also a lack of standardization of data, which means that, when the CDC gets it, they have to spend a lot of time cleaning and verifying it, which then delays release of the data to the public.

And there is simply an absence of much data, such as others have outlined: age, race and ethnicity, income level, et cetera, of cases and hospitalizations. There is a lack of data around adequate staffed beds. HHS reports hospital beds and hospital capacity, period but doesn't take account for staffing shortages.

The wastewater data is a great thing that is going to be really important for us for predicting future surges. I could go on.

The best analogy that I can make is I think back to when we fought the epidemic of car crash deaths back in the 1970's. We developed NHTSA, and we developed multiple, well-funded data initiatives within NHTSA, such as the fatality accident reporting system, the EMS information systems. Those are critical ways that we can monitor in real time new reasons for increasing car crashes and car crash deaths, and then change things accordingly. We need the same type of system in place for COVID data to allow us to have early warnings, and to respond in kind.

Mr. CARTER. Well, thank you. Thank you for that.

Dr. Riley, I will ask you the same thing. What data should the CDC be collecting at this time that you don't think that they are collecting?

Dr. RILEY. So I really think I would just add on to that, that one of the major issues that doesn't ever come up is whether or not someone is pregnant or lactating. And so that field alone would allow us to understand, you know, what is happening to that particular patient population.

And as I said in my testimony earlier, I think that we need to understand two things: one is what is the impact of COVID infection on pregnancy and lactating women; and then what is the effect of or the effects of vaccination on that same population. But without asking those questions, we are sort of left not knowing.

Mr. CARTER. Hey, great responses, thank both of you.

Dr. McBride, I will go to you. Do you think there should be a wider variety, if you will, of voices that—at the COVID-19 response itself? Are we including enough different people, and enough different—and a variety of people, of professionals?

Dr. MCBRIDE. Thank you for that question. I think the more voices, the more diverse array of experiences and areas of expertise, the better.

Personally, I wish that there were more mental health experts—

Mr. CARTER. Exactly.

Dr. MCBRIDE [continuing]. In the COVID-19—because this is a collective trauma, this is like no other experience in at least my lifetime, but it is a collective trauma that really warrants careful attention to individual and population mental health.

But yes, absolutely. We need all sorts of races, ethnicities, income levels, areas of expertise—

Mr. CARTER. Absolutely, good.

Dr. MCBRIDE. All of it.

Mr. CARTER. Thank you. Thank you.

Ms. Austin, I wanted to ask you very quickly, in—do you feel like—that the clarity that you got from CDC for your nursing staff on when to wear PPE, and what kind of PPE, do you think that that was sufficient?

Ms. AUSTIN. I think early on we had a great deal of trust in the information that we were receiving from the CDC. I think the thing that caused a little bit of concern was when some of those things changed. I have heard from many of the nurses at the—on the front lines, is their concerns about the changing mandates, the changing information.

So I would just say that, yes, there was concern about the information that changed. But overall, I would say that I respect the CDC's position, and have followed their guidance throughout this pandemic.

Mr. CARTER. Good.

And Dr. Calac, I guess you are the only one I haven't asked a question. The same question there. Any—the consistency of the CDC and the information you were getting.

Dr. CALAC. I would just echo Ms. Austin's comment. Yes, the PPE that—we have been trained for many years in its use in multiple different situations, other than just COVID, I think was a usable practice that we had instituted.

However, the effectiveness of different masks, whether they be two layers, cloth, N95s, was somewhat disparate as we moved forward in the pandemic. But still looking forward to additional support and improved guidance as we round out the pandemic and looking forward to the next.

Mr. CARTER. My time has expired. Thank you, Madam Chair.

Ms. DEGETTE. I thank the gentleman. The Chair now recognizes Mr. Sarbanes for 5 minutes.

Mr. SARBANES. Thank you very much, Madam Chair, and thank you for allowing me to waive on to this hearing today. I appreciate it very much.

Obviously, the focus here has largely been on workforce shortages, particularly aggravated or exacerbated by the pandemic, when we look at the healthcare workforce. But we know these shortages have been accumulating. It is a, I guess, a strange turn of phrase, "shortages accumulating," but that is what has been happening for years now. And we are just looking at new and extra dimensions of that challenge.

I have been focused on this for a long time, was able to work to get a provision into the Affordable Care Act that would create a

National healthcare Workforce Commission to kind of systematically look at and assess what the shortages are, and put forward recommendations, policy recommendations, on how to address, and we are going to continue to try to bring that focus to bear. But we also have to get creative, I think, and innovative about how to meet those shortages, whether it is nurses or physicians, other caregivers in the continuum of care.

And Dr. Ranney, I apologize if I am not pronouncing your name correctly, but I would be interested in getting your perspective. I have a bill that I am re-introducing called the Primary Care Physician Reentry Act. It would direct the Department of Health and Human Services to establish a demonstration program that could facilitate physician reentry into primary care clinical practice after an absence from their practice for one reason or another after retirement to try to create an incentive, an expedited process of bringing these physicians back.

Do you think that that is a good idea, could that help us?

Do you think that it would be appealing to retired physicians?

Do you think it could help us address this workforce shortage?

If you could speak to that, I would appreciate it.

Dr. RANNEY. Thank you. I am not familiar with your bill, but look forward to learning about it.

I will also say that Dr. McBride is the primary care doc, not me, so I will let her talk about what will get folks into primary care.

But I do think that providing avenues, on-ramps to get physicians who have left bedside care back comfortable with the current clinical care environment, with current data around medical care, and getting them back into the clinical sphere is certainly something that would be helpful.

Whether it is about retired physicians or others who have left bedside care for a variety of other reasons, having a way to re-acclimate, to buildup our clinical skills, and get back into bedside care is a terrific idea.

Mr. SARBANES. Thank you.

Dr. McBride, if you could, give me a quick thumbs up or thumbs down on that as a possible benefit, in terms of getting more physicians into the—

Dr. MCBRIDE. Yes, absolutely—

Mr. SARBANES [continuing]. To address the shortage, I would appreciate it.

Dr. MCBRIDE. Whatever we can do to get more people into primary care. And not just to get more people in primary care, but to incentivize them to go into primary care, instead of subspecialty medicine, for example.

You know, those of us in primary care went into this field to be able to have time with patients, to establish a relationship so they can talk to you about their depression, their anxiety, and their dementia, and their diabetes, and their myriad health issues.

My patient who is 82 I saw earlier this week. He is on 15 medications. He has a new heart valve. He has atrial fibrillation. He has hypertension. He has diabetes. And he has newly lost his wife. If I have 5 minutes to talk to the patient, I really cannot do my job. I cannot do what needs to be done.

So we need to make sure that we are not only incentivizing doctors out of medical school to go into primary care, we need to change the system so that time with a trusted guide is the commodity, instead of, you know, treating primary care as just sort of a referral mill, where—and where the rapport and the relationship is, and the—isn't the commodity.

The commodity needs to be the trust, the rapport, and the relationship. There is a lot we can do when we sit down with our patients and talk to them, look them in the eye, and help them kind of meet their broad human needs by understanding who they are as a person, and what their specific vulnerabilities are, and how to protect them from the myriad threats that people face, whether it is COVID-19, or loss, or, you know, other health harms.

Mr. SARBANES. I appreciate that, and I like that idea of the commodity of trust, and how we can invest in it and make sure that we reimburse for it in a way that creates the right incentives.

Dr. RANNEY. I have just got a couple of seconds left here. Why shouldn't there be a school-based health center in every school in America to address not just physical health needs on the part of our students, but the increasing mental health needs that they need, fully staffed with counselors, with mental health professionals, with social workers, et cetera? If you could speak to that briefly, I would appreciate it.

Dr. RANNEY. I will say that, heck, right now I would just take a school nurse in every school in America. That, in and of itself, would be tremendous. School-based health centers are great, both for getting kids and families care, and they can be augmented with telehealth or with digital care.

I will also add that, in addition to getting physicians in the workforce, we also need all the staff around us. We are a team. It is not just a physician, it is also nurses, medical assistant, home health aides, and more.

Mr. SARBANES. Thank you very much.

Madam Chair, thank you.

Ms. DEGETTE. I thank the gentleman.

I gotta to tell you, Mr. Griffith and I both want to thank all of the witnesses for coming today. You were a wonderful panel, and a wonderful team. You gave us a lot of great information, and we will use it going forward.

I want to remind members that, pursuant to committee rules, that they have ten business days to submit additional questions for the record to be answered by witnesses that appear in front of the subcommittee.

And I want to ask the witnesses, if you do get these questions, if you can, respond promptly to any of them.

And with that, the subcommittee is adjourned.

[Whereupon, at 1:16 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

3/2/22, 11:27 AM

The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects - The New York Times

The New York Times<https://www.nytimes.com/2022/02/20/health/covid-cdc-data.html>

The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects

The agency has withheld critical data on boosters, hospitalizations and, until recently, wastewater analyses.



By Apoorva Mandavilli

Published Feb. 20, 2022 Updated Feb. 22, 2022

For more than a year, the Centers for Disease Control and Prevention has collected data on hospitalizations for Covid-19 in the United States and broken it down by age, race and vaccination status. But it has not made most of the information public.

When the C.D.C. published the first significant data on the effectiveness of boosters in adults younger than 65 two weeks ago, it left out the numbers for a huge portion of that population: 18- to 49-year-olds, the group least likely to benefit from extra shots, because the first two doses already left them well-protected.

The agency recently debuted a dashboard of wastewater data on its website that will be updated daily and might provide early signals of an oncoming surge of Covid cases. Some states and localities had been sharing wastewater information with the agency since the start of the pandemic, but it had never before released those findings.

Two full years into the pandemic, the agency leading the country's response to the public health emergency has published only a tiny fraction of the data it has collected, several people familiar with the data said.

Much of the withheld information could help state and local health officials better target their efforts to bring the virus under control. Detailed, timely data on hospitalizations by age and race would help health officials identify and help the populations at highest risk. Information on hospitalizations and death by age and vaccination status would have helped inform whether healthy adults needed booster shots. And wastewater surveillance across the nation would spot outbreaks and emerging variants early.

Without the booster data for 18- to 49-year-olds, the outside experts whom federal health agencies look to for advice had to rely on numbers from Israel to make their recommendations on the shots. (After several inquiries from The New York Times about the booster data for that age group, the agency posted it on its website Thursday night.)

3/2/22, 11:27 AM

The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects - The New York Times

Kristen Nordlund, a spokeswoman for the C.D.C., said the agency has been slow to release the different streams of data “because basically, at the end of the day, it’s not yet ready for prime time.” She said the agency’s “priority when gathering any data is to ensure that it’s accurate and actionable.”

Another reason is fear that the information might be misinterpreted, Ms. Nordlund said.

Dr. Daniel Jernigan, the agency’s deputy director for public health science and surveillance said the pandemic exposed the fact that data systems at the C.D.C., and at the state levels, are outmoded and not up to handling large volumes of data. C.D.C. scientists are trying to modernize the systems, he said.

“We want better, faster data that can lead to decision making and actions at all levels of public health, that can help us eliminate the lag in data that has held us back,” he added.

The C.D.C. also has multiple bureaucratic divisions that must sign off on important publications, and its officials must alert the Department of Health and Human Services — which oversees the agency — and the White House of their plans. The agency often shares data with states and partners before making data public. Those steps can add delays.

“The C.D.C. is a political organization as much as it is a public health organization,” said Samuel Scarpino, managing director of pathogen surveillance at the Rockefeller Foundation’s Pandemic Prevention Institute. “The steps that it takes to get something like this released are often well outside of the control of many of the scientists that work at the C.D.C.”

The performance of vaccines and boosters, particularly in younger adults, is among the most glaring omissions in data the C.D.C. has made public.

Last year, the agency repeatedly came under fire for not tracking so-called breakthrough infections in vaccinated Americans, and focusing only on individuals who became ill enough to be hospitalized or die. The agency presented that information as risk comparisons with unvaccinated adults, rather than provide timely snapshots of hospitalized patients stratified by age, sex, race and vaccination status.

3/2/22, 11:27 AM

The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects - The New York Times



President Biden joined a virtual meeting with the White House Covid-19 Response Team in December. Cheriss May for The New York Times

But the C.D.C. has been routinely collecting information since the Covid vaccines were first rolled out last year, according to a federal official familiar with the effort. The agency has been reluctant to make those figures public, the official said, because they might be misinterpreted as the vaccines being ineffective.

Ms. Nordlund confirmed that as one of the reasons. Another reason, she said, is that the data represents only 10 percent of the population of the United States. But the C.D.C. has relied on the same level of sampling to track influenza for years.

Some outside public health experts were stunned to hear that information exists.

“We have been begging for that sort of granularity of data for two years,” said Jessica Malaty Rivera, an epidemiologist and part of the team that ran Covid Tracking Project, an independent effort that compiled data on the pandemic till March 2021.

A detailed analysis, she said, “builds public trust, and it paints a much clearer picture of what’s actually going on.”

Concern about the misinterpretation of hospitalization data broken down by vaccination status is not unique to the C.D.C. On Thursday, public health officials in Scotland said they would stop releasing data on Covid hospitalizations and deaths by vaccination status because of similar fears that the figures would be misrepresented by anti-vaccine groups.

But the experts dismissed the potential misuse or misinterpretation of data as an acceptable reason for not releasing it.

"We are at a much greater risk of misinterpreting the data with data vacuums, than sharing the data with proper science, communication and caveats," Ms. Rivera said.

When the Delta variant caused an outbreak in Massachusetts last summer, the fact that three-quarters of those infected were vaccinated led people to mistakenly conclude that the vaccines were powerless against the virus — validating the C.D.C.'s concerns.

But that could have been avoided if the agency had educated the public from the start that as more people are vaccinated, the percentage of vaccinated people who are infected or hospitalized would also rise, public health experts said.

"Tell the truth, present the data," said Dr. Paul Offit, a vaccine expert and adviser to the Food and Drug Administration. "I have to believe that there is a way to explain these things so people can understand it."

Knowing which groups of people were being hospitalized in the United States, which other conditions those patients may have had and how vaccines changed the picture over time would have been invaluable, Dr. Offit said.

Relying on Israeli data to make booster recommendations for Americans was less than ideal, Dr. Offit noted.

"There's no reason that they should be better at collecting and putting forth data than we were," Dr. Offit said of Israeli scientists. "The C.D.C. is the principal epidemiological agency in this country, and so you would like to think the data came from them."

It has also been difficult to find C.D.C. data on the proportion of children hospitalized for Covid who have other medical conditions, said Dr. Yvonne Maldonado, chair of the American Academy of Pediatrics's Committee on Infectious Diseases.

The academy's staff asked their partners at the C.D.C. for that information on a call in December, according to a spokeswoman for the A.A.P., and were told it was unavailable.

Ms. Nordlund pointed to data on the agency's website that includes this information, and to multiple published reports on pediatric hospitalizations with information on children who have other health conditions.

The pediatrics academy has repeatedly asked the C.D.C. for an estimate on the contagiousness of a person infected with the coronavirus five days after symptoms begin — but Dr. Maldonado finally got the answer from an article in The New York Times in December.

"They've known this for over a year and a half, right, and they haven't told us," she said. "I mean, you can't find out anything from them."

Experts in wastewater analysis were more understanding of the C.D.C.'s slow pace of making that data public. The C.D.C. has been building the wastewater system since September 2020, and the capacity to present the data over the past few months, Ms. Nordlund said. In the meantime, the C.D.C.'s state partners have had access to the data, she said.

Despite the cautious preparation, the C.D.C. released the wastewater data a week later than planned. The Covid Data Tracker is updated only on Thursdays, and the day before the original release date, the scientists who manage the tracker realized they needed more time to integrate the data.

"It wasn't because the data wasn't ready, it was because the systems and how it physically displayed on the page wasn't working the way that they wanted it to," Ms. Nordlund said.

The C.D.C. has received more than \$1 billion to modernize its systems, which may help pick up the pace, Ms. Nordlund said. "We're working on that," she said.

The agency's public dashboard now has data from 31 states. Eight of those states, including Utah, began sending their figures to the C.D.C. in the fall of 2020. Some relied on scientists volunteering their expertise; others paid private companies. But many others, such as Mississippi, New Mexico and North Dakota, have yet to begin tracking wastewater.

Utah's fledgling program in April 2020 has now grown to cover 88 percent of the state's population, with samples being collected twice a week, according to Nathan LaCross, who manages Utah's wastewater surveillance program.

Wastewater data reflects the presence of the virus in an entire community, so it is not plagued by the privacy concerns attached to medical information that would normally complicate data release, experts said.

"There are a bunch of very important and substantive legal and ethical challenges that don't exist for wastewater data," Dr. Scarpino said. "That lowered bar should certainly mean that data could flow faster."

Tracking wastewater can help identify areas experiencing a high burden of cases early, Dr. LaCross said. That allows officials to better allocate resources like mobile testing teams and testing sites.

Wastewater is also a much faster and more reliable barometer of the spread of the virus than the number of cases or positive tests. Well before the nation became aware of the Delta variant, for example, scientists who track wastewater had seen its rise and alerted the C.D.C., Dr. Scarpino said. They did so in early May, just before the agency famously said vaccinated people could take off their masks.

3/2/22, 11:27 AM

The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects - The New York Times

Even now, the agency is relying on a technique that captures the amount of virus, but not the different variants in the mix, said Mariana Matus, chief executive officer of BioBot Analytics, which specializes in wastewater analysis. That will make it difficult for the agency to spot and respond to outbreaks of new variants in a timely manner, she said.

“It gets really exhausting when you see the private sector working faster than the premier public health agency of the world,” Ms. Rivera said.

Dr. Megan L. Ranney

Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”
March 2, 2022**

Dr. Megan L. Ranney, Academic Dean, School of Public Health, Brown University

The Honorable Diana DeGette (D-CO)

1. How have chronic and acute workforce shortages impacted the ability of our nation’s health system to respond to the current pandemic and what are the implications of these shortages as the health system seek to remedy the effects of deferred care during the pandemic?

Subcommittee-member DeGette, both chronic and acute workforce shortages affect our ability to respond to not only the Covid-19 pandemic, but also other healthcare needs. As described in my original testimony and elaborated below, some shortages existed prior to the pandemic - but our workforce has been universally, negatively impacted by the pandemic.

Over the last two years, burnout in my own specialty of emergency medicine has increased from 43 to 60 percent; rates of moral injury have risen; 75 percent of healthcare workers reported symptoms of depression in winter 2020-2021; and both objective and subjective reports of workplace violence increased in conjunction with Covid-19 cases.^{1 2 3 4} In response, 18 percent of healthcare workers have quit; depending on the source, between 1/3 and 2/3 of nurses report that they’re planning to leave bedside care.^{5 6 7} These staffing shortages not only impact hospital systems, but also every other part of the healthcare system - home healthcare aides, nursing home staff, and more.

Despite the current lull in cases, the number of healthcare workers is not recovering fast enough. A recent Kaiser Family Foundation analysis shows that, as of February 27th, 2022, 29

¹ https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?uac=85323SN&faf=1&sso=true&impID=3962382&src=wnl_physrep_220122_Burnout2022

² <https://www.cnn.com/2020/11/18/opinions/health-care-workers-covid-19-burnout-ranney-gold/index.html>

³ <https://link.springer.com/article/10.1007/s11606-021-07252-z>

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8457914/>

⁵ <https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/>

⁶ <https://www.aha.org/fact-sheets/2021-11-01-data-brief-health-care-workforce-challenges-threaten-hospitals-ability-care>

⁷ <https://www.beckershospitalreview.com/workforce/66-of-nurses-say-pandemic-has-made-them-consider-leaving-profession.html>

Dr. Megan L. Ranney

percent of nursing facilities reported having staff shortages.⁸ This is slightly improved from the 32 percent reported in January 2022, but still dramatically higher than the 19 percent vacancy rates reported in February and March of 2021 (Note: Nursing facilities only began reporting this data in May 2020).⁹ In Pennsylvania, Allegheny Health Network has had three times as many nurse openings this March compared to the same time last year.¹⁰ Nurses who had been with the system left to become travel nurses for higher pay, leaving the healthcare system with a myriad of open spots that it, in turn, has to fill with travel nurses itself. This, in itself, is nothing more than a stopgap measure, as travel nurse rates place considerable strain on health systems' finances, which in turn may cause other strains in the system and further exacerbate staffing shortages down the line.

These chronic and acute issues have culminated in a healthcare system that does not serve patients' needs. We've had to increase wait times, stop non-emergent surgeries, and delay preventive care - all of which have significant direct impacts on patients. The average emergency department wait time in the United States increased three-fold during the pandemic, from roughly 22.4 minutes pre-pandemic to 62 minutes in 2021.¹¹ Due to staffing shortages, many hospitals across the country have had to make the difficult decision to prioritize emergency care over non-emergent operations.^{12 13 14} Many patients have been unable to much-needed undergo procedures such as colonoscopies, heart surgeries, and brain surgeries. In a February 2022 CVS Health-Harris Poll National Health project, researchers found that a quarter of adults had treatments or surgeries delayed, and that a fifth of adults had doctors who stopped practicing entirely.¹⁵

⁸ <https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/>

⁹ <https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/>

¹⁰ <https://www.wsj.com/articles/covid-19-hospitalizations-are-down-but-nurse-shortages-stretch-hospitals-11646217000>

¹¹ <https://health.usnews.com/health-care/patient-advice/articles/2018-10-26/why-do-i-have-to-wait-so-long-to-be-seen-in-the-emergency-room>

¹² <https://www.nbc15.com/2022/01/06/madison-health-systems-postpone-non-emergent-surgeries-amid-peak-capacity/>

¹³ <https://www.wglt.org/local-news/2021-12-30/pritzker-urges-hospitals-to-delay-non-emergency-surgeries-as-mclean-county-sets-new-covid-records>

¹⁴ <https://www.fiercehealthcare.com/hospitals/hospitals-postpone-elective-surgeries-amid-omicron-surge>

¹⁵ <https://www.axios.com/the-health-worker-shortage-is-starting-to-get-real-for-americans-6b5775fa-49c6-45c6-a557-cbc03c442c2b.html>

Dr. Megan L. Ranney

The lack of adequate home healthcare services restricts nursing homes' ability to discharge patients home, which in turn causes a lack of nursing home space, which then worsens hospital overcrowding.¹⁶ We've also seen dramatic increases in boarding for mental health emergencies, and decreases in availability of outpatient behavioral health care.^{17 18}

¹⁶ <https://www.forbes.com/sites/howardgleckman/2022/02/17/how-nursing-home-staff-shortages-are-hurting-hospital-care/?sh=615121e237eb>

¹⁷ <https://www.usnews.com/news/health-news/articles/2022-01-07/emergency-departments-a-frayed-safety-net-for-behavioral-mental-health>

¹⁸ <https://www.thenationalcouncil.org/news/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/>

Dr. Megan L. Ranney

The Honorable H. Morgan Griffith (R-VA)

1. Do you believe that health systems benefit from the use of digital health technologies, like remote patient physiologic monitoring (RPM), to help clinicians care for patients and relieve stress on nursing staff?

Subcommittee-member Griffith, during the pandemic, we saw a quick pivot to the use of telehealth and digital health, because we simply had no other choice. Utilization of digital health technologies skyrocketed as healthcare systems quickly adapted to social distancing, self-quarantine, and lockdown policies.

A December 2021 HHS study found that Medicare Fee-For-Service telehealth visits increased 63-fold during the pandemic; from 840,000 in 2019 to 52.7 million in 2020.¹⁹ Expanding the scope beyond just Medicare-related telehealth services, we saw that, in general, telehealth usage was 38 times higher than pre-pandemic rates - with a 78-fold peak in April 2020.²⁰ Since April 2020, telehealth has comprised roughly 17 percent of all outpatient/office visits, with variations in uptake by specialty.²¹ From April 2020 to July 2021 for example, telehealth utilization in psychiatry comprised 50 percent of all psychiatric sessions while telehealth utilization for ophthalmology comprised only two percent of all ophthalmology sessions.²² Growth of remote patient monitoring - a part of digital health that allows tracking of vital signs and other physiologic measures at home - has grown by a third (from 29.1 million U.S. users in 2020 to 39.3 million users in 2021) over the course of the pandemic, and is expected to increase to 53.1 million users by 2023.²³ Use of other forms of digital health has grown, as well.

Preliminary data suggests that telehealth and digital health innovations successfully de-stressed hospitals and improved care of patients at home during the worst of the pandemic. For example, Northwell Health used Conversa's automated chat system to provide Covid test results and to provide "quarantine chats" for recently diagnosed patients; Northwell estimated that this system reduced hospital labor needs by 20 to 30 percent.^{24 25} Similarly, a 2021 study on Penn Medicine's *COVID Watch* system - an automated text messaging system that helped monitor patients' Covid-19 symptoms at home - found that this system reduced mortality rates,

¹⁹ <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fc3433e18b192be42dbf2351/medicare-telehealth-report.pdf>

²⁰ <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>

²¹ <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>

²² <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>

²³ <https://www.insiderintelligence.com/insights/remote-patient-monitoring-industry-explained/>

²⁴ <https://coronavirushealthchats.com/>

²⁵ <https://www.youtube.com/watch?v=3cCacIpAQSU>

Dr. Megan L. Ranney

improved equity in healthcare delivery, and was experienced positively by hospital nurses and support staff.^{26 27}

This increase in use of digital and telehealth was facilitated, of course, by changes in policies and payment rules. The March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act enabled Medicare providers to be paid at the same rates for telehealth sessions as in-person visits.²⁸ The CARES Act also removed Medicare policies that had restricted telehealth utilization to only rural providers, thereby enabling providers in more urban areas to offer digital health services as well.²⁹

Preliminary data suggests that patients and providers want telehealth and digital health to stay. They report that it breaks down the social, economic, and geographic barriers to healthcare - especially for patients who have difficulty with transportation, stigma, or limited work flexibility.³⁰ Patients report being satisfied with telehealth services, with 40 percent of surveyed consumers in a July 2021 McKinsey study reporting that they wanted to continue to use telehealth (a drastic increase from the 11 percent pre-pandemic).³¹ In the same McKinsey study, 58 percent of physicians responded that they viewed telehealth more favorably than they did before the pandemic.³²

However, it is critically important to maintain the factors that have allowed these innovations to thrive. Flexibilities in insurance cost-sharing and billing for telehealth services enabled telehealth visits to be billed the same as in-person visits.³³ In addition, telehealth implementation was expanded from solely rural healthcare providers to more urban providers while also enabling remote care to be practiced across state lines - allowing telehealth coverage to encompass larger swaths of the population than ever before.³⁴ These regulatory changes were essential to the successes of telehealth and digital health in adapting to Covid-19, and we must continue to maintain such a flexibility to better bolster our healthcare system for years to come.

²⁶ <https://www.pennmedicine.org/news/news-releases/2021/november/automated-texting-system-saved-lives-weekly-during-first-covid-surge>

²⁷ <https://www.acpjournals.org/doi/10.7326/M21-2019>

²⁸ https://www.aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf?_ga=2.263152908.1288477598.1638811694-1417522139.1637192937

²⁹ https://www.aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf?_ga=2.263152908.1288477598.1638811694-1417522139.1637192937

³⁰ [https://www.npjournals.org/article/S1555-4155\(20\)30515-8/fulltext](https://www.npjournals.org/article/S1555-4155(20)30515-8/fulltext)

³¹ <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>

³² <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality>

³³ <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>

³⁴ <https://www.hhs.gov/coronavirus/telehealth/index.html>

Dr. Megan L. Ranney

2. Do you think that the appropriate use of medical technology to safely and reliably monitor patients can help reduce burnout in our healthcare workforce?

Subcommittee-member Griffith, medical technology has a huge potential impact on safety, reliability, and equity of healthcare access - with two caveats.

First, it has to be designed and implemented in a way that's not only safe and private for patients, but also safe and usable for the provider. There are safety and health risks to poorly designed digital health. For example, one study reports that as many as $\frac{3}{4}$ of commercially available applications share patient data with 3rd parties without consent.³⁵ Another study reports that only 34% of commercially available digital health applications provide accurate symptom diagnosis.³⁶ The FDA's creation of their Digital Health Center of Excellence is an important step towards improving patients' and providers' trust in digital health and telehealth, but more is needed. Similarly, provider experience needs to be considered. EHRs' poor design are reported to have enhanced risk of physician burnout; adding new digital technologies to existing cognitive and time overload would potentially worsen providers' burnout.^{37 38}

Second, medical technology needs to be designed in ways and for conditions that reduce rather than worsen disparities in patient health outcomes. While about 77 percent of Americans in 2021 have broadband connections at home, access heavily varies across demographics.³⁹ For instance, in 2021, about 80 percent of white households had access to broadband compared to only 65 percent of Hispanic households.⁴⁰ Similarly, 92 percent of households with an annual household income of \$75,000 or greater reported having access to broadband, compared to only 57 percent in households with annual household incomes less than or equal to \$30,000.⁴¹ In comparison, there are few disparities in cellphone access: as of April 2021, 97 percent of all Americans (regardless of income, age, race, ethnicity, or urbanicity) report having a cell phone, and 85 percent have smartphones (again, regardless of income, age, race, ethnicity, or urbanicity).⁴²

³⁵ <https://www.hcinnoationgroup.com/population-health-management/patient-engagement/article/21158201/health-data-privacy-and-thirdparty-apps-reframing-the-conversation>

³⁶ <https://www.bmj.com/content/351/bmj.h3480>

³⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5559244/>

³⁸ <https://pubmed.ncbi.nlm.nih.gov/35062195/>

³⁹ <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/>

⁴⁰ <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/>

⁴¹ <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/>

⁴² <https://www.pewresearch.org/internet/fact-sheet/mobile/>

Dr. Megan L. Ranney

Not surprisingly, systems designed for cellphones, social media, or text-messaging (particularly if available in multiple languages or for low-literacy populations) can help lessen disproportionate health outcomes. In fact, this was precisely what had been done in the pandemic. The March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act allowed audio-only telehealth services through FFS Medicare during the pandemic, which resulted in a 100-fold uptake from 2019 to 2020.⁴³ Similarly, text-message-only vaccination sign-up systems increased vaccination rates by 30%.⁴⁴

In sum: yes, if digital health and telehealth technologies are not designed well; evaluated well; and incorporated into existing workflows, they can have a tremendous positive impact for patients and clinicians alike.

⁴³ <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>

⁴⁴ <https://www.nature.com/articles/d41586-021-02043-2>

Ms. Tawanda Austin, M.S.N., R.N., NE-BC

Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”
March 2, 2022**

Ms. Tawanda Austin, M.S.N., R.N., NE-BC, Chief Nursing Officer, Emory University Hospital
Midtown

The Honorable Diana DeGette (D-CO)

1. What can be done to better support nurses and other frontline health care workers as they deal with abuse from their patients while managing heavier workloads during the pandemic?
 - a. Have in place an organization-wide program to daily manage workplace violence including reporting, interventions to prevent and manage, and support of the individual targeted by the violence. The goal is for clinicians to know their organization works to improve safety and protect them from danger.
 - b. Currently in GA, assault on emergency personnel including emergency department personnel is a felony. All other instances are not. Laws should be extended to include assault on all healthcare workers as a felony, preferably at the federal level.
 - c. Establish appropriate penalties for first offense, second or subsequent abuse, and when creating a disturbance inside a healthcare facility against nurses and other frontline healthcare workers.
 - d. Mayo Clinic currently provides the gold standard regarding policies that support staff when they are faced with patient physical, emotional, and psychological abuse from patients. They have created an algorithm for staff to use to receive support after experiencing abuse. Policies like Mayo's put staff first. Emory is working on our own policy based on Mayo's work. We need clear pathways for staff to follow that are supported (and socialized) by Human Resources, so that staff feel psychological safety and support from the leadership and the organization when they experience abuse from patients.
 - e. Congress should provide sufficient funding for the recently passed Lorna Breen Act, which stands up programs to support the mental and behavioral health of health care providers.

Ms. Tawanda Austin, M.S.N., R.N., NE-BC

The Honorable H. Morgan Griffith (R-VA)

1. Do you believe that health systems benefit from the use of digital health technologies, like remote patient physiologic monitoring (RPM), to help clinicians care for patients and relieve stress on nursing staff?

Yes, remote patient monitoring of acute care and critical care patients is beneficial to complement the clinician/nurse who is directly providing care. Most health care systems will hire increased numbers of new graduate resident nurses to rebuild the nursing workforce. These residents can be best supported by an experienced nurse in a virtual setting easily accessed by the direct care nurses to assist in patient care.

Additionally care model shifts that allow patients to remain in the comfort of their home for as much of their healthcare journey as possible relieves the burden of task work from professional nurses and allows them to practice at the top of their scope. Of course, like all technology, the success or failure of utilizing this model hinges on solid inclusion/exclusion criteria for patients who are clinically appropriate for this type of remote/virtual care.

2. Do you think that the appropriate use of medical technology to safely and reliably monitor patients can help reduce burnout in our healthcare workforce?

Yes, if the technology is designed and proven to ensure positive patient outcomes and will create situations that allow the nurse to spend more time interacting with the patient rather than with the machine or computer. One of the greatest benefits of medical technology that monitors patients is in populations who are high risk for falls or at risk for elopement. Systems that successfully monitor these patients (remote camera monitored at a central hub by a clinician) may reduce burnout because they provide improved safety to the patient, allowing the clinician on site to care for other patients successfully. Given the challenging nature of nursing work, any measures to improve their effectiveness can also improve their well-being.

At Emory, we currently utilize the E-ICU program for our ICUs. Using the newest technology and private, high-speed data lines, our critical care physician experts and experienced critical care nurses work in partnership with physicians and nurses at the patient's bedside by providing round-the-clock monitoring from an off-site location and rapid treatment and intervention at a moment's notice. The e-ICU service does not replace front line healthcare providers but provides additional support to ensure the best possible outcome for patients by working in a team-based healthcare setting.

Ms. Tawanda Austin, M.S.N., R.N., NE-BC

It is important to note that the technology should be designed to ensure positive patient outcomes and validated third party evaluation. The technology should create situations where the Nurse is spending more time in true human interaction with the patient rather than “treating the machine.”

I would encourage our congressional leaders to continue to meet with their local hospitals, front line healthcare providers, and healthcare professional associations (e.g., American Nurses’ Association, American Organization of Nurse Leaders) to better understand the many causes of burnout in healthcare professionals like the impacts of the COVID pandemic, social unrest, and staffing; and then provide support where needed.

Dr. Laura E. Riley

Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“Lessons from the Frontline: COVID-19’s Impact on American Health Care”
March 2, 2022**

Dr. Laura E. Riley, Obstetrician and Gynecologist-in-Chief, New York Presbyterian Hospital

The Honorable Diana DeGette (D-CO)

1. How have misinformation and data gaps affected pregnant women during the pandemic and what can Congress and the Administration do to better support public health messaging in an effort to reduce confusion and restore confidence?
- a. Thank you, Chair DeGette, for the recent opportunity to provide testimony during the Subcommittee on Oversight and Investigations hearing entitled “Lessons from the Frontline: COVID-19’s Impact on American Health Care”. I appreciate the thoughtful question provided following my testimony.

Perhaps the best measure of how misinformation and data gaps are affecting pregnant individuals is vaccine hesitancy. Despite the growing body of evidence that pregnant individuals are at increased risk for adverse outcomes and urgent calls from the medical and public health community, pregnant and lactating individuals were and continue to be excluded from COVID-19 vaccine and therapeutic trials.ⁱ As I discussed in my testimony, the exclusion of pregnant individuals in clinical trials resulted in the availability of minimal data to make an informed, evidence-based recommendation for the use of COVID-19 vaccines during pregnancy. This delayed the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), the Centers for Disease Control and Prevention (CDC), and others from providing an affirmative recommendation for COVID-19 vaccination during pregnancy until more data were collected, which did not occur until several months after the vaccines were made available.ⁱⁱ

Unfortunately, vaccine uptake remained slow despite these recommendations for COVID-19 vaccination for pregnant women. By September 2021, the CDC issued an urgent health advisory to encourage individuals who are pregnant, lactating, or who might become pregnant, to get the vaccination.ⁱⁱⁱ At the time of the health advisory, the CDC reported only 31 percent of pregnant individuals had been vaccinated against COVID-19, while more than 22,000 were hospitalized and 161 deaths had occurred through the pandemic.^{iv} Further, data still indicate a gap in COVID vaccination for pregnant individuals, especially Black and Latinx

Dr. Laura E. Riley

populations.^v As of March 26, 2022, CDC data indicate just over 70 percent of all pregnant individuals are fully vaccinated, compared to 75 percent of all eligible adults ages 18 and older.^{vi} However, only 56 percent of pregnant individuals who are Black are fully vaccinated.^{vii}

The routine exclusions of pregnant and lactating individuals from research, presumably for their protection, leaves them disproportionately vulnerable and may have in this instance contributed to avoidable loss of life. In order to avoid future data gaps, federal agencies should prioritize the safe inclusion of pregnant and lactating individuals in the development of vaccines and therapeutics and ensure that industry includes this population in their study plans from the outset. In addition, Congress should provide CDC with appropriate funding to ensure that culturally-appropriate messaging regarding vaccination is reaching this vulnerable population, and that resources focus not only on the safety of the vaccine during pregnancy, but also pre-pregnancy.

The Honorable H. Morgan Griffith (R-VA)

1. Do you believe that health systems benefit from the use of digital health technologies, like remote patient physiologic monitoring (RPM), to help clinicians care for patients and relieve stress on nursing staff?

- a. Thank you, Ranking Member Griffith, for the recent opportunity to provide testimony during the Subcommittee on Oversight and Investigations hearing entitled “Lessons from the Frontline: COVID-19’s Impact on American Health Care”. I appreciate the thoughtful question provided following my testimony.

As I discussed in my testimony, one of the most important health care system shifts during the pandemic was to increase both the utilization and health insurance coverage of telemedicine, which includes remote patient monitoring (RPM). In fact, a systematic literature review found that RPM has been shown to provide benefit in obstetric and gynecologic care.^{viii} For example, ACOG guidance suggests remote blood pressure monitoring with text-based surveillance shows promise in decreasing unscheduled or unanticipated in-person visits and improving adherence rates to ACOG’s recommendations for blood pressure monitoring in the first 10 days after birth.^{ix}

Further, there are studies that report high satisfaction for RPM, especially among pregnant individuals related to monitoring blood pressure.^x As more research is published from the increasing use of RPM during the public health emergency, we will better understand its benefit to clinicians and impact on patient health outcomes.

- 2. Do you think that the appropriate use of medical technology to safely and reliably monitor patients can help reduce burnout in our healthcare workforce?

Dr. Laura E. Riley

- a. Thank you, Ranking Member Griffith, for the recent opportunity to provide testimony during the Subcommittee on Oversight and Investigations hearing entitled “Lessons from the Frontline: COVID-19’s Impact on American Health Care”. I appreciate the thoughtful question provided following my testimony.

While I unequivocally support the increased utilization and health insurance coverage of telemedicine, more research needs to be published specifically related to telemedicine and medical technology to adequately assess the benefit it may provide in reducing burnout in our health care workforce. For example, more evaluation is needed to assess whether the ease of documentation afforded by telemedicine and medical technology enhances efficiency or instead creates more unnecessary work for clinicians, potentially leading to disillusion and burnout. In light of this, Congress should consider providing additional resources and funding to federal agencies in an effort to encourage research in physician mental health, particularly as it relates to the impact of rapid increases in utilization of telemedicine and medical technology seen during the public health emergency.

ⁱ Letter from the Coalition to Advance Maternal Therapeutics to the National Institutes of Health and Food and Drug Administration. March 18, 2020. Available at: <https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/letters/letter-to-nih-and-fda-on-covid-19-camt.pdf?la=en&hash=696162B7BEC34A9F3998E3AE2CE99F93>.

ⁱⁱ ACOG and SMFM Recommend COVID-19 Vaccination for Pregnant Individuals. July 30, 2021. Available at: <https://www.acog.org/news/news-releases/2021/07/acog-smfm-recommend-covid-19-vaccination-for-pregnant-individuals?msclkid=d8daa5cdb4fe11ec88b54767d3d11ee0>.

ⁱⁱⁱ CDC Statement on Pregnancy Health Advisory. September 29, 2021. Available at: <https://www.cdc.gov/media/releases/2021/s0929-pregnancy-health-advisory.html>.

^{iv} Ibid.

^v Latest Data on COVID-19 Vaccinations by Race/Ethnicity. Kaiser Family Foundation. March 9, 2022. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-by-race-ethnicity/>.

^{vi} COVID-19 vaccination among pregnant people aged 18–49 years overall, by race/ethnicity, and date reported to CDC - Vaccine Safety Datalink, * United States. Accessed April 4, 2022. Available at: <https://covid.cdc.gov/COVID-data-tracker/#vaccinations-pregnant-women>.

^{vii} Ibid.

^{viii} Implementing Telehealth in Practice. Committee Opinion No. 798. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2020;135:e73–9.

^{ix} Ibid.

^x Thomas, N., Drewry, A., Racine Passmore, S. et al. Patient perceptions, opinions and satisfaction of telehealth with remote blood pressure monitoring postpartum. *BMC Pregnancy Childbirth* 21, 153 (2021). <https://doi.org/10.1186/s12884-021-03632-9>

Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations

Hearing on “Lessons from the Frontline: COVID-19’s Impact on American Health Care”

March 2, 2022

Dr. Lucy McBride, Internist, Private Practice

The Honorable Diana DeGette (D-CO)

Q: How do health care workforce shortages limit the nation’s ability to prepare for a more resilient future public health emergency response that puts community and patient needs at the forefront?

A: Health care workforce shortages significantly threaten our ability to care for patients. Not only do we need a more robust workforce to treat sickness and prevent disease; it’s critical to avoid adding extra stress to already-burned health care workers. We need to incentivize students coming out of high school to go into allied health care professions. We need to appropriately compensate health care providers for their time and expertise, and we need to work on loan forgiveness for medical and nursing students. Last, supporting the social-emotional wellbeing of students and current health care providers is essential to retaining talent and optimizing patient care and outcomes.

The Honorable H. Morgan Griffith (R-VA)

Q: Do you believe that health systems benefit from the use of digital health technologies, like remote patient physiologic monitoring (RPM), to help clinicians care for patients and relieve stress on nursing staff?

Telehealth has become a lifeline for many patients during the pandemic and we should continue to invest in free broadband/internet service to all parts of the country in order to improve access to needed health care services. Particularly for patients in rural areas, and also for patients with physical, financial, and geographical constraints to seeing a medical provider in person, virtual visits provide critical support and services. The convenience of remote services can also help decompress busy offices and limit unnecessary administrative burdens for patients’ medical issues that don’t require an in-person visit. In short, the added efficiency is a boon to all—though there is no substitute for in-person care for certain kinds of visits, particularly when a physical exam is needed. Telehealth is an excellent adjunct to traditional medical practice and should be woven into the fabric of modern medicine.

Q: Do you think that the appropriate use of medical technology to safely and reliably monitor patients can help reduce burnout in our healthcare workforce?

As stated above, I think that telehealth services can help increase access to quality care for patients while reducing the administrative burden on patients. I also think we can employ telehealth to more actively monitor patients’ medical conditions between visits to the doctor’s office. For example, a

physician “extender” could check in by video conference with an elderly patient to check on his/her medication compliance and home safety, solidifying and helping implement the plans made in the office with the doctor—and added structure and support where needed. So much of what doctors do is help patients “mind the gap” between good intentions and the execution of healthy behaviors, and telehealth offers an easier way to more regularly check in with patients’ in their everyday lives. That said, in-person care is critical for relationship-building and of course for physical examinations. But the ease of access and the portability of telehealth modalities is a nice adjunct as we move into the future.

