From:	Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject:	Gizmodo: The Worst Charlatans of the Covid-19 Pandemic
Date:	2021/07/09 14:57:41
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Type:	Note

The Worst Charlatans of the Covid-19 Pandemic

During the pandemic, some took advantage of the situation to peddle misinformation and exploit a broken system.

tommckay

Tom McKay
Today 9:00AM

For some people, crisis is an opportunity. More specifically, an opportunity to blow up their own profile by preying on people's fears, making baseless claims, grabbing resources intended for others, and being generally dishonest, disingenuous, or greedy.

A comprehensive list of those matching this archetype over the grueling months of the covid-19 pandemic would be far too large to relay in full. But it would include a former president, medical professionals spreading exaggerated or simply fabricated claims about how best to fight the virus, amateur statisticians claiming their analyses proved the virus wasn't dangerous, fraudsters, far-right activists looking to convert influence into money, and wealthy businesses that filled their coffers.

So we sliced and diced that list down to a palatable sample size of seven. We've excluded Donald Trump out of fairness to the other contenders. Here's what they've been up to since everything went to shit in early 2020.

Slideshow

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From: Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject: Globe and Mail: Too good to be true? Why science and medicine are in the throes of a replication crisis
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Too good to be true? Why science and medicine are in the throes of a replication crisis

Susan Pinker
Contributed to The Globe and Mail
Published July 10, 2021 Updated 5 hours ago

Susan Pinker is a psychologist and columnist whose most recent book, The Village Effect, *explores the science of social interaction.*

By May of last year, the number of research papers on COVID-19 was doubling every two weeks. This steady churn has unleashed more than 200,000 journal articles on the coronavirus so far, more than 30,000 of them as preprints, meaning studies that are not yet peer-reviewed. Most are also too fresh to have been replicated by other scientists.

Still, many of these findings are cited by scientists and journalists alike and have been shared with millions of people. Indeed, the human brain seems to be the perfect growing medium for untested, often too-good-to-be-true ideas.

Just one example: A year ago, a preprint, followed by a published scientific paper, reported that an anti-parasitic drug, Ivermectin, used to treat river blindness in sub-Saharan Africa and head lice everywhere else, could suppress SARS-CoV-2. If this were true, it would be a godsend, as Ivermectin is cheap, FDA-approved as an anti-parasitic, and widely available.

The Ivermectin study did not succeed when replicated, however, and there's no clear evidence that it has any effect on humans with the disease. Like hydroxychloroquine – a malaria drug that was touted as a cure by Donald Trump when he was the U.S. president – Ivermectin has no clinical effects on COVID-19 in the real world.

But the cat video is out of the bag, so to speak. Ivermectin has become an internet meme; dozens of so-called scientific talks have received millions of views on YouTube, each one promoting Ivermectin's anti-COVID benefits, with the backstory that pharmaceutical companies are suppressing this information lest it staunch the flow of profits from vaccines. In a short time, a single, non-replicated study has become the new bleach, or in medical history terms, the new snake oil.

Over the past 18 months, two pandemics have collided. On one hand, the SARS-CoV-2 virus was novel, terrifying and constantly evolving; there was a push for quick answers. On the other hand, science and medicine were in the throes of a replication crisis.

Many iconic studies, especially in my own field, psychology, were being repeated by other scientists and found to be wanting; their findings could not be duplicated. In other words, science was in the process of examining itself when COVID-19 struck. There was a desperate thirst for information and a glut of

new studies. But there was also little time or patience for a basic due diligence step – replication, simply repeating an experiment to see whether it produces the same results.

Now that COVID-19 infection rates are slowing down, it's a good time to step back and look at what types of studies seem impossible to reproduce yet have remarkable staying power. Once launched, they continue to breathe new life into what are essentially rumours; they promote misinformation while giving it the patina of science.

[section break]

Many of us think that science progresses in a straight line. But it zigzags. One hypothesis emerges, changing our outlook for a moment; if it fails to be confirmed by further evidence, it drops out of sight and another one takes its place. Onward and upward, in infinitesimal steps.

Recently, though, the fact-finding trajectory seems to have changed course. Attention-grabbing studies are briskly published. The press and other researchers latch on; a TED talk and a book contract often follow. Social media help turn it into a meme, one that is often surprising, easy to grasp and sticky, like an ear-worm or gossip. If the information hits a sensitive spot, such as a latent fear of hypodermic needles, contamination or public speaking, and also presents a tidy way to dispatch those anxieties, so much the better.

Somewhere along the way, though, another research team has repeated the experiment and couldn't get the same results. But a non-finding is usually non-newsworthy, and in any case, the surprising "fact" has already made a dent on our collective psyches. That's just one way splashy findings like Ivermectin as a cure for COVID-19 continue to get attention, even after having been debunked.

Now, a fascinating new study out of University of California San Diego, led by behavioural economists Uri Gneezy and Marta Serra-Garcia, shows that experiments that could not be repeated have a bigger influence over time than the ones that could. In other words, the more interesting and novel-sounding the idea, the more it is cited by other scientists and the media, and the less likely it can be replicated. There seems to be a trade-off between the wow factor of a study and its ability to be reproduced – which should affect its credibility – but does not. In Nature and Science, two high-profile and high-status journals, the non-replicable papers were cited 300 times more than the replicable ones.

Published in May in the journal Science Advances, the Gneezy-Serra-Garcia study analyzed the findings from three massive replication projects, two of them led by psychology professor Brian Nosek, from the Center for Open Science at the University of Virginia, and the third directed by behavioural economist Colin Camerer at the California Institute of Technology. All three focused on social science experiments that have been published in highly reputable journals. Volunteer scientists from the same field then repeated the experiment and hoped to get the same results, much as a cookbook author might test her recipes by baking the same torte in a different kitchen, with different utensils, to see if it looked and tasted the same.

To test a study's replicability alongside its popularity, Prof. Gneezy and Prof. Serra-Garcia matched each original study's outcomes to its citations on Google Scholar, starting roughly in 2008 and ending in 2019. Although they didn't cherry-pick the wow studies, they still found that just 39 per cent of psychology studies replicated, as did 61 per cent in economics, and 62 per cent of those published in Nature and Science.

Yet over a decade, studies that failed to replicate were cited 16 times more often a year than reproducible ones, with "no significant change" after it was shown that they couldn't be replicated. "Papers that failed to replicate were cited much more than papers that were reproducible," Prof. Gneezy told me. "If citations are just a proxy for how sexy an idea is, then the findings that are more interesting and get the most attention are the least likely to be true."

[section break]

Some of the social science findings that haven't been replicated include one showing that gripping a pen between your teeth, thus forcing a smile, makes you feel happy. Only one out of 18 attempts by other

labs could reproduce this effect (it only works if no one is watching, apparently). Not just facial expression but body posture, too, is supposed to elicit emotions, according to a well-known study of "power-posing." The idea that striking a victory stance – legs braced, arms in a V – can boost one's confidence and alter one's hormone levels (not to mention attenuate one's jitters before public speaking or a job interview) has become the poster child for the replication crisis, mainly because it was such an easy fix for the universal fear of failure. Even if the power-posing study didn't replicate, it continues to top the charts in scientific citations; a TED talk on the topic has garnered 61 million views.
The notion of "stereotype threat" – which is a fancy way of saying that believing stereotypes about your gender, race or ethnic group becomes self-fulfilling prophecy – has also largely failed to replicate. For example, the belief that they are bad at math necessarily hampers girls' math performance has been studied extensively and is now widely accepted. Yet systematic replications of the phenomenon can't reproduce it. Still, stereotype threat has influenced educational policy, training programs and even admission practices at some universities.
Studies on growth mindset, implicit bias research and ego depletion have faltered in replications – thus showing their findings to be exquisitely sensitive to context and statistical nuance. To extend the cooking metaphor, these findings might be like soufflés that only rise when the weather is right. Or, they might simply be false. Either way, they persist in the scientific literature, in corporate and educational trends, and in the public imagination.
The Gneezy-Serra-Garcia study focused on social science. But the phenomenon of non-replicability has hit the worlds of natural science, economics and medicine as well. Here's just a small sampling: A paper published in the journal Nature last year reported that a small inhibitory molecule could tamp down the formation of tau, a sign of Alzheimer's disease. Though the study could not be reproduced, it has been cited 605 times in papers published by other scientists. Similarly, animal studies showing successful treatment of Type 1 diabetes based on combining two existing drugs, a neurotransmitter and a malaria medication, raised hopes when published in the journal Cell in 2017. Two other prestigious teams tried and failed to reproduce the results. Still, the research has been cited 238 times.
Other findings that didn't pass muster include a 21 percentage-point boost for the soccer player who kicks first in penalty shots, published in 2010 in American Economic Review. The finding couldn't be coaxed out of a larger sample two years later. Yet the first-mover advantage has been cited 483 times in research, not to mention innumerable soccer broadcasts.
Why is this happening? The researchers who authored the Science Advances study speculate that journal editors – perhaps unconsciously – might overlook methodological problems in studies with intuitive appeal. These findings may be surprising, or they might provide an easy fix to a complex problem. Ivermectin for COVID-19, power-posing, stereotype threat and first-mover advantage in soccer all fit both bills. Once published, such findings take on a life of their own, gaining currency and momentum. "Extraordinary claims require extraordinary evidence," Carl Sagan, the American astronomist, said. When our expectations are high, the burden of proof should be high, as well.
Still, it's a likely overstatement to call this a crisis. Enthusiasm for replication and attempts to confirm catchy findings have been growing, and that's a good thing. Having studied the problem for years, Prof. Nosek, the executive director of the Center for Open Science, seems unconcerned.
"This is about the scientific community self-scrutinizing," he said. "It's not surprising that the things that push the boundaries fail to replicate. That's how it should be. We should be trying things that are not likely to be true. Then we investigate to see if they are."
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From:	Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject:	Google trends, the COVID-19 vaccine and infertility misinformation
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Priority:	Normal
Type:	Note

13-Jul-2021

Google trends, the COVID-19 vaccine and infertility misinformation

Researchers document a nearly 35,000% increase in COVID-19 vaccine and infertility Google searches following a misinformation event

American Osteopathic Association

Research News

Google searches related to infertility and coronavirus (COVID-19) vaccines increased by 34,900% after a pair of physicians submitted a petition questioning the safety and efficacy data of the COVID-19 Pfizer vaccine. Referencing the petition, anti-vaccine activists circulated claims that misconstrued the information regarding the possibility that the vaccine could impact fertility in women.

The inaccurately represented information spread rapidly on social media channels, potentially influencing public perception and decision-making among pregnant patients or those seeking to become pregnant, according to research published in the *Journal of Osteopathic Medicine*. This happened despite the fact that the European Medicines Agency (EMA) and the US Food and Drug Administration issued emergency use authorization for the vaccine, deeming the concerns in the petition insignificant.

"Misinformation is a significant threat to healthcare today and a main driver of vaccine hesitancy," said Nicholas Sajjadi, a study researcher and third-year osteopathic medical student at Oklahoma State University College of Osteopathic Medicine. "We're seeing well-intentioned research and concerns taken out of context to stoke fear and anxiety about vaccination."

The making of a misinformation campaign

On December 1, 2020, Drs. Wolfgang Wodarg and Michael Yeadon petitioned to withhold emergency use authorization of the BNT162b2 mRNA vaccine for COVID-19 manufactured by BioNTech and Pfizer. The petitioners raised unfounded concerns that female infertility could arise from vaccine-induced antibodies. It is important to note that the petitioners acknowledged the absence of any evidence associating female infertility risks with COVID-19 vaccines.

Anti-vaccine advocates seized on this concern to create a misinformation claim misrepresenting the EMA petition, and the public turned to Google to understand if the information was legitimate. At peak interest, the Google search terms "infertility," "infertility AND vaccine," and "infertility AND COVID vaccine" experienced increases of 119.9%, 11,251%, and 34,900%, respectively, when compared with forecasted values.

"I'm disappointed this misinformation occurred, but I am pleased to see spikes in searches because it reflects genuine interest and suggests that people are doing their research and trying to make informed decisions," said J. Martin Beal, DO, an OB-GYN with Tulsa OB-GYN Associates. "What I'd like to emphasize to patients is that your doctor would love to have this conversation with you to help clarify any questions or concerns you may have. Additionally, I highly encourage getting vaccinated--it will protect you and the baby."

Support for COVID-19 vaccination during pregnancy

The American College of Obstetricians and Gynecologists currently recommends that COVID-19 vaccines not be withheld from pregnant patients who meet criteria for vaccination based on priority groups recommended by the Advisory Committee on Immunization Practices and those at increased risk for COVID-19 acquisition, such as women healthcare workers.

"Dispelling misinformation and informing patients about the risks and benefits of COVID-19 vaccination, or other misrepresented claims, can save lives and slow the spread of disease," said Sajjadi. "In the battle to fight misinformation, Google Trends can be an effective tool to help physicians recognize and proactively address false claims with patients."

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About the *Journal of Osteopathic Medicine*

The *Journal of Osteopathic Medicine*, founded in 1901 and known for 119 years as The Journal of the American Osteopathic Association, is the premier scholarly, peer-reviewed publication of the osteopathic medical profession. JOM conducts peer review of academic research manuscripts from a wide variety of medical specialties, covering the full spectrum of clinical settings in which osteopathic physicians practice. All submissions are vetted by a distinguished group of Section Editors led by Editor-in-Chief Ross Zafonte, DO, and supported by a full Editorial Board.

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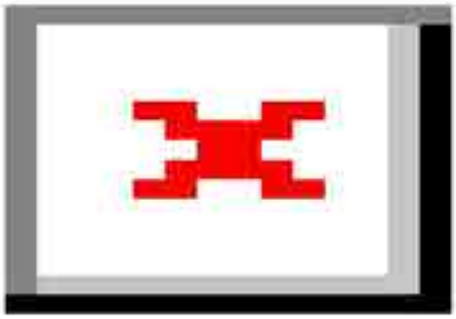
From:	Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject:	Guardian: HIV after Covid: Anthony Fauci and an army of researchers seek to regain momentum https://bit.ly/3fVKbbI
Date:	2021/06/06 10:06:30
Priority:	Normal
Type:	Note

Aids and HIV

HIV after Covid: Anthony Fauci and an army of researchers seek to regain momentum



Anthony Fauci speaks at the 9th International AIDS Society Conference in Paris, in July 2017.

Anthony Fauci speaks at the 9th International Aids Society Conference in Paris, in July 2017. Photograph: Benjamin Ryan

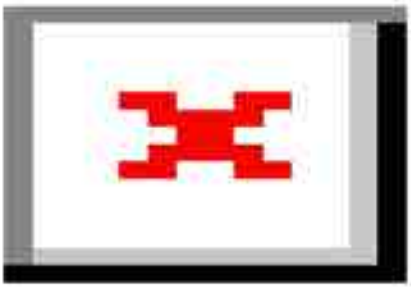
In the summer of 1981, public health professionals faced a terrifying crisis. Their work helped shape victories against the current pandemic – but some fear hard-won ground is lost

Benjamin Ryan

Sun 6 Jun 2021 02.00 EDT

Last modified on Sun 6 Jun 2021 02.02 EDT

As Anthony Fauci marks 40 years since HIV emerged, he regrets how the extraordinary disruptions that Covid-19 have wreaked upon society have hampered efforts to tackle the major pandemic that preceded it.



'New disease, no treatment, no cure': how Anthony Fauci's fight against Aids prepared him for Covid-19

The longtime National Institute of Allergy and Infectious Diseases (Niaid) director was one of the chief architects of a federal plan, launched last year, to meet the audacious goal of largely ending the HIV transmission in the US over the next 10 years.

Now, at 80, Fauci looks back half a lifetime to that foreboding early summer of 1981, when he read the first case reports about what would become known as Aids. He marvels at how epidemiological history in many ways repeated itself with Covid-19. And he hopes that the HIV fight will also benefit from a vaccine.

Fauci also knows what an unsung debt the Covid-19 response owes to HIV research. The nation's top virologist said he would "argue forcibly with anybody" that had the HIV pandemic not helped train vast armies in the scientific, medical and public health sectors to mobilize in a moment of crisis, the battle against Covid-19 would be much further behind where it is today.

"It's no accident that a lot of people who jumped in to address Covid right away are people who are involved in HIV," said Jennifer Kates, director of global health &HIV policy at the Kaiser Family Foundation. "They're a group of diverse scientists, activists, epidemiologists who said, 'An emerging infectious disease that's starting to harm people and kill people – we've been here before.'"

Fauci said: "What I learned from HIV was very helpful in my appreciating how Covid-19 evolved."

'Elegant science'

The highly effective Covid-19 vaccines now sending the US epidemic into retreat were whisked with lightning speed through clinical trials thanks, in many ways, to HIV paving the way.

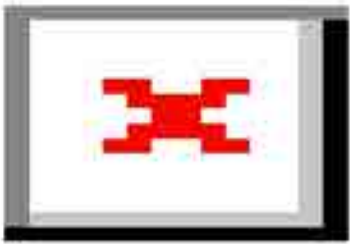
In March last year, Fauci began overseeing the retooling of three major HIV global clinical trials networks into the Covid-19 Prevention Network (CoVPN). This meant teams of investigators already skilled at recruiting and retaining diverse participant populations, dealing with byzantine regulatory requirements and paperwork and conducting necessary statistical analyses soon enrolled tens of thousands into trials that have given the world the Moderna and Johnson &Johnson vaccines.

Fauci praised the "elegant science" that went into selecting the most promising Covid-19 vaccine candidates – a process, he stressed, facilitated by the pioneering efforts of HIV vaccinologists. Over the decades, such researchers honed the methods that in Fauci's words allowed scientists to "determine the

precise confirmation of the SARS-CoV-2 spike protein that allowed maximal immunogenicity, thus leading to high efficacious vaccines".

Larry Corey, director of the HIV Vaccine Trials Network – one of the three National Institutes of Health–funded networks that collaborated to launch the CoVPN – said that without the HIV research field, scientists would not have had at the ready the non-human primate research model that was used to transition from laboratory studies to human clinical trials of Covid-19 vaccines.

"We were able to do this in 11 months, start to finish, because science does build on science," said Corey, who has run the HVTN out of the Fred Hutchinson Cancer Research Center in Seattle since 1999.



Myron Cohen, director of the Institute of Global Health and Infectious Diseases at the University of North Carolina, speaks in Paris.

Myron Cohen, director of the Institute of Global Health and Infectious Diseases at the University of North Carolina, speaks in Paris. Photograph: Benjamin Ryan

On the east coast, Myron Cohen, a professor of medicine at the University of North Carolina and co-principal investigator of the HIV Prevention Trials Network, a CoVPN collaborator, took his own global team's expertise in developing broadly neutralizing antibodies against HIV and channeled it into the increasingly fruitful effort to bring to market cocktails of monoclonal antibodies that attack SARS-Cov-2.

Other HIV experts have leapt at the chance to lend their skills to the Covid-19 endeavor. One is Steven Deeks, a leader in the HIV cure research field at University of California, San Francisco, who said his lab's extensive experience with the thorny logistics of establishing long-term research cohorts allowed them to start a study following people with "long Covid" in mere weeks.

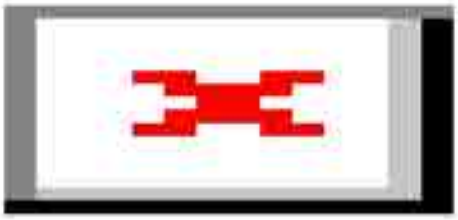
HIV specialists have been among the most prominent voices educating the public and combating misinformation about Covid-19. Monica Gandhi of UCSF has championed evidence-based optimism and sanity in the face of anxiety and hysteria; Julia Marcus of Harvard has advocated harm-reduction methods to curb SARS-Cov-2; and Carlos del Rio of Emory University has covered anything and everything in between.

Each scientist has tweeted up a storm and given hundreds of interviews.

'Many people with HIV fell out of care'

Fauci was keen to stress that the HIV epidemic trained the public health sector to prepare for – and mitigate – the disproportionate impact of Covid-19 on marginalized populations.

As for how Covid-19 has in turn affected HIV's trajectory, US epidemiologists remain in the early stages of analyzing surveillance data. But an initial read of the tea leaves has troubled many experts, who fear that progress in combatting HIV has stalled or even reversed since Covid-19 hit.

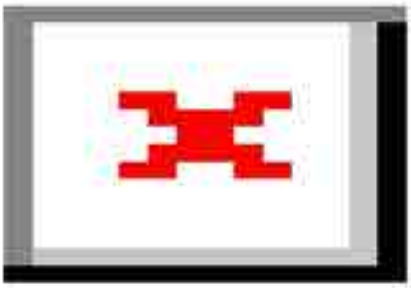


Annual HIV infections in the US 2015-2019

Annual HIV infections in the US 2015-2019 Photograph: CDC

This comes as the Centers for Disease Control and Prevention newly estimates that annual HIV transmissions in the US declined by only 14% between 2009 and 2019, from 40,500 to 34,800 new cases. Perhaps unrealistically ambitiously, the "Ending the HIV Epidemic" plan seeks to reduce the latter figure to below 3,000 by 2030.

The CDC recently reported that between March and September of last year, the US saw an estimated 21% fewer prescriptions for the HIV prevention pill, known as PrEP, than expected. Concerningly, HIV tests conducted by CDC-funded community-based organizations plunged 73% between March and August 2020, compared with that period in 2019.



Truvada and the truth: is HIV prevention propelling the STI epidemic?

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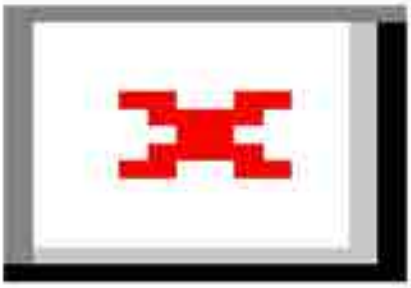
"It was very clear that many people with HIV fell out of care in 2020," said Hansel Tookes, an infectious disease physician at the University of Miami who reported an increase of people presenting in the emergency room with Aids-defining illnesses.

"I think that we have a lot of ground to make up post-pandemic," he said.

"We're definitely seeing our outcomes get worse in 2020," agreed Andrea Kim, chief of HIV and STD surveillance in Los Angeles county, which saw modest but worrying declines in the proportions of the local HIV population retained in medical care and successfully treated.
"Overall, I think that Covid was extremely negative for HIV," said Gandhi, who cares for a highly vulnerable population at the Ward 86 safety net clinic in San Francisco. Her team saw the likelihood that a patient's virus wasn't treated and fully suppressed soar 31% following the spring 2020 lockdowns, leading them to quietly recall their patients to in-person visits.
Critically, state and local health departments have diverted staffing and funding from HIV and STD control to Covid-19. By June 2020, 20% of such departments reported to the CDC that STD programs were completely disrupted and 76% reported significant disruption.
Covid-19 has also apparently fueled the opioid crisis. With Nora Volkow, director of the National Institute on Drug Abuse, expressed concern that the US will see more HIV outbreaks like the those among people who inject drugs in West Virginia and Boston.
"As bad as it is now, I think it's probably worse," said Sally Hodder, an infectious disease specialist at West Virginia University, predicting the 89 HIV diagnoses tied to injection drug use her state saw in 2020 would prove the tip of the iceberg.

'Get the ship righted'

Not all news is gloomy. Covid-19 has spurred two states to move toward expanding Medicaid programs, a shift found to benefit HIV populations. Lockdowns have also sparked innovations in healthcare delivery that could benefit people with HIV, including vastly expanded use of telemedicine and an increase in multi-month prescriptions.



Aids and Act Up: Sarah Schulman puts women and people of color back at the heart of the story

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Fauci noted that the extraordinary success of the mRNA Covid-19 vaccines has thrilled HIV vaccinologists, who are already pursuing vaccines based on the cutting-edge technology. Deeks said HIV-cure therapies could also rely on mRNA.

Fauci said he holds out hope that the three HIV vaccines in advanced clinical trials will prove at least 50% efficacious, justifying a global rollout. But he now hopes mRNA or other advanced technologies could yield even more powerful HIV vaccines.

Then there's Fauci's hope of capping his storied career by the time he turns 90, by ending as a public health threat the epidemic that changed his life 40 years ago.

"I hope that as we get the Covid-19 under control, we can play a bit of catch up with HIV and get the ship righted again," he said. "I still think there's a good chance that we'll get there."

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Subject:	Hans in the news
Date:	2021/08/12 08:32:15
Priority:	Normal
Type:	Note

Flagging this piece, in advance of your meeting today! He was also on Morning Joe just now...

https://www.statnews.com/2021/08/11/covid19-pandemic-misinformation-technology-vaccines/

Loyce Pace, MPH (she/her)
Director, Office of Global Affairs
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From:	Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject:	Harvard T.H. Chan School of Public Health Today / A Look Back, A Path Forward: A Town Hall Event -- Monday, April 26, 2021, 1pm ET
Date:	2021/04/26 09:52:06
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Monday, April 26, 2021, 1pm ET
Monday, April 26, 2021, 1pm ET

A Look Back, A Path Forward: A Town Hall Event

Fourteen months into an unprecedented, worldwide pandemic, we now find ourselves on the precipice of hope. Thanks to the miracle of science and increases in production and distribution, the U.S. is now averaging more than 3 million vaccinations a day. Yet many hurdles remain. A race against a fourth wave driven by variants. A fight to overcome vaccine misinformation and resistance. Enduring inequities in both vaccine access and disease treatment. And a new, long-overdue testing strategy that is still in its nascent stages.

Anthony Fauci, who has led the nation since day one of this crisis, will join Karen DeSalvo, chief health officer of Google Health, Garth Graham, director and global head of healthcare and public health at YouTube, and Harvard experts Michael Mina and Mary Bassett for a special town hall program. Moderated by Axios Health Editor Sam Baker.

Register to watch online

Easy Registration

Michelle A. Williams, Dean of the Faculty at the Harvard T.H. Chan School of Public Health, is pleased to present

A Look Back, A Path Forward: A Town Hall Event
Featuring Dr. Anthony Fauci

Moderated by Axios Health Editor Sam Baker

Today, Monday, April 26, 2021
1-2pm ET

#FauciAtHarvard
#DoseOfReality
A Signature School Event

WELCOME

Michelle A. Williams, Dean of the Faculty, Harvard T.H. Chan School of Public Health; Angelopoulos Professor in Public Health and International Development, Harvard T.H. Chan School of Public Health and Harvard Kennedy School
(@HarvardChanDean)

WITH

Anthony Fauci, NIAID Director and Chief Medical Advisor to the President

Mary T. Bassett, Director, FXB Center for Health and Human Rights, Harvard University
(@DrMaryTBassett)

Karen DeSalvo, Chief Health Officer, Google Health (@KBDeSalvo)

Garth Graham, Director and Global Head of Healthcare and Public Health, Google/YouTube

Michael Mina, Assistant Professor of Epidemiology, Harvard T.H. Chan School of Public Health
(@michaelmina_lab)

MODERATOR

Sam Baker, Health Care Editor, Axios (@sam_baker)

Add event to calendar

COVID-19: A Dose of Reality

Spring 2021 Series

The Harvard T.H. Chan School of Public Health presents a one-of-a-kind, three-part event series on the COVID-19 pandemic—where we are, how we got here, and where we're going next. Harvard Chan's world-renowned researchers will join forces with Google's health and content experts to tackle the crucial issues facing our physical and emotional health during this unprecedented time in public health history.

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From:	Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
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Add event to calendar

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NAM-OSG Healthcare Leaders Meeting on Clinician Well-Being
Themes from July 15 Meeting

On July 15, 2021, the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience and the US Office of the Surgeon General co-hosted a Health Care Leaders Meeting on Clinician Well-Being, inviting C-suite leaders and key decision makers across health professions. This closed event convened stakeholders to focus on:

- Establishing clinician well-being as a shared priority among leaders of key health care organizations;
- Identifying ongoing organizational efforts and areas for coordination with the NAM Action Collaborative on Clinician Well-Being and Resilience; and
- Discussing commitments to engage organizational efforts with the Collaborative's national strategy for clinician well-being.

Participants each had an opportunity to convey their views on the most pressing issues concerning clinician well-being, as well as the toolkits and strategies being implemented at their respective organizations (see appendix for a compilation of resources). The following themes were identified from the discussion:

Impacts from COVID-19

Next Normal

The Delta variant is a continued source of anxiety for the immediate future. COVID-19 has been a significant burden on the workforce and exacerbated pre-existing concerns about burnout. Clinicians really want to know that the organizations they work for—and are dedicated to—understand the toll that the pandemic has taken on them. COVID-19 has also caused many indirect changes within health care, even among patients with non-COVID-related health concerns. Health systems are overloaded with patients long overdue for primary care and management of chronic illnesses. Given the stress already put on healthcare systems from the pandemic alone, clinicians cannot be asked to continue to tolerate broken systems. Interventions must address clinicians' concerns to ensure they feel heard and valued, while also learning from the crisis to better adjust to this "next normal."

Mental Health

Need for Stigma Reduction

Professional repercussions, barriers to seeking care, shame, and a general "culture of silence" all contribute heavily to mental health stigma within health care. Mental health strain appears to be particularly prevalent for those who have been out of school five years or less, perhaps due to increasing debt, technological challenges, or general changes within the industry.

Potential Solutions

Appointing chief wellness officers creates personnel with dedicated obligation to uphold wellness recommendations and encourage frontline workers to care for their mental health. This would aid in receptivity of care, stigma reduction, and internal accountability across facilities.

One of the most important aspects of stigma reduction is conversation. The assembled group of healthcare leaders at this meeting currently occupy positions of power in the healthcare sector. Therefore, speaking

of personal mental health challenges can bring comfort to colleagues experiencing similar struggles in silence, and demonstrate that mental health management has not impeded their professional career.

External Drivers of Burnout and Barriers to Well-Being

Administrative Burden

Administrative burden continue to be a significant cause of mental fatigue and dissatisfaction in the healthcare workforce. In particular, a reexamination of documentation procedures and how they may or may not have actual clinical influence could provide perspective on what the role of documentation should include and what can be omitted.

The EHR is largely considered a tool that is "so close to being helpful," yet often acts as a source of tedium and difficulty; this indicates a clear target for intervention.

Insurance-Related Challenges

Frustrations with prior authorization and managing claim denial or gaps in coverage for essential procedures are examples of barriers to providing care and satisfaction in medicine. Lack of mental health parity among insurance companies creates further reluctance and access issues around mental health services for clinicians.

Staffing Issues

Shortages

Healthcare workforce retention, particularly after the pandemic, is a looming concern across health professions. For example, both younger nurses (who have been in the profession for 5-7 years) and older nurses are leaving the profession or retiring early. This creates shortages not only among nursing personnel, but also as faculty members and more experienced nurses who oversee educational and training facilities. This can result in student waitlists that affect the training pipeline. In some cases, shortages demand travel nurses, who are often paid more than non-travel nurses, which subsequently creates a host of financial and structural challenges. The field of psychiatry also appears to be experiencing an "aging out" of their community.

Stressors

In addition to cross-cutting stressors for clinicians, some professions and specialties face particular system barriers. For example, nurses are typically not allowed to or incentivized to adjust their workload and take time off; this lack of flexibility considers attending meetings and activities beyod directly providing care as "unproductive" time. Clinicians have also grown disillusioned with the "hero" narrative during the pandemic, and instead express a need to feel valued in more tangible ways.

Potential Solutions

- Ideally, facilities could ask staff what would make them feel valued, or (if applicable), why they are considering leaving the profession. This line of questioning could provide a foundation in which changes are being made based on real input from clinicians themselves.
- Strategies should focus on filling an immediate nursing shortage with skilled professionals, who are the "untapped" workforce already trained with similar skills, such as corpsmen or paramedics. Additional training could be provided to upgrade their certifications and capabilities.
- Collaboration is needed on the staffing and the skill sets for the new care models that are rapidly developing, with consideration to care settings outside of the hospital (e.g., telehealth).

- Leaders need to be more creative in attracting people to health care and asking questions about what would help retain them and what system challenges they see. Whether this could look like 4-hour shifts for nurses over age 60 or otherwise, this is an opportunity to get creative with solutions.

Additional Systems Issues

Workplace Safety

The issue of workplace safety has taken on a new significance during COVID-19, with clinicians experiencing risk of infection as well as harassment or endangerment from rampant misinformation and anger about the pandemic. These conditions layer even more pain and trauma on top of the burnout and hardships already being endured by clinicians.

Diversity, Equity, and Inclusion

Microagressions, macroagressions, and other issues related to diversity and equity characterize a distinct burnout prevalent in minoritized groups—in particular, among Black, Indigenous, and people of color. In addition, educational barriers further separates both who has access to care, and who has the socioeconomic ability to learn and practice medicine.

Potential Areas for Coordination and Action

Resources

Common toolkits were identified as a way for institutions to share their best practices and implement change. With enough well-rounded input, these could provide guidance both for challenges facing all clinicians or those focusing on specialized practices. For example, promoting shared use of measures of wellness could aid in creating accountability and awareness of any shortcomings, as well as helping to standardize and reward organizations that have done well.

Communications and Convenings

There is a shared desire for communication tools to help leaders talk about clinician well-being in "one voice" to different constituencies, as well as to open the door for two-way communication. Including frontline workers in conversations provides a crucial, firsthand perspective on how to improve well-being. The Collaborative in particular has the power to bring groups like frontline workers into the same room as policymakers and other decision makers to develop informed, relevant interventions. Engaging the right stakeholders is critical to advance clinician well-being.

Closing Discussions

The Collaborative co-chairs reflected on the perspectives shared during the full group discussion. Among the healthcare leaders present, there seemed to be no disagreement on stress of healthcare workforce shortages and the importance of clinician well-being. Therefore, the Collaborative and their organizations need to continue to track the issue of burnout and well-being, moving toward a national data set. The depletion of the healthcare workforce. The Collaborative's work needs to stay focused on system-level issues and their dysfunctions, including but not limited to the role of EHRs in driving administrative burden. There is a strong desire to combat mental health stigma, particularly since the pandemic provides an opportunity to talk openly about the impacts of stigma. Similarly, COVID-19 has provided opportunity to explicitly address racial and other inequities that were exacerbated during the pandemic. In juggling these priorities, it is critical to develop a shared vocabulary to communicate about clinician well-being,

alongside a national strategy for clinician well-being that capitalizes on this window of opportunity and commitment expressed by healthcare leaders.

CONFRONTING HEALTH MISINFORMATION

The U.S. Surgeon General's Advisory on Building a Healthy Information Environment

2021

I am urging all Americans to help slow the spread of health misinformation during the COVID-19 pandemic and beyond. Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people's health, and undermine public health efforts. Limiting the spread of health misinformation is a moral and civic imperative that will require a whole-of-society effort.

Vivek Murthy

Vivek H. Murthy, M.D., M.B.A.
Vice Admiral, U.S. Public Health Service
Surgeon General of the United States

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ABOUT THE ADVISORY

A Surgeon General's Advisory is a public statement that calls the American people's attention to a public health issue and provides recommendations for how that issue should be addressed. Advisories are reserved for significant public health challenges that need the American people's immediate awareness. For additional background, visit SurgeonGeneral.gov.

BACKGROUND

During the COVID-19 pandemic, people have been exposed to a great deal of information: news, public health guidance, fact sheets, infographics, research, opinions, rumors, myths, falsehoods, and more. The World Health Organization and the United Nations have characterized this unprecedented spread of information as an "infodemic."[1]

While information has helped people stay safe throughout the pandemic, it has at times led to confusion. For example, scientific knowledge about COVID-19 has evolved rapidly over the past year, sometimes leading to changes in public health recommendations. Updating assessments and recommendations based on new evidence is an essential part of the scientific process, and further changes are to be expected as we continue learning more about COVID-19.[2] But without sufficient communication that provides clarity and context, many people have had trouble figuring out what to believe, which sources to trust, and how to keep up with changing knowledge and guidance.[3, 4, 5]

Amid all this information, many people have also been exposed to health misinformation: information that is false, inaccurate, or misleading according to the best available evidence at the time.[6, 7, 8 *] Misinformation has caused confusion and led people to decline COVID-19 vaccines, reject public health measures such as masking and physical distancing, and use unproven treatments.[5, 9, 10] For example, a recent study showed that even brief exposure to COVID-19 vaccine misinformation made people less likely to want a COVID-19 vaccine.[11] Misinformation has also led to harassment of and violence against public health workers, health professionals, airline staff, and other frontline workers tasked with communicating evolving public health measures.[12, 13]

Misinformation can sometimes be spread intentionally to serve a malicious purpose, such as to trick people into believing something for financial gain or political advantage. This is usually called "disinformation."[14, 15] But many people who share misinformation aren't trying to misinform. Instead, they may be raising a concern, making sense of conflicting information, or seeking answers to honest questions.[16]

Health misinformation is not a recent phenomenon. In the late 1990s, a poorly designed study, later retracted, falsely claimed that the measles, mumps, rubella (MMR) vaccine causes autism.[17] Even after the retraction, the claim gained some traction and contributed to lower immunization rates over the next twenty years.[18] Just since 2017, we have seen measles outbreaks in Washington State, Minnesota, New York City, and other areas.[19, 20, 21] Health misinformation is also a global problem. In South Africa, for example, "AIDS denialism"—a false belief denying that HIV causes AIDS—was adopted at the highest levels of the national government, reducing access to effective treatment and contributing to more than 330,000 deaths between 2000 and 2005.[22] Health misinformation has also reduced the willingness of people to seek effective treatment for cancer, heart disease, and other conditions.[1, 23, 24, 25]

* *This advisory focuses on health information specifically, not other kinds of misinformation. Defining misinformation is a challenging task, and any definition has limitations. See References for further discussion of the definition used in this Advisory, including the benchmark of "best available evidence at the time."*

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In recent years, the rapidly changing information environment has made it easier for misinformation to spread at unprecedented speed and scale, especially on social media and online retail sites, as well as via search engines.[26, 27] Misinformation tends to spread quickly on these platforms for several reasons.

First, misinformation is often framed in a sensational and emotional manner that can connect viscerally, distort memory, align with cognitive biases, and heighten psychological responses such as anxiety.[28, 29, 30] People can feel a sense of urgency to react to and share emotionally charged misinformation with others, enabling it to spread quickly and go "viral."[24, 31]

> *In recent years, the rapidly changing information environment has made it easier for misinformation to spread at unprecedented speed and scale.*

Second, product features built into technology platforms have contributed to the spread of misinformation. For example, social media platforms incentivize people to share content to get likes, comments, and other positive signals of engagement.[32] These features help connect and inform people but reward engagement rather than accuracy, allowing emotionally charged misinformation to spread more easily than emotionally neutral content.[33] One study found that false news stories were 70 percent more likely to be shared on social media than true stories.[34]

Third, algorithms that determine what users see online often prioritize content based on its popularity or similarity to previously seen content. As a result, a user exposed to misinformation once could see more and more of it over time, further reinforcing one's misunderstanding.[34] Some websites also combine different kinds of information, such as news, ads, and posts from users, into a single feed, which can leave consumers confused about the underlying source of any given piece of content.[35]

The growing number of places people go to for information—such as smaller outlets and online forums—has also made misinformation harder to find and correct.[36] And, although media outlets can help inform and educate consumers, they can sometimes inadvertently amplify false or misleading narratives.[37, 38]

Misinformation also thrives in the absence of easily accessible, credible information.[39, 40] When people look for information online and see limited or contradictory search results, they may be left confused or misinformed.

More broadly, misinformation tends to flourish in environments of significant societal division, animosity, and distrust. For example, distrust of the health care system due to experiences with racism and other inequities may make it easier for misinformation to spread in some communities.[41] Growing polarization, including in the political sphere, may also contribute to the spread of misinformation.[42, 43]

Additional research is needed to better understand how people are exposed to and affected by misinformation and how this may vary across subpopulations based on factors such as race, ethnicity, socioeconomic status, education, age, sexual orientation, gender identity, cultural and religious practices, hobbies and interests, and personal networks.[44]

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WE CAN TAKE ACTION

Because it pollutes our information environment, misinformation is harmful to individual and public health. Together, we have the power to build a healthier information environment. Just as we have all benefited from efforts to improve air and water quality, we can all benefit from taking steps to improve the quality of health information we consume. Limiting the prevalence and impact of misinformation will help all of us make more informed decisions about our health and the health of our loved ones and communities.

> *Together, we have the power to build a healthier information environment.*

During the COVID-19 pandemic, there have been significant efforts to address health misinformation. Here are just a few examples:

- Trusted community members, such as health professionals, faith leaders, and educators, have spoken directly to their communities to address COVID-19-related questions (e.g., in town halls, community meetings, via social and traditional media)
- Researchers have identified leading sources of COVID-19 misinformation, including misinformation "super-spreaders"[45]
- Media organizations have devoted more resources to identify and debunk misinformation about COVID-19[46, 47]
- Some technology platforms have improved efforts to monitor and address misinformation by reducing the distribution of false or misleading posts and directing users to health information from credible sources[48, 49, 50]
- Governments have increased their efforts to disseminate clear public health information in partnership with trusted messengers[51]

But there is much more to be done, and each of us has a role to play. Before posting or sharing an item on social media, for example, we can take a moment to verify whether the information is accurate and whether the original source is trustworthy. If we're not sure, we can choose not to share. When talking to friends and family who have misperceptions, we can ask questions to understand their concerns, listen with empathy, and offer guidance on finding sources of accurate information.[52, 53, 54, 55, 56]

It will take more than individual efforts, however, to address health misinformation. The threat of misinformation raises important questions we must answer **together**: How do we curb the spread of

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harmful misinformation while safeguarding user privacy and free expression? What kinds of measures should technology platforms, media entities, and other groups adopt to address misinformation? What role is appropriate for the government to play? How can local communities ensure that information being exchanged—online and offline—is reliable and trustworthy? How can we help family and friends who may have been exposed to harmful misinformation?

Addressing health misinformation will require a whole-of-society effort. We can start by focusing on the following areas of action:

- **Equip Americans with the tools to identify misinformation,** make informed choices about what information they share, and address health misinformation in their communities, in partnership with trusted local leaders

- **Expand research that deepens our understanding of health misinformation,** including how it spreads and evolves; how and why it impacts people; who is most susceptible; and which strategies are most effective in addressing it

- **Implement product design and policy changes on technology platforms** to slow the spread of misinformation

- **Invest in longer-term efforts to build resilience against health misinformation,** such as media, science, digital, data, and health literacy programs and training for health practitioners, journalists, librarians, and others

- **Convene federal, state, local, territorial, tribal, private, nonprofit, and research partners** to explore the impact of health misinformation, identify best practices to prevent and address it, issue recommendations, and find common ground on difficult questions, including appropriate legal and regulatory measures that address health misinformation while protecting user privacy and freedom of expression

Addressing health misinformation will require a whole-of-society effort.

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WE CAN TAKE ACTION

WHAT INDIVIDUALS, FAMILIES, AND COMMUNITIES CAN DO

Learn how to identify and avoid sharing health misinformation. When many of us share misinformation, we don't do it intentionally: We are trying to inform others and don't realize the information is false. Social media feeds, blogs, forums, and group chats allow people to follow a range of people, news outlets, and official sources. But not every post on social media can be considered reliable. And misinformation can flourish in group texts or email threads among friends and family. Verify accuracy of information by checking with trustworthy and credible sources. If you're not sure, don't share.

Engage with your friends and family on the problem of health misinformation. If someone you care about has a misperception, you might be able to make inroads with them by first seeking to understand instead of passing judgment. Try new ways of engaging: Listen with empathy, establish common ground, ask questions, provide alternative explanations and sources of information, stay calm, and don't expect success from one conversation.

Address health misinformation in your community. Work with schools, community groups such as churches and parent-teacher associations, and trusted leaders such as educators and health care professionals to develop local strategies against misinformation. For example, invite local health professionals to schools or to faith congregations to talk about COVID-19 vaccine facts.

When many of us share misinformation, we don't do it intentionally: We are trying to inform others and don't realize the information is false... If you're not sure, don't share.

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WHAT EDUCATORS AND EDUCATIONAL INSTITUTIONS CAN DO

Strengthen and scale the use of evidence-based educational programs that build resilience to misinformation. Media, science, digital, data, and health literacy programs should be implemented across all educational settings, including elementary, secondary, post-secondary and community settings. In addition to teaching people how to be more discerning about the credibility of news and other content, educators should cover a broader set of topics, such as information overload, internet infrastructure (e.g., IP addresses, metadata), the challenges of content moderation, the impact of algorithms on digital outputs, algorithmic bias, artificial intelligence (AI)-generated misinformation (e.g., deepfakes), visual verification skills, and how to talk to friends and family who are sharing misinformation.

Educate students and the public on common tactics used by those who spread misinformation online. Recent research suggests that teaching people how to spot these tactics can reduce people's willingness to share misinformation.[57] Examples of misinformation tactics used by those who deny scientific consensus on health issues include presenting unqualified people as experts; misleading consumers with logical fallacies; setting impossible expectations for scientific research; cherry-picking data or anecdotes; and introducing conspiracy theories.[58]

Establish quality metrics to assess progress in information literacy. While there is substantial media and information literacy work being carried out across the United States, there is a need for more consistent and empirically evaluated educational materials and practices.

> *Media, science, digital, data, and health literacy programs should be implemented across all educational settings.*

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WHAT HEALTH PROFESSIONALS AND HEALTH ORGANIZATIONS CAN DO

Proactively engage with patients and the public on health misinformation. Doctors, nurses, and other clinicians are highly trusted and can be effective in addressing health misinformation.[59] If you are a clinician, take the time to understand each patient's knowledge, beliefs, and values. Listen with empathy, and when possible, correct misinformation in personalized ways. When addressing health concerns, consider using less technical language that is accessible to all patients. Find opportunities to promote patient health literacy on a regular basis.

Use technology and media platforms to share accurate health information with the public. For example, professional associations can equip their members to serve as subject matter experts for journalists and effectively communicate peer-reviewed research and expert opinions online.

Partner with community groups and other local organizations to prevent and address health misinformation. For example, hospital systems can work with community members to develop localized public health messages. Associations and other health organizations should offer trainings for clinicians on how to address misinformation in ways that account for patients' diverse needs, concerns, backgrounds, and experiences.

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WHAT JOURNALISTS AND MEDIA ORGANIZATIONS CAN DO

Train journalists, editors, and others to recognize, correct, and avoid amplifying misinformation. Media organizations should develop in-house training programs and partner with journalism schools, nonprofits, technology platforms, and others to democratize access to high-quality training for all media outlets.

Proactively address the public's questions. When something is new—such as a vaccine—people will understandably have questions. By anticipating and proactively answering those questions, media organizations and journalists can help get ahead of misinformation and increase the public's health and information literacy.

Provide the public with context to avoid skewing their perceptions about ongoing debates on health topics. For example, when discussing conflicting views on an issue, give readers a sense of where the scientific community stands and how strong the available evidence is for different views. Consider questions like: How much disagreement is there among experts? Is a given explanation plausible even if it is unlikely? If evidence is not equally strong on all sides of an issue, avoid presenting it as such.

Carefully review information in preprints. Preprints are research papers published online before peer review. They can provide scientists and the public with useful information, especially in rapidly evolving situations such as a pandemic. However, because preprints have not been independently reviewed, reporters should be careful about describing findings from preprints as conclusive. If reporting on such findings, include strong caveats where appropriate, seek out expert opinions, and provide readers with context.

Use a broader range of credible sources—particularly local sources. Research shows us that people have varying levels of trust in different types of people and institutions.[4] In addition to relying on federal and state public health authorities as sources, build relationships with local health professionals and local trusted, credible health organizations.

Consider headlines and images that inform rather than shock or provoke. Headlines are often what audiences will see and remember. If a headline is designed to fact-check a rumor, where possible, lead with the truth instead of simply repeating details of the rumor. Images are often shared on social media alongside headlines and can be easily manipulated and used out of context. Picture desk and social media editors should consider how provocative and medically inaccurate imagery can be a vehicle for misinformation.[60]

> *Give readers a sense of where the scientific community stands and how strong the available evidence is for different views.*

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WHAT TECHNOLOGY PLATFORMS CAN DO

Assess the benefits and harms of products and platforms and take responsibility for addressing the harms. In particular, make meaningful long-term investments to address misinformation, including product changes. Redesign recommendation algorithms to avoid amplifying misinformation, build in "frictions"—such as suggestions and warnings—to reduce the sharing of misinformation, and make it easier for users to report misinformation.

Give researchers access to useful data to properly analyze the spread and impact of misinformation. Researchers need data on what people see and hear, not just what they engage with, and what content is moderated (e.g., labeled, removed, downranked), including data on automated accounts that spread misinformation. To protect user privacy, data can be anonymized and provided with user consent.

Strengthen the monitoring of misinformation. Platforms should increase staffing of multilingual content moderation teams and improve the effectiveness of machine learning algorithms in languages other than English since non-English-language misinformation continues to proliferate.[39] Platforms should also address misinformation in live streams, which are more difficult to moderate due to their temporary nature and use of audio and video.

Prioritize early detection of misinformation "super-spreaders" and repeat offenders. Impose clear consequences for accounts that repeatedly violate platform policies.

Evaluate the effectiveness of internal policies and practices in addressing misinformation and be transparent with findings. Publish standardized measures of how often users are exposed to misinformation and through what channels, what kinds of misinformation are most prevalent, and what share of misinformation is addressed in a timely manner. Communicate why certain content is flagged, removed, downranked, or left alone. Work to understand potential unintended consequences of content moderation, such as migration of users to less-moderated platforms.

Proactively address information deficits. An information deficit occurs when there is high public interest in a topic but limited quality information available. Provide information from trusted and credible sources to prevent misconceptions from taking hold.[40]

Amplify communications from trusted messengers and subject matter experts. For example, work with health and medical professionals to reach target audiences. Direct users to a broader range of credible sources, including community organizations. It can be particularly helpful to connect people to local trusted leaders who provide accurate information.

Prioritize protecting health professionals, journalists, and others from online harassment, including harassment resulting from people believing in misinformation.

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WHAT RESEARCHERS AND RESEARCH INSTITUTIONS CAN DO

Strengthen the monitoring of health questions, concerns, and misinformation. Focus on a broader range of content and platforms, as well as on information flow across platforms. For example, examine image- and video-based content and content in multiple languages. To address existing research limitations, expand data collection methods (e.g., recruit social media users to voluntarily share data).

Assess the impact of health misinformation. There is an urgent need to comprehensively quantify the harms of health misinformation. For example, how and under what conditions does misinformation affect beliefs, behaviors, and health outcomes? What is the role of emotion, cognition, and identity in causing misinformation to "stick"? What is the cost to society if misinformation is left unchecked?

Prioritize understanding how people are exposed to and affected by misinformation, and how this may vary for different subpopulations. Tailor interventions to the needs of specific populations. Invite community members to participate in research design.

Evaluate the effectiveness of strategies and policies to prevent and address health misinformation. For example, can flagging certain content as misinformation have unintended consequences? Is it possible to build resilience to misinformation through inoculation methods such as "prebunking"? (*Debunking* involves correcting misinformation once someone has been exposed to it. *Prebunking*, or preemptively debunking, involves warning people about misinformation they might come across so they will be less likely to believe it when exposed.)[77]

There is an urgent need to comprehensively quantify the harms of health misinformation.

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WE CAN TAKE ACTION

WHAT FUNDERS AND FOUNDATIONS CAN DO

Move with urgency toward coordinated, at-scale investment to tackle misinformation. Assess funding portfolios to ensure meaningful, multi-year commitments to promising research and programs.

Invest in quantifying the harms of misinformation and identifying evidence-based interventions. Focus on areas facing private and public funding gaps. Examples could include independent and local journalism, accountability mechanisms for platforms, and community-based health literacy programs.

Provide training and resources for grantees working in communities disproportionately affected by misinformation (e.g., areas with lower vaccine confidence).

Incentivize coordination across grantees to maximize reach, avoid duplication, and bring together a diversity of expertise. For example, encourage coordination around monitoring health misinformation across multiple languages.

Assess funding portfolios to ensure meaningful, multi-year commitments to promising research and programs.

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WHAT GOVERNMENTS CAN DO

Convene federal, state, local, territorial, tribal, private, nonprofit, and research partners to explore the impact of health misinformation, identify best practices to prevent and address it, issue recommendations, and find common ground on difficult questions, including appropriate legal and regulatory measures that address health misinformation while protecting user privacy and freedom of expression.

Increase investment in research on misinformation. For example, more research is needed to better define misinformation, document and process its harms, and identify best practices for preventing and addressing misinformation across mediums and diverse communities.

Continue to modernize public health communications. Work to understand Americans' health questions, concerns, and perceptions, especially for hard-to-reach populations. Deploy new messaging and community engagement strategies, including partnerships with trusted messengers. Proactively and rapidly release accurate, easy-to-understand health information in online and in-person settings. Invest in fact-checking and rumor control mechanisms where appropriate.[62]

Increase resources and technical assistance to state and local public health agencies to help them better address questions, concerns, and misinformation. For example, support the creation of teams within public health agencies that can identify local misinformation patterns and train public health misinformation and infodemic researchers. Work with local and state health leaders and associations to address ongoing needs.

Expand efforts to build long-term resilience to misinformation. For example, promote educational programs that help people distinguish evidence-based information from opinion and personal stories.

Deploy new messaging and community engagement strategies, including partnerships with trusted messengers. Proactively and rapidly release accurate, easy-to-understand health information in online and in-person settings.

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WHERE WE GO FROM HERE

> *We are all still learning how to navigate this new information environment. But we know enough to be sure that misinformation is an urgent threat, and that we can and must confront it together.*

During the COVID-19 pandemic, health misinformation has sowed confusion, reduced trust in public health measures, and hindered efforts to get Americans vaccinated. And misinformation hasn't just harmed our physical health—it has also divided our families, friends, and communities.

While health misinformation has always been a problem, today it spreads at unprecedented speed and scale. We are all still learning how to navigate this new information environment. But we know enough to be sure that misinformation is an urgent threat, and that we can and must confront it together.

The only way to address health misinformation is to recognize that all of us, in every sector of society, have a responsibility to act. Every single person can do their part to confront misinformation. But it's not just an individual responsibility. We need institutions to recognize that this issue is their moral and civic responsibility, too, and that they are accountable.

We have the power to shape our information environment, but we must use that power together. Only then can we work toward a healthier information environment—one that empowers us to build a healthier, kinder, and more connected world.

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MEMORANDUM

TO: OSG Misinformation Tiger Team
FROM: Eric
RE: Health Misinformation Next Steps

SUMMARY

VM/WH made major news and put tech and stakeholders alike on notice that health misinformation was a significant public health issue. Psaki plus POTUS lean ins around FB has created a new moment of entry with FB and other tech companies to apply pressure given confluence of Delta surge, vaccine misinformation amplification across platforms. Our office can and should prod this work forward, with technical and policy support from WH CDO and external orgs, while not going "all in" and taking away from other key office priorities.

BACKGROUND

As we consider our approach on a "Task Force" for tech/data, we can go really formal with a FACA, or more informal

OPTIONS:

1. *Maximum Pressure/Engagement*: Use "Summit/Commitments" approach and host a "Health Misinformation Summit/Day of Action" with Stanford or Shorenstein ~November 2.
    a. Commitments: secure commitments from each vertical flagged in report
    b. Partner with external activism arm for "scorecard" for tech: allow external group with expertise to provide updates to OSG/WH/public on how tech is doing on slowing spread of health misinformation (i.e., Stanford + COVID States Project)
    c. Comms: continue robust tier 1 press/tv interviews where VM calls out tech to do more/faster; rollout viral celebrity humor video series
    d. Announce key coalition of orgs who will be "field organizers" to follow up day to day on each vertical/quarterly report (e.g, PHA/CAP/Civic Nation).

Nick Clegg Approach: Share timeline and approach. Offer that if they do the right thing, Summit can be a moment for applause. If they do not, HHS/WH will continue to call them out.

Pros: Take advantage of our moment to hold tech accountable. Move needle significantly. While high lift, highest ROI.

Cons: Lack of policy expertise on our team on data side; FB has insurmountable advantage on data, which means we'll never know if they are on the level; takes us away from Starfish/Oscar and other office priorities; politicizes office by further engaging in social media/censorship war.

2. *Targeted Engagement (Medium):* Use launch of toolkit (post Labor Day/) as hook for a lower lift commitments play.
    a. "Listening tour" convenings with communities impacted by health misinformation
    b. Bring researchers and tech together for closed door session with clear asks (basically one meeting in August before deadline in September around commitments

c. Keep scorecard partnership with Stanford + COVID States project
d. Comms: Keep Misinfo in TPs. Target late night; have at least one partnership humor video to announce in September (e.g., Funny or Die)
e. Announce updated commitments fact sheet we will publish with toolkit.

Nick Clegg Approach: Share timeline and approach. Note we don't have a lot of faith they'll do anything other than say they are doing a lot, but not give us any way to verify. Put onus on them to say how they'll restore our faith.

Pros: We can take momentum and show how many people are taking action (i.e., YouTube policy change and even Twitter banning MTG for day). Allows us to keep all of society approach. Helps us see past just tech.
Cons: Will still be a lot of work, even for lower lift.

3. *Bully Pulpit/CTO Handoff (Low):* Essentially run ersatz #2 but give new WH CDO the ball on holding FB accountable on the data/technical side, along with a more formal "Task Force". (Kyla spoke to incoming CDO and she's willing to do this)
   a. We continue to do listening sessions/partnerships/lighter commitments/lower level comms. (i.e., misinfo is in our constellation, but it's not the sun)

Nick Clegg Approach: Use DJ to follow-up on data asks until Denise takes on CDO mantle/announcement of Task Force. Put onus on them to say how they'll restore our faith.

Pros: We can take momentum and show how many people are taking action (i.e., YouTube policy change and even Twitter banning MTG for day). Allows us to keep all of society approach. Helps us see past just tech.
Cons: Will still be a lot of work (esp if we go higher level formality on "Task Force"), even for lower lift.

RECOMMENDATION:

Bully Pulpit + CDO Tech Handoff/Task Force:

VM continues to use his bully pulpit to address health misinformation as one of his top three talking points (Masks, Mental Health, Misinformation). Staff level listening sessions on all eight verticals run by Public Engagement. Use CDO/Task Force model to convene experts to hold FB and other tech providers accountable with push on more open data.

Suggested Approach for rest of CY 2021 will include [list below from easiest to hardest]

- Convenings: [low lift]
  - *Closed Door Policy Roundtable/Listening Sessions*: Aug-Sept. Rafael, Eric, Kyla, and Daniel will host listening roundtable sessions with leaders from each of the eight subgroups called out in the report. Goal: collect stories around on the ground experiences as well as best practices

        - Health Professionals: NYC Health Commissioner team; This is Our Shot;
        - Tech: FB; Insta; Google/YouTube; Twitter; Snap
        - Research: Aspen report in late Sept/Early Oct on Misinfo landscape
    - VM outreach to groups: July-October
        - Educators: 7/29 WH Call with College Presidents; TBD convo with STEM Teachers/NEA/AFT
        - Health Care: ASTHO 7/27 Call; AMA
        - Business Community: Aug Chamber of Commerce
        - Research: Launch event with Stanford
- TV/Media/Press [medium lift] [July – December]
    - *Monthly Tier 1*: In addition to keeping misinfo as a top three talking point, VM should plan at least one monthly tier 1 media hit on Health Misinfo (e.g., NYTimes feature with D. Leonhardt or feature on "The Daily"; interview with theVerge and Wired) [Alex will have better ideas]
    - *Completed press:* Fox News Sunday; ABC with Martha Raddatz; CNN SOTU; NPR, etc. [too many to list! #AlexCrushingIt]
- Digital/Partnership Assets [Aug-Oct]
    - *Toolkit*: Digital team is designing. Will be ready to launch by late Sept.
    - *Digital Postcard*: still in design/process, but could be part of late Sept launch.
    - *Comedy Video Series*: launch video series (TBD nonprofit partner); discussions around Will Ferrell; Selena Gomez; Prince Harry; RuPaul. Discussions ongoing for a potential ongoing C3 partner to continue to create/run content on an ongoing basis. Announce video commitment with launch of toolkit. Videos tentatively start in October.
    - *Ted Allen Convo*: Social launch on 7/30
- Data Play: [heavy lift] [Aug-February]
    - *Data Task Force:* In partnership with CDO, launch health misinformation "Task Force": We still have to decide how big to go here, but the Day One Project helped put together a helpful proposal detailing an umbrella, 9/11 like commission (link). Kyla has been leading calls with Claire Wardle on how to drive this forward. For the Task Force, we would try and get DJ to help lead, along with folks like Dana Boyd, Ash Carter, Bill McRaven, etc. Kyla can quarterback this with Denise Ross (CDO) once we decide on level of formality on the Task Force (FACA vs informal). We should have an honest conversation about how much work this will be for Kyla et al. Still probably the right thing to do.

From:	Lesko, Max (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=4F2CC293A2714518ACF3B8F1FE98D057-LESKO, MAX <Max.Lesko@hhs.gov>
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Subject:	Health Misinformation Launch Date -- 7/15
Date:	2021/06/28 12:25:27
Priority:	Normal
Type:	Note

Hi all,

We left a conversation earlier this AM and wanting to contemplate the drawbacks of a release during a holiday week (July 4th week), and if we were to push to the week of the 12th, how it would interact with the New Mexico trip.

Vivek and I just touched base briefly and agreed that we should push to the following week, and to give some buffer with the NM trip (7/12-13), **plan for a Health Misinformation rollout on Thursday July 15th**. Can folks tell their teams as appropriate (Eric > Rafael, Adam > S&P, Ann > Kyla).

A few points on what this means:

1) This buys us time to strengthen our rollout, which we should do (e.g. consider an op-ed, how to line up partners further, and maybe replacement event if Stanford moves forward this week), but we should not try to overhaul the rollout plan. We have the pieces in place, lets strengthen and add to strategically.
2) We also have to walk and chew gum over the next two weeks, not be unilaterally focused on Misinformation as many of our team has been over the last 2-4 weeks to drive some additional priorities while continuing to prepare for a strong rollout.

Thanks for the thoughtfulness around this.

Max

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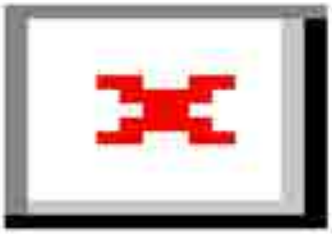
From: Folkers, Greg (NIH/NIAID) [E] <gfolkers@niaid.nih.gov>
Subject: Helen Branswell and Amy Maxmen share 2021 Victor Cohn Prize https://bit.ly/3lABnLC
Date: 2021/08/05 14:11:35
Priority: Normal
Type: Note

Council for the Advancement of Science Writing
Helen Branswell and Amy Maxmen share 2021 Victor Cohn Prize



Journalists Helen Branswell (@HelenBranswell) of *STAT* and Amy Maxmen (@amymaxmen) of *Nature* have been chosen to receive the 2021 Victor Cohn Prize for Excellence in Medical Science Reporting.

Given the remarkable quality and impact of Branswell and Maxmen's reporting on infectious disease in a year of outstanding and critically important science journalism, the judges elected to split the prize for the third time in the history of the award. They cited Branswell for her extraordinary depth of knowledge and her prescient, sharp, high-impact coverage of the COVID-19 pandemic. Maxmen was cited for intrepid, rigorous, humane reporting that revealed the unequal toll of the pandemic by centering the voices and experiences of underserved communities.

The two journalists, the judges noted, have lifted their readers above the fog of confusion and misinformation as they worked in parallel and complementary ways to provide the public the accessible, rigorous, thoughtful coverage and authoritative insight needed to weather a dangerous and fast-moving public health crisis.

The Victor Cohn Prize for Excellence in Medical Science Reporting is awarded annually by the Council for the Advancement of Science Writing (CASW) for a body of work published or broadcast within the last five years. Branswell and Maxmen will share a $3,000 award and be recognized this fall during ScienceWriters2021, a joint meeting of CASW and the National Association of Science Writers.

Helen Branswell

When Helen Branswell joined STAT as a senior writer in 2015, she was already one of the world's most authoritative reporters on infectious disease and global health, having covered the SARS crisis and the West African Ebola epidemic for The Canadian Press, in addition to myriad topics including sexually transmitted diseases and antibiotic resistance, the avian and swine flu pandemics, and MERS. She has been a Knight Fellow at the Centers for Disease Control and Prevention and a Nieman Fellow at Harvard. The judges noted that the years spent in research and reporting have paid off for readers in explanatory writing that conveys complex ideas in sharp, informative prose. Her work has also attracted more than 200,000 Twitter followers.

STAT Managing Editor Gideon Gil noted in his nomination letter that Branswell was the first American journalist to write about the coronavirus pandemic—posting a tweet on New Year's Eve 2019 that led *Esquire* to dub her "the one who called it"—and filed no less than 161 articles on COVID-19 during 2020 alone. For her relentless coverage of the pandemic, Branswell was honored with the 2020 George Polk Award for Public Service and was a finalist, with *STAT* colleagues Andrew Joseph and Sharon Begley, for the Pulitzer Prize in Breaking News Reporting.

The Cohn Prize judges made special note of Branswell's April 2020 story "The months of magical thinking: As the coronavirus swept over China, some experts were in denial." They said the story, a demonstration of the veteran reporter's "rare insight into human nature," helped readers understand "how even some of the best scientists didn't quite allow themselves to see the magnitude of what was coming."

Amy Maxmen

Trained in evolutionary biology, Amy Maxmen was an award-winning freelance science writer when she joined *Nature* full time as a senior reporter in 2017. In nominating her, *Nature* Features Editor Brendan Maher noted that Maxmen has reported on outbreaks around the world, including drug-resistant malaria in Myanmar and Cambodia, HIV in South Africa, tuberculosis in Tanzania, and Ebola in the Democratic Republic of the Congo and Sierra Leone. Her enterprise reporting has appeared in *The New York Times, National Geographic, Wired*, and other outlets in addition to *Nature* and has been honored with both the AAAS Kavli Science Journalism Award and the Bricker Award for Science Writing in Medicine, in addition to awards from the National Association of Science Writers and Association of Health Care Journalists.

In the teeth of the COVID-19 pandemic, Maxmen spent eight months reporting on the unequal toll of the SARS-CoV2 virus in California's rural San Joaquin Valley with support from a fellowship from the Knight Science Journalism Program at MIT, and a subsequent award from the Pulitzer Center. The judges made note of the intrepid reporting and vivid, compassionate writing that went into "Inequality's deadly toll," a multimedia package published in English and Spanish by *Nature* in April 2021. In her demonstration of how decades of low wages, the erosion of labor protections, and housing segregation exacerbated the toll of COVID-19 among agricultural workers, one judge said, "she is holding a massive mirror up to our society as a whole." Another called the story one that is "nuanced and will haunt me for years."

Branswell and Maxmen are the 24th and 25th recipients of the Cohn prize, given for a body of work published or broadcast within the past five years.

CASW, a not-for-profit organization committed to improving the quality of science news and information reaching the public, produces the New Horizons in Science program at the annual ScienceWriters conference. In addition to conference presentations and workshops, CASW's programs include the Taylor/Blakeslee Fellowships in support of graduate study in science writing; the Clark/Payne Award for a young science journalist; a new early-career fellowship program in science, health and environmental reporting; and other efforts in support of quality, diversity, and sustainability in science journalism.

The Victor Cohn Prize

This year's Cohn Prize entries were judged by Jill U. Adams, a freelance science journalist and *Washington Post* health columnist; freelance writer and author Christie Aschwanden, a *New York Times* contributor and author most recently of *Good to Go: What the Athlete in All of Us Can Learn from the Strange Science of Recovery*; John Fauber, *Milwaukee Journal Sentinel* investigative reporter and winner of the Cohn Prize in 2013; freelance science writer and editor Lauren Gravitz; Cristine Russell, a senior fellow and adjunct lecturer at the Harvard Kennedy School; and Ed Yong, staff writer for *The Atlantic* and recipient of the 2020 Cohn Prize.

The Victor Cohn Prize for Excellence in Medical Science Reporting has been presented since 2000. In addition to Fauber and Yong, past recipients include Laurie Garrett of *Newsday*; Lawrence K. Altman of *The New York Times*; Jon Palfreman, a public television documentarian; Daniel Q. Haney, medical editor of The Associated Press; Shannon Brownlee, a noted magazine writer and book author; Michelle Trudeau of National Public Radio; Rick Weiss of the *Washington Post;* Jerome Groopman of *The New Yorker;* Geeta Anand of *The Wall Street Journal;* Denise Grady of *The New York Times;* Marilynn Marchione of The Associated Press; Ron Winslow of *The Wall Street Journal;* Jon Cohen of *Science* magazine; freelance health reporter and former NPR correspondent Joanne Silberner; Elisabeth Rosenthal of *The New York Times;* Mark Johnson of the *Milwaukee Journal Sentinel*; Liz Szabo, health writer for *USA Today* and senior correspondent for Kaiser Health News; Sharon Begley, senior science writer at STAT; freelance medical writer Laura Beil; and Apoorva Mandavilli, founder and editor-in-chief of the autism website *Spectrum* and now a New York Times science writer.

The award honors the late *Washington Post* medical writer and health columnist Victor Cohn, known as the dean of medical science reporting. He distinguished himself by the clarity and effectiveness of his reporting during a 50-year career that began with outstanding coverage of early "wonder" drugs and the polio vaccine, as well as the dawn of the modern space age. Late in his career, Cohn started a *Post* column called "The Patient's Advocate," and authored *News &Numbers: A Guide to Reporting Statistical Claims and Controversies in Health and Other Fields*. Cohn, who died of cancer in 2000, was a co-founder in 1959 of CASW.

Image: Helen Branswell (left) *and Amy Maxmen, winners of the 2021 Victor Cohn Prize for Excellence in Medical Science Reporting*

To read Helen Branswell's recent work (Twitter: @HelenBranswell), visit her page at STAT.

To read Amy Maxmen's recent work (Twitter: @amymaxmen), visit her website and her page at Nature.

To learn more about CASW (Twitter: @sciencewriting), the Cohn Prize, and past recipients, visit the CASW website.

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Special Report

States Hardest Hit By Delta.

nmeled By Delta Variant. By Dan Goldberg and Tucker Doherty, Politico. "Demand for Covid-19 vaccines is surging in
e renewed interest will fizzle. The number of Americans receiving a first vaccine dose each week has nearly doubled

oated; Mandates Bad Idea. By Sudhin Thanawala, AP. "The state has seen an increase in COVID-19 vaccinations since
emp said Friday. But he said some people may never be willing to take the shots, and he reiterated his opposition t
ship in government.'"

s As Coronavirus Roars To Record Levels In Florida. By Fenit Nirappil, Brittany Shammas, and Lori Rozsa, Washington
ar exceeding a record already shattered over the weekend — Florida Gov. Ron DeSantis (R) was fed up. Not with th
easures."

se As COVID Cases Rise. By Will Weissert and Brendan Farrington, AP. "It didn't take much for the White House to s
t, President Joe Biden asked GOP governors to 'get out of the way' of efforts to contain the virus."

The Covid Surge In Florida. By Glenn Kessler, Washington Post. "'Joe Biden has the nerve to tell me to get out of the
border by the hundreds of thousands. No elected official is doing more to enable the transmission of COVID in Ame

antis (R), in a fundraising letter, Aug. 4 'He's imported more virus from around the world by having a wide-open sc
to be in the grip of the delta variant as covid-19 hospitalizations keep breaking records. DeSantis has insisted he's
e mandates and barred schools from implementing mask requirements for students."

urge In Coronavirus Cases Isn't The Fault Of Immigrants. By Philip Bump, Washington Post. "On Thursday night, Sen. T
J.S.-Mexico border and, specifically, what Hannity called 'the biggest superspreader in the country.' 'I'm going to ar
that is infected because Joe's not enforcing the laws of this country, you can blame Joe Biden for covid,' Hannity sa
t surge in coronavirus cases."

s 6,000 Amid Case Surge. By AP. "More than 6,000 people in Nevada have died of COVID-19, a grim milestone the st
avirus. Gov. Steve Sisolak called it 'another significant and heartbreaking milestone' for the state and issued anothe

Be Mulling Covid-19 Vaccination Mandates.

panies Shift From Carrot To Stick On Coronavirus Vaccinations. By Adela Suliman, Bryan Pietsch, and Derek Hawkins, W
starting to shift from the carrot to the stick in an effort to boost coronavirus vaccinations, as cases rise. The effort c
l funds from institutions to persuade them to mandate vaccines — just days after he called for state and local gove

ngs Distrust, Support. By Julie Watson, Associated Press. "Since President Joe Biden asked the Pentagon last week t
rmy lawyer Greg T. Rinckey has fielded a deluge of calls. His firm, Tully Rinckey, has heard from hundreds of soldie
any legal action if ordered to get inoculated for the coronavirus."

den Administration Will Force Them To Get COVID Shot. By Zoe Stroszewski, Newsweek. "After President Joe Biden's r
the military, some members have expressed concern about potential mandatory vaccination, the Associated Press
ndreds of calls from soldiers, Marines and sailors troubled by Biden's inquiry."

yees To Be Vaccinated. By David Koenig, AP. "United Airlines will require employees in the U.S. to be vaccinated aga
corporations that are responding to a surge in virus cases. Company leaders called it a matter of safety and cited 'ir

ds, Delta Surge Causes Some Back-to-office Plans To Be Scrapped. By Lisa Rein and Eli Rosenberg, Washington Post. "
employees get vaccinated or face repeated testing as a bold step that will allow the government to safely bring its
ntagious delta variant surges. But for many federal agencies, the White House's public stance and its internal comm
ndreds of thousands of employees and contractors still logging in to work from the safety of their homes — belies

mune Boost, Studies Show. By Lauran Neergaard and Mike Stobbe, AP. "Even people who have recovered from COV
ariant surges — and a new study shows survivors who ignored that advice were more than twice as likely to get re
o growing laboratory evidence that people who had one bout of COVID-19 get a dramatic boost in virus-fighting im
they're vaccinated."

mmunocompromised Expected To Be Authorized Soon. By Laurie McGinley, Lena H. Sun, and Derek Hawkins, Washing
s with weakened immune systems can get additional shots of coronavirus vaccines to protect them against the hig
horized in days or weeks, according to federal officials who spoke on the condition of anonymity because the plan h

e Doses For Immunocompromised Patients. By Apoorva Mandavilli and Sharon Lafraniere, New York Times. "The Food
ronavirus vaccines for Americans with weakened immune systems, a change that reflects a growing concern within
ta variant surges nationwide. The regulatory move would mean that people with impaired immune responses who r
legally."
e Amid Vaccine Shortages. By Victoria Milko and Aniruddha Ghosal, AP. "Salimullah, a Rohingya refugee, has been liv
mar. Stateless, and now homeless after a fire razed his camp, the 35-year-old lives in a tent with as many as 10 ot
ourt, Warning Of Delta Threat. By Katy O'Donnell, Politico. "The Justice Department on Friday urged a federal court to
ect Americans from becoming homeless during a resurgence of Covid-19. DOJ was responding to a lawsuit brought
argue the Centers for Disease Control and Prevention lacked the power to impose the ban."
Vaccine-rich Countries. In The Hospital, They Changed Their Minds. By Jennifer Hassan and Adela Suliman, Washington
da. A conservative talk radio host in Tennessee. All chose not to get vaccinated against the coronavirus, despite livi
ng severely ill, they have since expressed an overwhelming sense of regret and urged others not to make the same

le. By Bryce Covert, New York Times. "On a July day in downtown Lowell, Mass., the first sunny Saturday of the mo
e empanada or egg roll. A D.J. played music. There were kid-friendly activities, too, like a touch-a-truck station wit
me. The real motivation was to get people in the community vaccinated against Covid-19."

Some With Optional Masking.

In Many US Classrooms. By Jeff Amy, AP. "As Tussahaw Elementary opened this week for a new school year, teary-e
d off fifth graders looking forward to ruling their school. The biggest clue to the lingering COVID-19 crisis was the m

icts Requiring Masks. By Brendan Farrington and Adriana Gomez Licon, AP. "Florida's Board of Education decided Fri
mask-wearing requirements amount to harassment of their children. The move to take private tuition costs from pu
ol boards and Republican Gov. Ron DeSantis over coronavirus safety measures in schools."
ools Sparks Legal Battle. By Susan Montoya Bryan, AP. "A legal battle is brewing in New Mexico over what power stat
o that authority. The fight stems from the Public Education Department's suspension this week of a rural school boa

Hospital To Require Jabs. By AP. "The University of Vermont reinstated an indoor mask requirement for all faculty, st
Also on Friday the UVM Health Network announced that beginning Oct. 1 it will require all its nearly 15,000 employe
-19 or undergo weekly testing."
' About Maskless School. By AP. "The school year is days away for many kids in Utah and public health experts are w
id a wave of coronavirus cases. Salt Lake County Health Department Executive Director Dr. Angela Dunn tells KUTV

19 Cases.

es, As Government Struggles To Contain Spread. By Michelle Ye Hee Lee and Simon Denyer, Washington Post. "Japan's
he hospital system amid a slow vaccine rollout, an increasingly apathetic public and the government's unsuccessful
ed 5,042 new coronavirus cases, its highest daily count and nearly double the record set nine days before."
ally Through Year's End. By Huizhong Wu, AP. "Chinese President Xi Jinping pledged 2 billion doses of COVID-19 vac
mitment as the largest exporter of the shots. Xi's announcement was delivered at the International Forum on COVI
virtually."
COVID Backdrop In UK. By Pan Pylas, AP. "Further evidence emerged on Friday to show that the latest outbreak of t
positive for COVID-19 falling across most parts of the country. In its weekly survey of the levels of infection across
falling in England, Scotland and Wales, though not in Northern Ireland, with the declines most noticeable among yo
id Surge In Infections. By Vladimir Isachenkov, AP. "Russia saw mortality rise at a faster pace last month amid a surg
Tatyana Golikova, who leads the government's coronavirus task force, told the Tass news agency that Russia saw

ow Blood Platelet Cases: EU Regulator. By Helen Collis, Politico Europe. "Johnson &Johnson's single-shot COVID-19 va
gency said on Friday. The regulator's drug safety committee, PRAC, said it reached the conclusion after assessing a
ide effects reported to the drugmaker and to European and U.S. regulators."
ss' To Prove Vaccination On Its First Day. By Jason Horowitz, New York Times. "On Friday, the first day that Italians m
eums, gyms, theaters and a wide range of social activities, Margherita Catenuto, 18, from Sicily, proudly showed a
'It's like showing you have a conscience,' said Ms. Catenuto as she walked in."
andemic's Second Wave Of Protests. By Rick Noack and Kate Brady, Washington Post. "When French President Emma
nation, immunity or a recent coronavirus test to access trains, restaurants and other venues — pharmacy worker Ag
days, interest in getting vaccinated surged."
nti-vaccine Protest. By Associated Press. "Ralph Gonsalves, the prime minister of St. Vincent and the Grenadines, wa
accine protest led by nurses and other workers in the eastern Caribbean island, officials said late Thursday. Gonsalv
ment from his office."
s Global Hunger. By Christina Goldbaum and Joao Silva, New York Times. "Even as thousands died and millions lost
azi Stishi, a single mother, was able to feed her family with the steady support of her father, a mechanic at a Merce
ected and died within days."
ells Us About International Trade. By Paul Krugman, New York Times. "For many of us, Chad Bown of the Peterson Ins
nternational economics — has become the go-to guy for current developments in trade policy. His work tracking the
rmative new paper with Thomas Bollyky on the vaccine supply chain."

D-19.

agements) highlighted: "@GreatKellyB @GovRonDeSantis and Putin puppet, Michael Caputo, just moved there full t
@HinduAmerican, official account of the Hindu American Foundation (37.4K followers, 24 engagements), announce
vaccine education campaign. Need a vaccine? Here are three ways to fine one. Protect yourself and others by getti

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To Blame Biden For The Covid Surge In Florida – Shares: 1,312

s Masks, Restrictions As Coronavirus Roars To Record Levels In Florida – Shares: 517

: Pandemic Deepens Global Hunger – Shares: 477

ster Shots For The Immunocompromised Expected To Be Authorized Soon – Shares: 280

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Special Report

ns Begin Deploying To Midwest, South.

lling Out To A Hostile Heartland. By Erin Banco and Dan Goldberg, Politico. "The Biden administration's coronavirus su
re the highly contagious Delta variant is leading to a rapid rise in hospitalizations, according to four state health off
rge team to Nevada, but multiple local health officials there said they aren't sure if the federal aid — including help
he state respond to the spread of Delta, or whether it would have an immediate and significant impact."

Orders For Mass Transit: 'Part Of Our Arsenal'. By Lexi Lonas, The Hill. "A Centers for Disease Control and Prevention
wmakers are pushing for the mandates to be revoked. 'Masks are really powerful and we should make sure they're
Migration and Quarantine, said in an interview with Reuters."

mic Of The Unvaccinated'. By AP. "The director of the Centers for Disease Control and Prevention says the COVID-19
during a White House briefing, Dr. Rochelle Walensky says cases in the U.S. are up about 70% over the last week,

Campaign Of Vaccine Misinformation. By Salvador Rizzo, Washington Post. "'The fact of the matter is it looks like natu
risk to the vaccine. Again, it's very small, but there are some pretty serious side effects, including death. We are alr

warning system.' — Sen. Ron Johnson (R-Wis.), in an interview on 'Hannity' on Fox News, July 14 Johnson has em

rnia Leans On Masks And Vaccines. By Shawn Hubler and Mitch Smith, New York Times. "Exactly one month after Go
from more than a year of health restrictions, Los Angeles County said on Thursday that face masks would again be
from the University of California that most unvaccinated faculty, staff and students would be barred from its camp
ay be poised for a resurgence, although not one nearly as bad as past spikes."
bers Have Received First Dose Of Covid Vaccine. By Quint Forgey, Politico. "Seventy percent of U.S. active duty servic
announced on Friday, and 62 percent of the force is now fully vaccinated. The latest numbers come despite initial s

an't Share Your Data, But Airlines Can. By Alex Rouhandeh and Paloma Green, Newsweek. "As the United States near
r to travel again, vaccine documentation has emerged as a hot topic in the polarized political forum. Blue states lik
e passports of their own, while red states like Florida, Utah, and Texas have passed laws banning the requirement c

ases In One Day.

Before Virus Rules Eased. By Pan Pylas, AP. "The U.K. recorded more than 50,000 new coronavirus cases in one day
lser warned that the number of people hospitalized with COVID-19 could hit 'quite scary' levels within weeks. Gover
since mid-January."
atory Masks Sows Confusion. By Jill Lawless, AP. "For many, it's common courtesy or a sensible precaution. For othe
of debate, confusion and anger around the world during the coronavirus pandemic — is now dividing people as the
t Half A Million Exposure Notifications In A Week. By Karla Adam, Washington Post. "Employers in Britain are raising fe
after more than half a million people in a single week were pinged by the government's contact-tracing app, alertin
up to 10 days. Already, factories, pubs, restaurants and schools are reporting staff shortages resulting from quara
plies to people who are fully vaccinated."
S. Donated COVID-19 Vaccines In Days. By Stephanie Nebehay, Reuters. "Nearly 50 African countries are to receive 25
rst shipments to Burkina Faso, Djibouti and Ethiopia in coming days, U.S. officials and the Gavi vaccine alliance said
ccines with countries around the world to protect the most vulnerable and stem transmission of the coronavirus."
ccines Are Still Far Off. By Abdi Latif Dahir and Josh Holder, New York Times. "Africa is now in the deadliest stage of
eping across the continent. Namibia and Tunisia are reporting more deaths per capita than any other country. Hosp
stretched thin and recorded deaths jumped 40 percent last week alone. But only about 1 percent of Africans have
To The Test A Week Before Starting. By Shashank Bengali, Hisako Ueno and Alexandra E. Petri, New York Times. "Ca
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COVID Vaccine Sharing. By Rod McGuirk and Aamer Madhani, AP. "Leaders of Asian Pacific nations agreed on Friday
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, Chinese Prime Minister Xi Jinping, Japanese Prime Minister Yoshihide Suga and Russian President Vladimir Putin,
ound the globe."
Open Its Borders To Vaccinated Travelers By Early September, Trudeau Says. By Erin Cunningham, Washington Post. "
early September, and possibly welcome immunized Americans as soon as mid-August, the office of Prime Minister

States in March 2020 as the pandemic first accelerated, and has since restricted entry for other foreign visitors to h
mission slows, those controls could be lifted in the coming weeks, Trudeau said in a call with Canadian provincial le

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or Ron Johnson's Campaign Of Vaccine Misinformation – Shares: 1,430

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ngagements), quoted Sec. Becerra stating: "We have a certain amount of authority at the federal level. We can mar
official account of New Hampshire Senator Jeanne Shaheen (120.6K followers, 14 engagements), announced: "Thr
ericanRescuePlan through @HHSGov's Health Center Program – which has been a priority for me during COVID. This
HopkinsSPH, Johns Hopkins Bloomberg School of Public Health (500.4K followers, 13 engagements) announched: "W
ther states? Vermont Health Commissioner, Dr. Mark Levine, joins the @publichealthpod to talk about the state's re
ted: "There were 938 new cases of COVID-19 reported Thursday, according to the Nevada Department of Health ar

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Special Report

anged CDC Masking Guidance.

nge Sets Off Scramble Across U.S. At Local Level. By Mitch Smith, Benjamin Guggenheim and John Yoon, New York Ti
state's largest city, face coverings are still required."

CDC Mask Guidance Means. By Heather Hollingsworth and Stephen Groves, AP. "More than a dozen states quickly em
d to wear masks indoors or out in most cases. But other states and cities and some major businesses hesitated ami

s — At Least For Now — Even With New CDC Guidance. By Abha Bhattarai, Washington Post. "Many of the country's la
rictions, though industry groups and workers' advocates fear enforcement will become increasingly difficult and com
day that fully vaccinated Americans no longer need to wear masks in most situations."

, Skip Social Distancing. By Zeke Miller and Michael Balsamo, AP. "In a major step toward returning to pre-pandemic
ance for fully vaccinated people, allowing them to stop wearing masks outdoors in crowds and in most indoor settin
a Rose Garden address heralding the new guidance, an event where he and his staff went without masks."

cal Milestone. By Natasha Korecki and Christopher Cadelago, Politico. "When the news broke that Americans no long
move. He took off his mask and so did the Republicans sitting across from him negotiating an infrastructure deal a
Vaccines After China-Taiwan Tussle. By Michael Martina, Reuters. "The United States stands with Honduras and conde
Department said, after Taiwan blasted China for seeking to use vaccines to make diplomatic inroads with one of Tai
aintain diplomatic ties with Taiwan, has said it was considering opening an office in China in a bid to acquire much r
ccine-for-recognition deal."
: Shrinking, But Work Remains. By Amy Schoenfeld Walker, Albert Sun, Yuriria Avila, Laney Pope and John Yoon, New
disproportionately smaller share of vaccinations to date, according to a New York Times analysis of state-reported
f the most socially vulnerable parts of the nation, leaving many low-income communities of color with vaccination ra
acelets. Vaccination Cards Are The New Ticket. By Jennifer Steinhauer, New York Times. "At Fort Bragg, soldiers who h
uired, with no limits on who can work out together. Treadmills are on and zipping, unlike those in 13 other gyms wi
estrictions remain on how many can bench-press at one time."
Messages About Whether To Take The Coronavirus Vaccine. By Jeremy Barr, Washington Post. "If you're a Fox News fa
on when and whom you watch. On his 8 p.m. show, opinion host Tucker Carlson has consistently derided efforts to
D-19 Falsehoods Online. By Ali Swenson and Beatrice Dupuy, AP. "Dr. Michelle Rockwell lost a pregnancy in Decemb
she received the COVID-19 vaccine and posted about that, too."

For Third Straight Day.

s Infections Pass 24 Mln. By Reuters. "Prime Minister Narendra Modi sounded the alarm over the rapid spread of COV
virus for the third straight day and total infections crossed 24 million. India is in the grip of the highly transmissible
the globe."
es Of Sputnik V Vaccine In Next Few Months. By Reuters. "Indian drugmaker Dr. Reddy's Laboratories Ltd said on Fridl
couple of months under its contract with Russia's sovereign wealth fund. India's catastrophic second wave of the pa
ry, the world's biggest vaccine producer, low on stocks."
Cost Of Living. By Reuters. "Ashok Khondare, a 39-year-old vegetable seller in the western Indian city of Pune, had a
ate hospital two weeks after contacting COVID-19. While trying to overcome the tragedy, he also had to deal with

OVID-19 Calamity. By David Klepper and Neha Mehrotra, AP. "The man in the WhatsApp video says he has seen it we
tice what I am about to say with faith, you will be free of corona in five seconds,' says the man, dressed in tradition
rus Cases Surge In Nepal. By Pamela Constable, Washington Post. "Just one month ago, after dropping steadily since
aued at around 100 cases per day. Many hoped the worst was behind them."
Forcing The U.K. To Rethink Its Approach. By Elian Peltier and Marc Santora, New York Times. "The British authorities
oducing local lockdowns to stem the spread of a coronavirus variant first detected in India, a warning sign for count
are incomplete. The numbers of cases involving the variant, known as B.1.617, rose from 520 last week to 1,313 ca

kdown To Go Ahead On Monday, Says Spokesman. By Reuters. "Prime Minister Boris Johnson expects an easing of Brit
rns were raised over the spread of a coronavirus variant first detected in India. 'We've announced the changes that

expects they will go ahead,' the spokesman said, adding that a five-week period before the next planned step in th

s To Be Lifted Next Week. By Sylvia Hui, AP. "When London's Science Museum reopens next week, it will have some r
ng the pandemic, to be featured in a new COVID-19 display. Britain isn't quite ready to consign the coronavirus to

d Vaccine Dose Sooner. By AP. "British Prime Minister Boris Johnson says second doses of coronavirus vaccines will b
ohnson says people over age 50 can receive their second COVID-19 shot eight weeks after their first, rather than t
sts, Ending Uncertainty. By Barry Hatton, AP. "British tourists can return to Portugal from next Monday, ending days
stinations would be allowed. British visitors will be admitted on nonessential travel from May 17, the Portuguese fo

v, Vaccinations Speed Up. By Geir Moulson, AP. "Germany's coronavirus infection rate dropped to its lowest level in r
most successful day yet of its vaccination campaign this week. Still, Jens Spahn called for caution as authorities mo
ing restaurants and calling for Germans to choose vacation destinations carefully."
liracle COVID-19 Cures. By Reuters. "Brazilian President Jair Bolsonaro, addressing the nation last month in a social r
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ad Of Tokyo Olympics. By Mari Yamaguchi, AP. "Japan on Friday further expanded a coronavirus state of emergency
d his determination to hold the Olympics in just over two months. Japan has been struggling to slow infections ahe
s Tokyo Games Canceled. By Stephen Wade and Yuri Kageyama, AP. "An online petition with more than 350,000 sig
l organizers, the International Olympic Committee and others. The Olympics are scheduled to open in just 10 weeks
of emergency."
es, Travel Bubble Unlikely. By Zen Soo, AP. "Singapore further tightened its COVID-19 measures as it seeks to contr
until June 13, gatherings will be limited to two people, and restaurants can only provide delivery or takeout service
For 'proper Investigation' Into Virus Origins. By Katerina Ang and Jennifer Hassan, Washington Post. "Americans recei
xing its recommendations on mask use for vaccinated individuals, signaling the end of the coronavirus pandemic is
utions is now calling for a 'proper investigation' into the origins of the pandemic — and the possibility of a laborator

Ruled Out, Leading Scientists Say. By Reuters. "The origin of the novel coronavirus is still unclear and the theory tha
a rigorous data-led investigation that proves it wrong, a group of leading scientists said. COVID-19, which emerge
dollars in lost income and upended normal life for billions of people."

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Coronavirus Infections Pass 24 Mln – Shares: 429
es Up The Cost Of Living – Shares: 223
rd-hit India, Coronavirus Cases Surge In Nepal – Shares: 202

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t watchdog (1.6M followers, 600 engagements), reported: "Judicial Watch &Daily Caller received 301 pages of ema
to China's terms &WHO conducted an unreleased, "strictly confidential" COVID analysis in Jan. 2020." @SecBecerr
gagements), announced: "Getting back to normal means making vaccines as accessible as possible. @HHSGov will
need to make the choice that is right for them."

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n Runs Into Partisanship, Vaccine Fear-Mongering.

y Adam Cancryn, Politico. "The Biden administration is running out of ideas for jumpstarting the pace of coronaviru
ould still be vulnerable to the virus into the fall. The federal immunization campaign has slammed into rising partisa
curning what was once an all-out sprint into a marathon with no clear end in sight."

House Goes Off On Vaccine Fear Mongers. By Natasha Korecki and Eugene Daniels, Politico. "The Biden administratio
and extreme, adopting a more aggressive political posture in an attempt to maneuver through the public health co
scare tactics after Republican lawmakers and conservative activists pledged to fight the administration's stated pla

Biden's Vaccination Outreach, Likening It To Nazi Tactics. By Joshua Cohen, Forbes. "Since May, Covid-19 vaccination
inated and particularly susceptible to the ascendant Delta variant. As the Delta variant has become dominant in ma
last two weeks."

icing Citizens' Lives For Political Gain. By Michael Gerson, Washington Post. "Here is perhaps the most important med
the United States occur among unvaccinated people; 0.5 percent of covid deaths occur among vaccinated people. If

ning On Johnson &Johnson Vaccine Related To Rare Autoimmune Disorder. By Laurie McGinley and Lena Sun, Washing
a new warning for the Johnson &Johnson coronavirus vaccine saying the shot has been linked to a serious but rare s
rves, according to four individuals familiar with the situation. About 100 preliminary reports of Guillain-Barré have b
ered, the Centers for Disease Control and Prevention said in a statement."
Booster With US Officials. By Hope Yen, AP. "Pfizer says it plans to meet with top U.S. health officials Monday to discu
-19 vaccine as President Joe Biden's chief medical adviser acknowledged that 'it is entirely conceivable, maybe likel
e meeting with the Food and Drug Administration and other officials Monday, days after Pfizer asserted that booste

ccination Milestone. By Myah Ward, Politico. "Utah Gov. Spencer Cox said Monday that the state's Covid data team 's
, admitting the error just days after celebrating the milestone. 'Welp. We screwed up. Because of a reporting error
on Twitter Monday."
Treatment. By Sheri Fink, New York Times. "During a surge of coronavirus cases at Houston Methodist Hospital last
nore option, a last-resort treatment that can mechanically substitute for badly damaged lungs."

ctions Next Week.

Most Restrictions Next Week. By Isabella Kwai, New York Times. "Most remaining coronavirus restrictions in England
long-awaited milestone some critics have called reckless, meaning nightclubs will reopen and social gatherings, we
nson said they would 'expect' people to wear face coverings in public transportation and other confined spaces with
nd in most places."
estrictions On July 19. By Pan Pylas and Sylvia Hui, AP. "All remaining lockdown restrictions in England will be lifted
Boris Johnson confirmed Monday. He said it was 'the right moment to proceed' as schools close for summer vacatio

Most Covid-19 Restrictions Next Week. By Jason Douglas and Karina Shah, Wall Street Journal (Subscription Publicatio
in England next week, gambling that vaccines can prevent another surge of deaths, even as cases linked to the Del
Variant, Boost Vaccines. By Angela Charlton, AP. "Is France's summer over already? Just three days ago, the country
ed national effort at returning to a pre-pandemic normal just in time for summer vacation."
On More Than Case Numbers. By Frank Jordans, AP. "With COVID-19 cases again on the rise, German officials said c
ction rate to fully gauge the impact the pandemic is having on the health system and the kind of measures that sho
9 cases are confirmed per 100,000 people each week — has been key to the government's decisions over what rest
nonymous Skin Sample In Italy. By Eric Sylvers, Drew Hinshaw and Betsy McKay, Wall Street Journal (Subscription Pe
n Italian woman in Milan who, in November 2019, visited the hospital and left behind a skin sample that tested pos
mine how long the virus was circulating before cases emerged in Wuhan in December 2019.

s Infections Surge. By Derek Gatopoulos, AP. "Health care workers in Greece will be suspended if they refuse to get
e minister. Staff at nursing homes will be suspended starting Aug. 16 if they fail to book a vaccination appointment
rivate hospitals."

r At-Risk Adults As Delta Cases Rise. By Dov Lieber, Wall Street Journal (Subscription Publication). Israel has begun a
d-19 vaccine on Monday. The country confronts an outbreak of the Delta variant, and it is one of the first in the wor
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aurants As The Pandemic Spread Through Wuhan. By Jim Geraghty, National Review. "Perhaps the most intriguing de
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gs on bat coronavirus research. Covid-19 was already spreading in the city. He used public transportation and took

f Thais Inoculated With Sinovac Are Infected As Cases Spike In Southeast Asia. By Bryan Pietsch, Washington Post. "Mo
ccine were infected by the coronavirus, which is now raging through Southeast Asia. The 618 cases were among the
navirus vaccine between April to July, government data show."

Vaccines, Not Use Boosters. By Maria Cheng, AP. "Top officials at the World Health Organization say there's not enou
ealed Monday for the scarce shots to be shared with poor countries who have yet to immunize their people instead
or-general Tedros Adhanom Ghebreyesus said the world's grotesque vaccine disparity was driven by 'greed,' as he
r countries instead of lobbying rich countries to use even more doses."

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nce': White House Goes Off On Vaccine Fear Mongers – Shares: 238
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t watchdog (1.6M followers, 380 engagements), announced if filed a "FOIA lawsuit against the HHS for COVID-19 t
l aliens released by the Homeland Security and U.S. Customs and Border Patrol." @BryanLowry3, McClatchy White
n and Human Services announces $23.5 million for Kansas to improve rural COVID response through the Small Rura
me program."

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Special Report

mid Delta Surge Fears.

ntine, Mar 'Freedom Day'. By Urooba Jamal and Jill Lawless, AP. "Corks popped, beats boomed out and giddy revelers
s the country lifted most remaining coronavirus restrictions after more than a year of lockdowns, mask mandates ar
ers, the moment lived up to its media-given moniker, 'Freedom Day.'"

Come Off At Nightclubs, Even As Coronavirus Cases Approach Peak. By Karla Adam and William Booth, Washington Pos
of the Piano Works nightclub pushed back the tables, cranked up the volume and threw open the dance floor to mar
st all legal requirements to maintain coronavirus social distancing measures in England. 'You could just feel it. The
berserk,' Tristan Moffat, operations director of the club, told The Washington Post."

ted About Breaking Quarantine Rules, And Australia Deported Her. By Rachel Pannett and Bryan Pietsch, Washington P
sted on social media about appearing naked and maskless in hotel quarantine, in breach of the country's strict rules
ed 1,000 Australian dollars (about $740) and escorted by police to the Sydney airport, where she boarded an aftern

cinated U.S. Citizens On Aug. 9. By Amanda Coletta, Washington Post. "Canada on Monday said it would begin to ease
citizens and permanent residents in the United States who are fully vaccinated with Canadian-authorized vaccines
ffect on Aug. 9, follows months of criticism from U.S. lawmakers across the political spectrum, business groups and
os that have split families, battered the tourism sector and upended life in close-knit border communities."
Lose Members If COVID-19 Vaccine Is Required. By Jenni Fink, Newsweek. "The U.S. military is keeping the door open
omas Massie thinks a shift in the military's policy could prompt people to leave the armed forces. An estimated 70 p
19, the minimum threshold needed for herd immunity."
holds Indiana University's Student Vaccine Requirement. By Stephanie Saul, New York Times. "In what appeared to be
al judge affirmed on Monday that Indiana University could require that its students be vaccinated against the virus.
d their right to bodily integrity and autonomy, and that the coronavirus vaccines have only emergency use authoriza
ered as part of the normal range of vaccinations schools require."
r On Vaccines. By Peter J. Hotez, Daily Beast. "More than 600,000 Americans have already lost their lives from COV
f defiance—defiance against social distancing, contact tracing, masks, and most recently, vaccines."
book 'killing People' With Vaccine Misinformation. By Eugene Scott and Rachel Lerman, Washington Post. "President B
d actors on the website for spreading dangerous misinformation about the coronavirus and vaccines, but he still ca
m. The president said he hopes that 'instead of taking it personally,' Facebook spends more energy focusing on 'the
ial network."
Sharing How Many Americans Viewed Vaccine Misinformation. By Cat Zakrzewski, Washington Post. "Facebook's back-a
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nalized Vaccine Skepticism. By Philip Bump, Washington Post. "Chris Wallace welcomed Surgeon General Vivek H. M
c — now described as 'a pandemic of the unvaccinated' by the director of the Centers for Disease Control and Preve
d of the virus and in saving lives."
n About Vaccines Suggests Trouble Ahead. By Greg Sargent, Washington Post. "It was only a matter of time until Don
s supporters to show their loyalty to him — and even worse, to the 'big lie' that his 2020 loss was illegitimate. 'Peop
on,' the former president said in a statement Sunday, referring to President Biden."
ted Insist On Going Without. By Brian Broome, Washington Post. "Ever since I was young, I have known this dude wh
."

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n Commentator Boasted About Breaking Quarantine Rules, And Australia Deported Her – Shares: 999
Border To Fully Vaccinated U.S. Citizens On Aug. 9 – Shares: 535
ew Trump-GOP Claim About Vaccines Suggests Trouble Ahead – Shares: 307
ny Of The Unvaccinated Insist On Going Without – Shares: 101
202: Facebook Isn't Sharing How Many Americans Viewed Vaccine Misinformation – Shares: 54

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nents) reported The FBI and U.S. Department of Health and Human Services' inspector general warned the public "
ncouraging others to print fake cards at home." @fox5ny (125.2K followers, 3 engagements) reported: "With COVI
hairs the Health Committee, is calling for the indoor mask mandate to be reinstated even for the vaccinated."

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Special Report

n Campaign Seen As Faltering Among African Americans.

ne Equity Push. By Adam Cancryn, Politico. "The Biden administration knew the key to a successful Covid vaccinatio
e months in, even a blueprint that's worked with other ethnic and racial groups isn't doing enough to win over Blac
ter Safety Pause. By Michael Erman, Reuters. "Safety concerns about Johnson &Johnson's (JNJ.N) COVID-19 vaccine
to a crawl, leaving close to half of the 21 million doses produced for the United States sitting unused. J&J's vaccine
Americans because it requires only one shot and has less stringent storage requirements than the two-dose vaccin

Vaccine Authorization Covering Teens. By Politico Europe. "U.S. biotech Moderna filed Monday data for an EU conditio
2 to 18. It's the second COVID-19 vaccine maker to apply for a license in children in the EU after BioNTech/Pfizer,
wo doses of Moderna's mRNA vaccine were shown to be 100 percent effective at preventing illness from COVID-19
nce Were Just As Daunting. By Dan Sewell, AP. "The COVID-19 pandemic and the distribution of the vaccines that wi
gh an earlier time when the country was swept by a virus that, for so long, appeared to have no cure or way to prev

From Covid Hot Spot To A Model For Vaccination And Safety. By Laura Reiley and Melina Mara, Washington Post. "With
t high risk for the coronavirus last summer. This spring, D'Arrigo California gained approval to begin vaccinating Mo

onavirus Transmission Levels In The U.S. By Luke Money, Rong-Gong Lin II, Los Angeles Times. "California is one of
ssion, a designation that underscores its continued progress toward extinguishing the pandemic a week ahead of the
l and Prevention is based on the number of new cases confirmed statewide over the last week as well as the rate at

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navirus pandemic brought the world to a standstill. Instead of serving a jail sentence, he stayed at home, his case c
educed their populations to stop the spread of COVID-19."

ling Comes With A Side Of Coronavirus Vaccine Misinformation. By Aaron Blake, Washington Post. "The true extent of
s difficult to gauge. Many Americans — particularly Republicans — are declining vaccination, but plenty of them are
pound, including about what's in the vaccines and potential side effects."

fied The Tech Censorship Debate. By Alexandra Ellerbeck, Washington Post. "For four months, Facebook censored cla
s reversed its stance, in a prime example of how the pandemic has intensified the free speech questions already pl

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ter internal emails were published by The Washington Post and BuzzFeed."

eries Of The Coronavirus And Brains. By Ben Guarino and Frances Stead Sellers, Washington Post. "In the coronaviru
world, scientists wrestled with a question: Should they cut open the skulls of patients who died of covid-19 and ext
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Became So Powerful. By Carl Zimmer, New York Times. "In December, British researchers discovered that a new var
riant, now known as Alpha, tended to become more common in its new homes as well."

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accine Program Amid Criticism. By Karan Deep Singh, New York Times. "Amid criticism of the government's handling
er Narendra Modi of India said in a nationwide address on Monday that the federal government would play a bigger
in confusion because of squabbling between the central and state governments and a lack of vaccine supply."

inations With Bigger Federal Role. By Suryatapa Bhattacharya and Rajesh Roy, Wall Street Journal (Subscription Pub
ke a greater vaccine procurement role in order to accelerate vaccinations in the country, which has been hit hard by
turing powerhouse, but it has faltered in both domestic and international supply.

flops. By Krishna Das, Reuters. "India's COVID-19 immunisation campaign has struggled to keep pace with demand
with patients and killed more than 180,000 people since April. Prime Minister Narendra Modi said on Monday the fed
d criticism from health experts and the country's highest court for his inconsistent vaccine polices."

fections Hit 2-month Low. By Arshad R. Zargar, CBS News. "The roads of India's sprawling capital city were choked w
tion numbers in two months have led the government to ease restrictions implemented in several areas as the nati

l With The Devastation. By Sheikh Saaliq and Biswajeet Banerjee, AP. "Two months ago Radha Gobindo Pramanik an
birth of their long-awaited grandchild. They were so happy that they paid little attention to his wife's cough. It's an

Varrants Punishment By A Biden-led Coalition. By Mike Pompeo and Lewis Libby, Washington Post. "A great diplomatic
malfeasance sped the coronavirus into an unsuspecting world, killing 3.7 million people so far and inflicting global

a But Supplies Are Tight. By Chalida Ekvittayavechnukul and Tassanee Vejpongsa, AP. "Health authorities in Thailanc
accines on Monday, but it appeared that supplies were falling short of demand from patients who had scheduled vac
osting notices for several days that some scheduled appointments would be delayed, adding to existing public skept
month."

Bear Most Of Cost Of Vaccinating Low-income Countries, Former Leaders Say. By Paul Schemm and Marisa Iati, Washi
of the $66 billion it will cost to vaccinate low-income countries, according to a letter signed by more than 200 promi
d at the leaders of the Group of Seven nations, the world's top economies, ahead of their in-person summit in Britai

19 Vaccine IP Waiver. By Doug Palmer, Politico. "APEC members agreed Saturday on the need to waive intellectual p
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ure our community has info in our fight against COVID. Learn about COVID-19 vaccinations and get help schedulin
t watchdog (1.6M followers, 1.3k engagements), announced "that it obtained 280 pages of documents from the HH
te of Virology for bat coronavirus research by the NIAID, which is headed by Dr. Fauci." @IRSnews, official account
"If you're a small employer, a tax credit may help you provide paid leave to employees receiving COVID-19 vaccine

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Special Report

For Healthcare Workforce.

ts For Its Health Workers. By Ricardo Alonso-Zaldivar, Associated Press. "The federal Health and Human Services De
et their COVID-19 shots, officials announced Thursday. The order from Secretary Xavier Becerra will affect more tha
the National Institutes of Health, the Indian Health Service, and the U.S. Public Health Service Commissioned Corp
rce To Be Vaccinated Against Covid-19. By Jeremy Diamond and Devan Cole, CNN. "Covid-19 vaccinations will be requ
Department of Health and Human Services, Secretary Xavier Becerra announced Thursday. 'Staff at the Indian Heal
erated health care and clinical research facilities and interact with, or have the potential to come into contact with,
ment."
For Health Care Workforce. By Adam Cancryn, Politico. "The Department of Health and Human Services is requiring a
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g umbrella, including staff at the Indian Health Services and National Institutes of Health who operate health and c

ver 25,000 Employees To Get COVID Vaccine. By Rebecca Klapper, Newsweek. "The U.S. Department of Health and Hu
eceive their COVID-19 vaccination, officials announced Thursday. The order affects employees who provide care or s
he National Institutes of Health, the Indian Health Service, and the U.S. Public Health Service Commissioned Corps.
r Pentagon Chief. By Ellen Mitchell, The Hill. "Defense Secretary Lloyd Austin's decision to require the COVID-19 vac
at risks souring his relationship with the rank and file. The move, which would add the coronavirus vaccine to the Pe
ghly 2 million service members, already has Austin battling calls from conservatives to keep the immunization volun
Health Crisis' As Border Patrol Releases Migrants Without COVID Tests. By Brittany Bernstein, National Review. "The m
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rande Valley to his city."
ping Amid COVID Cases Rising, Paying To Bus Away Migrants. By Zach Davis and Christian Alejandro Ocampo, Laredo
indicated that he has received an invitation to meet with Department of Homeland Security Secretary Alejandro M
And his planned topics of conversation to highlight Laredo's needs will surely have some talking as one seems to run

rants With Covid-19. By Miriam Jordan, New York Times. "On the edge of the Rio Grande in South Texas, sprawling A
nd fishing. But earlier this month, the grassland expanse with barbecue grills and picnic tables was put off-limits, tr
crossed from Mexico."
Are Strained As Delta Variant Spreads. By Edgar Sandoval and Giulia Heyward, New York Times. "Hospitals in Texas a
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v Seeing A Crush Of Cases. By Jennifer Sinco Kelleher and Sara Cline, AP. "The COVID-19 surge that is sending hosp
awaii and Oregon that were once seen as pandemic success stories. After months in which they kept cases and hosp
d numbers of patients overwhelm bone-tired health care workers."
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still short of herd immunity. The Post analysis illustrates how rapidly the state of the pandemic changed in July from

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lorida is being slammed with the highest rate of coronavirus admissions in the country. Memorial has enough beds.
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Prevention data, the CDC says the state saw 15,322 new COVID-19 cases on Monday. Even after correcting the rec

or Teachers And Staff. By Jocelyn Gecker and Kathleen Ronayne, AP. "California will become the first state in the nat
COVID-19 testing, as schools return from summer break amid growing concerns about the highly contagious delta
policy at a San Francisco Bay Area school that reopened earlier this week to in-person classes."
-12 Schools In Virginia This Fall, Even For The Vaccinated. By Hannah Natanson, Washington Post. "Virginia will requir
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ed against Covid or submit to regular testing. It is the latest in a rapid series of shifts that could make widespread
nt spreads in the United States."

New Yorkers Are Vaccinated. By Joseph Goldstein and Matthew Sedacca, New York Times. "A construction site safety
spect of being stopped by the police than he was about getting Covid-19. A graduate student in the Bronx who had
hat the government was directing to Black and poorer neighborhoods was briefly suspended over a small number o

borhood. So Why Won't Its Residents Vaccinate? By Téa Kvetenadze, Politico. "Diamond Wright says she won't get the
e virus last year. Her neighbors in New York's Far Rockaway died at a rate nearly 50 percent higher than the rest o
g anew the specters of spring 2020. But none of that has changed her mind."

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tes, continues to drive a surge throughout the country, with average new cases topping 100,000 for the past week.
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avirus Shots As Officials Weigh Who Should Get Them. By Derek Hawkins, Laurie McGinley, and Lena H. Sun, Washing
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nally over."

t Reversal And A Study From India. By Glenn Kessler, Washington Post. "'There's already discussions about a mask m
on 'Sunday Morning Futures,' Aug. 8 'Think about what the CDC did just this week. They forced vaccinated America
America that has not been peer-reviewed.' — House Minority Leader Kevin McCarthy (R-Calif.), remarks to reporters
a single study from India. The study was rejected in peer review. But CDC used it anyway.' — Rep. Dan Crenshaw (

irus Surges In Red States. By Will Weissert, AP. "Top Republicans are battling school districts in their own states' urb
hask up as they head back to school — reigniting ideological divides over mandates even as the latest coronavirus s
can Gov. Ron DeSantisof Florida has issued an executive order threatening to cut funding from school districts that

ching Conservatives On Covid. By Harold Pollack, Politico. "As American public health officials wring their hands over
ed: Politically speaking, the people spreading the message about the Covid vaccine don't look or sound much like t
ns dug in against the vaccine skew decidedly conservative."

ristina Caron, New York Times. "Two years ago, a sneeze or a cough wouldn't have been cause for concern, but no
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Masks? By Roni Caryn Rabin, New York Times. "An internal presentation circulated within the Centers for Disease Co
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— And Became Social Media Evangelists For The Shot. By Travis M. Andrews, Washington Post. "'Anybody else out ru
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g Borders Early Next Year. By Nick Perry, AP. "New Zealand, which has completely stamped out the coronavirus, plar
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ory, Unveils A Reopening Strategy. By Natasha Frost, New York Times. "New Zealand, a global standout in its success
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e Back International Travelers Next Year — But Only If They're Vaccinated. By Rachel Pannett, Washington Post. "New Z
proach to the novel coronavirus, said Thursday it could open its borders for quarantine-free travel early next year.
s Find Their Own Ways To Speed Vaccinations. By Damien Cave, New York Times. "After an order of the AstraZeneca
n realized on Monday that a busy pharmacy he manages in Western Sydney would soon run out of doses. He raced
fficials for extra supplies."
Says Chinese Officials Pressured Investigation To Drop Lab-leak Hypothesis. By Adam Taylor, Emily Ruhala, and Martin
l a controversial joint probe into the origins of the coronavirus pandemic says in a documentary airing Thursday nig
their findings. Speaking to Danish documentarians, Peter Ben Embarek said Chinese researchers on the team had
Wuhan in a report about the investigation."

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owers, 1.6K engagements), reported: "The Department of Health and Human Services will require Covid-19 vaccin
son, Nonpartisan Investigative Journalist for Full Measure News (315.3K followers, 779 engagements), highlight: "1
S #2 under Trump falsely stated that all Covid vaccine side effects are short term and last just a week or two. This

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Special Report

As US Schools Reopen.

Fear As US Schools Open. By Lindsey Tanner, AP. "The day before he was supposed to start fourth grade, Francisco
th dangerously low oxygen levels and an uncertain outcome. It wasn't supposed to be like this, thought his frighten

a' Now A Virus Hotspot. By Jay Reeves, AP. "Tourists and servers alike dance atop tables and in the aisles at one rest
ern Gulf Coast where beaches, bars and stores are packed. Yet just a few miles away, a hospital is running out of cr
s."

Mississippi, Top Doctor Says As 20,000 Students Are Quarantined. By Timothy Bella, Washington Post. "Mississippi's top
vaccination rate is now suffering through 'the worst part of the pandemic,' in a week in which more than 20,000 st
e Health Officer Thomas Dobbs acknowledged the severity of the state's health crisis, which has seen a surge in cas
ful of intensive care unit beds still available for dozens of patients who need them."

CU Beds As COVID-19 Cases Surge. By Joe Hernandez, NPR. "Alabama hospitals have run out of ICU beds as COVID-
There were negative 29 intensive care unit beds available on Wednesday night, according to the Alabama Hospital A
29 more patients in need of ICU care than there were beds available."

Covid-19 After Vaccination. By Maeve Sheehey, Politico. "Sens. Roger Wicker and Angus King both have Covid-19 bre
epublican from Mississippi and King, an Independent from Maine who caucuses with Democrats, both tested positive
ot the first senators to test positive for Covid-19 after getting vaccinated: Sen. Lindsey Graham (R-S.C.) reported a

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rly seven weeks amid a resurgence of the coronavirus pandemic. White House Covid-19 Data Director Cyrus Shahp
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panies With Vaccine Mandates Deploy Tech To Verify Records. By Danielle Abril, Washington Post. "As vaccine mandate
rging for employers: how best to verify vaccination records. A growing number of companies, from Facebook to Go
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Walmart Pharmacists They 'could Be Executed' For Administering Shots. By Jaclyn Peiser, Washington Post. "By the tir
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out the coronavirus pandemic, Key was on a mission to give the pharmacists inoculating shoppers a warning."
lasts Plans For Booster Shots. By Abdi Latif Dahir, New York Times. "The Africa director at the World Health Organiza
rt administering coronavirus booster shots, saying the decisions 'make a mockery of vaccine equity' when the Africa
ue to lag far behind other continents in inoculations, with only 2 percent of the continent's 1.3 billion people fully va
Coronavirus Booster As U.S. Recommends Third Shot To Americans. By Adela Suliman and Bryan Pietsch, Washington P
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ome people are appearing in court to contest mask mandates by school districts and airlines, the Associated Press
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Their Schools To Require Masks. By Doron Dorfman and Mical Raz, Washington Post. "The school year is upon us, an
amantly opposed to their children wearing masks as well as parents, pediatricians and public health experts who sa
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bably Don't Help And May Make Things Worse. By Tara Parker-Pope, New York Times. "Covid precautions have turned
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eatments While Fighting Masks. By Dan Goldberg, Politico. "Republican governors in some of the states hardest hit by
vernors in Florida, Missouri and Texas are promising millions of dollars in antibody treatments for infected people e
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Coronavirus Mandates. By Aaron Blake, Washington Post. "Early in the coronavirus pandemic, mitigation was by and
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s Origins Probe Shocked The WHO — And Led Its Director To Push Back. By Adam Taylor, Washington Post. "From the
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VID-19 Vaccines Globally? By Maria Cheng, AP. "What is being done to distribute COVID-19 vaccines globally? Severa
what's needed to curb outbreaks around the world."

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s: W.H.O. Official Blasts Plans For Booster Shots – Shares: 450

ver Been Worse In Mississippi, Top Doctor Says As 20,000 Students Are Quarantined – Shares: 379

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ioner (214.9K followers, 4.7K engagements) reported: "A record 17,295 people are being treated for COVID-19 in F
afford for any more people to be hospitalized. Get vaccinated. Mask indoors." @JxnFreePress (36.6K followers, 4 er
er or Moderna COVID-19 vaccinations, the U.S. Department of Health and Human Services anticipates a booster sh

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Special Report

nce COVID-19 Vaccine Mandate For Active Duty Troops.

ID-19 Vaccine Policy As Early As Friday: Reports. By James Webb, Military Times. "Following a rise in COVID-19 cases
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Making COVID-19 Vaccines Mandatory For All Active-duty US Troops, Report Says. By Sinéad Baker, Insider. "COVID-1
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pushing inoculation in recent weeks, according to a new poll. A Morning Consult poll published Wednesday found re
with 27 percent of Fox viewers surveyed saying they 'probably or definitely won't get vaccinated.'"
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ump to press his supporters to get the COVID-19 vaccine, which the South Carolina Republican called 'the antidote
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Vaccines In 'Darkest Days' Of Pandemic. By Rick Rojas, New York Times. "Officials in Louisiana have been willing to t
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the FDA approval of COVID-19 vaccines may bring additional confidence and encourage them to get vaccinated,' Pe
FDA, said in a statement on Aug. 4."

s Its Vaccine Is 93 Percent Effective Six Months After Full Immunization. By Adela Suliman, Carolyn Y. Johnson, Tyler Pa
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e, Nursing Home Chains Require Staffers Be Vaccinated. By Christopher Rowland, Washington Post. "Families got the f
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022 Amid Renewed Covid-19 Surge. By Aaron Tilley, Wall Street Journal (Subscription Publication). Amazon.com Inc. s
2022, as conditions around the Covid-19 pandemic and in particular the Delta variant evolve. The company joins a
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s Of Genetic Data From Wuhan Lab In Covid Origins Hunt. By Katie Bo Williams, Zachary Cohen and Natasha Bertrand,
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the Chinese Communist Party is trying to spread disinformation about the origins of COVID-19 and cast doubt on c
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Victoria state officials detected 'multiple mystery cases' of what they suspect to be the highly contagious delta varia
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ng Clip Job Claiming 'vaccine Misinformation' By Democrats – Shares: 564

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pondent (1.2M followers, 622 engagements), reported: "As he seeks to tamp down concerns about how quickly the
ation, specifically former HHS Secretary Azar, on vaccine development." @StevenTDennis, Bloomberg senate report
have COVID patients in them, per HHS."

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OVID-19 Cases.

ls Rising U.S. Caseload As Vaccinations Slow. By Hannah Beech, New York Times. "Reports of new coronavirus cases
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With H.I.V., Large Study Finds. By Apoorva Mandavilli, New York Times. "People living with H.I.V. are more likely to be
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Coronavirus Dose For Immunocompromised Patients. By Lena H. Sun, Yasmeen Abutaleb, and Laurie McGinley, Wash
health-care workers should be allowed to give additional coronavirus shots to patients with fragile immune systems

widely needed. The prospect of booster shots emerged last week as the maker of a two-dose coronavirus vaccine, P
amid rising global concern about the highly transmissible delta variant."
ty, As Opposition To Shots Hardens. By Dan Diamond, Hannah Knowles, and Tyler Pager, Washington Post. "On July
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panies, health care workers, journalists and everyday Americans to do more to address a 'serious public threat.' In
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o Rule Out COVID Lab Leak. By Frank Jordans and Maria Cheng, AP. "The head of the World Health Organization ackn
demic and a laboratory leak, and he said Thursday he is asking China to be more transparent as scientists search fo
o powerful member countries, WHO Director-General Tedros Adhanom Ghebreyesus said getting access to raw data
earlier this year to investigate the source of COVID-19."
Lab-Leak Hypothesis 'Premature'. By Zachary Evans, National Review. "The head of the World Health Organization sa
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t the early days of the pandemic,' director-general Tedros Adhanom Ghebreyesus said at a press conference."
COVID-19 Lab Leak Theory. By Justine Coleman, The Hill. "The World Health Organization (WHO) chief said on Thursd
hout enough evidence. WHO Director-General Tedros Adhanom Ghebreyesu acknowledged to reporters during a br
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port On Origins Of Coronavirus. By Celine Castronuovo, The Hill. "The World Health Organization (WHO) is planning t
ns of the coronavirus pandemic, months after the study's initial release. WHO spokesman Tarik Jasarevic confirmed
port, but noted that the issues did not affect 'the data analysis process, nor the conclusions.'"
Athens And Paris Over New Coronavirus Restrictions, Vaccine Mandates. By Erin Cunningham and Isabelle Khurshudya
dents angry over coronavirus curbs and vaccine mandates in both countries marched against new, stricter regulatio
s, demonstrators clashed with police after French President Emmanuel Macron announced sweeping measures to fig
a To Restore Curfew. By Joe Wilson, AP. "Barcelona and the surrounding northeast corner of Spain are curtailing pub
s running wild among unvaccinated younger people and placing hospitals under growing pressure. Regional authori
n towns with populations over 5,000 which surpass the rate of 400 infections per 100,000 inhabitants over 14 days.
us Variant Slams Asia. By David Rising and Victoria Milko, AP. "As many Asian countries battle their worst surge of C
nally picking up speed, giving hope that low inoculation rates can increase and help blunt the effect of the rapidly s
of infection spiking across multiple countries, however, experts say more needs to be done to help nations struggli
pplies."
Covid-19 Patients As Gravediggers Work Into The Night. By Jon Emont and Ismira Lutfia Tisnadibrata, Wall Street Journ
ly climbed in recent weeks, with the Delta variant fueling a surge echoing the one India experienced in the spring:
en.

d Messages And Rising Cases Are Muddying The Picture. By Michael E. Miller, Washington Post. "A pale and feverish y
s around for help while weakly tugging at the oxygen tube in her nose."
Battles The Pandemic. By Jill Lawless, AP. "Here's some of what happened while the world was distracted by the corc
ong Kong's last pro-democracy newspaper."
Shots In US Border Tunnel. By AP. "The Canadian government has rejected a creative plan to have Ontario residents
by Michigan, a mayor said. A white stripe was painted inside the Detroit-Windsor Tunnel in the Detroit River."

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y Morphs Into Hostility, As Opposition To Shots Hardens – Shares: 248
Updates Protests Hit Athens And Paris Over New Coronavirus Restrictions, Vaccine Mandates – Shares: 163
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ion for librarians (240.4K followers, 4 engagements), announced: "U.S. Surgeon General Issues Advisory During CO
#Misinformation." @Outlookindia, news magazine from India (233.5K followers, 4 engagements), reported: "The #
umber of new cases per day doubling over the past 3 weeks, driven by the fast-spreading #DeltaVariant, lagging va

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Special Report

s COVID-19 Cases Rising.

es, C.D.C. Director Warns U.S. At 'Another Pivotal Point'. By Sheryl Gay Stolberg, New York Times. "The director of the on Thursday about the coronavirus pandemic, warning that the United States is 'not out of the woods yet' and is on elta variant rips through communities with low rates of vaccination. The warning from the director, Dr. Rochelle Wal , was a marked shift from just weeks ago, when President Biden threw a big Fourth of July party on the South Law

Government's Back-to-the-office Plans. By Lisa Rein, Washington Post. "The Biden administration's effort to bring muc ption just as the government was firming up detailed plans to move past the coronavirus pandemic. Hundreds of ag meet last Monday's deadline, laying out how they would begin to phase out remote work for hundreds of thousand e end of the year."

Of Pfizer And AstraZeneca Coronavirus Vaccines Effective Against Delta Variant, Study Says. By Erin Cunningham, Washi es is about as effective against the more contagious delta variant as it was against a previously dominant version of

Medicine. Two doses of the Pfizer-BioNTech vaccine offer 88 percent protection against symptomatic disease caused
s first discovered in Britain and became dominant across the globe earlier this year, the study said."
or Covid Vaccinations Amid Rising Infections. By Jonathan Weisman, New York Times. "House Republican leaders anc
ericans to get vaccinated against the coronavirus amid rising infections across the United States, but they used the
rigins of the virus. The appearance by the second and third-ranking House Republicans, Representatives Steve Scal
d that a resurgence in the spread of the virus, driven by the more contagious Delta variant, had prompted the part
the Covid-19 vaccine."
h To Hard-hit Areas As Delta Variant Surges. By Sarah Owermohle, Politico. "The White House is directing $100 millio
up vaccine outreach and Covid-19 tracking in rural and heartland states as the Delta variant continues to surge. T
accination rates have stalled at 68 percent of adults, with uptake far lower in some parts of the South."
That Dialed Back Health Powers. By Alice Miranda Ollstein and Dan Goldberg, Politico. "The Delta strain of the corona
. But local and state officials this time have fewer options to slow the spread."
ending Masks Again Due To Delta Variant. By Heather Caygle, Katherine Tully-Mcmanus and Burgess Everett, Politico.
ndation in the Capitol after two months of mostly face-covering-free business in the House and Senate, according to
ted, but the Office of the Attending Physician is weighing whether to suggest that people don masks again inside th

ing 'Breakthrough' Infections. By Apoorva Mandavilli, New York Times. "A wedding in Oklahoma that led to 15 vaccin
rations that dispersed the virus from Provincetown, Mass., to dozens of places across the country."

Further Study Of COVID-19 Origins.

vestigation Into Covid Origins In Wuhan. By Eva Dou, Washington Post. "China said it will not accept the World Health
gins of the coronavirus, pointing to obstacles ahead for international efforts to determine the source of the pandem
nal Health Commission, fired back against WHO criticism of China's level of cooperation, and said the U.N. agency's

ner COVID-19 Origins Study. By Ken Moritsugu, AP. "China cannot accept the World Health Organization's plan for the
cial said Thursday. Zeng Yixin, the vice minister of the National Health Commission, said he was 'rather taken abac
might have leaked from a Chinese lab."
te Of Virology Workers Caught COVID. By Ed Browne, Newsweek. "A Chinese government health official denied that w
before the disease first emerged. Zeng Yixin, deputy head of China's National Health Commission, made his commen

Plan To Trace COVID Origins: 'Impossible'. By John Feng, Newsweek. "China has rejected the next phase of the Worl
l saying it would be 'impossible' for Beijing to agree to a plan that proposes a reinvestigation of Wuhan. Zeng Yixin,
ijing on Thursday in which he expressed shock at the WHO's intention to look into research facilities including the c

ng COVID Raises Questions. By Eddie Pells, AP. "The low numbers came in from across the globe and covered most e
improving times throughout the sport of track and field were every bit as diverse: better shoe technology, better r
d just a good old-fashioned itch to start running for real again."

Day Before Olympics Open. By Mari Yamaguchi, AP. "Tokyo hit another six-month high in new COVID-19 cases on Th
infections during the Games. Thursday's 1,979 new cases are the highest since 2,044 were recorded on Jan. 15."
s Virus Wave Spreads. By David Rising and Eileen Ng, AP. "Indonesia has converted nearly its entire oxygen producti
ng to breathe. Overflowing hospitals in Malaysia had to resort to treating patients on the floor."
Authorities After Months Of Critical Coverage. By Gerry Shih and Niha Masih, Washington Post. "Indian tax authorities
nalists and the political opposition denounced as retaliation for the outlet's hard-nosed coverage of the government
oadsheet boasts a combined circulation of more than 4 million, was raided simultaneously in at least four locations,

Day,' Scotland Opts For Caution. By Mark Landler, New York Times. " 'Freedom Day' means something different nort
Scotland declined to fall in line earlier this week when Prime Minister Boris Johnson of Britain lifted virtually all rem
d follow England in relaxing curbs — the British tabloids proclaimed it 'Freedom Day' — nightclubs in Edinburgh and
he government has told people to stay one meter apart from one another and keep working from home."
e, But So Are Covid Restrictions. By Hannah Sampson, Washington Post. "European summer vacations are back for A
ece, France and Spain reopened to U.S. travelers, they are putting new restrictions into place amid a rise in corona
Brazilian President Jair Bolsonaro That Spread Coronavirus Misinformation. By Miriam Berger, Washington Post. "YouTu
Bolsonaro's channel for violating rules against spreading misinformation about the coronavirus. The far-right leade
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Shook A Fragile Foundation. By AP. "Paska Itwari Beda knows hunger all too well. The young mother of five children
nd her entire family is lucky to scrape together a single daily meal, even with much of the money Beda makes clea

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Przybyla (203.9K followers, 116 engagements), reported Sec. Becerra is in Vegas where COVID infections and hosp
uld you wanna die?" @CHHSAgency, official account of California Health and Human Services (6.8K followers, 95 er
ave occurred among unvaccinated Californians: With the emergence of the more transmissible Delta variant, there'

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Special Report

Longer Need Masks, Physical Distancing In Most Cases.

s No Longer Need Masks Indoors Or Outdoors In Most Cases. By Yasmeen Abutaleb and Lauren McGinley, Washington
ical distancing in most cases, even when they are indoors or in large groups, federal officials said Thursday, paving
olically and practically for pandemic-weary Americans, millions of whom have lived with the restrictions for more th
nove Masks In Most Group Settings. By Erin Banco, Politico. "The Centers for Disease Control and Prevention said Thu
masks indoors and outdoors, even if some in their group are unvaccinated. The announcement marks the first tim
sks in any kind of group gathering — big or small, indoors or outdoors, no matter who is present — a major step to

e On Indoor Mask-wearing. By Zeke Miller and Michael Balsamo, AP. "The Centers for Disease Control and Prevention
ple, allowing them to safely stop wearing masks inside in most places, according to a person briefed on the announ
ings like buses, planes, hospitals, prisons and homeless shelters, but could ease restrictions for reopening workplac
inated People Can Go Maskless In Most Places. By Roni Caryn Rabin and Apoorva Mandavilli, New York Times. "In a s
on Thursday advised that Americans who are fully vaccinated against the coronavirus may stop wearing masks or

f size. The advice from the Centers for Disease Control and Prevention comes as welcome news to Americans who h

out Begins For Children Ages 12 To 15. By Sarah Mervosh, Julie Bosman and Joseph Goldstein, New York Times. "Edua
news on the television: Younger adolescents, including his 14-year-old daughter, Raquel, were now eligible for the
ediately," he said."

te Children Gathers Speed In U.S. By Marc Santora, New York Times. "The world's first mass coronavirus inoculation c
after the federal government recommended making the Pfizer-BioNTech vaccine available to those aged 12 to 15. I
restrictions and desperate to get their children back into classrooms, states, counties and school districts around the
ffer the shots."

ares Plea: 'Schools Must Be Open' In Fall. By Dana Goldstein, New York Times. "Randi Weingarten, president of the na
ning of the nation's schools for the next academic year, saying: 'There is no doubt: Schools must be open. In person

Anyone Charged For Defying COVID Rules. By Lee Brown, New York Post. "Florida Gov. Ron DeSantis will pardon any
— breaking the news live on air to a gym-owning couple who were facing jail time for defying coronavirus safety re
ement on Fox News Wednesday as he decried county officials penalizing people."

S. Want The Shot, New Survey Finds. By Jan Hoffman, New York Times. "Latino adults in the United States have the lo
nographic group most willing to receive the Covid shots as soon as possible, a new survey shows. The findings sugg
the shots, but also misinformation about their cost and access, as well as concerns about employment and immigra
ovid-19 Vaccine Monitor."

nt Women, Another Study Suggests. By Emily Anthes, New York Times. "When the coronavirus vaccines were first aut
regnant women, who had been excluded from the clinical trials. Since then, scientists have accumulated a small bu
pregnancy."

ne Covid-19 Vaccines Trigger Rare Clots. By Bojan Pancevski, Wall Street Journal (Subscription Publication). Scientist
Johnson Covid-19 vaccines and rare but serious blood clots. Doing so would help doctors and health officials better
COVID-19 Booster Shots. By Reuters. "COVID-19 vaccine developers are making ever bolder assertions that the wor
variants, but some scientists question when, or whether, such shots will be needed. In interviews with Reuters, me
said there is growing evidence that a first round of global vaccinations may offer enduring protection against the c

ccine Disinformation. By Michelle R. Smith and Johnatan Reiss, AP. "The couple in the website videos could be hawki
arlene Bollinger tells viewers, as a picture of a DVD set, booklets and other products flashes on screen."

Can Be Found In Existing Agencies. By W. Craig Vanderwagen, Kevin Yeskey and Jennifer B. Alton, The Hill. "As we s
d we get our country on the road to recovery, it is time to take steps to improve the federal government's structure
ite House and the Department of Health and Human Services are needed, as was pointed out by the former White

ful Concept For Covid-19. It's Time To Retire It. By Abraar Karan and Julie Parsonnet, Washington Post. "Americans are
oted lately. But they also don't need to in order to resume life free of the virus."

s For Second Straight Day.

-19 For Second Straight Day. By Reuters. "India recorded more than 4,000 COVID-19 deaths for a second straight da
ne virus has become rampant in rural areas where cases can go unreported due to a lack of testing. Experts remain
ility of the variant that is driving infections in India and spreading worldwide."

or 12 Frantic Days, Two Sisters Tried To Save Them. By Ruby Mellen, Washington Post. "It was midnight on April 16 in
spital bed. His oxygen levels had dropped that evening."

19 Vaccines To Become Available India Soon, Govt Advisor Says. By Reuters. "More than 2 billion doses of coronavirus
top government advisor said on Thursday. Those doses would include 750 million of AstraZeneca's (AZN.L), vaccin
loses of Covaxin, made by Bharat Biotech, government advisor V K Paul told reporters at a news conference on Thu

ate To Spend Up To $1.36 Bln On COVID Shots. By Reuters. "India's most populous state will spend up to $1.36 billion
fizer (PFE.N) and the local partner of the maker of Russia's Sputnik V, a state official said on Thursday. The move b
curtail vaccinations due to severe shortages amid a record surge in coronavirus infections, with India recording mo
cope."

Of This Disaster. We Need Modi To Listen. By Shahid Jameel, New York Times. "As of Tuesday, India had over 23 milli
nay be much higher, as the country reported an average of more than 380,000 new cases per day in the past week

ghbors Brace For The Worst. By Bhadra Sharma, Aanya Wipulasena and Vivian Wang, New York Times. "Most of Nepa
ccination sign-ups after promised supplies were cut off. Sri Lanka's hopes of a tourism-led economic revival have co
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econd wave of the coronavirus batters Nepal. The expedition company that organized their climbs, Seven Summit T
und Mount Everest's 'death zone,' an area above 8,000 meters (about 26,000 feet) named for its thin air and bruta

Bangladesh At Risk. By Julhas Alam, AP. "Tens of thousands of people left Bangladesh's capital on Thursday to join t
Eid al-Fitr, despite stark warnings that the exodus could worsen the country's sharply rising coronavirus outbreak. F
ntil Sunday and a suspension of long-distance passenger buses, trains and ferries."

n Virus Variant In UK. By Mike Fuller, AP. "British Prime Minister Boris Johnson said Thursday he was 'anxious' about
sely-monitored study of infections in England found the variant is becoming more prevalent just ahead of the next
ut it,' Johnson said."

cesses Lag In Vaccinations. By Nick Perry, AP. "Some wealthy nations that were most praised last year for controllin
— and some, especially in Asia, are seeing COVID-19 cases grow. In Japan, South Korea and New Zealand, the vac

Doses Through Next Year. By Rod McGuirk, AP. "Australia has reached a supply agreement for 25 million doses of M
tralian adults have access to inoculation this year. The deal included 10 million doses of the vaccine against the and
oster to be delivered in 2022, U.S.-based Moderna said on Thursday."

Hospital Strain. By AP. "Tunisian authorities plan to reopen the economy next week amid public pushback against vir
n to treat a persistently high number of COVID-19 patients. Tunisia shut down shops and restaurants and banned a
system risked collapsing."

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ays He Found Why Some Covid-19 Vaccines Trigger Rare Clots – Shares: 166

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y of Health &Human Services (11.3k followers, 106 engagements), announced: "Easing vaccine access for adolesce
e scientists at @CDCgov, @NIH, and @HHSGov that made this possible." @levie, official account of CEO of Box (2.
ith the US Department of Health and Human Services to power collaboration around COVID-19 vaccine logistics an
cerra statement to essential workers: "We're going to go where you are because we know at this stage, it's up to u
et you vaccinated."

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States With Low Vaccination Rates.

Soar In States With Low Vaccination Rates. By Ethan Hauser and Ron Depasquale, New York Times. "The summer beg
d travel swelled over the Fourth of July weekend to prepandemic levels. But the celebrations have turned out to be s
ces and momentum gains for mandating Covid-19 vaccines and, once again, masks."

OVID Cases Over 2 Weeks, Straining Hospital Capacity. By Maggie Gile, Newsweek. "Texas saw a 165 percent increase
hospital capacity, the Associated Press reported. The Johns Hopkins University research data reported 8,533 COVID

nor Faces Legal Challenges On Mask Mandate Ban As Hospitalizations Soar. By Derek Hawkins, Bryan Pietsch, Adela Su
ng hospitals to stop non-emergency medical procedures to free up space for covid-19 patients as the rise in new int
t touted the move as 'taking action' to combat coronavirus cases that are now averaging more than 10,000 each da

ate Nurses Will Come Wear The Masks Texans Don't Have To. By Philip Bump, Washington Post. "Across the state of Tex
d, according to data collected by the Department of Health and Human Services. More than 50 hospitals have no IC
n hit hard in the current wave of coronavirus infections."

Mandates, While Rand Paul Urges Defiance Amid Delta Variant Surge. By Timothy Bella, Washington Post. "As a resurge
s, Republican Sens. Ted Cruz (Tex.) and Rand Paul (Ky.) denounced health mandates against the virus at a time wh
nuary. The United States reported nearly 160,000 cases on Monday, pushing the seven-day average to almost 115,

D At The Southern Border. By CBS News. "The COVID surge in Texas is largely driven by unvaccinated Americans, bu
city of McAllen, Texas, said more than 7,000 migrants who tested positive for COVID have been processed since Fe

rump, Anti-mask GOP Governors Is Gaining Steam. By Greg Sargent, Washington Post. "Let's state this up front: GOP
s to actively thwart efforts to fight the spread of the coronavirus. Some are choosing not to do that: In South Dako
rkansas the governor admitted that an earlier ban on them was an 'error.'"
By Gary Fineout, Politico Playbook. "Late last night the Florida Department of Health — which ceased releasing its o
mer — contended that the data issued earlier in the day by the Centers for Disease Control and Prevention were in
formation (that is supposed to come from the state) that showed that nearly 57,000 cases had been reported over
't Escape Delta. By Erin Banco, Politico. "Steven was finally getting his Covid-19 shot because Mama told him to. And
ds at the Uinta County fairgrounds in southwestern Wyoming, the 42-year-old in the Trump 2020 hat said 'Mama' —

s As Hospitals Swell With Covid Patients. By Jonathan Edwards, Washington Post. "A week after saying he regretted b
Coronavirus patients were packing into hospitals in record numbers, leaving a mere eight intensive care unit beds fr
er that 1,376 coronavirus patients were hospitalized across the state, an increase of 103 people since Sunday."
y Get Swamped With COVID. By Terry Spencer, Jennifer Sinco Kelleher and Andrew Selsky, AP. "The rapidly escalatin
and other front-line staff in virus hotspots that can no longer keep up with the flood of unvaccinated patients and a
rida, Arkansas and Louisiana all have more people hospitalized with COVID-19 than any other point in the pandemi

s Vaccine Or Get Tested Weekly, Mayor Says. By Perry Stein, Washington Post. "D.C. Mayor Muriel E. Bowser (D) anno
regular testing for the coronavirus, with vaccination required for new employees. The employees will be required to

Military Under New US Plan. By Lolita C. Baldor, AP. "Members of the U.S. military will be required to get the COVID-1
ed by President Joe Biden. In memos distributed to all troops, top Pentagon leaders said the vaccine is a necessary
D Vaccine By Mid-September. By Ernie Mundell and Robin Foster, HealthDay News. "All members of the U.S. military
nday. Defense Secretary Lloyd Austin noted that the deadline could be moved up if the vaccine receives final approv
ue to rise."
nes Will Be Mandatory For Troops By Mid-September. By Eleanor Watson, CBS News. "Secretary of Defense Lloyd Aus
VID-19 vaccines a requirement by mid-September. 'I have every confidence that Service leadership and your comm
, skill, and compassion,' Austin said in the memo."
r Mandated Vaccines? By Jacob Jarvis, Newsweek. "Talk around mandates to enforce COVID-19 vaccines upon milita
ndating the COVID-19 vaccine for military personnel question the appropriateness and even legality of such an orde
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Cases Surge. By Davey Alba, New York Times. "In late July, Andrew Torba, the chief executive of the alternative soc
ry who refused to get vaccinated against the coronavirus would face a court-martial. His post on Gab amassed 10,0
t Over Vaccine Misinformation. By Zolan Kanno-Youngs and Cecilia Kang, New York Times. "In March, Andy Slavitt, th
president for global affairs, and delivered an ominous warning. For many weeks, Mr. Slavitt and other White House
e spread of misinformation about the coronavirus vaccines."
ene For 7 Days Over Vaccine Misinformation. By Davey Alba, New York Times. "Twitter on Tuesday suspended Represe
r seven days after she posted that the Food and Drug Administration should not approve the coronavirus vaccines a
fourth 'strike,' which means that under the company's rules she could be permanently barred if she violated Twitte

To Boost Vaccine Rates. By James Anderson, AP. "As a police sergeant in a rural town, Carlos Cornejo isn't the proto
0,000 followers was exactly what Colorado leaders were looking for as they recruited residents to try to persuade t
Trust In Doctors, Nurses. By Emily Swanson and Tom Murphy, AP. "Most Americans have high trust in doctors, nurse
important in the push to increase COVID-19 vaccinations, as long as unvaccinated people have care providers they

uture Teachers Are Trained. By Kantele Franko, AP. "Before last year, a one-credit technology course for students pu
as the program's most relevant. Then COVID-19 hit, schools plunged into remote learning, and suddenly material

ports To Do Fun Things? By Matt O'Brien, AP. "Ready to go out on the town before summer ends? In parts of the U.
to restaurants, bars, nightclubs and outdoor music festivals."
accine Mandates? Among Religious Groups, There Is Wide Disagreement. By Michelle Boorstein, Washington Post. "Las
h organization to announce a vaccine mandate for the hundreds of people who come indoors for preschool and vari
like the obvious Jewish thing to do as the delta variant became more threatening, said chief executive Dava Schub
or Coronavirus Vaccine Approvals. By Paige Winfield Cunningham, Washington Post. "Coronavirus vaccines are now r
ministration, the job is hardly wrapped up."
hot Isn't Enough. A New Study Offers Answers — And Questions. By Lateshia Beachum, Lindsey Bever, and Marisa Iati
venience for Amy Riley. She was knee-deep in planning a virtual event for her communications job when she becar
effects from a two-dose mRNA vaccine."
versal Masking Works. By Kanecia Zimmerman and Danny Benjamin Jr., New York Times. "Big questions loom over t
s? Should children go to in-person classes at all?"

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ellion Against Pro-Trump, Anti-mask GOP Governors Is Gaining Steam – Shares: 676
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rter (154.7K followers, 1.9K engagements), highlighted: "% of ALL staffed adult ICU beds filled with COVID patient
ıri: 38% Alabama: 34% Texas: 32% Nevada: 31% Georgia: 29%" @kaitlancollins, CNN White House Correspondent
cerns about how quickly the Covid-19 vaccines were produced, Dr. Fauci gives credit to the Trump administration,

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usations.

ade Charges Of Lying. By AP. "Dr. Anthony Fauci the nation's top infectious disease expert, angrily confronted Kentu
insinuation that the U.S. helped fund research at a Chinese lab that could have sparked the COVID-19 outbreak. Pa
National Institutes of Health funded so-called 'gain of function' research — the practice of enhancing a virus in a la

Funding Claim: 'You Do Not Know What You're Talking About'. By Teagane Finn, NBC News. "Sen. Rand Paul, R-Ky., ar
got into a heated exchange at a Senate hearing Tuesday after Paul accused Fauci of lying to Congress about the role
nator Paul, you do not know what you're talking about, quite frankly, and I want to say that officially.'"

ations About Gain-of-function Research In Hearing On Delta Variant. By Tyler Olson, Fox News. "Top government epider
out gain-of-function research at a Tuesday Senate hearing, continuing the long-running feud between the National
ky senator. Centers for Disease Control and Prevention (CDC) Director Rochelle Walensky was also asked about co
accine mandates for school children."

Talking About 'And I Want To Say That Officially'. By Nathaniel Weixel, The Hill. "Anthony Fauci clashed with Sen. Rand
al Institutes of Health (NIH) played in funding controversial research in Wuhan, China. During a Senate Health Com
egal gain of function research in the Wuhan Institute of Virology, which created a highly dangerous and transmissibi
l Pushback On Covid Vaccine Disinfo. By Christopher Cadelago and Sam Stein, Politico. "As President Joe Biden scram
e has largely steered clear of Fox News, the major cable news outlet whose opinion hosts and guests have been spa
taken an arms-length approach to Fox, despite its strong following among supporters of former President Donald T
l are less likely to be vaccinated than the average American."
mid Efforts To Push Social Media Giants To Crack Down On Misinformation. By Betsy Klein, CNN. "The White House is r
blishing misinformation via Section 230, a law that protects companies' ability to moderate content, White House co
taking on new urgency in recent days as the administration has called on social media platforms to take a more agg

en's Promises Of Swift Economic Comeback. By Jeff Stein and Heather Long, Washington Post. "A resurgence in coro
omic recovery, with Wall Street getting battered on Monday and some leading forecasters beginning to rethink their
conomic risks associated with the delta variant, and senior U.S. officials have in recent days suggested local restrict

Of US Cases. By Associated Press. "Health officials say the Delta variant of the coronavirus continues to surge and a
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rd Down Against Covid, US Surgeon General Says. By Madeline Holcombe, CNN. "Although vaccinations have offered
g to get rates where they need to be. And having been tricked by the virus before, the US Surgeon General says no
Numbers. By Gary Fineout, Politico Playbook. "For months and months, Gov. Ron DeSantis touted his brand of Floric
surge in cases — primarily among those who remain unvaccinated — is creating an inconvenient interruption to that
Course Again. The Biden Administration Urgently Needs To Do The Same. By Leana S. Wen, Washington Post. "With co
once more, the Biden administration needs to strongly urge a return of covid-19 restrictions. The United States is c
isease Control and Prevention issued guidance that fully vaccinated people no longer needed to wear masks."
Ross Douthat, New York Times. "Late last week Michael Brendan Dougherty of National Review stirred up a mix of i
be extended to unvaccinated Americans, whose hesitancy about getting Pfizered or Modernafied often reflects a rea
nders and misleading messaging. The alternative perspective, judging from responses to his column, regards the g
e blame for which can be laid partly on their own partisan self-delusion and partly on wicked actors in the right-win
ptics interviewed by Tucker Carlson to Republican politicians who have pandered to vaccine resistance."
And Victims' Families Aim To Become A Political Force. By Sheryl Gay Stolberg, New York Times. "In Facebook group
hose who died from it are organizing into a vast grass-roots lobbying force that is bumping up against the divisive p
Covid Survivors for Change, groups born of grief and a need for emotional support are turning to advocacy, writing
disability benefits; paid sick leave; research on Covid 'long haulers'; a commission to investigate the pandemic and
Call For 9/11-style Commission On Covid-19. By Josh Rogin, Washington Post. "When the Biden administration finishe
's efforts to investigate the issue will be just beginning. Now, a group of national security-focused, centrist Democra
he source of the outbreak and our country's response."

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UK's Johnson Over Virus. By Jill Lawless, AP. "A disgruntled former top aide to Prime Minister Boris Johnson claims t
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s of excoriating attacks on his former boss."
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s for gatherings, the lot — effectively leaving protection from the coronavirus to vaccinations and, er, the goddess c

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What He's Talking About 'And I Want To Say That Officially' – Shares: 312
Lying' Accusations About Gain-of-function Research In Hearing On Delta Variant – Shares: 161
s Wuhan Lab Funding Claim: 'You Do Not Know What You're Talking About' – Shares: 146
es Major Risk To Biden's Promises Of Swift Economic Comeback – Shares: 72
ays Rising Covid-19 Numbers – Shares: 66

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nents) reported the FBI and U.S. Department of Health and Human Services' inspector general warned the public "t
ncouraging others to print fake cards at home." @fox5ny (125.2K followers, 3 engagements) reported: "With COVI
hairs the Health Committee, is calling for the indoor mask mandate to be reinstated even for the vaccinated."

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Special Report

Resume Wearing Masks Indoors.

end Some Vaccinated People Wear Masks Indoors Again. By Apoorva Mandavilli, New York Times. "Reversing a decisio
on is expected to recommend on Tuesday that people vaccinated for the coronavirus resume wearing masks indoors
ugh infections with the Delta variant of the virus in people who were fully immunized, and case surges in regions w
gh-transmission Areas To Resume Wearing Masks Indoors As Delta Variant Spreads. By Yasmeen Abutaleb, Joel Achenb
se Control and Prevention will recommend on Tuesday that vaccinated Americans wear masks indoors in certain circ
irus. The agency is recommending that vaccinated people who live in high-transmission areas wear masks in indoo
with the guidance."
out The C.D.C.'s New Mask Guidance For Vaccinated People. By Daniel E. Slotnik, Apoorva Mandavilli and Sheryl Gay S
mended on Tuesday that people vaccinated against the coronavirus resume wearing masks in schools and in public
rp turnabout from their advice just two months ago. The pandemic in the United States is very different than it was

e Masking Guidelines. By Mike Stobbe, AP. "The Centers for Disease Control and Prevention was expected to backpec
ople wear masks indoors in parts of the U.S. where the coronavirus is surging, a federal official said. The official spc
details of the new policy."

ca's Hardest-Partying Lake Are Not About To Get Vaccinated. By Natasha Korecki, Politico. "The petite blonde bartende
bikinis and shirtless men lined up on a sweltering afternoon to order Bud Light, vodka and soda, and piles of nacho
d a Covid hot spot, in a state with one of the lowest vaccination rates in the nation, and in a region where hospitals
r Jack's, couldn't be in a more vulnerable position."

oers Ditch Their Masks: 'Don't Believe This Delta Variant Nonsense'. By Jaclyn Peiser, Washington Post. "Since the earl
a church, has repeatedly called covid a hoax, undermined emergency mandates and refused to comply with guidan
aking a sharp warning regarding mask-wearing."

oly Lines Struggle Amid Virus Outbreaks In The Developing World. By David J. Lynch, Washington Post. "Fresh coronav
and Bangladesh, aggravating supply chain disruptions that could leave some U.S. retailers with empty shelves as co
are just the latest twist in almost 18 months of pandemic-related manufacturing and transportation woes."

Breakthrough Covid Cases. Now They're Requiring Vaccine Cards To Enter. By Julian Mark, Washington Post. "At the La
Voisine, 54, asked patrons for proof of vaccination at the San Francisco bar known for its stiff margaritas."

erson Events Over Covid Fears. By Daniel Lippman and Betsy Woodruff Swan, Politico. "Homeland Security Secretary
nent official who later tested positive for Covid-19, a DHS spokesperson told POLITICO. 'Secretary Mayorkas has a
later tested positive for COVID-19,' DHS spokesperson Marsha Espinosa said in a statement."

rce Impossible Choices For ICU Doctors Like Me. By E. Wesley Ely, Washington Post. "Covid-19 surges among the unv
mas just as they're battling other stressors. With emerging strains of the SARS-CoV-2 virus now a predominant con
nfected patients flowing into our ICUs with failing lungs, clotted blood vessels and delirium."

on Spreads Among The Vaccinated: Anger. By Roni Caryn Rabin, New York Times. "As coronavirus cases resurge acro
e holdouts who, they say, are neglecting a civic duty or clinging to conspiracy theories and misinformation even as
The country seemed to be exiting the pandemic; barely a month ago, a sense of celebration was palpable."

accine Refusers. By Paul Waldman, Washington Post. "Imagine how the United States must look to someone in Sout
nst the coronavirus, or India, where the number is 6.9 percent. People in those nations and a hundred others are d
vaccine doses than we know what to do with, and we're terribly worried about not hurting the delicate feelings of t

oire. The U.S. Might Just Let Them Go To Waste. By Govind Persad and Holly Fernandez Lynch, Washington Post. "Afte
accinate at least 13 million people are now in danger of expiring. Meanwhile, domestic vaccination rates have stagna

ave Us The Best Weapons Against Covid-19. We Should Use Them. By Kay Ivey, Washington Post. "Washington, D.C., i
ed out the earnest pleas of the nation's top doctors, their elected leaders, superstar athletes and other celebrities w
ere is the truth: Closing businesses will not defeat covid-19. Wearing masks will not defeat covid-19. And keeping c

ational Travel Restrictions.

Restrictions For Now. By Aamer Madhani, AP. "The United States will keep existing COVID-19 travel restrictions on in because of the delta variant, according to a White House official. President Joe Biden earlier this month said that hi he ban on European travel bound for the U.S. after the issue was raised by German Chancellor Angela Merkel durin-

Against Travel To Israel, Portugal And Spain As Delta Fuels Outbreaks. By Erin Cunningham, Washington Post. "The Unit as the more contagious delta variant fuels coronavirus outbreaks mostly among the unvaccinated. The State Depart les Monday for Israel, Cyprus, Portugal and Spain, as well as Kyrgyzstan, citing surging case numbers in all five cou

White House Maintains Trump-era Covid Travel Restrictions. By Rick Noack, Reis Thebault, and Quentin Ariès, Washin- n of the Biden administration on Tuesday, after the White House said its restrictions on international travel would re en allowed to return to much of Europe for weeks, most Europeans continue to be unable to travel to the United St rch 2020."

avirus Infections, But The Games' Bubble Holds. By Simon Denyer, Washington Post. "In the months leading up to the spect of tens of thousands of foreigners coming in and infecting them with the coronavirus. Their concerns might ha

ys After Olympics Begin. By Mari Yamaguchi, AP. "Japan's capital, Tokyo, reported its highest number of new corona hide Suga urged people to avoid non-essential outings, but said there was no need to consider a suspension of the

fusing' British Traffic-Light System. By Ceylan Yeginsu, New York Times. "So-called 'Freedom Day' in Britain, which la ements, was a far cry from the blithe liberty that many locked-down British residents had dreamed of for the past y re the anticipated day, while hundreds of thousands of people received a notification on a government tracing app, ."

le Adults Within A Week. By Wasbir Hussain and Rishi Lekhi, AP. "The Himalayan kingdom of Bhutan has fully vaccin said Tuesday. The tiny country, wedged between India and China and home to nearly 800,000 people, began givi arguably the fastest vaccination campaign to be executed during a pandemic.'"

Of Covid, Her Sons Beat Up The Country's Top Health Officials. By Robyn Dixon, Washington Post. "After the Tajik pre acked and beat up the country's health minister and a senior doctor, according to local media. The reports, widespr this Central Asian country that for a time denied it had any infections."

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cinated People In High-transmission Areas To Resume Wearing Masks Indoors As Delta Variant Spreads – Shares: 1

e At America's Hardest-Partying Lake Are Not About To Get Vaccinated – Shares: 707

il Yards, Global Supply Lines Struggle Amid Virus Outbreaks In The Developing World – Shares: 540

r Demands Churchgoers Ditch Their Masks: 'Don't Believe This Delta Variant Nonsense' – Shares: 319

Some Masking Guidelines – Shares: 251

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agements) announced: "DOJ and @HHSGov Issue Guidance on 'Long COVID' and Disability Rights Under the #ADA, y nondiscrimination laws apply to certain people affected by COVID-19." @USCG, official account for the U.S. Coast -130 Hercules crew from Coast Guard Air Station Elizabeth City delivered 500,000 doses of the COVID vaccine to a

and Human Services. @SecBecerra, official account of Secretary of Health &Human Services (15.1K followers, 73 e
of guidance and resources from the @usedgov, @TheJusticeDept, @USDOL and @HHSgov to support individuals ex

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Special Report

Get Covid-19 Vaccine.

Women Should Get Coronavirus Vaccine. By Lenny Bernstein and Brittany Shammas, Washington Post. "The Centers
women be vaccinated against the coronavirus, updating its advice after it found no increased risk of miscarriage an
nt women, the new guidance officially moves the CDC off its previous neutral stance on whether immunization is sa
regnancy As Delta Surges. By Lindsey Tanner and Mike Stobbe, AP. "The Centers for Disease Control and Prevention
hot spots around the U.S. see disturbing numbers of unvaccinated mothers-to-be seriously ill with the virus. Expec
the coronavirus, including perhaps miscarriages and stillbirths."
cinated Or Submit To Weekly Virus Testing. By Luz Lazo, Washington Post. "The nation's passenger railroad will requir
Amtrak announced Wednesday. The company's mandate will apply to its more than 18,000 employees."
Vaccinate Teens Against The Coronavirus. By Laura Meckler, Washington Post. "As schools prepare to open for a thirc
irus vaccinations for their children, taking a wait-and-see attitude or, for many, outright opposing the shots, a new
o increasing vaccination among children ages 12 to 17, who have the lowest rates of any age group at 41 percent."

Covid-19 Vaccine For Workers. By Tarini Parti and Sabrina Siddiqui, Wall Street Journal (Subscription Publication). P
kers be vaccinated at a meeting with corporate leaders on Wednesday.
ntial Biden Vaccine 'threat'. By Rachel Roubein, Politico. "Republicans and some industry groups are signaling they wo
olding federal funds to push some employers — like nursing homes and health facilities — to mandate Covid vaccine
dministration has used the power of the purse to increase vaccinations."
A Week Following Criticism Of Face Masks. By Nick Niedzwiadek, Politico. "YouTube took action against Sen. Rand Pa
ent for a week after Paul posted a clip challenging the utility of mask-wearing to slow the spread of the coronavirus
le himself a frequent antagonist to Anthony Fauci when the head of the National Institute of Allergy and Infectious D
Week Over A Video Disputing The Effectiveness Of Masks. By Daniel Victor, New York Times. "YouTube on Tuesday rem
ded him from publishing for a week after he posted a video that disputed the effectiveness of wearing masks to lim
n senator's claims in the three-minute video had violated the company's policy on Covid-19 medical misinformatior
Over Coronavirus Mask Skepticism A 'badge Of Honor'. By Adela Suliman, Washington Post. "Sen. Rand Paul (R-Ky.)
moved a video in which he claimed most masks don't prevent the spread of the coronavirus. Paul said he had been
be account, after saying in a three-minute video, posted last week, that 'most of the masks you get over the count
sk Mandates Is Dealt 2 Legal Setbacks. By Azi Paybarah, New York Times. "Two court rulings on Tuesday cleared the
andates to at least temporarily require face coverings to help curb a rise in cases. The first ruling came in Bexar Co
Favor Mask Mandates In Schools. By Alexandra Ellerbeck, Washington Post. "Mask mandates in schools have been a
hts between school districts and state leaders. But a new poll finds most parents are in favor of requiring masks."
k Mandates — But Not Republicans. By Marc Caputo, Politico. "A majority of voters support mandatory coronavirus va
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ve sent numbers spiking equally on the unvaccinated and on political leaders opposed to mask-wearing and social-
lators From U.S. Government To Help State's Record Hospitalizations. By Timothy Bella, Washington Post. "The federal
a — a response to the record number of coronavirus hospitalizations in a state that has become the epicenter of the
es approved sending 200 ventilators and 100 smaller breathing devices and related supplies earlier this week, an ag

Cases Expected In August. By AP. "New cases of COVID-19 are expected to continue rising in Vermont through the e
missioner of the Vermont Department of Financial Regulation who oversees pandemic statistics for the state, said T
ollowed a similar pattern of increasing for seven to nine weeks and then declining."
king Their Salaries To Defy DeSantis On Masks. By Leyla Santiago and Sara Weisfeldt, CNN. "Tina Certain took a pay
School Board. She still needs the $40,000 or so annual salary – but that's now at risk in a fight with Florida Gov. R
Delta Surge As Key GOP Governors Oppose Anti-covid Measures. By Felicia Sonmez and Hannah Knowles, Washington
nting mask requirements even as he pleads for emergency medical help in combating a surge in coronavirus cases
of thousands of revelers to the Sturgis motorcycle rally that last year bore characteristics of a superspreader event
Of Vaccination Or Face Regular Testing, The Governor Says. By Jill Cowan, New York Times. "Schoo lteachers and scho
weekly testing, Gov. Gavin Newsom said on Wednesday, making the state the first in the nation to make the move
afe,' he said, 'and that's our children.'"

ildren's Hospitals As Schools Reopen. By Dan Goldberg and Alice Miranda Ollstein, Politico. "The number of kids infec
nd schools reopen, pushing children's hospitals around the country to the brink. Nearly 1,600 kids with Covid-19 we
ention — a new seven-day record and a 27 percent increase from the week before."
olicy Costs Lives. By Mark Morgan, National Review. "Six months into the Biden administration, the president's borde
stitutional crisis. It represents one of the most substantial public-health crises facing the United States as we strugg
Another Major Coronavirus Surge. By Sammy Westfall, Washington Post. "This patchwork of mandates, permissions a
pandemic that continues to be defined by inequalities. The prospect of an express ticket out of the coronavirus pan

y Get Swamped With COVID. By Jon Gambrell, AP. "Iranians are suffering through yet another surge in the coronaviru
cinated Westerners without face masks on the internet or on TV while they remain unable to get the shots. Iran, lik
ating its public, with only 3 million of its more than 80 million people having received both vaccine doses."
Amid A Wave Of COVID-19. By Leo Correa and Cheikh A.t. Sy, AP. "The paramedics get the urgent call at 10:30 p.m
-19, is now having serious trouble breathing. Yahya Niane grabs two small oxygen cylinders and heads to the ambu
aving an envelope in front of her mouth, a desperate effort to send more air her way. Her situation is dire: Niane sa
and the baby."
on Network That Claimed Coronavirus Vaccines Turn People Into Chimpanzees. By Rachel Pannett, Washington Post. "Fa
tion campaign largely run out of Russia that also used social media influencers to peddle fake claims about coronav
stigators said they traced the origins of the campaign to Fazze, a subsidiary of a U.K.-registered marketing firm wh

s Around The World Face Expiration. By Adam Taylor and Danielle Paquette, Washington Post. "For months, a refrige
ed 90 or so small white boxes that contain thousands of dollars worth of AstraZeneca vaccine doses. But most of th
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s Rand Paul For A Week Over A Video Disputing The Effectiveness Of Masks. – Shares: 1,740
ow Official: Pregnant Women Should Get Coronavirus Vaccine – Shares: 643
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ring Pregnancy As Delta Surges – Shares: 191
rs Must Have Proof Of Vaccination Or Face Regular Testing, The Governor Says. – Shares: 191

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ts) reported: "The Biden administration sent hundreds of ventilators to Florida in recent days as the state responds
l confirms. But GOP Gov. Ron DeSantis says he's unaware of the shipment." @wfaa (574.2K followers, 147 engage
ommittee, saying their hospitals are short-staffed and overwhelmed by unvaccinated COVID patients."

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Special Report

Surging Elsewhere.

a Grows, Others Have Worst Outbreaks Yet. By Shashank Bengali, New York Times. "The authorities in Malaysia have b
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When It Seems Like It's Getting Better. By Ishaan Tharoor, Washington Post. "In the United States, life is returning to
l flights are selling out. At sporting events, maskless fans are hugging and cheering."
Wave Of New Infections. By Richard C. Paddock and Chau Doan, New York Times. "For more than 20 years, the husb
nded a small church in Ho Chi Minh City, Vietnam, where they led services and distributed food and clothing to the r
a major coronavirus outbreak, are facing a criminal investigation and have been held accountable on social media fo

Toll After Concerns Of Undercount. By Celine Castronuovo, The Hill. "Peru has tripled its total coronavirus death toll to
ounted COVID-19 fatalities. According to data compiled by Johns Hopkins University, Peru now has the highest coro

Secret, But Citizens See Many Deaths. By Kejal Vyas and Ryan Dube, Wall Street Journal (Subscription Publication). **I**
derreporting Covid-19 deaths. The officialy daily death toll appears to be one-sixth of the body count as tallied by V
Giving Pfizer Boosters To Recipients Of Chinese Vaccine. By Yaroslav Trofimov and Summer Said, Wall Street Journal
espite high vaccination rates with a Chinese vaccine, and is now giving vulnerable citizens booster shots with the Pfi
zer Vaccine And Myocarditis Cases. By Reuters. "Israel's Health Ministry said on Tuesday it found the small number c
's (PFE.N) COVID-19 vaccine in Israel were likely linked to their vaccination. Pfizer has said it has not observed a hi
ected in the general population."
M To UN-backed COVAX. By AP. "Japan's prime minister announced another $800 million to the U.N.-backed progra
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land-made Vaccines. By AP. "AstraZeneca's partner in Thailand on Wednesday began its first deliveries of COVID-19
ntry and parts of Southeast Asia. Siam Bioscience said the first locally produced AstraZeneca doses were delivered
nass vaccination program."
n't 'Compromise Our Dignity' For COVID Vaccines. By Maggie Gile, Newsweek. "Costa Rican President Carlos Alvarado
gs attached, the Associated Press reported. 'We're talking about saving lives, but that doesn't mean in receiving a c
ference with U.S. Secretary of State Antony Blinken."
'Deadly' Misinformation. By Jill Lawless, AP. "Three-quarters of Britain's adult population has received at least one do
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y vaccinated after two doses."
ries Are Starting To Issue Vaccine Passports. The System Is Very Different Than The U.S. Approach. By Cat Zakrzewski, V
ts' yesterday, underscoring how digital credential systems could play a critical role in resuming international travel.
en or printed out to verify that a person has been vaccinated against the coronavirus, received a negative test or ha

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demic Origin. By Bill Gertz, Washington Times. "U.S. intelligence agencies have zeroed in on a bat coronavirus modi
backbone' for the virus behind the COVID-19 pandemic, according to American government officials. The virus in qu
sheet on the Wuhan lab in January."
idence' Points To Wuhan Lab Leak. By John Feng, Newsweek. "'Every piece of evidence' points to the theory that the
ke Pompeo said Tuesday. President Donald Trump's former top diplomat at the State Department has stuck to his C
n of evidence despite skepticism from the media and prominent members of the scientific community."
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cy' in April 2020, newly released emails to Dr. Anthony Fauci have revealed. In an email chain released by BuzzFeed
al Institute of Allergy and Infectious Diseases, a link to a Mediaite article."
ng U.S.-China Relations Worse. By Bloomberg. "Of all the issues that have roiled ties between China and the West sin
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y? Or did it arise naturally, jumping from an animal to a human, as so many other dangerous infectious organisms
oup For A Covid-19 Commission. Here's Why We Need One. {By Marc Lipsitch, Mark McClellan, and Robert Rodriguez, W
accines is enabling the United States, and a growing number of other countries, to emerge from the worst national
her parts of the world, it is not too soon to begin a systematic, comprehensive process to learn from both the failur

Fauci's Email Exchanges. By Paige Winfield Cunningham, Washington Post. "Early in the coronavirus pandemic, Anth
0,000. He called the public's fascination with him 'surrealistic.' And he assured China's top public health official that
Emails. By John Feng, Newsweek. "Dr. Anthony Fauci's inbox was flooded with correspondence from all corners of th
ding to excerpts of his emails published this week. The White House's leading public health expert appears to maint
and Prevention, George Gao, to whom Fauci said last spring: 'We will get through this together.'"
olicy Is A Nightmare. By Noam Scheiber, New York Times. "The Kroger supermarket in Yorktown, Va., is in a county
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iden 'Month Of Action'. By Zeke Miller, AP. "Free beer is the latest White House-backed incentive for Americans to ge
n' Wednesday to get more shots into arms before the July 4 holiday. Speaking from the White House, Biden is set t
partially vaccinated by Independence Day — essential to his goal of returning the nation to a pre-pandemic sense
Covid-19 Vaccine Booster Shots. By Joe Barrett, Wall Street Journal (Subscription Publication). Millions of immunoco
cope with reduced vaccine effectiveness in comparison with those with normal immunse systems. They are experim
regimens, or contending with bureaucratic hurdles to get access to monoclonal antibodies, while researchers seek

ccination Sites. By Null, AP. "New Jersey will be shutting down its six mass COVID-19 vaccination sites as the state
es, Gov. Phil Murphy said Wednesday. New Jersey opened the six large sites early on in the vaccination effort and
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facturing With New Dutch Site. By Jillian Deutsch, Politico Europe. "Moderna will start producing a retooled version of
ected EU production, the company announced today. The new contract, inked with the subcontractor Lonza, will all
f 2021."
alks To Switch Factories For Vaccine Production For U.S. Government. By Noah Weiland, Sharon Lafraniere and Sheryl
negotiating with the federal government to shift production of its coronavirus vaccine from a troubled Baltimore pla
o people familiar with the government's plans. Catalent, headquartered in New Jersey, already produces AstraZene

Process To Distribute 80 Million Vaccines Globally. By Tal Axelrod, The Hill. "Secretary of State Antony Blinken said th
n coronavirus vaccine doses across the world. Speaking during a joint press conference Tuesday with Costa Rican P
ning weeks regarding how the domestically authorized doses will be sent out across the globe."

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Getting Worse, Even When It Seems Like It's Getting Better – Shares: 976

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art Of A Planning Group For A Covid-19 Commission. Here's Why We Need One. – Shares: 37

D-19.

non-profit (745 followers, 21 engagements), announced: "Thrilled to announce that we're joining hundreds of orga
on to ensure as many US adults as possible get at least one COVID-19 vaccine dose by July 4th." @MikeScarcella, s
keeps CDC covid-era nationwide temporary eviction moratorium in place pending outcome of HHS appeal. Trial judg
and Wilkins—refuses to disturb the stay."

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Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for April 26, 2021:

Highlights from Friday's White House COVID-19 Response Team Briefing

Jeff Zients

- **Vaccination Achievements:** We have 75,000 places for Americans to get vaccinated. Importantly, now 90 percent of all Americans live within five miles of a vaccination site. By the end of May, we'll have enough vaccine supply for every adult who wants one. Thanks to President Biden's directive, everyone 16 and over is now eligible to get a vaccine. As we announced on Wednesday, we delivered 200 million shots in less than 100 days — an incredible American achievement. This crucial milestone of 200 million shots in less than 100 days enabled more than 52 percent of adults across the country to have at least one shot. That's more than 135 million Americans who are on their way to being protected from this virus. More than 80 percent of individuals 65 years and older now have at least one shot. Seniors accounted for 80 percent of COVID deaths. Now, we've seen an 80 percent reduction in deaths and a 70 percent reduction in hospitalization among seniors, proving just how effective vaccination is in preventing death and severe disease. (Editor's note: this data is from Friday, April 23)
- **Next Steps in Our Vaccination Process:** First, we will continue to vaccinate millions of Americans each day. Our current seven-day average is 2.9 million shots — nearly 3 million shots per day. Second, we will continue to increase accessibility and make it easier and easier for Americans to get a shot. We took a very important step on this front earlier this week by calling on all employers to give paid time off for vaccination and announcing a tax credit for small and medium-sized businesses to do this more easily. No one should lose a single dollar from their paycheck in order to get vaccinated. Third, now that everyone 16 and over is eligible for a free COVID shot across the nation, we are laser focused on educating the public about these lifesaving vaccines. As Americans have seen their friends, family, and neighbors get vaccinated, confidence has increased. Finally, as we have since the start of the administration, we continue to place equity at the center of everything we do. We are committed to reaching everyone in our response and ensuring everyone has equitable access to vaccines by expanding our Community Health Center program, deploying more mobile and pop-up clinics, providing transportation options, and meeting people where they are. To that end, we're opening two new federally run vaccination sites today in Kentucky, with a combined capacity of 7,000 shots per week.

Dr. Walensky

- **Case Update:** Yesterday, CDC reported nearly 63,000 cases of COVID-19. Our average seven-day is going down — 62,500 per day. This is a 10 percent drop in average cases from the prior week and a hopeful trend. The seven-day average of admissions is 5,600 and is just a small increase of 1.6 percent from the prior week. The seven-day average of daily deaths has decreased slightly to about 691 per day. Again, a number that's going in the right direction.
- **Get Vaccinated:** Because this virus is an opportunist, we anticipate that the areas of lightest vaccine coverage now might be where the virus strikes next. With modest protection of our oldest population, many more deaths could ensure. While we have some reason to celebrate, we also have the need to do more to protect more people now. On the CDC's Data Tracker website, we provide disease data down to the county level. This allows you to join us and learn how the virus might be spreading in your community, and what percent of your county is vaccinated. Vaccination is about protecting ourselves from COVID-19. It's also about protecting those in your community, our family, our friends, and our neighbors.
- **COVID-19 Vaccine Surveillance in Pregnant Persons:** On Wednesday, the New England Journal of Medicine published the preliminary findings of post-COVID-19 vaccine surveillance in pregnant persons. Clinical trials of COVID-19 vaccines did not include pregnant people, leaving us with limited data on the safety of vaccination in pregnant people and babies to date. Through country-wide surveillance, using the CDC v-safe app and the v-safe Pregnancy Registry, as well as the Vaccine Adverse Event Reporting System, we were able to follow over 35,000 pregnant people who were vaccinated. Pregnant people experienced the same side effects as others following vaccination. We were also able to follow, in detail, more than 3,900 pregnant women, and over 800 of whom have completed their pregnancies. Importantly, no safety concerns were observed for people vaccinated in the third trimester or safety concerns for their babies. As such, CDC recommends that pregnant people receive the COVID-19 vaccine.

Dr. Fauci

- **Therapeutic Landscape:** My colleague and I published a paper in *Med*, which is a new journal from Cell Press, reviewing the therapeutic landscape. One of the important points that we made was that the results from one stage of disease should not be extrapolated between disease stages, even though we're getting more candidates that have been shown to have positive effect in clinical trials. I encourage physicians to check out the treatment guidelines if you have any questions about treatment. Furthermore, the case fatality rate of individuals has come down, very likely due to best practices being implemented, in both taking care of patients and the introduction of several therapies.
- **New Clinical Therapeutic Trials:** There are three new clinical trials that have started over the past week for direct antiviral therapies. The first is a trial called ACTIV-6, which is a randomized, placebo-control trial that is looking at seven existing prescription and over-the-counter medications that participants will self-administer. The second trial is a Phase II/III called ACTIV-2, which is an interesting trial of a polyclonal antibody that has been derived from the immunization of transgenic cows that will be placed into a therapeutic protocol involving a number of other agents. Finally, there's a clinical trial of therapeutics for severely ill individuals – it's randomized, blinded, and placebo control. It's going to study Zyesami — which is a synthetic version of a vasoactive peptide — and remdesivir alone and in combination against a placebo.

Dr. Murthy

- **"We Can Do This: Live" Initiative:** In response to research that shows that people want to ask questions about the vaccine directly to healthcare professionals, including their doctors, we are launching "We Can Do This: Live," which is an initiative to connect people with facts on vaccines from medical experts in the places where they already consume content online. We're pairing doctors, scientists, and health officials with influencers and organizations with accounts that can reach millions of Americans through events like Instagram Live Q&As and social media account takeovers. The goal here is to reach audiences who may not be following the news or government accounts or medical doctors or scientists. If we put doctors and experts directly into their feeds on the platforms that people are already following, we believe we can help get trusted information from trusted sources to people where they already are. It's just one more way that we're seeking to build confidence in the vaccines.

Vaccine Updates

FDA and CDC Lift Recommended Pause on Johnson & Johnson COVID-19 Vaccine: Following a thorough safety review, including two meetings of the CDC's Advisory Committee on Immunization Practices, the FDA and CDC have determined that the recommended pause regarding the use of the Johnson & Johnson (Janssen) COVID-19 Vaccine in the U.S. should be lifted and use of the vaccine should resume. The two agencies have determined the following: use of the Janssen COVID-19 Vaccine should be resumed in the United States; the FDA and CDC have confidence that this vaccine is safe and effective in preventing COVID-19; the FDA has determined that the available data show that the vaccine's known and potential benefits outweigh its known and potential risks in individuals 18 years of age and older; at this time, the available data suggest that the chance of TTS occurring is very low, but the FDA and CDC will remain vigilant in continuing to investigate this risk; and health care providers administering the vaccine and vaccine recipients or caregivers should review the Janssen COVID-19 Vaccine Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) and Fact Sheet for Recipients and Caregivers, which have been revised to include information about the risk of this syndrome, which has occurred in a very small number of people who have received the Janssen COVID-19 Vaccine.

FDA and CDC Virtual Press Conference on the Johnson & Johnson COVID-19 Vaccine: CDC and FDA held a virtual press conference to discuss the Johnson & Johnson COVID-19 vaccine via Zoom on Friday. Watch the recording here.

FEMA's Response to Johnson & Johnson: In alignment with the CDC and FDA recommendation to lift the temporary pause on the use of the Johnson & Johnson vaccine, FEMA will resume the use of this vaccine at our federal community vaccination center pilot sites and where applicable, state-run mobile vaccine units. Each federal community vaccination center pilot site is different, so the use of Johnson & Johnson vaccine may resume on different timelines depending on availability and dosage schedule. Mobile vaccination unit vaccine doses are provided by the state with FEMA infrastructure support.

Johnson & Johnson Vaccine: CDC updated their information on vaccines for COVID-19 to reflect the CDC and FDA's recommendation to lift the temporary pause on the use of the Johnson & Johnson vaccine. CDC and FDA have recommended that use of Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 Vaccine resume in the United States, effective April 23, 2021. However, women younger than 50 years old should be aware of the rare risk of blood clots with low platelets after vaccination, and that other

COVID-19 vaccines are available where this risk has not been seen. If you received a J&J/Janssen vaccine, here is what you need to know. CDC also released the presentation slides from the Advisory Committee on Immunization Practices (ACIP) meeting on Friday.

COCA Update for Clinicians on Johnson & Johnson COVID-19 Vaccine: This COCA Call (Tuesday, April 27 from 2:00pm – 3:00pm ET) will present the latest evidence on thrombosis with thrombocytopenia syndrome (TTS) after administration of the Johnson & Johnson/Janssen COVID-19 vaccine. Speakers will discuss information on TTS and updated vaccine recommendations.

FEMA Vaccination Sites: There are 31 active or temporarily closed federal community vaccination center pilot sites and 41 mobile pop-up sites in 26 states. Additionally, there are 10 mobile vaccination units deployed to six states and Indian Health Service areas across the Great Plains. These centers and units have administered more than 3.9 million vaccinations. Since March 30, mobile units have delivered more than 20,000 vaccines to individuals. Although FEMA transitioned management of the federal community vaccination center pilot sites in Oakland, California; Brooklyn and Queens New York; and Dallas and Houston, Texas to the states, the agency continues to support sites with federal personnel. This week, federal community vaccination center pilot sites are scheduled to open in Henderson and London, Kentucky. Ten mobile vaccination units are deployed to Connecticut, Maine, Maryland, Nevada, New Mexico, and Oregon. Two units in North Dakota and South Dakota are supporting the Indian Health Services mission to vaccinate tribal communities across the Great Plains.

COVID Data Tracker Weekly Review: On Friday, CDC released their COVID data tracker weekly review, which includes updated data on reported cases, SARS-CoV-2 variants, testing, hospitalizations, deaths, and vaccinations. The weekly review also reported that as of April 22, 2021, one in three people in the United States over the age of 18 years are fully vaccinated and more than half of U.S. adults have received at least one dose of a COVID-19 vaccine. Widespread vaccination is a critical tool to help stop the pandemic. A recent CDC study shows that, once fully vaccinated, a person's risk of infection is reduced by up to 90%. The efficacy seen in clinical trials is now being shown in the real world. Current data also suggest that COVID-19 vaccines offer protection against the variants circulating in the United States. The daily COVID-10 data tracker has also been updated to include information on the following: global COVID-19 vaccinations, cases among pregnant people by week, variant proportions by region, and additional testing metrics.

Vaccination Demographic Data: CDC updated their vaccination demographic data. Demographic data is currently collected by the jurisdiction and reported to CDC.

Long-term Care Facility Vaccine Data: CDC updated their information on long-term care facility vaccine data in the United States. As of April 23, 2021, the federal Pharmacy Partnership for LTC Program has ended. Data on the Federal Pharmacy Partnership for Long-Term Care (LTC) Program Tracker page reflects cumulative totals as of 4/23/21. The total number of doses administered in long-term care facilities totals to be 7,791,490 doses. 4,864,427 people have received at least one dose in a long-term care facility, and 2,869,761 people have been fully vaccinated in a long-term care facility.

Common Questions about Budget Revisions: CDC released a Common Questions about Budget Revisions (Redirections) webpage. The document is intended increase IP19-1901 immunization awardees understanding of "budget redirections". Please direct any questions you may have that are not answered by this document to your POB Project Officer.

Testing and Treatment

SARS-CoV-2 Variant Classifications and Definitions: CDC updated their information on SARS-CoV-2 variant classifications and definitions. Genetic variants of SARS-CoV-2 have been emerging and circulating around the world throughout the COVID-19 pandemic. A US government interagency group developed a Variant Classification scheme that defines three classes of SARS-CoV-2 variants: Variant of Interest, Variant of Concern, and Variant of High Consequence. The B.1.526, B.1.526.1, B.1.525, and P.2 variants circulating in the United States are classified as variants of interest. The B.1.1.7, B.1.351, P.1, B.1.427, and B.1.429 variants circulating in the United States are classified as variants of concern. To date, no variants of high consequence have been identified in the United States. In laboratory studies, specific monoclonal antibody treatments may be less effective for treating cases of COVID-19 caused by variants with the L452R or E484K substitution in the spike protein. L452R is present in B.1.526.1, B.1.427, and B.1.429. E484K is present in B.1.525, P.2, P.1, and B.1.351, but only some strains of B.1.526 and B.1.1.7.

Nucleic Acid Amplification Tests (NAATs): CDC updated their information on Nucleic Acid Amplification Tests (NAATs). A Nucleic Acid Amplification Test, or NAAT, is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs detect genetic material (nucleic acids). NAATs for SARS-CoV-2 specifically identify the RNA (ribonucleic acid) sequences that comprise the genetic material of the virus. NAATs can use many different methods to amplify nucleic acids and detect the virus, including but not limited to: reverse transcription polymerase chain reaction (RT-PCR) and isothermal amplification, which further includes nicking endonuclease amplification reaction (NEAR), transcription mediated amplification (TMA), loop-mediated isothermal amplification (LAMP), helicase-dependent amplification (HDA), clustered regularly interspaced short palindromic repeats (CRISPR), and strand displacement amplification (SDA).

COVID-19 Treatment Guidelines: The NIH published an updated Coronavirus Disease 2019 (COVID-19) Treatment Guidelines, which includes a growing volume of information regarding the treatment of COVID-19. In April thus far, information on the following topics has been updated: outpatient management of acute COVID-19, colchicine, fluvoxamine, therapeutic management of adults with COVID-19, overview of COVID-19, clinical spectrum of SARS-CoV-2 infection, anti-SARS-CoV-2 monoclonal antibodies, convalescent plasma, interleukin-6 inhibitors, and special considerations in children.

Electronic Case Reporting: CDC updated their information on electronic case reporting. Electronic case reporting (eCR) is the automated, real-time exchange of case report information between electronic health records and public health agencies. In partnership with the Association of Public Health Laboratories (APHL) and the Council of State and Territorial Epidemiologists (CSTE), CDC is rapidly onboarding healthcare facilities to eCR during the COVID-19 pandemic. As of April 20, 2021, more than 7,200 facilities are sending COVID-19 electronic initial case reports to public health using eCR.

FDA Testing Update: As of Friday, 369 tests and sample collection devices are authorized by the FDA under emergency use authorizations (EUAs). These include 270 molecular tests and sample collection devices, 76 antibody and other immune response tests, and 23 antigen tests. There are 49 molecular authorizations and one antibody authorization that can be used with home-collected samples. There is one molecular prescription at-home test, two antigen prescription at-home tests, four over-the-counter

(OTC) at-home antigen tests, and two OTC molecular tests. The FDA has authorized 8 antigen tests and 2 molecular tests for serial screening programs. The FDA has also authorized 466 revisions to EUA authorizations.

Funding

FEMA Funeral Assistance: On April 12, FEMA began processing applications for funeral assistance and will provide financial assistance for COVID-19-related funeral expenses incurred after Jan. 20, 2020 under the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 and the American Rescue Plan Act of 2021. Multilingual services are available. The assistance line has helped applicants in nearly 40 languages. It is important that FEMA is able to contact applicants, so callers should ensure their contact information is correct. Callers who use a relay service, videophone or captioned telephones should provide their specific number assigned to that service. As of April 25, FEMA has received more than 130,000 funeral assistance applications and has awarded more than $320,000.

USDA to Provide Critical Nutrition Assistance to 30M+ Kids Over the Summer: Today, the USDA announced a new effort funded by the American Rescue Plan to provide adequate nutrition to more than 30 million children over the summer by expanding Pandemic Electronic Benefit Transfer (P-EBT) benefits. Summer months are difficult for low-income children because they lack access to school meals that fill a nutrition gap during the school year. When school is out of session, summer feeding programs—considered a lifeline for some families—reach just a small fraction, typically less than 20%, of the number served during the school year. This summer, USDA will offer P-EBT benefits to all low-income children of all ages, helping families put food on the table during the COVID-19 pandemic. The Biden-Harris Administration's American Rescue Plan Act provides over $12 billion in new nutrition assistance to address hardship caused by the pandemic.

USDA Expands Nutrition Assistance for Seniors Amid Pandemic with ARP Funding: Today, the USDA is increasing food assistance to low-income seniors – a population that has been especially hard-hit by the pandemic – by providing nearly $37 million in additional support to the Commodity Supplemental Food Program (CSFP). States and Tribal nations will receive the new funding from the American Rescue Plan (ARP) Act to serve additional seniors, in addition to up to $2.6 million in administrative funds from a previous COVID relief bill.

Reopening Guidance

K-12 School Operational Strategy: CDC updated their K-12 school operational strategy. CDC revised physical distancing recommendations to reflect at least 3 feet between students in classrooms and provide clearer guidance when a greater distance (such as 6 feet) is recommended. CDC also clarified that ventilation is a component of strategies to clean and maintain healthy facilities, removed recommendation for physical barriers, clarified the role of community transmission levels in decision-making, and added guidance on interventions when clusters occur.

Guidance for Operating Youth and Summer Camps: CDC updated their guidance for operating youth and summer camps during COVID-19. As of April 24, the CDC edited the following topics: updated background for what is known about COVID-19 and transmission among children and in summer camp settings; added vaccination information; updated guidance on physical distancing; updated guidance on camp activities, including sports and athletic activities; updated considerations for

screening testing and contact tracing; updated guidance on cleaning and disinfection; removed guidance on physical barriers; updated guidance on developing emergency operations plans; updated guidance on ventilation and water systems; updated guidance for communal spaces, food service, playgrounds, and play space; and updated guidance for overnight camps.

Travel Health Notices: CDC updated their travel health notices, providing the risk assessment level for COVID-19 for each country.

Information for Specific Populations

Statement of President Joe Biden on Senate Passage of the COVID-19 Hate Crimes Act: I applaud the United States Senate and the leadership of the Congressional Asian Pacific American Caucus (CAPAC) for passing the COVID-19 Hate Crimes Act by an overwhelming margin. This critical legislation will bring our nation one step closer to achieving justice and equality for Asian American, Native Hawaiian, and Pacific Islander communities.

VP Addresses UN Dialogue on Pandemic Preparedness and Response: Vice President Kamala Harris addresses the United Nations Dialogue on Pandemic Preparedness and Response.

Infection Control After Vaccination: CDC updated their information on infection control after vaccination. CDC has updated select healthcare infection prevention and control recommendations in response to COVID-19 vaccination. This guidance applies to all healthcare personnel (HCP) while at work and all patients and residents while they are being cared for in a healthcare setting.

Contact Tracing Resources for Health Departments: CDC updated their contact tracing resources for health departments. CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Medical Conditions: CDC updated their information for different groups of people, specifically people with medical conditions regarding the getting the COVID-19 vaccine. Adults of any age with certain underlying medical conditions are at increased risk for severe illness from the virus that causes COVID-19. COVID-19 vaccines are recommended for and can be administered to most people with underlying medical conditions. The list of high-risk medical conditions that put people at increased risk for severe COVID-19-associated illness is updated routinely as new data become available.

Staffing Resources: CDC updated their information on staffing resources and guidance. CDC updated the number of COVID-19 response staff deployed across America.

School Nutrition Resources: CDC updated their school nutrition resources for school nutrition professionals, teachers, and staff. The resources include information on safely distributing school meals and modifying school spaces to mitigate COVID-19 during mealtimes.

Guidance for Fully Vaccinated People: CDC updated their guidance for fully vaccinated people. Fully vaccinated people can resume domestic travel and do not need to get tested before or after travel or self-quarantine after travel. Fully vaccinated people do not need to get tested before leaving the United States (unless required by the destination) or self-quarantine after arriving back in the United States.

Transportation in the Face of Communicable Disease: The National Academies of Sciences, Engineering, and Medicine updated their resources for those working in the transportation industry.

CDBG-CV Economic Development Quick Guide: The Department of Housing and Urban Development (HUD) released the CDBG-CV Economic Development Quick Guide, a user-friendly tool to help grantees plan and implement economic development activities that help to prevent, prepare for, and respond to the impacts of COVID-19. This resource includes topics such as: national Objective and overall benefit, eligible activities, and CARES Act requirements and flexibilities. Additionally, the Quick Guide addresses program design and delivery considerations to help position CDBG-CV funded economic development and small business assistance programs for successful compliance, underwriting and community impact.

HUD Pandemic Recovery Webinar Series: The Department of Housing and Urban Development (HUD) released their materials from previous COVID-19 vaccine confidence webinars. With COVID-19 vaccination efforts increasing across the country each day, promoting COVID-19 vaccine confidence is crucial to ensure that racial and economic equity remains at the forefront of our country's pandemic recovery. This is especially important for HUD-assisted households and communities, who are not only disproportionately affected by COVID-19, but also have fewer opportunities to access the COVID-19 vaccines and educational materials that help combat vaccination hesitancy and misinformation.

Esperanza Health Centers Work to Deliver COVID-19 Vaccines: CDC provides information on Esperanza Health Centers working to deliver COVID-19 vaccines in the southwest side of Chicago. Throughout the pandemic, Esperanza Health Centers, a federally qualified health center in southwest Chicago, continued to provide much-needed medical care to its patients, including adult care, pediatrics, women's health, behavioral health, and psychiatry. Once COVID-19 vaccines became available, Esperanza continued its mission to care for its patients and community by setting up COVID-19 vaccination clinics. Working in partnership with organizations and neighborhood institutions, Esperanza staff have moved beyond the walls of their existing facilities to reach people in specific groups, like older adults (aged >65).

Stay Safer While You Wait for COVID-19 Vaccines: CDC updated their information on how to stay safe while you wait for COVID-19 vaccines, as part of their Easy to Read COVID-19 Materials.

Research

COVID-19 Vaccine Responses to be Studied in People with Immune Deficits: A study assessing how people with immune system deficiencies or dysregulations respond to COVID-19 vaccination has begun enrolling participants at the National Institutes of Health Clinical Center in Bethesda, Maryland. The single-site study is led by researchers from the National Institute of Allergy and Infectious Diseases (NIAID) and aims to enroll 500 people, 400 with primary or secondary immune system disorders and 100 without such conditions. In addition to analyzing how they respond to vaccination, the study team will gather information about COVID-19 illness in people with immune deficiencies and dysregulation conditions.

Health Care Utilization and Clinical Characteristics of Non-hospitalized Adults: CDC released an *MMWR* on health care utilization and clinical characteristics of non-hospitalized adults in an integrated health care system 28-180 days after COVID-19 diagnosis in Georgia from May 2020 – March 2021. Among

3,171 non-hospitalized adult COVID-19 patients, 69% had one or more outpatient visits 28–180 days after the diagnosis. Two thirds had a visit for a new primary diagnosis, and approximately one third had a new specialist visit. Symptoms potentially related to COVID-19 were common new visit diagnoses. Visits for these symptoms decreased after 60 days but for some patients continued through 120–180 days. Clinicians and health care systems should be aware of the potential for post-COVID conditions.

COVID-19 Science Update: On Friday, CDC released their COVID-19 Science Update. This week's issue includes, but is not limited to, research on the following subjects: the effect of eviction moratoria on the transmission of SARS-CoV-2, genomic characteristics and clinical effect of the emergent SARS-CoV-2 B.1.1.7 lineage in London, UK, and fitted filtration efficiency of double masking during the COVID-19 pandemic.

Hospitalization and Death by Race/Ethnicity: CDC released updated data on the hospitalization and death rate from COVID-19 by race/ethnicity.

Communicating COVID-19 Vaccine Efficacy, Effectiveness, and Equity: As COVID-19 vaccinations continue and accelerate across the U.S., a new rapid expert consultation from the National Academies of Sciences, Engineering, and Medicine offers advice for decision-makers communicating to the public about vaccine efficacy, effectiveness, and equity — drawing on findings from social and behavioral science. Effective communication can help people make vaccination decisions that are right for them and their community and build public trust in the COVID-19 vaccination program, says the consultation.

Research of COVID-19 Protein: Through a National Science Foundation grant, researchers at Oregon State University have taken a key step toward new drugs and vaccines for combating COVID-19 with a detailed biophysical study of one protein's interactions with the SARS-CoV-2 genetic material; SARS CoV-2 is the virus that causes COVID-19. The virus' nucleocapsid protein, or N protein, has multiple functions, including packaging the RNA genome and interacting with other structural proteins during virion assembly. The N protein has critical roles in the coronavirus' infection cycle and, because it mutates at a comparatively slow pace, drugs and vaccines targeting the N protein could be highly effective for longer periods of time, making them less susceptible to resistance. Published in *Biophysical Journal*, the findings are an important jumping-off point for understanding how the N protein and its interactions with RNA contribute to SARS-CoV-2 replication and transmission.

COVID-19: The Therapeutic Landscape: Dr. Fauci co-authored a study in *Med*, a new journal from Cell Press about the COVID-19 therapeutic landscape. Therapeutics for hospitalized COVID-19 patients were identified through a robust research response with several lessons learned: clinical trial data should guide therapeutic use, results should not be extrapolated between disease stages, and robust studies should be designed to give clinically relevant data. These lessons should be applied to the outpatient research response.

National Academy of Sciences Webinar: NIH Director Dr. Francis Collins participated in a panel during the National Academy of Sciences annual meeting. The discussion covered NIH's role in the COVID-19 pandemic, NIH's plan to address structural racism in biomedical research, Citizen Science, and more.

Non-COVID-19 Updates

National Partners Combine to Boost Black American Enrollment at HealthCare.gov: HHS Secretary Xavier Becerra announced commitments from national organizations to support Black American outreach and enrollment efforts during the Special Enrollment Period (SEP) made available on HealthCare.gov by President Biden due to the COVID-19 Public Health Emergency. Black Americans represent roughly 13% of the U.S. population but 16% of the uninsured. As part of the Black American Week of Action, April 25 – May 1, HHS and its partnership organizations will combine social media efforts to inform Black American consumers and spur enrollment in affordable, quality health plans through HealthCare.gov. An estimated 66% of Black uninsured adults now may have access to a zero-premium plan and 76% may be able to find a low-premium plan as a result of expanded coverage. A recent report from the Centers for Medicare & Medicaid Services (CMS), which covers Marketplace plan selections from Feb. 15 to March 31, 2021, shows enrollment gains among historically uninsured communities – including Black consumers and Americans near the poverty level. Of applicants who identified a race, 17% identified as Black – compared to about 11% in both 2020 and 2019 during the same time period. Among consumers requesting financial assistance, 41% report being at or slightly above the federal poverty level, compared to 38% in 2020 and 33% in 2019.

Request for Information on FEMA Programs, Regulations, and Policies: On April 22, to meet requirements of three Executive Orders FEMA released a request for information to ensure that its programs, regulations and policies contain necessary, properly tailored and up-to-date requirements that effectively achieve the agency's mission in a manner that furthers the goals of advancing equity for all: EO 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, EO 13990 on Protecting Public Health and the Environment and Restoring Science to Tackle the Climate Crisis, and EO 14008 on Tackling the Climate Crisis at Home and Abroad.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Subject:	HHS COVID-19 Update - 5/3
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Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for May 3, 2021:

Highlights from Friday's White House COVID-19 Response Team Briefing

Jeff Zients

- **100th Day Vaccine Achievements:** We beat the President's aggressive goal of 200 million shots in his first 100 days, delivering more than 220 million shots in arms. By the end of May, we'll have enough vaccine supply for every adult American. In fact, just this week, we shipped our 300 millionth dose to states, Tribes, territories, and federal channels. Thanks to our accelerated vaccination program, we are far ahead of where anyone thought we would be in our war against the virus. Everyone 16 and over is eligible. With 90 percent of Americans living within five miles of a vaccination site, it's never been easier to get a shot. As I said last week, given that we have succeeded in getting vaccinations to the lion's share of those most at risk and those most eager to get vaccinated, we are now increasingly focused on other groups that will take time to reach. We expect the number of shots administered each day to moderate and fluctuate. That said, we will continue to vaccinate millions of Americans each and every day. This past week, our average was 2.6 million shots per day. Overall, as you can see on our vaccination progress report, 55 percent of adult Americans now have at least one shot. That's up from 38 percent at the end of March and 19 percent at the end of February. Today, 100 million Americans are fully vaccinated, nearly double the 55 million who were fully vaccinated at the end of March.

Dr. Walensky

- **Case Update:** Yesterday, CDC reported over 53,000 new cases of COVID-19. Our seven-day average is about 52,500 daily cases; this represents a decrease of about 16 percent from our prior seven-day average. The seven-day average of hospital admissions is just over 5,050 — again, a positive sign with a decrease of almost 10 percent from our previous seven days. The seven-day average of daily deaths has also declined to 628 per day, a decrease of about 8 percent.
- **Effectiveness of Vaccines**: Earlier this week, CDC released a study examining the real-world effectiveness of the Pfizer and Moderna COVID-19 vaccines. This study looked at hospitalization rates among people over the age of 65 and found that fully vaccinated seniors were 94 percent less likely to be hospitalized with COVID-19 than were there — those who are unvaccinated.

Importantly, this study was done in a high-risk population — those over 65, who have endured a tremendous burden during this pandemic.

- **Genomic Sequencing Achievements:** Genomic sequencing is a laboratory method that identifies mutations or changes in the virus that contribute to the emergence of new variants. Taken together, genomic sequencing of many virus samples allows us to understand the prevalence of variants in circulation. Over the past 100 days, CDC has dramatically built up our domestic genomic surveillance platforms to improve our visibility of circulating variants. Since January, CDC has increased the nation's sequencing output 75-fold. CDC has made significant strides to make our genomic surveillance data more accessible to the public through an interactive dashboard on our COVID Data Tracker website. This site is updated weekly with the prevalence of SARS-CoV-2 variants at the national, regional, and state levels. We look forward to continued advancement in this area with the additional investments made by the American Rescue Plan, which provided $1.7 billion to strengthen and expand much-needed activities and workforce related to genomic sequencing, genomic epidemiology, analytics, and disease surveillance. From a global perspective, CDC is also supporting sequencing capacity in more than 50 countries, such as India, Brazil, and South Africa. This support includes defining standardized approaches, providing technical assistance to investigate variants, and coordinating with the broader research community.

Dr. Fauci

- **Importance of Getting Your Second COVID-19 Vaccination Shot:** About 8 percent of people have not showed up for their second shot of a two-shot regimen, i.e. the mRNA regimen. For the Pfizer–BioNTech, you get a single dose, and then 21 days later, you get the boost. For Moderna, the interval is 28 days. In the real world, there are many reasons why this timing might not be feasible. The second dose may be scheduled for administration up to six weeks or 42 days after the first dose. In a survey about public uncertainty about the importance of second doses of COVID-19 mRNA vaccines, about 44 percent of adults reported that the vaccines provided strong protection by one to two weeks after the second dose. Twenty percent believe that the vaccines provide strong protection before the second dose. 36 percent, in a recent survey, were unsure.
- **Studies on Second Shots:** In a study that was recently published in the New England Journal of Medicine on the Pfizer-BioNTech mRNA in a nationwide mass vaccination setting in Israel, we see that although there is a significant degree of protection after the first dose, there is a difference in protection between the first and second dose on infection, symptomatic hospitalization, or severe disease: 46% versus 92%, 57% versus 94%, and 62% versus 92%. Here is a study I showed you at a previous briefing from employees at the University of Texas Southwestern. Again, the unvaccinated, when you look at the percent of infections there, they did not do well. You do much better if you're partially vaccinated, but there's a 36-fold difference of getting fully vaccinated versus partially vaccinated. When you look at the immune response to a single dose of mRNA vaccines in organ transplant or cancer patients — and very clearly, the single dose was not adequate — this becomes really important. There are a lot of people in society who are on things like glucocorticoids for autoimmune diseases that may not get a good enough response after the first dose, and we absolutely want them to get the second dose. Let's look at some of the data that backs up this clinical. This is the Pfizer-BioNTech, and we're here looking at neutralizing antibodies after the first dose, which is at the 21 day, versus the second dose, which is that day 28 to 35. Regardless of the age — younger individuals or older individuals — there is a dramatic difference in neutralizing antibodies between the first

and the second dose. We often talk about T-cell responses — we have the same thing. If you look at after the first dose — namely at day 29 on the Th1 responses to the spike protein — and you look at the responses at day 29 versus day 43, which is after the second dose — yet again, another important difference.

- **Second Shot's Effect on Variant Strains:** Let's look at the neutralization after the second dose of Pfizer with the variants. If you look at two weeks and then three weeks after the first dose of the vaccine, about a third of them had a good response against the D614G, which is the standard virus, less so with B.1.1.7, and nothing against B.1.351. After the second dose, both week four and week six, there is a dramatic difference not only against the standard wild type, but also against B.1.1.7, the dominant strain in this country. There are also neutralizing antibodies in vitro against the B.1.351, or South African isolate. Again, a much, much better advantage after the second dose.

Dr. Murthy

- **Vaccine Confidence:** Tracking vaccine confidence is nuanced, but there are two realities that remain true. First, the surveys and studies continue to show us that since the winter, a growing share of people in our country have gotten or plan to get vaccinated. We've come a long way since the end of last year. Second, we know, not only from the data, but from conversations with community members and leaders, that there are still people who have questions and want more information about vaccines. That's why we're continuing to grow the scope and reach of our COVID-19 Community Corps, which, you'll remember, is a nationwide grassroot network of health professionals; community organizations; rural, union, and faith leaders; and Americans from all walks of life who share a commitment to protecting their communities by helping people get vaccinated. The Community Corps is ultimately built on a simple but powerful idea: that protecting the nation from COVID-19 requires individuals and committees to take action, not just the government.
- **Combatting Misinformation:** Ultimately, we know that people have questions for multiple reasons. Sometimes because there's misinformation that they've encountered; sometimes because they've had a bad experience with the healthcare system and they're wondering who to trust; and some people have just heard lots of different news as we continue to get updates on the vaccine, and they want to hear from someone they trust. That's why, you know, our efforts are focused on mobilizing trusted messengers, which include doctors and nurses, faith leaders, and family members to get information out to people. Just keep in mind that for people to get vaccinated, they need confidence. They need to know that this is urgent and important. And they need access. That's why we are working hard on all three fronts. We recognize that misinformation and disinformation thrive in the absence of accurate information. So, one of our strategies is to put as much accurate information out there as possible with trusted voices — not only the people from government, but also reputable medical sources and experts in communities. We are also working closely with these social media companies and other platforms to push them, also, and partner with them on rooting out active disinformation campaigns. You know, I said at the top of this press briefing is that it is all of our responsibilities to step up and to help address this crisis and get people vaccinated. I specifically mentioned that we need social media companies and platforms to not only put out accurate information, but to root out both blatant and subtle disinformation that's on their sites. I think that they have work to do. We are certainly here to partner with them to get the job done. But clearly, we still have way too much disinformation spreading on those sites. It presents a clear and present danger, I

believe, to people who need to be protected from COVID and who could potentially get vaccinated.

Vaccine Updates

Johnson & Johnson/ Janssen Update: CDC updated their information on the Johnson & Johnson/ Janssen COVID-19 vaccine. CDC and the U.S. Food and Drug Administration (FDA) recommend use of Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 Vaccine resume in the United States, after a temporary pause. Reports of adverse events following the use of J&J/Janssen vaccine suggest an increased risk of a rare adverse event called thrombosis with thrombocytopenia syndrome (TTS). Nearly all reports of this serious condition, which involves blood clots with low platelets, have been in adult women younger than 50 years old. A review of all available data at this time shows that the J&J/Janssen COVID-19 Vaccine's known and potential benefits outweigh its known and potential risks. However, women younger than 50 years old especially should be aware of the rare but increased risk of this adverse event and that there are other COVID-19 vaccine options available for which this risk has not been seen. CDC and FDA will continue to monitor the safety of all COVID-19 vaccines. Seek medical care right away if you develop any of these symptoms after receiving the J&J/Janssen COVID-19 Vaccine.

Frequently Asked Questions about COVID-19 Vaccination: CDC updated their Frequently Asked Questions page on the COVID-19 vaccines.

Combatting COVID-19 Vaccine Hesitancy: HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) released a recording of a panel discussing combatting COVID-19 vaccine hesitancy. The COVID-19 pandemic has posed an incredible threat to public health and the economy. It has also magnified the systemic health and social disparities that have long existed for ethnic and racial minority communities. A panel of BARDA experts came together to talk about the different yet significant ways they have contributed to developing medical countermeasures against COVID-19. Watch our discussion about the issues surrounding COVID-19 vaccine and treatment hesitancy – and what it means to contribute to the pandemic response as members of one of the communities that have been disproportionately affected by this disease.

COVID-19 Data Tracker Weekly Review: CDC updated their COVID-19 data tracker weekly review. The CDC updated their numbers on reported cases, SARS-CoV-2 variants, testing, vaccinations, hospitalizations, and deaths. The CDC also included travel information, as many countries and states are now loosening restrictions for visitors. CDC recommends delaying travel until you are fully vaccinated because travel increases your chance of getting and spreading COVID-19. International travel poses additional risks, and even fully vaccinated travelers are at increased risk for getting and possibly spreading new COVID-19 variants. The COVID-19 situation differs from country to country, and you should pay close attention to the situation at your destination before traveling. CDC also provides further information on how vaccine data is collected and reported.

FEMA Update: April 29 marked the 100th day of the Biden presidency. In those 100 days, FEMA been proud to: provide support to more than 1,700 community vaccination centers; prioritize equitable outcomes for everyone seeking vaccinations; leverage partnerships at all levels of government, and non-

profit and private sectors to deliver funeral assistance to those who lost a loved on to COVID-19; and continue to provide support to disaster survivors and their communities.

FEMA Vaccination Sites: There are 23 active or temporarily closed federal community vaccination center pilot sites and 60 mobile pop-up sites in 23 states. Additionally, there are 15 mobile vaccination units deployed to support states and the Indian Health Service. The federal community vaccination center pilot sites have administered more than 4.5 million vaccinations. The mobile units have delivered more than 26,000 vaccines. Mobile vaccination units are deployed to Arizona, Connecticut, Idaho, Maine, Maryland, Nevada, New Mexico, and Oregon. Two units are supporting the Indian Health Services mission to vaccinate tribal communities across the Great Plains.

Testing and Treatment

SARS-CoV-2 Variants: CDC updated their information on SARS-CoV-2 variant classifications and definitions. Genetic variants of SARS-CoV-2 have been emerging and circulating around the world throughout the COVID-19 pandemic. Viral mutations and variants in the United States are routinely monitored through sequence-based surveillance, laboratory studies, and epidemiological investigations. A US government interagency group developed a Variant Classification scheme that defines three classes of SARS-CoV-2 variants: Variant of Interest, Variant of Concern, and Variant of High Consequence. The B.1.526, B.1.526.1, B.1.525, and P.2 variants circulating in the United States are classified as variants of interest. The B.1.1.7, B.1.351, P.1, B.1.427, and B.1.429 variants circulating in the United States are classified as variants of concern. To date, no variants of high consequence have been identified in the United States. In laboratory studies, specific monoclonal antibody treatments may be less effective for treating cases of COVID-19 caused by variants with the L452R or E484K substitution in the spike protein. L452R is present in B.1.526.1, B.1.427, and B.1.429. E484K is present in B.1.525, P.2, P.1, and B.1.351, but only some strains of B.1.526 and B.1.1.7.

COVID-19 Electronic Case Reporting: CDC updated their information on Electronic case reporting (eCR), the automated, real-time exchange of case report information between electronic health records and public health agencies. In partnership with the Association of Public Health Laboratories (APHL) and the Council of State and Territorial Epidemiologists (CSTE), CDC is rapidly onboarding healthcare facilities to eCR during the COVID-19 pandemic. As of April 30, 2021, more than 7,300 facilities are sending COVID-19 electronic initial case reports to public health using eCR.

FDA Testing Update: As of Friday, 369 tests and sample collection devices are authorized by the FDA under emergency use authorizations (EUAs). These include 270 molecular tests and sample collection devices, 76 antibody and other immune response tests, and 23 antigen tests. There are 49 molecular authorizations and one antibody authorization that can be used with home-collected samples. There is one molecular prescription at-home test, two antigen prescription at-home tests, four over-the-counter (OTC) at-home antigen tests, and two OTC molecular tests. The FDA has authorized 8 antigen tests and 2 molecular tests for serial screening programs. The FDA has also authorized 477 revisions to EUA authorizations.

EUA Authorized Serology Test Performance: On April 28, the FDA updated the EUA Authorized Serology Test Performance page on the FDA's website. The FDA provided information on the expected predictive value of authorized serology tests that have submitted performance data with SARS-CoV-2 antibody prevalence assumptions ranging from 5% to 50%. These estimates may help health care providers

interpret these antibody test results for their patients. Additionally, the updated web page clarifies the use of serology tests when assessing a patient's adaptive immune response.

FDA Approved Two Abbreviated New Drug Application: On April 28, the FDA approved an abbreviated new drug application (ANDA) for 23.4% Sodium Chloride Injection USP, 120 mEq/30 mL (4 mEq/mL) single dose vial, indicated as an additive in parenteral (injection) fluid therapy for use in patients who have special problems of sodium electrolyte intake or excretion (to replenish sodium in patients with unusual fluid and electrolyte needs). Side effects include edema (fluid retention) and clinical symptoms resembling those of congestive heart failure. On April 29, the FDA approved an ANDA for Morphine Sulfate Injection USP, 30 mg/30 mL (1 mg/1 mL) Single-dose (preservative-free Patient Controlled Analgesia [PCA] vial), indicated for the management of pain severe enough to require use of an opioid analgesic by PCA and for which alternative treatments are inadequate. Side effects include respiratory depression, respiratory arrest, circulatory depression, shock, and cardiac arrest. The FDA recognizes the increased demand for certain products during the COVID-19 public health emergency, and we remain committed to facilitating access to medical products to help address critical needs of the American public.

COVID-19 Data Tracker: CDC added new information to their COVID-19 data tracker. CDC updated new hospital admissions and current hospitalization tabs to display trends by region, state, jurisdiction, or territory. CDC also updated new state-issued prevention measure tabs at the state and county levels to show prevention measures alongside case and death trends.

Funding

COVID Coverage Assistance Fund: Today, the US Department of Health and Human Services, through the Health Resources and Services Administration (HRSA) is announcing a new program covering costs of administering COVID-19 vaccines to patients enrolled in health plans that either do not cover vaccination fees or cover them with patient cost-sharing. Since providers cannot bill patients for COVID-19 vaccination fees, this new program, the COVID-19 Coverage Assistance Fund (CAF), addresses an outstanding compensation need for providers on the front lines vaccinating underinsured patients. CAF is focusing on instances where individuals have insurance, but vaccines are either not covered or are but typically with patient cost-sharing. To address these gaps, the CAF will be compensating providers for eligible claims, at national Medicare rates which increased in March to reflect newer information on the true costs associated with administering the vaccines. CAF also builds on the HRSA COVID-19 Uninsured Program, which has been reimbursing providers for vaccine administration fees associated with uninsured individuals.

ACL American Rescue Plan: The Administration for Community Living updated both their general Frequently Asked Questions Page and their Fiscal Frequently asked Questions Page on the American Rescue Plan (ARP). The ARP updates include the follow: purpose of funding, state plan and area plan administration, match requirements, program income used as match, and transfer authority. General updates and clarifications include the following: transfer due date chart, match chart, NSIP hold harmless for GGY 2022, SF-425 report extensions, no cost extensions, project period end date chart, additional questions and responses.

FEMA's Vaccination Effort: FEMA continues to play a significant role in the ongoing battle against COVID-19, delivering on the agency's commitment to bring vaccinations to hard-to-reach and historically underserved communities during the first 100 days of the Biden-Harris Administration. The agency has provided more than $4.7 billion to states, tribes, territories and the District of Columbia in support of pandemic response efforts across the country. FEMA's strong partnerships with state, local, territorial and tribal governments is helping ensure everyone who wants a vaccine can get one, especially communities of color. Read more about each region's vaccination efforts here.

FEMA Funeral Assistance: As of May 3, FEMA has received more than 157,600 funeral assistance applications and has awarded more than $4.8 million.

Information for Specific Populations

TSA Extends Face Mask Requirement at Airports and Throughout the Transportation Network: The Transportation Security Administration (TSA) is extending the face mask requirement for individuals across all transportation networks throughout the United States, including at airports, onboard commercial aircraft, on over-the-road buses, and on commuter bus and rail systems through September 13. TSA's initial face mask requirement went into effect on February 1 with an expiration date of May 11. The CDC recently announced that fully vaccinated travelers with an FDA-authorized vaccine can travel safely within the U.S., but the CDC guidelines still require individuals to wear a face mask, socially distance, and wash their hands or use hand sanitizer. The extension of the face mask requirement is consistent with this most recent CDC guidance. TSA encourages all commuters, and airline and bus travelers, including people considering international travel, to stay up to date with any changes to these requirements by checking the TSA and CDC websites prior to taking their trip.

Travelers Prohibited from Entry to the US: CDC updated their information on travelers prohibited from entry to the U.S. With specific exceptions, several Presidential proclamations suspend and limit entry into the United States, as immigrants or nonimmigrants, of noncitizens who were physically present within the following countries during the 14-day period preceding their entry or attempted entry into the United States. After reviewing the public health situation within the Republic of India, CDC has concluded that proactive measures are required to protect the Nation's public health from travelers entering the United States from that jurisdiction. Given the determination of CDC, working in close coordination with the Department of Homeland Security, it has been determined that it is in the interests of the United States to take action to restrict and suspend the entry into the United States, as nonimmigrants, of noncitizens of the United States ("noncitizens") who were physically present within the Republic of India during the 14_day period preceding their entry or attempted entry into the United States.

Travel Health Notices: CDC updated their travel health notices. CDC updated the risk assessment levels for COVID-19 in other countries.

Refugee Populations: CDC updated their guidance for refugees upon arrival in the United States. Public health professionals, community organizations, resettlement agencies, and healthcare providers can assist refugees arriving in the United States by providing them with information they need to protect themselves from COVID-19.

School Nutrition Professionals and Volunteers: CDC updated their guidance for school nutrition professionals and volunteers. CDC added a section on Guiding Principles to Keep in Mind, updated and expanded guidance on Healthy Behaviors to Reduce Transmission Among Employees and Volunteers, updated and expanded guidance on Healthy Environments, updated and expanded guidance on Health Business Operations, added guidance on Preparing for Sick Employees and Volunteers, and updated their list of additional resources.

Long-term Care Facilities: CDC updated their information for residents of long-term care facilities (LTCFs). LTCF residents are adults who reside in facilities that provide a range of services, including medical and personal care, to people who can't live independently. The communal nature of these facilities, which often have a population of older adults with underlying medical conditions, puts residents at increased risk. All LTCF residents are recommended to get vaccinated against COVID-19.

Healthcare Personnel: CDC updated their guidance for healthcare personnel. Healthcare personnel continue to be on the front line of the nation's fight against COVID-19. By providing critical care to those who are or might be infected with the virus that causes COVID-19, some healthcare personnel are at increased risk of infection from COVID-19. All healthcare personnel are recommended to get vaccinated against COVID-19.

Employers of Essential Workers: CDC updated their toolkit for employers of essential workers. CDC has designed this toolkit to help employers educate their essential workers about this important prevention tool. Essential workers perform duties across critical infrastructure sectors and maintain the services and functions that U.S. residents depend on daily. The toolkit includes digital and print communication resources, printable stickers, and social media guidance. View other communication resources here.

Staffing Resources: CDC updated their information on COVID-19 response staff deployments. A total of 609 CDC staff are currently working in state, tribal, local, and territorial health agencies. Three staff are deployed with the Navajo Tribe.

Indian Health Service Reports on the First 100 Days: Last week, the Biden Administration completed its first 100 days in office. President Biden has delivered immediate relief for Indian Country including actions to control the COVID-19 pandemic, launching a national vaccination program to immunize everyone over the age of 16, efficiently and equitably, and to provide economic relief. These are critical steps in defeating the pandemic and a pathway to more equitable health care for American Indians and Alaska Natives. The COVID-19 pandemic has disproportionately affected American Indian and Alaska Native populations across the country. American Indians and Alaska Natives have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19 and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with its tribal partners and with urban Indian organizations as well as federal, state and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. IHS has worked closely with these partners over the past 100 days to accelerate its fight against the pandemic.

COVID-19 Vaccination Implementation for People Experiencing Homelessness: CDC updated their interim guidance for health departments on COVID-19 vaccinations for people experiencing homelessness. When implementing the vaccination phases, it is important to consider that people experiencing homelessness might have low levels of trust in the medical system and often have difficulty

accessing vaccinations through traditional healthcare delivery methods, such as clinics or health departments. his webpage outlines implementation strategies to improve delivery of COVID-19 vaccination services to people experiencing homelessness. Please review Vaccination Implementation Strategies to Consider for Populations Recommended to Receive Initial Doses of COVID-19 Vaccine for general considerations for vaccination implementation.

People with Medical Conditions: CDC updated their guidance for people with medical conditions. Older adults are more likely to get severely ill from COVID-19. More than 80% of COVID-19 deaths occur in people over age 65, and more than 95% of COVID-19 deaths occur in people older than 45. Long-standing systemic health and social inequities have put various groups of people at increased risk of getting sick and dying from COVID-19, including many racial and ethnic minority groups and people with disabilities. Studies have shown people from racial and ethnic minority groups are also dying from COVID-19 at younger ages. People in minority groups are often younger when they develop chronic medical conditions and may be more likely to have more than one condition. People with disabilities are more likely than those without disabilities to have chronic health conditions, live in congregate setting, and face more barriers to healthcare. Studies have shown that some people with certain disabilities are more likely to get COVID-19 and have worse outcomes. CDC also updated their information for providers caring for patients with underlying medical conditions.

Correctional and Detention Facilities: CDC updated their guidance and resources for people who work and reside in prisons, jails, and detention centers to protect themselves and others during the COVID-19 pandemic.

COVID-19 Weekly Partner Calls: CDC updated their information on upcoming COVID-19 Partner Calls. CDC invites representatives from community-based organizations, local government, the private sector, academia, and the general public to learn more about how they can help slow the spread of COVID-19 in their communities. We feature experts from different parts of CDC's COVID-19 response to deep dive into specific topics, helping you learn more about the latest scientific findings, guidance for operations, information resources, and answering your COVID-19 questions. CDC also posted the recordings of the three most recent calls.

Easy to Read COVID-19 Materials: CDC updated their easy to read COVID-19 materials. CDC updated the following pages: COVID-19 Vaccines are Important, Stay Safer While You Wait for COVID-19 Vaccines, People with Disabilities and COVID-19, and Different COVID-19 Vaccines.

U.S. Sends Medical Supplies to India to Help in COVID-19 Fight: As part of a whole-of-government effort to slow and eventually end the pandemic, the United States is sending medical supplies and equipment to India as that country battles the most recent outbreak. Wednesday evening, a C-5M Super Galaxy aircraft loaded with oxygen cylinders and regulators, N95 masks and COVID-19 rapid diagnostic kits left Travis Air Force Base, California, bound for India. Wednesday's shipment was just the first. In all, the United States expects to deliver more than $100 million in medical supplies to the U.S. partner nation. Thursday morning, a C-17 Globemaster III departed Travis for India carrying additional oxygen cylinders and diagnostic kits. The medical supplies were donated to India by the U.S. government though the U.S. Agency for International Development. Airmen with the 60th Air Mobility Wing are responsible for delivering those supplies. In the coming week, more oxygen cylinders will be sent, as will oxygen concentrators, oxygen generation units, additional personnel protective equipment, rapid diagnostic tests and therapeutics. The U.S. is also providing vaccine manufacturing supplies. In fact, the U.S. has

redirected its own order of AstraZeneca manufacturing supplies to India, which will enable the country to make over 20 million doses of the COVID-19 vaccine.

CMS Updates

CMS to Adopt Rules to Lower Health Care Costs in 2022 Federal Health Insurance Marketplace Plans: On Friday, the Centers for Medicare & Medicaid Services (CMS) adopted new provisions to lower maximum out-of-pocket costs to consumers by $400, while increasing competition and improving the consumer experience for millions of Americans who will rely on the Federal Health Insurance Marketplaces in plan year 2022. These actions demonstrate a strong commitment by the Biden-Harris Administration to protect and build on the Affordable Care Act (ACA), reduce health care costs, and make our health care system easier to navigate and more equitable. The second 2022 Notice of Benefit and Payment Parameters final rule (also known as the "2022 payment notice") includes several provisions to help consumers more easily distinguish between plan options and increase opportunities to qualify for future special enrollment periods (SEPs), when consumers are eligible to enroll in marketplace plans outside annual open enrollment. These SEP policies will offer greater flexibility for those who need coverage—particularly those communities hardest hit by COVID-19. Already, an additional 800,000 Americans have enrolled in the ACA under the SEP enacted by the Administration. Consult the fact sheet and final rule in its entirety for more information.

PPE

FDA Revoked EUA: On April 30, the FDA revoked the emergency use authorization (EUA) of the Battelle CCDS Critical Care Decontamination System, which was authorized for use in decontaminating compatible N95 respirators for multiple-user reuse by healthcare personnel. The FDA revoked the EUA in response to Battelle's request for voluntary withdrawal of the authorization. In response to changing customer needs, as of March 31, 2021, Battelle has ceased all Battelle CCDS decontamination site operations and marketing activities. As a reminder, decontaminated respirators and respirators that have undergone bioburden reduction should be used only when there are insufficient supplies of new filtering facepiece respirators (FFRs) or any new respirators. Moreover, earlier this month, the FDA issued a letter to health care providers recommending transitioning from use of decontaminated disposable respirators.

Research

U.S. Case Reports of CVST with Thrombocytopenia after J&J Vaccination: *JAMA Network* released a study on U.S. case reports of cerebral venous sinus thrombosis (CVST) with thrombocytopenia after Ad26.COV2.S (Janssen/ Johnson & Johnson) COVID-19 vaccine. In this case series of 12 patients, all were women, younger than 60 years, and had symptom onset ranging from 6 to 15 days after vaccination requiring hospitalization. Of 11 patients with heparin-platelet factor 4 enzyme-linked immunosorbent assay (ELISA) heparin-induced thrombocytopenia (HIT) antibody test results, all were positive. At last follow-up, outcomes were death (n = 3), intensive care unit (ICU) care (n = 3), non-ICU hospitalization (n = 2), and discharge to home (n = 4). This case series may inform clinical guidance and investigations into the potential relationship between the Ad26.COV2.S vaccine and CVST with thrombocytopenia.

Tracking the COVID-19 Virus with a Smartphone: Researchers at NIH-supported Emory University are applying a new technology to detect SARS-CoV-2, the virus that causes COVID-19, in the air. A

smartphone app will report the findings back to researchers in real time. This faster and automated approach may help reduce the spread of the virus. The sensor would allow researchers, health officials, and local lawmakers to know right away when SARS-CoV-2 virus is circulating in the air. They can then take steps to prevent its spread and possible transmission.

Anxiety-Related Adverse Event Clusters After Janssen COVID-19 Vaccination: CDC released an *MMWR* on anxiety-related adverse event clusters after Janssen COVID-19 vaccination. Syncope and other anxiety-related events can occur after vaccination and have been reported to the Vaccine Adverse Events Reporting System (VAERS) for other vaccines. Five mass vaccination sites reported 64 anxiety-related events, including 17 events of syncope (fainting) after receipt of Janssen COVID-19 vaccine. The reporting rates of syncope to VAERS after Janssen COVID-19 and influenza vaccines (2019–20) were 8.2 and 0.05 per 100,000 doses, respectively. Vaccine providers should be aware of anxiety-related events after vaccination and observe all COVID-19 vaccine recipients for any adverse reactions for at least 15 minutes after vaccine administration.

Safety Monitoring of the Janssen (Johnson & Johnson) COVID-19 Vaccine: CDC released an *MMWR* on the safety monitoring of the Janssen (Johnson & Johnson) COVID-19 vaccine. An Emergency Use Authorization of the Janssen COVID-19 vaccine was granted February 27, 2021. Use was paused during April 12–23, 2021, after detection of six cases of cerebral venous sinus thrombosis (CVST). By April 21, nearly 8 million doses of the Janssen COVID-19 vaccine had been administered. Review of safety monitoring data found that 97% of reported reactions after vaccine receipt were nonserious, consistent with preauthorization clinical trials data. Seventeen thrombotic events with thrombocytopenia have been reported, including three non-CVST events. Ongoing monitoring for rare and common adverse events after vaccination is important for evaluating the balance between risks and benefits for each authorized COVID-19 vaccine, including the Janssen COVID-19 vaccine.

COVID-19 Science Update: On Friday, CDC released their COVID-19 Science Update. This week's issue includes, but is not limited to, research on the following subjects: viral sequencing reveals U.S. healthcare personnel rarely become infected with SARS-CoV-2 through patient contact; psychological impact of the lockdown due to the COVID-19 pandemic in university workers; and the prevalence and clinical profile of acute respiratory syndrome coronavirus 2 infection among farmworkers in California.

Critical Findings on COVID-19: For more than 150 years, the National Academies of Sciences, Engineering, and Medicine have issued reports detailing leading research on public health and infectious disease. In response to the global outbreak of COVID-19 in 2020, the National Academies has continued this work by issuing publications related to disease transmission, preventative measures, vaccinations, and more that can inform the public response to the pandemic. *Critical Findings on COVID-19* includes summaries and highlights of many of our key publications on COVID-19, including consensus study reports, workshop and webinar proceedings, and rapid expert consultations.

Non-COVID-19 Updates

Asian Pacific Heritage Month: Today, Department of Health and Human Services (HHS) Secretary Xavier Becerra kicked off Asian Pacific Heritage Month by announcing that HHS will be partnering with select, national organizations the first week in May to support and enhance outreach and enrollment efforts for this population during the HealthCare.gov Special Enrollment Period (SEP). During the Asian American and Pacific Islander (AAPI) Week of Action, which runs May 3-7, 2021, HHS and partnering organizations

will provide education and enrollment assistance to AAPI consumers and use social media to encourage them to enroll in affordable, quality health coverage available through HealthCare.gov. An estimated 197,000 uninsured Asian Americans, Native-Hawaiian and other Pacific Islanders are eligible to save money on health care coverage, and an estimated 50,000 will be eligible for zero-premium Marketplace plans after subsidies, as a result of the American Rescue Plan Act of 2021 (ARP). ARP has increased tax credits available to consumers, helping to reduce premiums and giving consumers access to affordable health care coverage. More than 800,000 Americans have already signed up for health coverage since the SEP was made available on HealthCare.gov on Feb. 15, 2021.

Ebola Outbreak Over in the Democratic Republic of the Congo: Today the U.S. Centers for Disease Control and Prevention (CDC) and the global health community mark the end of the Ebola outbreak in North Kivu Province, Democratic Republic of the Congo (DRC). The DRC Ministry of Health (MOH) and the World Health Organization made the declaration after reaching 42 days with no new cases following the last survivor testing negative and being discharged from an Ebola treatment unit. This Ebola outbreak, DRC's 12th, was announced on February 7, 2021.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Subject:	HHS COVID-19 Update - 6/22
Date:	2021/06/22 19:54:51
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Type:	Note

Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for June 22, 2021:

Highlights from the White House COVID-19 Response Team Briefing

Jeff Zients

- **Biden's July 4th Call for Independence:** In March, the one-year anniversary of the start of the pandemic and less than two months after taking office, President Biden provided Americans with an update on the whole-of-government effort he was mobilizing to defeat the virus and set what, at the time, seemed like an audacious goal for the country: Independence from COVID-19 by July 4th. The president was clear on what achieving this very ambitious goal would require. First, we needed to build on the work we began on January 20th, taking additional bold steps to make vaccines even more accessible to all Americans and to further accelerate the pace of vaccinations. Second, we needed every American to do their part. He said that this would *not* mean large crowds with lots of people together, but rather with small groups of close family and friends.
- **Update on COVID-19 Vaccinations:** Since the president took office, COVID-19 cases and deaths are down by over 90%, nearly every state is open for most activities, and the economy is rebounding strongly. For those ages 30 and above, 70% have at least one shot. More than 175 million Americans have rolled up their sleeves and gotten at least one shot. Over 150 million Americans are now fully vaccinated. We got here because the president treated this as a wartime effort, built a whole-of-government response to defeat the pandemic, and mobilized state and local governments, the private and nonprofit sectors, and asked every American to join this fight. In the past 150 days, we went from not having enough supply, to securing enough supply to vaccinate all Americans and making every adult eligible for vaccinations months ahead of expectations. We went from not having enough places to get vaccinated to more than 81,000 convenient vaccination sites. Today, 90% of all Americans live within five miles of a vaccine site. Tens of thousands of sites offer walk-in vaccinations. Thousands are open 24 hours a day on Fridays in June. As a result, we've successfully executed the most complex logistical task: administering 300 million shots in just 150 days.
- **Vaccination Goals and Progress:** We asked Americans, state and local governments, and the private sector to help get to 70% of all adults with at least one shot by July 4th. Sixteen states and the District of Columbia have already met this goal. When the president took office, we had approximately 5% of adults with one shot. In just five months, we've been racing from 5% to

70%. When we began our vaccination campaign, we prioritized the most vulnerable. It's clear from the numbers that this strategy has worked. With respect to the first goal of getting at least one shot to 70% of American adults, already we're at almost 90% for those 65 and over, over 75% for 40 and older, and 70% for 30 and older. We will meet the 70% goal for ages 27 and older by the end of the July 4th weekend, with a few extra weeks needed for the 18- to 26-year-olds to get vaccinated. The second aspirational goal was to have 160 million Americans fully vaccinated by July 4th. In just 5 months, we've grown that number from 3 million to over 150 million fully vaccinated Americans. That represents more than 56% of the adult population. We will hit 160 million Americans fully vaccinated no later than mid-July.

- **Importance of Continued Vaccination:** For all the progress we've made as a nation, individuals who are still unvaccinated are still at risk. We are not leaving anyone behind in our response. We will continue putting equity at the center of everything that we do and focus on helping at-risk and hard-hit communities drive up vaccination rates. We want every American in every community to be protected and free from fear of the virus. That's why we'll keep working to vaccinate more Americans across the summer and into the fall. We are not stopping at 70% and not stopping on July 4th.
- **Global Vaccination Effort:** As we push to get more Americans vaccinated, we're also focused on leading the efforts to vaccinate the world. We're in a position to do so because of our success here at home and because we've secured more than enough supply for all Americans. In the last week alone, we have shipped millions of surplus US doses overseas, including to our neighbors in Mexico and Canada, as well as Taiwan. In total, we have already committed to sharing over 580 million doses and we expect to continue to commit more and more to the world over the summer months as we help lead the fight to end the pandemic across the globe.

Dr. Fauci

- **Threat of Delta Variant:** The transmissibility of the Delta variant is unquestionably greater than the wild-type SARS-CoV-2 and the Alpha variant. It is associated with an increased disease severity as reflected by hospitalization risk compared to Alpha. In lab tests of the Delta variant associated with modest decreased neutralization by sera from previously infected and vaccinated individuals, efficacy is something that has held up. Let's take a look at the U.K. because we have followed the U.K. in so many respects with regard to the Alpha variant. Look at what's happened to the U.K. from February to June (this month). Compared to the Alpha variant, the Delta variant began to dominate the isolates throughout the U.K. to the point where it's well over 95 percent now. The Imperial College of London did a study on over 100,000 homes and found that youth were driving the U.K. surge with a five-fold high of positivity among children 5-12 and young adults 18-24, versus people older than 65 years old. In the United States, as was the case with the Alpha variant, we seem to be following the patterns with the Delta variant. On May 8th, the Delta variant accounted for 1.2 percent of the isolates. A couple of days ago, 20.6 percent of the isolates are Delta.
- **Vaccine Efficacy to the Delta Variant:** The effectiveness of the vaccine, and in this case two weeks after the second dose of Pfizer-BioNTech, is 88 percent effective against the Delta and 93 percent effective against the Alpha when you're dealing with symptomatic disease. When you look at hospitalizations again, both the Pfizer-BioNTech and the Oxford-AstraZenca are between 92 and 96 percent effective against hospitalizations. If you put all of these things together, you come to what we would call a self-evident conclusion. Similar to the situation in the U.K, the Delta variant is currently the greatest threat in the U.S. to our attempt to eliminate COVID-19.

The good news is that our vaccines are effective against the Delta variant. Conclusion: we have the tools so let's use them and crush the outbreak.

Dr. Walensky

- **Case Update:** Yesterday CDC reported 9,860 new cases of COVID-19 and our seven-day average is about 10,350 cases per day. This represents a decrease of nearly 18 percent from the prior seven-day average and is the lowest seven-day average since March 25th, 2020. The seven-day average of hospital admissions is about 1,790 per day, a decrease of about 14 percent from the prior seven-day period. The seven-day average of daily deaths have also declined to 273 per day.
- **Importance of Getting Vaccinated and the Delta Variant:** COVID-19 vaccines are available for everyone ages 12 and up. They are nearly 100 percent effective against severe disease and death, meaning nearly every death due to COVID-19 is particularly tragic because nearly every death, especially among adults due to COVID-19, is preventable. This new virus forced too many of our families to accept death as its outcome for too many of our loved one. But now this should not be the case. As more Americans have rolled up their sleeves to get vaccinated, we have chipped away at the ability of the COVID-19 virus to cause more illness and more suffering. As I've often said, this virus is opportunist. As long as there are those who are not vaccinated, COVID-19 will remain a threat. CDC continues to follow the prevalence of the Delta variant of COVID-19. In the last two weeks, the prevalence of cases resulting from the Delta variant has doubled to just over 20 percent. This is concerning but expected knowing what we do about how efficiently this variant spread and by what we saw in the United Kingdom with this variant. We know our vaccines work against this variant; however, we know this variant represents a set of mutations that could lead to mutations that evade our vaccine. That's why it's more important than ever to get vaccinated now to stop the chain of infection, the chain of mutations that could lead to a more dangerous variant.
- **Post COVID Conditions:** While not everyone with COVID-19 may require hospitalization at the time of their infection, one of the unfortunate outcomes of COVID-19 is something known as post COVID conditions or long COVID. Post COVID conditions are an umbrella term for the wide range of physical and mental health problems that occur four or more weeks after being infected with COVID-19. Current research suggests that up to 20 percent of people are reporting post COVID condition symptoms, but additional research is needed and is ongoing with funding from NIH and CDC. Even people who did not have symptoms when they were infected, can have post COVID conditions. Symptoms vary and may include fatigue, brain fog, headache, loss of smell or taste, dizziness on standing, heart palpitations, chest pain, difficulty breathing, cough, joint or muscle pain, depression and anxiety, and insomnia. These symptoms can persist for weeks or months after first being infected with the virus that causes COVID-19 or appear weeks after infection.
- **Post COVID Conditions *MMWR:*** A recent study published in *MMWR* found that two out of three adults who had COVID-19 and were not hospitalized from their initial illness went on to have at least one outpatient visit for symptoms such as chest or throat pain, shortness of breath, or fatigue and cough one to six months after they were initially diagnosed with COVID-19. The study also found that more than one in three patients had to be referred to specialist such as doctors that specialize in pulmonology, neurology, cardiology, and behavioral mental health. In other words, even patients who were not hospitalized for COVID-19 infection were commonly referred for additional evaluation for COVID-19 related symptoms and conditions after their initial illness. We have seen post COVID conditions for people of all ages, and this makes it even

more important for anyone who is eligible to get vaccinated. There are many benefits of vaccination including preventing serious illness and death, but also the kind of long-term effects associated with post COVID conditions. I invite you to visit the CDC website to review new information to help healthcare professionals evaluating caring for patients with post COVID conditions. CDC is continuing to work to identify how long these longer-term effects are, who is most likely to get them, and whether symptoms eventually resolve. Multiyear studies are also underway that will help us better understand post COVID conditions and help us treat patients with these longer-term effects.

Dr. Murthy

- **COVID-19 College Challenge:** We've made remarkable progress in the last six months to get people vaccinated, and our work isn't done yet especially among young adults, 18-29-year olds. Today I want to talk about what we've been doing to increase our efforts to connect with them and to ensure that they can and should get vaccinated. First, we focused on connecting directly with students in this age group through the COVID-19 College Challenge that was launched for the Month of Action. Colleges and universities are now taking part in pledge to commit to take action to get their students and communities vaccinated. Over 700 colleges and universities have already signed the pledge, and last week we launched the Student Community Corps where students participate in bi-weekly calls to learn best practices and hear from their peers about how they can talk to friends, family members, and other community members about getting vaccinated.
- **Company Incentives for Young People:** Second, we've also partnered with companies nationwide who are offering incentives for young people. This includes major sports leagues, which are offering discounts and ticket giveaways, Spotify, which has launched a sweepstakes giveaway for tickets to independent music venues, and stores, that are now offering free items when a customer shows their vaccination card. As of today, Walgreens is giving every person who comes in to get a vaccine between now and July 4th, a $25 gift card.
- **Combatting Misinformation:** Third, we also know that misinformation continues to be rampant on many online platforms young people visit which is why we're meeting them there with accurate information through trusted messengers about the COVID-19 vaccine. We've launched media campaigns to reach different communities within this age group including our Digital Day of Action, which reached more than 280 million people across Facebook, Twitter, and Instagram plus celebrity PSAs on more than 850 radio stations. We've organized Instagram lives with influencers, and a YouTube Town Hall where influencers and creators are in conversation with public figures and doctors, including those of us on this press conference and President Biden. We're also meeting gamers where they are. Riot games has been airing vaccine.gov PSAs on their e-game livestreams and is working on other ways to connect with young people on video game platforms.

Testing and Treatment

FDA Warning Letter to Umbrella: As part of the FDA's effort to protect consumers, on May 18, 2021, the agency issued a warning letter to Umbrella for selling an unapproved product with unproven COVID-19 claims. Consumers concerned about COVID-19 should consult with their health care provider.

FDA Testing Updates: As of today, 388 tests and sample collection devices are authorized by the FDA under emergency use authorizations (EUAs). These include 278 molecular tests and sample collection devices, 82 antibody and other immune response tests and 28 antigen tests. There are 52 molecular authorizations and one antibody authorization that can be used with home-collected samples. There is one molecular prescription at-home test, three antigen prescription at-home tests, five antigen over-the-counter (OTC) at-home tests and two molecular OTC at-home tests. The FDA has authorized 11 antigen tests and three molecular tests for serial screening programs. The FDA has also authorized 541 revisions to EUA authorizations.

Guidance for Reporting SARS-CoV-2 Sequencing Results: CDC released updated guidance for reporting SARS-CoV-2 sequencing results. The guidance provides clarification on how laboratories may report sequencing results to patients and providers in compliance with CLIA. The guidance also adds 96895-8 as the preferred LOINC code to report sequencing results by molecular genetic methods and 98062-3 as the preferred code to identify sequencing studies.

Funding

Marketplace Assister Programs Accepting Applications and Deadlines Approaching: The Centers for Consumer Information and Insurance Oversight (CCIIO) is currently accepting applications for the Navigator Grant (deadline July 6th) and Certified Application Counselor Designated Organization (CDO) programs (deadline August 31st). View the Notice of Funding Opportunity here, (search for CFDA # 93.332) and the Frequently Asked Questions on the grant process here. For an overview of the CAC Program and application information, visit the technical assistance page of Marketplace.cms.gov.

FEMA Funeral Assistance Funding: FEMA has provided nearly $364 million to 54,000 people for COVID-19 related funeral costs. Find state-specific application numbers, amounts approved, and number of awards here.

Reopening Guidance:

Cruise Ship Color Status: CDC updated their information regarding cruise disembarkations through commercial travel. Ships that request the use of commercial travel for disembarking crew members will need to meet specific criteria. CDC updated their list of cruise ships operating or planning to operate in U.S. waters during the initial phases of the Framework for Conditional Sailing Order.

Information for Specific Populations

Considerations for Food Pantries and Food Distribution Sites: CDC updated their guidance for food distribution sites. The update includes new guidance on cleaning and disinfection, as well as encouraging employees to stay home when sick or in contact with someone suspected of having COVID-19.

Health Equity in Action: CDC updated their information providing a snapshot of some of CDC's work with partners to support communities at higher risk for COVID-19. During the COVID-19 response, CDC continues to focus its health equity efforts on these populations of focus. Visit the CDC COVID-19 Response Health Equity Strategy | CDC to learn more.

COVID-19 Effects Waning Across Defense Department, Pentagon: Pentagon Press Secretary John F. Kirby announced that, by Wednesday, the restrictions on Pentagon personnel that were the result of COVID-19 will lift a bit, providing the ability for more personnel to work in the building and for larger numbers of people to gather in one location. The Pentagon will drop from Health Protection Condition "Bravo-Plus" to HPCON Bravo, beginning June 23rd.

PPE

Wearing Masks as a COVID-19 Community Mitigation Strategy: CDC updated guidance on their monitoring and evaluation guide on wearing masks as a COVID-19 community mitigation strategy. The action guide is developed to help evaluators, program implementers, and policy makers monitor and evaluate wearing masks as a community mitigation strategy. This is not meant for healthcare settings. This guide provides practical considerations and examples of evaluation questions, indicators, and data sources.

FDA's Drug Safety Communication: FDA issued a Drug Safety Communication for hand sanitizers, warning that symptoms such as headache, nausea, and dizziness can occur after applying alcohol-based hand sanitizers to the skin and inhaling the vapors that linger. FDA reviewed case reports submitted to FDA and cases from calls to U.S. poison control centers of adverse events after applying alcohol-based hand sanitizers to the skin. While the majority of cases resulted in minor or minimal effects, some cases resulted in treatment by a health care professional. These reports have occurred after the start of the COVID-19 pandemic. Consumers should use hand sanitizer in a well-ventilated area.

Research

How Immunity Generated from COVID-19 Vaccines Differs from an Infection: NIH Director Francis Collins comments on the relative length of COVID-19 neutralizing antibody generation based on means of immunity. Now, a new NIH-supported study shows that the answer to this question will vary based on how an individual's antibodies against SARS-CoV-2 were generated: over the course of a naturally acquired infection or from a COVID-19 vaccine. The new evidence shows that protective antibodies generated in response to an mRNA vaccine will target a broader range of SARS-CoV-2 variants carrying "single letter" changes in a key portion of their spike protein compared to antibodies acquired from an infection. These results add to evidence that people with acquired immunity may have differing levels of protection to emerging SARS-CoV-2 variants. The data provide further documentation that those who've had and recovered from a COVID-19 infection still stand to benefit from getting vaccinated.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Type:	Note

Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for June 9, 2021:

Case Update

New Cases (based on 7-day rolling average)

- **33,207,488** US cases
- **26% decrease** in new cases (7-day average), as of June 7; (was 24% decrease last week)

Testing

- **449,948,356** tests completed (6/9)
- **2.1%** positive test rate as of the week of 5/30 – 6/5 (was 2.3% last week)

Hospitalizations

- **2,242,993** total COVID hospital admissions
- The 7-day average (5/31 – 6/6) number of new confirmed COVID-19 admissions **decreased by 19%** week on week (from 2,791 to 2,258 admissions per day)

Deaths

- **595,301** total US deaths
- The 7-day average (6/1 – 6/7) number of reported deaths **increased by 3%** week on week (from 359 to 370 deaths per day)

Vaccines

- **303,923,667** vaccine doses **administered** (6/8)
- **51.7%** (171.7 million people) of the population has received **1 or more doses** and **42.3%** (140.4 million people) of the population have been **fully vaccinated**
- **86.4%** of adults 65 and older have received **at least 1 dose** and **75.6%** have been **fully vaccinated**

Vaccine Updates

HHS Secretary Xavier Becerra's Statement to Insurers and Providers: Today, HHS Secretary Xavier Becerra issued a statement to COVID-19 vaccination and testing providers and insurers reminding them that COVID-19 testing and vaccinations must be free for patients. A segment of his statement is as follows: "In light of recent reports of consumer cost concerns, I am reminding health care providers of their signed agreements to cover the administration of COVID-19 vaccines free-of-charge to patients,

and group health plans and health insurers of their legal requirement to provide coverage of COVID-19 vaccinations and diagnostic testing without patients shouldering any cost. COVID-19 vaccines and their administration are free for any individual living in the United States, regardless of their insurance or immigration status. Currently, all providers administering COVID-19 vaccines are required to sign the Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Program Provider Agreement. Among other requirements, this agreement states that providers must administer COVID-19 vaccines at no out-of-pocket cost to patients. Furthermore, to ensure no surprise billing, providers may not require that patients have additional medical services to receive their COVID-19 vaccination – nor can they charge any type of fee if COVID-19 vaccination is the sole medical service provided."

Testing and Treatment

Biden Administration Announces U.S. Government Procurement of Merck's Investigational Antiviral Medicine for COVID-19 Treatment: The Biden Administration today announced that the U.S. government will procure approximately 1.7 million courses of an investigational antiviral treatment, molnupiravir (MK-4482), for COVID-19 from Merck, pending emergency use authorization (EUA) or approval from the U.S. Food and Drug Administration (FDA). Molnupiravir (MK-4482) is designed to induce viral genome copying errors to prevent the virus from replicating in the human body, and evidence to date from clinical trials in patients with COVID-19 suggests that molnupiravir may reduce replication of the SAR-CoV-2 virus. This treatment is being evaluated in an ongoing Phase 3 trial for its potential to reduce the risk of hospitalization or death in non-hospitalized patients who have symptoms for five days or less and are at high risk for severe illness. The trial plans to enroll a total of 1,850 patients globally with final data expected in the fall of 2021. This agreement is part of the Biden Administration's whole-of-government approach to develop new COVID-19 treatments and to respond to the health needs of the public through unprecedented partnership between agencies including the U.S. Department of Health and Human Services and the Department of Defense. This approach leverages all expertise and resources available to respond to COVID-19 such as funding the development and manufacturing of therapeutics, including antivirals.

DOD, HHS Award $4.6 Million Contract to DiaSorin Inc. to Increase Production of COVID-19 Tests: BARDA updated their information on the May 28, 2021 announcement that the U.S. Department of Defense (DOD), on behalf of and in coordination with the U.S. Department of Health and Human Services (HHS), awarded a $4.6 million contract to DiaSorin Inc. to increase production capacity of LIAISON SARS-CoV-2 TrimericS IgG serology tests to support the domestic COVID-19 response. The LIAISON SARS-CoV-2 TrimericS IgG antibody test joins the LIAISON SARS-CoV-2 Ag antigen test in the COVID testing portfolio developed by DiaSorin. This industrial base expansion effort will allow DiaSorin Inc. to increase its production capacity of LIAISON SARS-CoV-2 TrimericS IgG tests in its Stillwater, Minnesota, facility from 1.3 million tests per month to 10 million per month by May 2022.

Funding

HRSA Awards Nearly $66 Million to Bolster the Nation's Behavioral Health Workforce for Underserved Communities: Today, the Health Resources and Services Administration (HRSA), announced $22 million in awards to 56 recipients as part of the Behavioral Health Workforce and Education Training (BHWET) Program for Professionals. Thanks to the American Rescue Plan, this brings the total BHWET awards to $66 million for 168 organizations. Recipient organizations will train graduate level students of social work, psychology, and other behavioral and mental health disciplines to work with vulnerable

populations, particularly children, adolescents and transitional-aged youth at risk for behavioral health disorders. Through placements at health centers and other community-based settings, trainees will gain experience working in the underserved communities where behavioral health services are most urgently needed.

Reopening Guidance

Cruise Disembarkations through Commercial Travel: CDC updated their information on cruise disembarkations through commercial travel. Ships that request the use of commercial travel for disembarking crew members will need to meet specific criteria.

Information for Specific Populations

Volviendo a la Vida Normal: Vaccinating the Hispanic Community: HHS released a new episode of their podcast, *COVID-19: Immunity in Our Community,* called "Volviendo a la Vida Normal: Vaccinating the Hispanic Community." Historic and ongoing healthcare disparities -- along with vaccine misinformation -- contribute to a higher rate of vaccine hesitancy in the Hispanic community. In this episode, special guest host and award-winning journalist Maria Elena Salinas explores some of the causes and solutions for vaccine hesitancy among Hispanic Americans. She sits down with Travis Escobar, a Hispanic millennial who had to use patience and compassion to convince his mother to get vaccinated. Then, she speaks with Dr. Eliseo Pérez-Stable, Director of the National Institute on Minority Health and Health Disparities. Together, they discuss the barriers faced by the Hispanic community, and how listeners at home should approach their own friends and family for conversations about the COVID-19 vaccines.

DoD COVID-19 Travel Restrictions Installation Status Update: The Department of Defense updated their COVID-19 installation travel restrictions. The travel restrictions are lifted at 207 of 230 installations (90%). Of the 207 installations with lifted travel restrictions this week, 0 reinstated travel restrictions while 0 lifted restrictions.

Employer Information for Transit Maintenance Workers: CDC updated their information for employers of transit maintenance workers in order to reduce and slow the spread of SARS-CoV-2. The guidance outlines information on creating a COVID-19 workplace health and safety plan, taking action if an employee is suspected or confirmed to have COVID-19, and developing hazard controls using the hierarchy of controls to prevent infection among workers.

Guidance for Correctional and Detention Facilities: CDC updated their guidance on testing in correctional and detention facilities. Specifically, CDC streamlined and clarified diagnostic and screening testing for correctional and detention facilities, and provided further considerations for creating a long-term strategy based on community transmission and capacity for testing. CDC also updated their considerations for modifying COVID-19 prevention measures in correctional and detention facilities in response to declining community transmission. Furthermore, CDC updated their guidance on quarantine duration in correctional facilities. CDC clarified that incarcerated/detained persons who are fully vaccinated and do not have symptoms of COVID-19 do not need to quarantine at intake, after transfer, or following exposure to suspected or confirmed COVID-19. CDC also clarified that

incarcerated/detained persons who are fully vaccinated should continue to be tested for SARS-CoV-2 following exposure to suspected or confirmed COVID-19 or if they develop any symptoms of COVID-19.

Addressing Disaster Vulnerability Among Homeless Populations During COVID-19: *The National Academies of Sciences, Engineering, and Medicine* released a report – *Addressing Disaster Vulnerability among Homeless Populations during COVID-19* – that reviews research on disaster vulnerability, homelessness, the pandemic, and intersecting hazards and disasters. This rapid expert consultation includes considerations for alternative shelter facilities for homeless populations during a disaster; suggestions on how to navigate service reductions and support population-specific needs; and guidance for supporting populations experiencing homelessness in the aftermath of disasters.

Emergency Housing Vouchers Materials: The Department of Housing and Urban Development posted emergency housing voucher materials from previous webinars in response to the COVID-19 pandemic.

CMS Updates

Biden Administration Continues Efforts to Increase Vaccinations: CMS posted a press release today on the Biden Administration's continued efforts to increase vaccinations by bolstering payments for at-home COVID-19 vaccinations for Medicare beneficiaries. As part of President Biden's commitment to increasing access to vaccinations, the Centers for Medicare & Medicaid Services (CMS) today announced an additional payment amount for administering in-home COVID-19 vaccinations to Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach. This announcement further demonstrates continued efforts of the Biden-Harris Administration to meet people where they are and make it as easy as possible for all Americans to get vaccinated. There are approximately 1.6 million adults 65 or older who may have trouble accessing COVID-19 vaccinations because they have difficulty leaving home. To better serve this group, Medicare is incentivizing providers and will pay an additional $35 per dose for COVID-19 vaccine administration in a beneficiary's home, increasing the total payment amount for at-home vaccination from approximately $40 to approximately $75 per vaccine dose. For a two-dose vaccine, this results in a total payment of approximately $150 for the administration of both doses, or approximately $70 more than the current rate.

Research

Case Forecasts: This week's national ensemble predicts that the number of newly reported COVID-19 cases will likely decrease over the next 4 weeks, with 18,000 to 131,000 new cases likely reported in the week ending July 3, 2021. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of new reported cases per week will likely decrease in 45 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported cases are uncertain or predicted to remain stable in the other states and territories. View previous case forecasts.

Hospitalization Forecasts: This week's national ensemble predicts that the number of new daily confirmed COVID-19 hospital admissions will likely decrease over the next 4 weeks, with 400 to 2,800 new confirmed COVID-19 hospital admissions likely reported on July 5, 2021. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of daily confirmed COVID-19

hospital admissions will likely decrease in 30 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported hospital admissions are uncertain or predicted to remain stable in the other states and territories. View previous hospitalization forecasts.

Death Forecasts: This week's national ensemble predicts that the number of newly reported COVID-19 deaths will likely decrease over the next 4 weeks, with 700 to 4,000 new deaths likely reported in the week ending July 3, 2021. The national ensemble predicts that a total of 603,000 to 612,000 COVID-19 deaths will be reported by this date. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of newly reported deaths per week will likely decrease in 12 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported deaths are uncertain or predicted to remain stable in the other states and territories. View previous death forecasts.

BARDA and Dascena, Inc. Partner to Further Advance Machine Learning Software: BARDA is partnering with Dascena, Inc. to expand the use of the company's algorithm-based software to empower clinicians to predict disease severity in COVID-19 patients. This partnership will leverage Dascena's experience in developing improved prediction tools to advance the development of their COViage™ system, which received the U.S. Food and Drug Administration's Emergency Use Authorization (EUA) to predict unstable blood pressure as well as respiratory failure, which requires ventilation in COVID-19 patients. Further clinical and user evaluation of the tool in additional hospitals will aid Dascena in expanding its use and availability across the country.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Subject:	HHS COVID-19 Update - 7/15
Date:	2021/07/15 18:57:17
Priority:	Normal
Type:	Note

Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for July 15, 2021:

Vaccine Updates

U.S. Surgeon General Issues Advisory During COVID-19 Vaccination Push Warning American Public About Threat of Health Misinformation: HHS released a news update that U.S. Surgeon General Dr. Vivek Murthy issued the first Surgeon General's Advisory of this Administration to warn the American public about the urgent threat of health misinformation. Health misinformation, including disinformation, have threatened the U.S. response to COVID-19 and continue to prevent Americans from getting vaccinated, prolonging the pandemic and putting lives at risk, and the advisory encourages technology and social media companies to take more responsibility to stop online spread of health misinformation. Read the Surgeon General's full advisory here and watch the Surgeon's General's statement on health misinformation here.

Funding

Biden-Harris Administration Provides Nearly $144 Million in American Rescue Plan Funds to Support COVID-19 Response Efforts in Underserved Communities: HHS announced that the Biden-Harris Administration provided $144 million in American Rescue Plan funds to address COVID-19 response in underserved communities. As part of the Biden-Harris Administration's ongoing efforts to respond to the COVID-19 pandemic, HHS, through the Health Resources and Services Administration (HRSA), awarded nearly $144 million in American Rescue Plan funding to 102 HRSA Health Center Program look-alikes (LALs) to respond to and mitigate the spread of COVID-19, and enhance health care services and infrastructure in communities across the country. LALs are community-based health care providers that provide essential primary health care services to underserved communities and vulnerable populations but do not otherwise receive HRSA Health Center Program funding.

Reopening Guidance

Communication Resources for Travelers: CDC updated their tools and resources for partners to help travelers protect themselves, their families, and their community. CDC provides toolkits for domestic travelers, airline partners, a COVID-19 Travel Planner, and more.

Cruise Ship Color Status: CDC updated their information regarding cruise disembarkation through commercial travel. CDC implemented the COVID-19 color-coding system for cruise ships to mitigate transmission of COVID-19 onboard. Onboard preventive measures are recommended or required based on ship color status. All cruise ships operating in U.S. waters, or seeking to operate in U.S. waters, must comply with all of the requirements under the CDC Framework for Conditional Sailing Order (CSO) andTechnical Instructions even when outside U.S. waters.

Information for Specific Populations

Emergency Shelters in Disaster Response: CDC released a guidance in Spanish on operational considerations for COVID-19 mitigation measures in low resource settings. The document provides suggestions to assist disaster response shelter management and staff in taking appropriate actions for reducing the possibility of COVID-19 virus spread among shelter staff, volunteers, residents, and visitors before, during, or after a disaster. To view an English version of the guidance (previously released), click here.

Operational Considerations for Schools: CDC released guidance in Spanish, Portuguese, Urdu, and Arabic on the operational considerations in schools for the implementation of measures of COVID-19 mitigation in low-resource settings. This document provides suggestions for mitigating risks for COVID-19 transmission in schools in low-resource international settings and describes considerations associated with each mitigation measure, including considerations for secondary impacts such as food insecurity and exposure to violence and for students who are at high risk for dropping out of school, so that schools may safely resume and sustain operations. The proposals are presented by mitigation practice (respiratory hygiene (use of masks), hand hygiene, and physical distancing). To view an English version of the guidance (previously released), click here.

CMS Updates

2021 Marketplace Special Enrollment Period Report: Yesterday, the Centers for Medicare & Medicaid (CMS) released the 2021 Marketplace Special Enrollment Report. CMS reports that over 1.5 million Americans have signed up for health insurance through HealthCare.gov since February 15, 2021, the start of the 2021 Marketplace Special Enrollment Period (SEP) opportunity became available through HealthCare.gov, through June 30, 2021; with 373,000 consumers signing up for health insurance in the month of June.

Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule: On July 13, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, on or after January 1, 2022. The calendar year (CY) 2022 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation.

CMS Addresses Substance Use, Mental Health Crisis Care for Those with Medicaid: The Centers for Medicare & Medicaid Services (CMS) announced a funding opportunity made possible by the American Rescue Plan (ARP) to help states strengthen system capacity to provide community-based mobile crisis intervention services for those with Medicaid. The $15 million funding opportunity is available to state Medicaid agencies for planning grants to support developing these programs. This funding opportunity provides financial resources for state Medicaid agencies to assess community needs and develop programs to bring crisis intervention services directly to individuals experiencing a mental health or substance use related crisis outside a hospital or facility setting. These services may include screening and assessment, stabilization and de-escalation, and coordination of referrals after the initial treatment.

Proposed Policies for the Medicare Diabetes Prevention Program (MDPP) Expanded Model for the Calendar Year 2022 Medicare Physician Fee Schedule: On Tuesday, the Centers for Medicare & Medicaid (CMS) issued the Calendar Year (CY) 2022 Physician Fee Schedule (PFS) proposed rule. The PFS proposes changes to the Medicare Diabetes Prevention Program (MDPP) expanded model intended to boost supplier enrollment, with a goal of increasing beneficiary participation and access to services that can help them develop and maintain healthy behaviors to prevent onset of type 2 diabetes. CMS anticipates that these proposed changes would make it easier for local suppliers to participate and reach their communities and may allow CMS to perform a more robust evaluation of the expanded model.

CMS Opens National Coverage Determination Analysis on Treatment for Alzheimer's Disease: On Monday, the Centers for Medicare & Medicaid (CMS) opened a National Coverage Determination (NCD) analysis on the treatment for Alzheimer's Disease. The NCD is a process that will allow the agency to carefully review and determine whether Medicare will establish a national Medicare coverage policy for monoclonal antibodies targeting amyloid for the treatment of Alzheimer's disease. This NCD analysis will be applicable to national coverage considerations for aducanumab, which was recently approved by the Food and Drug Administration (FDA), as well as any future monoclonal antibodies that target amyloid for the treatment of Alzheimer's disease. As part of the NCD process, a 30-day public comment period will begin today. CMS will also host two public listening sessions in July to provide an opportunity for public input.

Research

COVID-19 Vaccine Administration, by Race and Ethnicity: CDC released an MMWR on COVID-19 vaccine administration, by race and ethnicity in North Carolina from December 14, 2020 - April 6, 2021. COVID-19 has disproportionately affected Black or African American and Hispanic communities. Among persons vaccinated during March 29–April 6, 2021, compared with December 14, 2020–January 3, 2021, in North Carolina, the proportion who were Black nearly doubled, and the share of vaccine doses administered to Hispanic persons doubled during this period, approaching the proportion of the state population for these groups aged ≥16 years. To promote equitable vaccination coverage, public health officials could consider using U.S. Census tract-level mapping to guide vaccine allocation, promote shared accountability for equitable distribution of vaccines with providers through data sharing, and facilitate community partnerships to support vaccine access.

COVID-19 Vaccination Coverage Among Insured Persons Aged ≥16 Years, by Race/Ethnicity and Other Selected Characteristics: CDC released an MMWR on COVID-19 vaccination coverage among insured persons aged ≥16 years, by race/ethnicity and other selected characteristics in eight integrated health

organizations in the United States from December 14, 2020 - May 15, 2021. Non-Hispanic Black and Hispanic persons experience higher COVID-19–associated morbidity and mortality, yet COVID-19 vaccination coverage is lower in these groups. As of May 15, 2021, 48.3% of persons identified in CDC's Vaccine Safety Datalink aged ≥16 years had received ≥1 COVID-19 vaccine dose and 38.3% were fully vaccinated. Coverage with ≥1 dose was lower among non-Hispanic Black (40.7%) and Hispanic persons (41.1%) than among non-Hispanic White persons (54.6%); coverage was highest (57.4%) among non-Hispanic Asian persons. Continued monitoring of vaccination coverage and efforts to improve equity in vaccination coverage are critical, especially among populations disproportionately affected by COVID-19.

SARS-CoV-2 B.1.617.2 (Delta) Variant COVID-19 Outbreak Associated with a Gymnastics Facility: CDC released an MMWR on the SARS-CoV-2 B.1.617.2 (Delta) variant COVID-19 outbreak associated with a gymnastics facility in Oklahoma from April - May, 2021. This report was released as an *MMWR* Early Release on July 9. The report has been corrected. The SARS-CoV-2 B.1.617.2 (Delta) variant emerged in India and is currently widespread. Evidence suggests that it is potentially more transmissible than other variants. During April 15–May 3, 2021, 47 COVID-19 cases were linked to a gymnastics facility, including 21 laboratory-confirmed B.1.617.2 cases and 26 epidemiologically linked cases. The overall facility and household attack rates were 20% and 53%, respectively. The B.1.617.2 variant is highly transmissible in indoor sports settings and households, which might lead to increased attack rates. Multicomponent prevention strategies including vaccination remain important to reduce the spread of SARS-CoV-2 among persons participating in indoor sports and their contacts.

Acceptability of Adolescent COVID-19 Vaccination Among Adolescents and Parents of Adolescents: CDC released an *MMWR* on the acceptability of adolescent COVID-19 vaccination among adolescents and parents of adolescents within the United States from April 15-23, 2021. This report was released as an *MMWR* Early Release on July 9. Pfizer-BioNTech's COVID-19 vaccine was authorized by the Food and Drug Administration and recommended by the Advisory Committee on Immunization Practices in May 2021 for adolescents aged 12–15 years. In April 2021, 52% of unvaccinated adolescents aged 13–17 years and 56% of parents of unvaccinated adolescents aged 12–17 years reported intent for adolescent COVID-19 vaccination. The most common factors that would increase vaccination intent were receiving more information about adolescent COVID-19 vaccine safety and efficacy. Efforts focusing on effectively communicating the benefits and safety of COVID-19 vaccination for adolescents to the public could help increase adolescent COVID-19 vaccine confidence and vaccination coverage.

Blood Donation Guidelines Get the Green Light: NIH released a study that shows that COVID-19 does not threaten the safety of the US blood supply. Researchers from NHLBI's Recipient Epidemiology and Donor Evaluation Study (REDS) program tested nearly 18,000 samples of donated blood, from supplies that represented more than 250,000 single blood donations, for the presence of SARS-CoV-2, the virus that causes COVID-19. The donations were collected between March and September 2020 in six major metropolitan areas. Only three of those samples came back positive for SARS-CoV-2, all with very low amounts of the virus. The likelihood of a patient receiving blood with trace amounts of SARS-CoV-2 is just 0.001% — a little over 1 in 100,000. This research should also reassure donors that even if they are asymptomatic SARS-CoV-2 carriers, they cannot spread the virus to blood recipients.

Non-COVID-19 Updates

Secretary Becerra's Press Conference in New Hampshire: Today, at a press conference in New Hampshire, Secretary Becerra highlights the importance of investing in the future of American families. The Secretary highlights what HHS is doing to improve the health and well-being of all families in the U.S.

Biden-Harris Administration Launches "Summer Sprint to Coverage" Campaign for Final 30 Days of Special Enrollment Period: HHS released a report that the Biden-Harris administration launched the "Summer Sprint to Coverage," on the heels of health coverage sign ups surpassing two million, the Biden-Harris Administration is launching the "Summer Sprint to Coverage" campaign as part of robust efforts to get more Americans to sign up for health coverage in the final 30 days of the Special Enrollment Period (SEP) on HealthCare.gov. The Centers for Medicare & Medicaid Services (CMS) will spearhead the "Summer Sprint to Coverage" campaign, mobilizing an all-hands effort including integrated paid media placements, increased community outreach, and more to encourage Americans who need coverage to sign up at HealthCare.gov by August 15 for zero-cost or low-cost, quality health insurance. Read President Biden's statement here.

Remarks by President Biden to Mark the Day That Tens of Millions of Families Will Get Their First Monthly Child Tax Credit Relief Payments Thanks to the American Rescue Plan: President Biden spoke today to commemorate the first child tax credit relief thanks to the American Rescue Plan. The Child Tax Credit is awarded as a monthly payment to families making under $150,000 or individuals making under $125,000 while raising children. For every child under the age of six, a parent will get $3,600 a year. For every child 6 to 17, a parent receives $3,000 per year.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Subject:	HHS COVID-19 Update - 7/19
Date:	2021/07/19 20:19:14
Priority:	Normal
Type:	Note

Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for July 19, 2021:

Renewal of Determination That A Public Health Emergency Exists: "As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective July 20, 2021, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, that a public health emergency exists and has existed since January 27, 2020, nationwide."

Highlights from Friday's (7/16) White House COVID-19 Response Team Briefing

Dr. Walensky

- **Case Update:** Yesterday, CDC reported more than 33,000 new cases of COVID-19. Our seven-day average is about 26,300 cases per day, and this represents an increase of nearly 70 percent from the prior seven-day average. The seven-day average of hospital admissions is about 2,790 per day — an increase of about 36 percent from the previous seven-day period. And, after weeks of declines, seven-day average daily deaths have increased by 26 percent to 211 per day.
- **COVID-19 and the Unvaccinated:** There is a clear message that is coming through: This is becoming a pandemic of the unvaccinated. We are seeing outbreaks of cases in parts of the country that have low vaccination coverage because unvaccinated people are at risk. Communities that are fully vaccinated are generally faring well. In the last week, 10 percent of counties have moved into "high transmission risk," and 7 percent of counties have moved into "substantial risk." Those counties most frequently correspond to counties with low vaccination rates. If you are not vaccinated, you remain at risk. Our biggest concern is that we are going to continue to see preventable cases, hospitalizations, and, sadly, deaths among the unvaccinated.
- **Reiterating the Effectiveness of Vaccines:** The good news is that if you are fully vaccinated, you are protected against severe COVID, hospitalization, and death, and are even protected against the known variants — including the Delta variant — circulating in the country. I want to reiterate the importance of getting fully vaccinated. I want to reiterate that the Pfizer and Moderna vaccines are most effective, two weeks after the second dose, with each exceeding 90 percent

effectiveness against severe disease, hospitalization, and death in real-world studies. Not completing the series puts those partially vaccinated at risk of illness.

Dr. Fauci

- **The Delta Variant from a Global Standpoint and in the U.S:** The Delta variant is dominant in the world. There are about 100 countries that have now had the Delta variant detected in them since June 2020. If you look at the average daily prevalence of SARS-CoV-2 Delta variant worldwide, you see the extraordinary surge in the dominance of this variant worldwide. Although Israel has the same issue with the dominance of the Delta strain (as the United States), their hospitalizations have dramatically diminished and are very low. We see it is similar in the U.K. – a dramatic diminution in hospitalizations. As was mentioned in several briefings we've had, we are seeing increment in our own country to the point of now having more than 50 percent dominance and, in some areas of the country, greater than 70 percent. However, there's a slight uptick that we're seeing in hospitalizations in our own country.
- **Vaccines Effective Against the Delta Variant:** We know that the vaccines that are being used in this country, both in lab studies and in clinical effectiveness studies, show the effectiveness of these vaccines against the Delta variant, particularly, and importantly, against hospitalization. The bottom line is that we are dealing with a formidable variant in the Delta variant, as reflected by the data that Dr. Walensky told you, and the extreme vulnerability of people who are not vaccinated, which will account for infections, hospitalizations, and, ultimately, deaths. The message loud and clear that we need to reiterate is that these vaccines continue to provide strong protection against SARS-CoV-2, including the Delta variant.

Jeff Zients:

- **Increase in COVID-19 Cases Among Unvaccinated:** As Dr. Walensky said, as the more transmissible Delta variant continues to spread across the country, we will likely continue to experience an increase in COVID cases in the weeks ahead, with these cases concentrated in communities with lower vaccination rates. In fact, just four states accounted for more than 40 percent of all cases in the past week, with one in five of all cases occurring in Florida alone. And within communities, these cases are occurring primarily among unvaccinated individuals. Unvaccinated Americans account for virtually all recent COVID-19 hospitalizations and deaths. Every American 12 and older, no matter where they live, has vaccines readily available to them. So, if you are unvaccinated, please get vaccinated now. The vaccines work. It's safe, it's free, it's readily available, and it's never been more important.
- **Trusted Messengers in Vaccination Effort:** First and foremost, we continue to vaccinate hundreds of thousands of new people each day — meeting unvaccinated Americans where they are, answering their questions, helping them make up their mind, and making it even easier and more convenient to get a shot as soon as they are ready to do so. We're doing this by entrusting and empowering trusted messengers to have the conversations we know work — whether it's vaccinated people in communities across the country talking directly to their neighbors, sharing their own vaccination journey and answering questions; or it's Olivia Rodrigo using her voice and platform to spread the word. We're working with doctors, pharmacists, employers, educators, and school administrators to bring vaccines to where people are.
- **Addressing Misinformation:** We continue to see efforts to deliberately mislead the American people about the importance of vaccination. Those who peddle and promote these dangerous lies are harming the very people who are most at risk and furthering a pandemic that has already taken more than 600,000 American lives. We are calling on everyone — social media

platforms, news organizations, individual Americans — to call this activity out and to help get the facts out to your friends, families, and communities so that we're protecting our fellow Americans, not purposely putting them in harm's way.

- **Recent Vaccination Progress:** In the past 10 days, 5 million Americans have rolled up their sleeves to get a shot in their arms, and millions more Americans will get vaccinated across the summer months. Importantly, states with the highest case rates are seeing their vaccination rates go up. In fact, in the past week, the five states with the highest case rates — Arkansas, Florida, Louisiana, Missouri, and Nevada — had a higher rate of people getting newly vaccinated compared to the national average.
- **COVID-19 Surge Response Teams:** Our COVID-19 Surge Response Teams are working with governors and local public health officials to provide specific federal resources and capabilities to fight outbreaks due to the spread of the Delta variant. We are already helping many states to identify and address specific needs, including testing, therapeutics, and vaccinations. This week, at the request of the Nevada governor, we are deploying more than a hundred people to the state to help enhance vaccine access and support vaccine outreach efforts. We're providing CDC's technical expertise — including on genetic sequencing, data analysis, and outbreak response — to Missouri to help support the state in its response.
- **COVID-19 Booster Shots:** We continue to be prepared for any and every scenario, including the possibility of booster shots, if and when the science shows they are needed. At this time, the CDC and FDA have said Americans who have been fully vaccinated do not need a booster shot. Independent and rigorous scientific CDC and FDA processes will determine if and when boosters are needed and who might need a booster shot. I want to be clear: The science will guide this. As Dr. Walensky and Dr. Fauci are making clear, this is a question that they are continually evaluating. We are ready for whatever the science tells us. We have secured enough vaccine supply, and, if needed, we will ensure Americans who might need a booster shot are able to get it quickly and easily.

Dr. Murthy

- **Surgeon General's Advisory on Health Misinformation:** Yesterday I issued a Surgeon General's Advisory on the dangers of health misinformation. Surgeon General Advisories are reserved for urgent public health threats. Today we live in a world where misinformation poses an urgent and insidious threat to our nation's health. Health misinformation is false, inaccurate, or misleading information about health according to the best evidence at the time. During this pandemic, health misinformation has led people to resist wearing masks in high-risk settings; to turn down proven treatments — in some cases to turn to unproven treatments – and to choose not to get vaccinated. Simply put, health misinformation has cost us lives.
- **Efforts to Address Health Misinformation:** If we want to address health misinformation, we'll need an all-of-society response, and that's why the advisory has recommendations for everyone. First, we include recommendations for individuals and families. We're asking people to raise their bar for sharing health information by checking sources before they share information to ensure it's backed by credible, scientific sources. We're also asking other organizations to do their part in every sector from health and education, to research and journalism, to philanthropy and government.
- **Misinformation and Technology Companies:** Technology companies must act as well. Technology companies have enabled misinformation to poison our information environment with little accountability to their users. We're asking them to operate with greater transparency,

to modify their algorithms to avoid amplifying misinformation, and to swiftly and consistently take action against misinformation super-spreaders on their platforms.

- **Organizational Response to Misinformation:** Shortly after releasing the advisory, we saw organizations like the Rockefeller Foundation, the Digital Public Library of America, and the American Academy of Pediatrics step up and respond to this call to action by committing their time, resources, and networks to confronting health misinformation. I'm encouraged by these commitments because turning the tide against health misinformation will take all of us. The longer we wait, the more lives we lose.

Vaccine Updates

FDA Accepts Pfizer's Biologics License Application for Pfizer-BioNTech Vaccine: On Friday, as Pfizer has announced the FDA has formally accepted the company's Biologics License Application (BLA) requesting licensure (approval) of the Pfizer-BioNTech COVID-19 Vaccine for the prevention of COVID-19 in individuals 16 years of age and older and has granted the application priority review. Currently, the vaccine is authorized for emergency use to prevent COVID-19 in individuals ages 12 and older. The Prescription Drug User Fee (PDUFA) Goal Date of January 2022 reflects the PDUFA deadline for Priority Review and does not mean approval will not happen before that time. Quite to the contrary, the review of this BLA has been ongoing, is among the highest priorities of the agency, and the agency intends to complete the review far in advance of the PDUFA Goal Date.

COVID-19 Data Tracker Weekly Review: On Friday, the CDC released their COVID-19 data tracker weekly review. CDC updated their data on reported cases, SARS-CoV-2 variants, testing, vaccinations, hospitalizations, and deaths. CDC also posted recent CDC COVID-19 publications. The weekly review contained specific analysis on how the conditions in which people live, learn, work, and play can affect a wide range of health risks and outcomes. Differences in the prevalence of many risks and outcomes differ by metropolitan and non-metropolitan* areas. Long-standing systemic health and social inequities have put some rural residents at increased risk of getting or having severe illness from COVID-19. The COVID-19 cumulative death rate in non-metropolitan areas has exceeded that of metropolitan areas since December 2020.

Percent of Delivered First Vaccine Doses Administered by U.S. States and Territories: CDC updated information regarding percentage of COVID-19 first vaccine doses administered. As part of the National Strategy for the COVID-19 Response and Pandemic Preparedness, CDC is committed to making sure that safe, effective vaccines are distributed and administered as quickly as possible. To help to understand vaccine administration CDC has created a map to show the percentage of first doses of vaccines that have been administered in each jurisdiction from their supply. This information can be used to better understand how states are using their supply to initiate vaccination within their community.

Testing and Treatment

FDA's New Product Codes: FDA announced that it has created new product codes for certain medical devices authorized for emergency use under Emergency Use Authorizations (EUAs). An applicable product code has been assigned to each authorized device category. The product codes are listed in the

tables for each category of devices that have EUAs. The categories of devices are available on the Coronavirus Disease 2019 (COVID-19) Emergency Use Authorizations for Medical Devices page.

FDA Testing Updates: FDA released new testing updates. As of Friday, 396 tests and sample collection devices are authorized by the FDA under emergency use authorizations (EUAs). These include 281 molecular tests and sample collection devices, 85 antibody and other immune response tests and 30 antigen tests. There are 52 molecular authorizations and one antibody authorization that can be used with home-collected samples. There is one molecular prescription at-home test, three antigen prescription at-home tests, five antigen over-the-counter (OTC) at-home tests and two molecular OTC at-home tests. The FDA has authorized 11 antigen tests and seven molecular tests for serial screening programs. The FDA has also authorized 576 revisions to EUA authorizations.

Risk for COVID-19 Infection, Hospitalization, and Death By Age Group: CDC updated information for the risk for COVID-19 infection, hospitalization, and death by age group. The update applies new data to keep figures current. All rates are relative to the 18- to 29-year-old age category.

Risk for COVID-19 Infection, Hospitalization, and Death By Race/ Ethnicity: CDC updated information for the risk for COVID-19 infection, hospitalization, and death by race/ ethnicity. The update applies new data to keep figures current. Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers.

Funding

HHS Announces $103 Million from American Rescue Plan to Strengthen Resiliency and Address Burnout in the Health Workforce: HHS announced on Friday, through the Health Resources and Services Administration (HRSA), the availability of an estimated $103 million in American Rescue Plan funding over a three-year period to reduce burnout and promote mental health among the health workforce. These investments, which take into particular consideration the needs of rural and medically underserved communities, will help health care organizations establish a culture of wellness among the health and public safety workforce and will support training efforts that build resiliency for those at the beginning of their health careers.

FEMA COVID-19 Funeral Assistance Tops $700 Million: FEMA announced that it has provided over $710 million to more than 107,000 people to assist with COVID-19-related funeral costs for deaths occurring on or after Jan. 20, 2020. Nearly 2,500 dedicated personnel continue to work with applicants to manually review every application and determine eligibility each week. Eligibility determinations are not driven by state/location; instead, they are based on when the applicant submits all required documentation. Additional information about COVID-19 funeral assistance, including frequently asked questions, is available on FEMA.gov.

Reopening Guidance

COVID-19 Travel Recommendations by Destination: CDC updated information on travel recommendations by country during the pandemic. The page provides up-to-date COVID-19 travel guidance by location.

Cruise Ship Color Status: CDC updated their information regarding cruise disembarkation through commercial travel. CDC implemented the COVID-19 color-coding system for cruise ships to mitigate transmission of COVID-19 onboard. Onboard preventive measures are recommended or required based on ship color status. All cruise ships operating in U.S. waters, or seeking to operate in U.S. waters, must comply with all of the requirements under the CDC Framework for Conditional Sailing Order (CSO) and Technical Instructions even when outside U.S. waters.

Information for Specific Populations

Interim Public Health Recommendations for Fully Vaccinated People: CDC updated their interim guidance for fully vaccinated individuals. Specifically, CDC updated considerations for people who are immunocompromised. People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and to follow current prevention measures (including wearing a mask, staying 6 feet apart from others they don't live with, and avoiding crowds and poorly ventilated indoor spaces) to protect themselves against COVID-19 until advised otherwise by their healthcare provider.

Title 42 Order Reassessment and Exception for Unaccompanied Non-Citizen Children: On Friday, CDC issued an Order confirming the exception for unaccompanied noncitizen children (UC) from the Order suspending the right to introduce certain persons into the United States (U.S.). In October 2020, CDC issued an Order (replacing an Order issued in March 2020), suspending the right to introduce covered noncitizens into the United States who would otherwise be introduced into a congregate setting at ports of entry (POE) or Border Patrol stations at or near the U.S. borders into the United States in order to protect the public health from an increase in risk of the introduction of COVID-19. Read more on COVID-19 laws and regulations here.

When You've Been Fully Vaccinated: CDC updated their information for individuals for when they have been fully vaccinated. Included are updates to the "What We Know" section of the page. COVID-19 vaccines are effective against variants of the virus that causes COVID-19, currently circulating in the United States including the Delta variant. People with weakened immune systems, including people who take immunosuppressive medications, may not be protected even if fully vaccinated.

Families with Vaccinated and Unvaccinated Members: CDC released information for families with both vaccinated and unvaccinated members. The information contains tips on how to protect an unvaccinated child or an immunocompromised family member from COVID-19. CDC also includes information on which activities are safer than others and how to navigate having members who are unvaccinated in a family.

Staffing Resources: CDC updated their information on CDC COVID-19 response staff deployed across America. A total of 571 CDC staff are currently working in state, tribal, local, and territorial health agencies.

New Partnership to Promote the Safety and Health of Temporary Workers: The National Institute for Occupational Safety and Health (NIOSH), which is part of the U.S. Centers for Disease Control and Prevention (CDC), and the American Staffing Association (ASA), are pleased to announce a five-year

partnership agreement to advance the protection of temporary workers, those who are paid by a staffing company and assigned to work for a host employer company. The new partnership will ensure the promotion of best practices, support the application of research to practice, and encourage staffing companies and host employers to develop and utilize safety and health management programs and effective prevention strategies and technologies. Throughout the COVID-19 pandemic, NIOSH and ASA, along with other representatives from the NORA Services Sector Council, have been working together to ensure temporary workers doing essential work are afforded the same protections and access to vaccines as non-temporary workers doing the same or similar work.

CMS Updates

CMS Proposes Rule to Increase Price Transparency, Access to Care, Safety and Health Equity: The Centers for Medicare & Medicaid Services (CMS) is proposing actions to address the health equity gap, ensure consumers have the information they need to make fully informed decisions regarding their health care, improve emergency care access in rural communities, and use lessons learned from the COVID-19 pandemic to inform patient care and quality measurements. In accordance with President Biden's Competition Executive Order, CMS is further strengthening its efforts to increase price transparency, holding hospitals accountable and ensuring consumers have the information they need to make fully informed decisions regarding their health care. Read the fact sheet on CY 2022 Medicare Hospital OPPS and ASC Payment System Proposed Rule here.

Research

COVID-19 Vaccination Coverage Among Insured Persons Aged ≥16 Years, by Race/Ethnicity and Other Selected Characteristics: CDC released an *MMWR* on COVID-19 vaccination coverage among insured persons aged ≥16 years, by race/ethnicity and other selected characteristics in eight integrated health organizations in the United States from December 14, 2020 - May 15, 2021. This report was released as an *MMWR* Early Release on July 15. Non-Hispanic Black and Hispanic persons experience higher COVID-19–associated morbidity and mortality, yet COVID-19 vaccination coverage is lower in these groups. As of May 15, 2021, 48.3% of persons identified in CDC's Vaccine Safety Datalink aged ≥16 years had received ≥1 COVID-19 vaccine dose and 38.3% were fully vaccinated. Coverage with ≥1 dose was lower among non-Hispanic Black (40.7%) and Hispanic persons (41.1%) than among non-Hispanic White persons (54.6%); coverage was highest (57.4%) among non-Hispanic Asian persons. Continued monitoring of vaccination coverage and efforts to improve equity in vaccination coverage are critical, especially among populations disproportionately affected by COVID-19.

COVID-19 Vaccine Administration, by Race and Ethnicity: CDC released an *MMWR* on COVID-19 vaccine administration, by race and ethnicity in North Carolina from December 14, 2020 - April 6, 2021. This report was released as an *MMWR* Early Release on July 15. COVID-19 has disproportionately affected Black or African American and Hispanic communities. Among persons vaccinated during March 29–April 6, 2021, compared with December 14, 2020–January 3, 2021, in North Carolina, the proportion who were Black nearly doubled, and the share of vaccine doses administered to Hispanic persons doubled during this period, approaching the proportion of the state population for these groups aged ≥16 years. To promote equitable vaccination coverage, public health officials could consider using U.S. Census tract-level mapping to guide vaccine allocation, promote shared accountability for equitable distribution

of vaccines with providers through data sharing, and facilitate community partnerships to support vaccine access.

Acceptability of Adolescent COVID-19 Vaccination Among Adolescents and Parents of Adolescents: CDC released an *MMWR* on the acceptability of adolescent COVID-19 vaccination among adolescents and parents of adolescents within the United States from April 15-23, 2021. This report was released as an *MMWR* Early Release on July 9. Pfizer-BioNTech's COVID-19 vaccine was authorized by the Food and Drug Administration and recommended by the Advisory Committee on Immunization Practices in May 2021 for adolescents aged 12–15 years. In April 2021, 52% of unvaccinated adolescents aged 13–17 years and 56% of parents of unvaccinated adolescents aged 12–17 years reported intent for adolescent COVID-19 vaccination. The most common factors that would increase vaccination intent were receiving more information about adolescent COVID-19 vaccine safety and efficacy. Efforts focusing on effectively communicating the benefits and safety of COVID-19 vaccination for adolescents to the public could help increase adolescent COVID-19 vaccine confidence and vaccination coverage.

SARS-CoV-2 B.1.617.2 (Delta) Variant COVID-19 Outbreak Associated with a Gymnastics Facility: CDC released an *MMWR* on the SARS-CoV-2 B.1.617.2 (Delta) variant COVID-19 outbreak associated with a gymnastics facility in Oklahoma from April - May, 2021. This report was released as an *MMWR* Early Release on July 9. The SARS-CoV-2 B.1.617.2 (Delta) variant emerged in India and is currently widespread. Evidence suggests that it is potentially more transmissible than other variants. During April 15–May 3, 2021, 47 COVID-19 cases were linked to a gymnastics facility, including 21 laboratory-confirmed B.1.617.2 cases and 26 epidemiologically linked cases. The overall facility and household attack rates were 20% and 53%, respectively. The B.1.617.2 variant is highly transmissible in indoor sports settings and households, which might lead to increased attack rates. Multicomponent prevention strategies including vaccination remain important to reduce the spread of SARS-CoV-2 among persons participating in indoor sports and their contacts.

What Severe COVID-19 Does to the Brain: NIH released new research on COVID-19's effects on the brain. Neurological effects were extremely common, appearing in about 80% of patients who had been hospitalized with COVID-19. The most common symptoms reported by patients were headache, which affected 37% of participants, and loss of taste or smell, which affected 26%. The most common neurological problems observed in patients by hospital staff were acute encephalopathy (affecting 49% of patients), coma (17%), and stroke (6%). Patients whose neurological symptoms were observed by hospital staff were more likely to die in the hospital than people with self-reported neurological symptoms — likely because symptoms reported by hospital staff occur in more severe cases of COVID-19. The researchers also found that people with pre-existing neurological conditions such as chronic migraines, brain or nerve diseases, or dementia were more likely to have neurological symptoms of COVID-19 than other people were.

COVID-19 Science Update: On Friday, CDC released their COVID-19 Science Update. This week's issue includes, but is not limited to, research on the following subjects: Persistent symptoms in adult patients one year after COVID-19: a prospective cohort study, REACT-1 round 13 interim report: acceleration of SARS-CoV-2 Delta epidemic in the community in England during late June and early July 2021, COVID-19 outbreak associated with a SARS-CoV-2 P.1 lineage in a long-term care home after implementation of a vaccination program – Ontario, April-May 2021, and Serologic status and toxic effects of the SARS-CoV-2 BNT162b2 vaccine in patients undergoing treatment for cancer.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Subject:	HHS COVID-19 Update - 7/22
Date:	2021/07/22 19:08:40
Priority:	Normal
Type:	Note

Dear Partner:

Nightly COVID-19 Email Update

Beginning next week (July 26), HHS IEA will distribute the nightly COVID-19 email on Mondays and Thursdays. We will continue to inform our stakeholders with updates on vaccines, testing and treatment, funding, new research, and critical guidance. Please reach out to Michael.baker@hhs.gov if you have any questions.

HHS Office of Intergovernmental and External Affairs COVID-19 update for July 22, 2021:

Highlights from the White House COVID-19 Response Team Briefing

Dr. Walensky

- **Case Update:** Yesterday, CDC reported 46,318 new cases of COVID-19. Our seven-day average is at about 37,700 cases per day, and this represents an increase of 53 percent from the prior seven-day average. The seven-day average of hospital admissions is about 35,000 per day — an increase of about 32 percent from the previous seven-day period. The seven-day average of daily deaths has also increased to 237 per day — an increase of about 19 percent from the previous seven-day period.
- **Delta Variant Update:** The Delta variant is spreading with incredible efficiency and now represents more than 83 percent of the virus circulating in the United States. Compared to the virus we had circulating initially in the United States at the start of the pandemic, the Delta variant is more aggressive and much more transmissible than previously circulating strains. It is one of the most infectious respiratory viruses we know of and that I have seen in my 20-year career. If you are not vaccinated, please take the Delta variant seriously. This virus has no incentive to let up, and it remains in search of the next vulnerable person to infect.
- **Addressing Vaccine Skepticism:** If you are still on the fence, if you still have questions about the vaccines, we welcome them. My request to you is this: Ask your questions. Talk to your healthcare provider. Talk to your pharmacist. Talk to your friends and neighbors who have gotten vaccinated and get your questions answered so that you feel comfortable and informed in making this critical decision. And, please, continue to do the things that we know work to protect you and your family until you are fully vaccinated.
- **Vaccination for Previously Infected Individuals:** If you've already had COVID infection, CDC guidance strongly recommends that you get vaccinated. It gives you longer lasting and more

robust protection with the breadth and depth of coverage needed to conquer the variants currently circulating in this country.

- **Vaccine Protection Efficacy:** Being fully vaccinated gives you a high degree of protection against infection and an even a higher degree of protection against severe illness, hospitalization, and death. These vaccines are some of the most effective that we have in modern medicine. Current scientific evidence shows that our current vaccines are working as they did in clinical trials, even against the Delta variant. Importantly, our data showed that infections are much less common in vaccinated people compared to unvaccinated, and most illness in vaccinated individuals is asymptomatic or mild. The most important public health step is to increase the vaccination coverage in all communities in the U.S. and globally.

Dr. Fauci

- **Infection After Full Vaccination:** It is important to remember that infections after vaccination are expected. No vaccine is 100 percent effective. However, even if a vaccine does not completely protect against infection, it usually, if it's successful, protects against serious disease. When you think about vaccines being successful or unsuccessful — i.e. a failure — you really have to look at it in multiple subsets. For example, [look at] one element of a successful vaccine — one in which there's no illness, but there's no replication of the virus, no dissemination of the virus, and clearance of the virus. Then, there is also, within the framework of a successful vaccine, one in which there's no clinical illness, but there is replication of the virus. Another element of a successful vaccine is one in which there might be mild illness that really does not interfere with the function of a person and has mild replication. You have a failure of a vaccine when you haven't prevented the disease caused by the virus or the pathogen in question. In this place, you get substantial replication; you get substantial dissemination; and unless you have a lethal virus that kills the patient, ultimately the virus is cleared from the body.
- **Applying Successful Vaccine Framework to the Delta Variant:** What we're talking about when we talk about infection after vaccination, which is clearly being discussed now in the context of the Delta variant, by no means does that mean that you're dealing with an unsuccessful vaccine. The success of the vaccine is based on the prevention of illness. Even though we are seeing infections after vaccination — referred commonly to as "breakthrough infections" — the effectiveness against severe disease is still substantial, which is, yet again, another argument which all of us say continually, "Get vaccinated. It offers good protection against disease."
- **Efficacy Data of COVID Vaccines:** The data that I've shown you multiple times about the efficacy of the Pfizer BioNTech and the Moderna is this: 95 and 94 percent respectively. Note: It is not 100 percent effective. The same holds true for the J&J, which, in the United States, is 72 percent effective against clinically recognizable disease — not 100 percent effective.

Jeff Zients

- **Efficacy of Vaccines:** Our vaccines work. Fully vaccinated individuals have a high degree of protection against severe illness, hospitalization, and death. While we will see some cases among those who are vaccinated, as to be expected with any vaccine, these cases are generally mild and oftentimes asymptomatic, which is just more proof that the vaccines work. In fact, unvaccinated individuals account for virtually all — 97 percent — of the COVID hospitalizations and deaths in the U.S.
- **Vaccination Metrics:** We have fully vaccinated 162 million Americans, including 80 percent of those most vulnerable — individuals 65 years and older. As a result, we have fundamentally

changed the course of this pandemic. The threat is now predominantly only to the unvaccinated.

- **Inverse Proportionality of Cases and Vaccinations** The data is clear: the case increases are concentrated in communities with low vaccination rates. In fact, the counties with the highest case rates have significantly lower vaccination rates than counties with lower case rates. This week, just three states—Florida, Texas, and Missouri; three states with lower vaccination rates—accounted for 40 percent of all cases nationwide. For the second week in a row, one in five of all cases occurred in Florida alone. Within communities, these cases are primarily among unvaccinated people.
- **Continued Vaccination Efforts:** The third reason we're in a different situation than earlier in the year is that we're continuing to make more progress by increasing the number of vaccinated Americans. Importantly, states with the highest case rates are actually seeing their vaccination rates go up. In fact, in the past week, the five states with the highest case rates — Arkansas, Florida, Louisiana, [Missouri, and] Nevada — had a higher rate of people getting newly vaccinated compared to the national average. For the second week in a row, states with lower vaccination and higher case rates are seeing their vaccination rates grow faster than the national average. People in these states are feeling the impact of being unvaccinated and responding with action. And across the country, in the past 10 days, more than 5.2 million Americans have gotten a shot.
- **Rural Health Clinic Funding:** Today, we are announcing that we are sending $100 million to rural health clinics to support vaccine education and outreach efforts in these communities where we are generally seeing low vaccine uptake. This funding, made possible by the American Rescue Plan, will provide nearly 2,000 rural health clinics the resources they need to better reach unvaccinated Americans in their communities with information about COVID-19 and the vaccines and answers to their questions.
- **COVID-19 Testing and Mitigation Funding:** Last week, we announced $400 million in American Rescue Plan funding for 1,540 small rural hospitals for COVID-19 to increase testing capacity in rural America. Today, as part of our efforts to reach more vulnerable individuals, we're making an additional $1.6 billion investment in American Rescue Plan funding to bolster testing and mitigation measures in high-risk congregate settings, including homeless shelters, mental health and substance abuse treatment centers, domestic violence shelters, and prison systems.
- **COVID-19 Surge Response Teams:** Our COVID-19 Surge Response Teams are also working with governors and local public health officials to identify specific needs on the ground and provide federal resources and support to fight outbreaks due to the spread of the Delta variant. We are now providing CDC's technical expertise, including on genetic sequencing, data analysis, and outbreak response to Missouri, Illinois, and Colorado.
- **FEMA and HHS Efforts to Combat COVID:** FEMA will be deploying mobile vaccination clinics in North Carolina. Today, HHS Secretary Becerra is traveling to Nevada, where we have deployed federal resources and 100 personnel from FEMA and HHS to support local health officials as they work to mitigate the spread of Delta and increase vaccinations.

Dr. Murthy

- **Overview of COVID-19 Cases and Vaccinations:** Cases are down dramatically from their January peak when we were averaging 200,000-plus cases a day. We've gotten more than 161 million people fully vaccinated, which means they have a high degree of protection against COVID-19. Every day, hundreds of thousands of people are still choosing to get vaccinated. One fact that has been proven time and time again during this past year is that vaccines save lives. That's why

99.5 percent of COVID-19 deaths and 97 percent of possible hospitalizations are among the unvaccinated. It's also why nearly every death from COVID-19 is a preventable tragedy.

- **Ongoing Vaccination Efforts through Trusted Messengers:** We are ramping up our work with trusted messengers in key communities. These groups include faith communities from the group Choose Healthy Life, which has worked with powerful networks of 48 Black churches in five cities to test and vaccinate people. It also includes the American Muslim and Multifaith Women's Empowerment Council, which has engaged their communities through phone banking, text banking, social media, and door-to-door canvassing. Healthcare professionals have also been stepping up and have had more conversations with patients. We're also continuing to work with the student COVID-19 Community Corps, where students participate in calls to learn best practices and hear from their peers about how they can talk about vaccines with their friends and family and community members .And we're working with platforms like Twitch to answer user questions about the vaccines.
- **Importance of Friends and Family Messaging:** We're also increasingly asking vaccinated people to help get their family and friends vaccinated. The importance of this last item — family and friends talking to family and friends — is underscored by recent data, which found that one out of five adults who were unsure about the vaccine in January have now been vaccinated. When asked what changed their mind, it was talking to family, friends, and their doctors, and seeing that people they knew had been safely vaccinated. We need to keep having these conversations, reminding people that vaccination is still the best way to keep our family and friends safe from the worst outcomes of COVID-19.
- **Addressing Health Misinformation:** The second way that we're gaining ground against the virus is by addressing health misinformation. Last week, I issued a Surgeon General's Advisory to call the nation's attention to the threat of health misinformation. Since then, we've continued to emphasize what individuals can do to stop health misinformation in its tracks. That includes asking everyone to raise their own bar for sharing health information by checking to make sure that it's backed by credible, scientific sources. We're also mobilizing other stakeholders to address misinformation — from technology companies and healthcare professionals, to researchers and community-based organizations. In fact, right after this briefing, my office will be hosting a conversation with community organizations around the country to discuss the steps that they can take to stop the spread of health misinformation. We recognize that equity must be at the center of our work to confront health misinformation and here's why: because unequal access to the healthcare system, education, and technology means that some people have more limited access to accurate information than others. And when those people instead encounter health misinformation, it can worsen their health outcomes, which exacerbates health inequities in what becomes a vicious cycle.

Vaccine Updates

Allergic Reactions and COVID-19 Vaccines: NIH released a report on a future study of COVID-19 vaccines for people who have severe allergic reactions. In a trial sponsored by the National Institute of Allergy and Infectious Diseases, researchers are testing the safety of the Moderna and Pfizer-BioNTech COVID-19 vaccines in people with severe allergies and mast cell disorders. The study will include 3,400 people between the ages of 18 and 69 — 60% with severe allergies or mast cell disorders and 40% without. Each participant will randomly be assigned the Moderna vaccine, the Pfizer-BioNTech vaccine, or a placebo to start. This study will help determine whether and how people with allergic and mast cell conditions can get vaccinated safely. To learn more, click here.

Selected Adverse Events Reported after COVID-19 Vaccination: On Wednesday (7/21) CDC updated their information on selected adverse events reported after COVID-19 vaccination. The update includes new data for deaths following COVID-19 vaccination. More than 339 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through July 19, 2021. During this time, VAERS received 6,207 reports of death (0.0018%) among people who received a COVID-19 vaccine.

Director of FDA's CBER, Peter Marks, M.D., Ph.D. on COVID-19 Vaccine Confidence: FDA released a video from FDA's CBER, Peter Marks, on COVID-19 vaccine confidence. The video stresses how the virus poses a greater risk than the potential risk factors posed by vaccination.

Funding

Biden Administration to Invest More Than $1.6 Billion to Support COVID-19 Testing and Mitigation in Vulnerable Communities: HHSannounced that as part of the Biden-Harris Administration's ongoing COVID-19 response efforts, HHS will invest more than $1.6 billion from the American Rescue Plan to support testing and mitigation measures in high-risk congregate settings to prevent the spread of COVID-19 and detect and stem potential outbreaks. As COVID-19 cases rise among unvaccinated people and where the more transmissible Delta virus variant is surging, this funding will expand activities to detect, diagnose, trace, and monitor infections and mitigate the spread of COVID-19 in homeless shelters, treatment and recovery facilities, domestic violence shelters and federal, state and local correctional facilities– some of the hardest hit and highest risk communities across the country.

Biden-Harris Administration Provides $100 Million to Rural Health Clinics for COVID-19 Vaccine Outreach in Their Communities to Increase Vaccinations: HHS announced that it provided nearly $100 million to rural health clinics across the country to support outreach efforts to increase vaccinations in rural communities. The funds will go to more than 1,980 Rural Health Clinics (RHCs) who will use these resources to develop and implement additional vaccine confidence and outreach efforts as many communities face the Delta variant and work to get more people vaccinated and protected from COVID-19 in medically underserved rural communities. The funding was made available by the American Rescue Plan and is being administered by the Health Resources and Services Administration (HRSA) through the Rural Health Clinic Vaccine Confidence (RHCVC) Program.

Reopening Guidance

Cruise Ship Color Status: CDC updated their information regarding cruise disembarkation through commercial travel. CDC implemented the COVID-19 color-coding system for cruise ships to mitigate transmission of COVID-19 onboard. Onboard preventive measures are recommended or required based on ship color status. All cruise ships operating in U.S. waters, or seeking to operate in U.S. waters, must comply with all of the requirements under the CDC Framework for Conditional Sailing Order (CSO) and Technical Instructions even when outside U.S. waters.

Information for Specific Populations

Interim Public Health Recommendations for Fully Vaccinated People: CDC updated its interim guidance for fully vaccinated people. The update includes new language concerning transportation requirements. Wearing a mask over your nose and mouth is required on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and while indoors at U.S. transportation hubs such as airports and stations.

FAQ on Use of Older Americans Act Funding for Incentives: The Administration for Community Living (ACL) released a FAQ on the use of the Older Americans Act Funding for incentives. Within the aging network, incentives can be a useful tool. When used thoughtfully, they can increase the success of many programs. The purpose of this FAQ is to provide Older Americans Act (OAA) grantees with a basic understanding of the most common types of incentives and how to use them effectively.

HOME COVID-19 Operating Deficit Reserve Workout Resources Now Available: HUD released new HOME COVID-19 operating deficit reserve workout resources. HUD's Office of Affordable Housing Programs (OAHP) has provided three new resources to assist HOME Participating Jurisdictions (PJs) that are providing HOME-funded operating deficit reserves to troubled projects under the waiver authority provided in the April 10, 2020 CPD Memo: Availability of Waivers and Suspensions of the HOME Program Requirements in Response to COVID-19 Pandemic, as amended in a subsequent CPD Memo issued on December 4, 2020. The new resources include: The HOME COVID-19 Operating Deficit Reserve Workout Project File Checklist, the HOME COVID-19 Operating Deficit Reserve Workout Tool, and the HOME COVID-19 Operating Deficit Reserve Workout Tool Tutorial, which walks users through how to complete the workout tool.

CDBG-CV Co-Managing Disaster Recovery and CARES Act Programs Quick Guide Now Available: HUD released on Tuesday (7/20) a quick guide to the CDBG-CV co-managing disaster recovery and CARES Act programs. The CDBG-CV Co-Managing Disaster Recovery and CARES Act Programs Quick Guide summarizes the key similarities and differences between the Community Development Block Grant CARES Act (CDBG-CV) and the CDBG-Disaster Recovery (CDBG-DR) programs and how their allocations can be used together. HUD provides these flexible grants to help cities, counties, and states recover from Presidentially declared disasters. The CDBG-CV and CDBG-DR programs are designed to primarily assist low-income households and areas. The Guide also covers typical activities, economic development opportunities, opportunities to address homelessness, and opportunities to fund public facilities.

Waivers and Alternative Requirements for the Emergency Solutions Grants (ESG) Program Under the CARES Act: HUD released on Monday (7/19) information on waivers and alternative requirements for the Emergency Solution Grants program under the CARES Act. This Notice supersedes Notice CPD-20-08, published on September 1, 2020, and reestablishes the allocation formula and amounts and reestablishes and announces new requirements for the$3.96 billion in funding provided for the Emergency Solutions Grants Program (ESG) under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). These ESG-CV funds must be used to prevent, prepare for, and respond to coronavirus among individuals and families who are homeless or receiving homeless assistance and to support additional homeless assistance and homelessness prevention activities to mitigate the impacts created by coronavirus.

Toolkit for H-2A Employers, Partner Agencies, and Partner Organizations: HHS updated their toolkit for H-2A employers, partner agencies, and partner organizations. The update includes new guidance on

transportation: CDC recommends that travelers who are not fully vaccinated continue to wear a mask and maintain physical distance when traveling.

Health Equity in Action: CDC updated their information on health equity in action in the response to the COVID-19 pandemic. The update includes new spotlights on areas of equity, including engaging faith leaders to protect their congregations and communities and the CDC Foundation Southern Alliance.

Communication Toolkit: CDC updated their community toolkit. CDC added more vaccine resources, including WhatsApp chat about COVID-19 vaccines in Spanish.

Staffing Resources: CDC updated their information on CDC COVID-19 response staff deployed across America. A total of 573 CDC staff are currently working in state, tribal, local, and territorial health agencies.

Research

Changes in Influenza and Other Respiratory Virus Activity During the COVID-19 Pandemic: CDC released an *MMWR* on changes in influenza and other respiratory virus activity during the COVID-19 Pandemic in the United States from 2020 - 2021. Nonpharmaceutical interventions introduced to mitigate the impact of COVID-19 reduced transmission of common respiratory viruses in the United States. Influenza viruses and human metapneumovirus circulated at historic lows through May 2021. In April 2021, respiratory syncytial virus activity increased. Common human coronaviruses, parainfluenza viruses, and respiratory adenoviruses have been increasing since January or February 2021. Rhinoviruses and enteroviruses began to increase in June 2020. Clinicians should be aware of increased circulation, sometimes off season, of some respiratory viruses and consider multi-pathogen testing. In addition to recommended preventive actions, fall influenza vaccination campaigns are important as schools and workplaces resume in-person activities with relaxed COVID-19 mitigation practices.

Non-COVID-19 Updates

Statement by Secretary Becerra on the Swearing-In of Miriam E. Delphin-Rittmon as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA: HHS released a statement on the swearing-in of Miriam E. Delphin-Rittmon. On July 14, 2021, U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra swore in Miriam E. Delphin-Rittmon, Ph.D., as the Assistant Secretary for Mental Health and Substance Use and Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA).

HHS Encourages States to Educate Eligible Immigrants about Medicaid Coverage: Today, HHS announced that it, through CMS issued an informational bulletin to states' Medicaid and Children's Health Insurance Program (CHIP) agencies reaffirming that the 2019 Public Charge Final Rule – "Inadmissibility on Public Charge Grounds" – is no longer in effect and states should encourage their eligible immigrant populations to access public benefits related to health and housing. Consistent with the Department of Homeland Security's (DHS) currently applicable 1999 guidance on public charge inadmissibility, accessing Medicaid benefits, for example, will usually have no bearing on anyone's immigration status. Today's informational bulletin to states emphasizes that the 2019 Rule is no longer in place and underscores DHS's call to action enlisting federal partners to ensure eligible immigrants are informed of these changes and their right to access public benefits like Medicaid, if applicable.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
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Subject:	HHS COVID-19 Update - 7/29
Date:	2021/07/29 22:06:33
Priority:	Normal
Type:	Note

Dear Partner:

Nightly COVID-19 Email Update

Beginning next week (August 2) HHS IEA will distribute the COVID-19 Update email from the HHS IEA mailbox. Please reach out to HHSIEA@hhs.gov if you have any questions.

HHS Office of Intergovernmental and External Affairs COVID-19 update for July 29, 2021:

President Biden Delivers Remarks on the Next Steps in our Effort to Get More Americans Vaccinated and Combat the Spread of the Delta Variant

- **Combatting the Delta Variant:** After months and months of cases going down, we are seeing a spike of COVID cases going up. Why? Because of this new variant called the Delta variant. This is a much different variant than the ones we dealt with previously. It's highly transmissible and it's causing a new wave of cases among those that are not vaccinated. Our experts tell me that cases will go up further before they start to come back down. While our cases are on the rise, we're not likely to see – according to experts – a comparable rise in hospitalizations or deaths in most areas in the country. It's because 164 million Americans are fully vaccinated, including 80 percent of the most vulnerable, our seniors. The vaccines are highly effective, we have enough vaccine for everyone to get vaccinated. Thanks to the American Rescue Plan and the hard work of the American people, we've administered over 325 million vaccination doses in the past six months. We have the tools to prevent this new wave of COVID, from shutting down our businesses, our schools, our society as we saw happen last year.
- **Guided by Science, New CDC Mask Guidance:** On Tuesday, the Center for Disease Control and Prevention, the CDC, announced its new mask recommendation in parts of the country where COVID cases are substantially higher where people didn't get vaccinated, which they define as 50 new cases for every 100,000 people in a week. The CDC recommends you wear a mask when you're in public and when you're indoors like work or in a grocery store. That's true for both the vaccinated and the unvaccinated. Because even if you've been fully vaccinated and protected from severe illness from COVID-19, you could have the Delta variant in your system and spread it to someone who isn't vaccinated. I hope all Americans who live in areas with substantial or high case rates will follow the mask guidance that's being laid down by the CDC. At my direction, all federal personnel and visitors to federal buildings will have to do the same thing. Masking is one defense against the spread of COVID-19.
- **Effectiveness of COVID-19 Vaccines:** We need to get more people vaccinated. Put simply, vaccines are designed to save lives and prevent severe illness. They're highly effective at both.

190 million Americans have had at least one shot. To those folks who have one shot, but not the second, go get the second shot. Even if you are overdue for the second shot, it's not too late. Go get the second shot now. The bottom line is if you're fully vaccinated, you're highly protected from COVID-19.

- **Breakthrough Cases and Booster Shots:** I also know that many of you who are vaccinated are concerned with what's called breakthrough cases. Yes, some fully vaccinated people will still test positive. Some will show some symptoms of COVID-19. That's expected for almost every vaccine there is for other diseases. But breakthrough cases remain rare and almost all are mild cases. In fact, almost all hospitalizations and deaths are among the unvaccinated. I also know many of you are wondering if you'll need a booster shot to add another layer of protection. No American needs a booster now, but if the science tells us that there is a need for boosters, then that is something we'll do. We have purchased all of the supply we need if that was called for.
- **Pandemic of the Unvaccinated:** As more people get vaccinated, we are better protected as a nation to continue reopening safely and responsibly. We are not fully out of the woods yet because what is happening in America right now is a pandemic of the unvaccinated. There are about 90 million Americans who are eligible to get the shot but haven't gotten it yet. As I just mentioned, nearly all of the cases, hospitalizations, and deaths due to COVID-19 today are from unvaccinated people. Last month a study showed that over 99 percent of COVID-19 deaths had been among the unvaccinated. I know people talk about freedom. Your decision to be unvaccinated impacts someone else. Unvaccinated people spread the virus. They get sick and fill up our hospitals and that means if someone else has a heart attack or breaks a hip, there may not be hospital bed for them. If you're unvaccinated, you put your doctors and nurses at risk. With freedom comes responsibility so please exercise responsible judgment. Get vaccinated.
- **Federally Reimbursed Paid Leave for Employers:** Today, I'm laying out additional steps we should be taking to deliver these lifesaving vaccines to more Americans. First, we're going to provide more incentives to encourage unvaccinated Americans to get vaccinated. That starts with paid leave to get the shot. We're still hearing that people are unable to get time off from their employer to get vaccinated. Thanks to the American Rescue Plan the federal government is fully reimbursing any small or medium size business that pays workers with paid time off to get vaccinated. Employers, this costs you nothing. If you haven't given employees paid time off, do it now, please. Today, we're taking this a step further. The Federal government will now reimburse those employers who give their staff time off not only to get themselves vaccinated but also to get their family members vaccinated. That means employers can get reimbursed if they give parents time off with paid leave to take their kids or their own parents to get vaccinated.
- **Increasing Vaccination Incentives:** Secondly, I'm announcing that we will continue the work with states to encourage unvaccinated people to get vaccinated Today, I'm calling on all states and local governments to use funding they have received, including from the American Rescue Plan, to give $100 to anyone who gets fully vaccinated. I know that paying people to get vaccinated might sound unfair to folks who have been vaccinated already but here's the deal: if incentives help us beat this virus, I believe we should use them. We all benefit if we can get more people vaccinated.
- **Requirements for Certain Groups to Get Vaccinated:** In addition to providing incentives to encourage vaccination, it's time to impose requirements on key groups to make sure they are vaccinated. Just this week, we took an important step to protect our veterans. The Department of Veterans Affairs will now require COVID-19 vaccines for doctors and nurses and other healthcare workers who provide medical care for our veterans. Next, since many vaccinations

are required for active duty military today, I'm asking the Defense Department to look into how and when they will add COVID-19 to the list of vaccinations that the armed forces must get. I think this is particularly important because our troops serve in places throughout the world, many where vaccination rates are low, and the disease is prevalent. Next, every federal government employee will be asked to attest to their vaccination status. Anyone who does not attest or is not vaccinated will be required to mask no matter where they work, test one or two times a week to see if they have acquired COVID, social distance, and generally will not be allowed to travel for work. Likewise, today, I am directing my administration to take steps to apply similar standards to all federal contractors. I also commend the National Football League, as they have announced that if there are outbreaks among unvaccinated players and personnel, then the team risks forfeiting games. I urge other sports leagues at every level to take every step they can. Every day more businesses are implementing their own vaccine mandates. The Justice Department has made it clear that it is legal to require COVID-19 vaccines.

- **Getting Children Back to School:** We can, and we must open schools this fall full time. It's better for our children's mental and emotional wellbeing and we can't afford another year out of the classroom. Every school should be open and we're giving them the tools to do so safely. Even in those areas where they have a higher rate of COVID, through the American Rescue Plan, we provided schools billions of dollars to implement safety measures: better ventilation, social distancing, and other measures. Almost 90 percent of educators and school staff are now vaccinated. Additionally, the CDC has provided clear guidance on how all schools can safely protect the kids and bring them back to the classroom: every student wears a mask, it's that simple.
- **Increasing Adolescent Vaccinations**: There's one more thing we need to do. Get more adolescents, ages 12 and up, vaccinated now that they've been cleared. In the past week, the good news is we've seen the average number of 12 to 17-year olds getting vaccinated increase 22 percent per day. Today I'm asking school districts to host one last pop-up vaccination clinic over the coming weeks, for ages 12 and up. We're directing the federal pharmacy program to make that happen. Parents: get your children vaccinated.
- **COVID-19 Hotspot Federal Response:** As we work to vaccinate more Americans, we are prepared for outbreaks in areas where there are unvaccinated people. My administration has made it clear to every governor that more federal resources are available to them. This includes deployment of surge teams, composed of experts from the CDC and the Federal Emergency Management Agency, FEMA. We're going to continue to provide states with more testing, treatments, protective equipment, personnel, and mobile vaccination clinics to stem the surge of the virus among the unvaccinated. We'll help any health system overloaded to cope with a spike in cases and we're ready to do that.

Vaccine Updates

Statement by Jamal Brown, Deputy Pentagon Press Secretary, on COVID-19 Vaccinations: The Department of Defense released the following statement: "The Department of Defense is moving quickly to meet President Biden's commitment to defeat COVID-19, and that includes being able to ensure every member of our civilian and military workforce is protected. "In accordance with the guidance the President issued today, all military and civilian DoD personnel will be asked to attest to their vaccination status. Personnel unable or unwilling to do that will be required to wear a mask, physically distance, comply with a regular testing requirement and be subject to official travel restrictions. "Secretary Austin will also begin consulting our medical professionals, as well as the Joint

Chiefs of Staff, to determine how and when to make recommendations to the President with respect to adding the COVID-19 vaccines to the full list of requirements for military personnel..."

Testing and Treatment

Force Health Protection Guidance (Supplement 15) Revision 2 - Department of Defense Guidance for Coronavirus Disease 2019 Laboratory Testing Services: DOD released a memorandum for the Force Health Protection Guidance (Supplement 15) Revision 2 - Department of Defense Guidance for Coronavirus Disease 2019 Laboratory Testing Services. This memorandum updates previous DoD coronavirus disease 2019 (COVID-19) laboratory testing guidance and rescinds and replaces reference (a). This force health protection (FHP) supplement provides guidance on COVID-19 testing for eligible persons suspected of having contracted COVID-19, and applies Centers for Disease Control and Prevention (CDC) testing guidance in the DoD context. DoD Components will continue to employ clinical diagnostic testing in accordance with this guidance. This guidance also supports the DoD surveillance strategy for the COVID-19 pandemic response with complementary health surveillance activities, screening, asymptomatic testing, and sentinel screening testing surveillance consistent with applicable law and in accordance with reference (b). The memorandum for the Force Health Protection Guidance (Supplement 15) Revision 2 - Department of Defense Guidance for Coronavirus Disease 2019 Laboratory Testing Services can be found here.

Funding

Biden-Harris Administration Provides $121 Million in American Rescue Plan Funds to Increase Vaccinations in Underserved Communities: HHS announced that the Biden-Harris Administration has provided $121 Million in American Rescue Plan funds to support local community-based efforts to increase COVID-19 vaccinations in underserved communities. These awards will go to community-based organizations across the country that are working in their communities to build vaccine confidence, share factual information about vaccines, and answer people's questions about getting vaccinated. This investment is part of the Biden-Harris Administration's commitment to support and empower local trusted voices within communities to help encourage vaccination, protect more people, and save lives. This funding was made available by the American Rescue Plan and is being distributed by the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA).

Information for Specific Populations

Interim Public Health Recommendations for Fully Vaccinated People: CDC updated interim public health recommendations for fully vaccinated people. They updated information for fully vaccinated people given new evidence on the B.1.617.2 (Delta) variant currently circulating in the United States. CDC added information that fully vaccinated people might choose to wear a mask regardless of the level of transmission, particularly if they are immunocompromised or at increased risk for severe disease from COVID-19, or if they have someone in their household who is immunocompromised, at increased risk of severe disease or not fully vaccinated, and added a recommendation for fully vaccinated people who have a known exposure to someone with suspected or confirmed COVID-19 to be tested 3-5 days after exposure, and to wear a mask in public indoor settings for 14 days or until they receive a negative

test result. CDC recommends universal indoor masking for all teachers, staff, students, and visitors to schools, regardless of vaccination status.

Bi-Weekly COVID-19 Update for Indian Country: IHS released a bi-weekly update on COVID-19 in Indian country. The report includes information on U.S. Surgeon General Dr. Vivek Murthy issuing an advisory about the dangers of health misinformation. It also includes a conversation between NIH Tribal Health Research Office Director David R. Wilson, Ph.D., and NIMH Director Joshua Gordon, M.D., Ph.D., where the two discuss some current issues related to mental health in American Indian and Alaska Native Communities. The conversation touches on the large-scale mental health impacts of COVID-19, the importance of suicide prevention, and relevant NIMH research and resources.

Health Equity in Action: CDC updated their health equity information. The update includes new information regarding the CDC's campaign to prevent and control infectious diseases among migrant foreign-born workers in protein-processing industries through a regional demonstration project.

Quarantine and Isolation: CDC updated their information on quarantine and isolation. The update includes new guidance that, while someone who has been fully vaccinated and shows no symptoms of COVID-19 does not have to stay at home after being in close contact with someone with COVID-19, fully vaccinated people should get tested 3-5 days after their exposure, even they don't have symptoms and wear a mask indoors in public for 14 days following exposure or until their test result is negative.

PPE

Guidance on Masking for Fully Vaccinated People: CDC updated their guidance on masking for individuals who have been fully vaccinated. To maximize protection from the Delta variant and prevent possibly spreading it to others, wear a mask indoors in public if you are in an area of substantial or high transmission. This updated language is reflected in the update for the COVID-19 information page, interim public health recommendations for fully vaccinated people, and information for when you've been fully vaccinated.

Updated Mask Guidance for the Pentagon Reservation: DOD announced updated mask guidance for the Pentagon Reservation. Effective immediately, in accordance with CDC guidelines and DoD direction, the Director of Administration & Management has directed that service members, federal employees, onsite contractor employees, and visitors, regardless of vaccination status, must wear a mask in an indoor setting in installations and other facilities owned, leased or otherwise controlled by DoD in the Pentagon Reservation. Further changes will be published in updated guidance for the Pentagon Reservation Health Protection Condition (HPCON). If you do not have a mask, DoD is prepared to provide one at Pentagon Reservation entrances. You can read the guidance memo here.

Research

When Kids Get Sick After COVID-19 Goes Away: NIH released a report that it is following children with MIS-C for five years to understand this COVID-related illness. Called multisystem inflammatory syndrome in children (MIS-C, pronounced by reading the individual letters), the illness can affect the heart and other organs. Researchers with the Long-Term Outcomes after the Multisystem Inflammatory Syndrome in Children (MUSIC) Study are seeking explanations for this mysterious illness and long-term outcomes for children infected with SARS-CoV-2, the virus that causes COVID-19. In children with MIS-C,

the immune system's overreaction causes organs to become inflamed — the same organs that COVID-19 affects.

Science Brief: COVID-19 Vaccines and Vaccinations – Updated: CDC updated a science brief on COVID-19 vaccines and vaccinations. In the update, data were added from studies published since the last update that demonstrate currently authorized mRNA vaccines provide protection against variants of concern, including the Delta strain that is now predominant in the United States. Vaccine effectiveness against hospitalization and death is high for all current SARS-CoV-2 variants; emerging data suggest lower effectiveness against confirmed infection and symptomatic disease caused by the Beta, Gamma, and Delta variants compared with the ancestral strain and the Alpha variant.

Disparities in COVID-19 Vaccination Coverage Among Health Care Personnel Working in Long-Term Care Facilities: CDC released an *MMWR* on disparities in COVID-19 vaccination coverage among health care personnel working in long-term care facilities, by job category, national healthcare safety network in the United States in March 2021. Residents of long-term care facilities (LTCFs) and health care personnel (HCP) who work in these facilities were prioritized for early COVID-19 vaccination. Achieving high coverage in this setting is critical to preventing additional outbreaks. During March 2021, 300 LTCFs reported COVID-19 vaccination coverage for their HCP. COVID-19 vaccination coverage was highest among physicians (75.1%) and lowest among aides (45.6%). Vaccination coverage among aides was lower in facilities located in zip code areas with higher levels of social vulnerability. Additional efforts to improve LTCF immunization practices, build confidence in COVID-19 vaccines, and promote COVID-19 vaccination are needed.

Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage: CDC released an *MMWR* on guidance for implementing COVID-19 prevention strategies in the context of varying community transmission levels and vaccination coverage. This report was released as an *MMWR* Early Release on July 27. COVID-19 vaccines authorized in the United States are effective against severe illness and death from SARS-CoV-2 infection; however, current U.S. coverage is uneven. Implementation of layered prevention strategies reduces SARS-CoV-2 transmission. Given the spread of the highly transmissible Delta variant, local decision-makers should assess the following factors to inform the need for layered prevention strategies across a range of settings: level of SARS-CoV-2 community transmission, health system capacity, vaccination coverage, capacity for early detection of increases in COVID-19 cases, and populations at risk for severe outcomes from COVID-19. Although increasing COVID-19 vaccination coverage remains the most effective means to achieve control of the pandemic, additional layered prevention strategies will be needed in the short-term to minimize preventable morbidity and mortality.

SARS-CoV-2 Infection in Public School District Employees Following a District-Wide Vaccination Program: CDC released an *MMWR* on SARS-CoV-2 infection in public school district employees following a district-wide vaccination program in Philadelphia County, Pennsylvania, from March 21 - April 23, 2021. This report was released as an *MMWR* Early Release on July 23. Vaccination of school staff members has been highlighted as an important strategy to maximize the safety of in-person education of K–12 students this fall. Weekly SARS-CoV-2 antigen screening tests required of all employees returning for in-school instruction in the School District of Philadelphia found a 95% lower percentage of positive test results among persons who reported receipt of 2 doses of COVID-19 mRNA vaccine (0.09%) than among those who were unvaccinated (1.77%). Efforts to promote COVID-19 vaccination among

school staff members before the upcoming 2021–22 school year will be foundational to ensure a safe learning environment.

Case Forecasts: This week's national ensemble predicts that the number of newly reported COVID-19 cases will likely increase over the next 4 weeks, with 200,000 to 1,200,000 new cases likely reported in the week ending August 21, 2021. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of new reported cases per week will likely increase in 5 jurisdictions, which is indicated in the forecast plots below. Trends in numbers of future reported cases are uncertain or predicted to remain stable in the other states and territories.
View previous case forecasts.

Hospitalization Forecasts: This week's national ensemble predicts that the number of new daily confirmed COVID-19 hospital admissions will likely increase over the next 4 weeks, with 4,800 to 20,000 new confirmed COVID-19 hospital admissions likely reported on August 23, 2021. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of daily confirmed COVID-19 hospital admissions will likely increase in 34 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported hospital admissions are uncertain or predicted to remain stable in the other states and territories. View previous hospitalization forecasts.

Death Forecasts: This week's national ensemble predicts that the number of newly reported COVID-19 deaths will likely increase over the next 4 weeks, with 1,800 to 6,900 new deaths likely reported in the week ending August 21, 2021. The national ensemble predicts that a total of 619,000 to 633,000 COVID-19 deaths will be reported by this date. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of newly reported deaths per week will likely increase in 11 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported deaths are uncertain or predicted to remain stable in the other states and territories. View previous death forecasts.

Non-COVID-19 Updates

SAMHSA Awards $250 Million to Improve Community Substance Use Disorder and Mental Health Treatment Services: HHS announced that SAMHSA awarded $250 million to 100 certified community behavioral health centers to improve community substance use disorder and mental health treatment services. Totaling $250 million, including $77 million from the American Rescue Plan (ARP), the grants support the Biden-Harris Administration's priority of addressing the behavioral health needs of Americans—particularly those impacted by the COVID-19 pandemic.

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U.S. Department of Health and Human Services
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Dear Partner:

HHS Office of Intergovernmental and External Affairs COVID-19 update for August 5, 2021:

Highlights from President Biden's August 3rd Remarks on Fighting the COVID-19 Pandemic

- **Delta Variant and Transmissibility:** President Biden stated that because the Delta variant is highly transmissible, it is causing a new wave of cases, accounting for over 80% of cases in the United States today, with a likelihood of an increase in cases in the future. Biden states that the predicted increase is "a largely preventable tragedy that will get worse before it gets better."
- **COVID-19 and Vaccines:** Biden stated that the best way to protect yourself from COVID-19 is to get vaccinated; if vaccinated, it is highly unlikely to get COVID-19 and, if you contract the virus, you will likely experience mild symptoms if any. The data shows that the vast majority of cases, hospitalizations, and deaths due to COVID-19 are from the unvaccinated population. Biden commented, "The best line of defense against the virus is the vaccine... We have a pandemic of the unvaccinated."
- **Data of Increased Vaccination:** Biden reported a 55 percent increase in the average number of new people getting vaccinated every day in the past two weeks, and the highest seven-day total in a month. The eight states with the highest current case rates have seen a doubling of the number of people newly vaccinated each day. Biden declared that "we have to continue our aggressive efforts to vaccinate the unvaccinated."
- **Federal Steps to Incentivize Vaccination:** Biden outlined steps taken by his administration and other government-affiliated organizations to increase vaccinations. Places that have offered $100 to get vaccinated have seen an uptick of 25 percent of daily vaccination rates. Biden reiterated his plan to reimburse small- and medium-sized businesses who give paid time off to their employees to get vaccinated, to work with the Pentagon on adding COVID-19 to required vaccines for troops, and to require healthcare workers in the Department of Veterans Affairs to be vaccinated. Biden stated that these restrictions are "tough, unpopular steps to keep people safe and our economy strong."
- **States' Lack of Action on COVID:** President Biden stated that many states' harmful laws on mask mandates is disappointing and harmful; seven states have both banned mask mandates statewide and in schools while many students are not yet eligible to be vaccinated. The president cited these measures and accompanying low vaccination rates as the cause of the rise of cases, citing Florida and Texas as accounting for a third of all new cases. Biden declared that

"COVID-19 is a national challenge, and we must come together — we have to come together — all of us together, as a country, to solve it."

- **Vaccination Abroad:** Biden stated that a global attack on the virus is in the United States' national interest. New, potentially more dangerous variants (such as the Delta variant) can mutate outside of the United States and threaten the country if a global approach is not taken. Biden highlighted American action in global vaccination, announcing that he will purchase and donate 500 million doses from Pfizer; he also stated that the U.S. has domestically manufactured 110 million doses for global vaccination. Biden reiterated that he's "been very clear-eyed that we need to attack this virus globally, not just at home, because it's in America's self-interest to do so."

Highlights from the White House COVID-19 Response Team Briefing

Jeff Zients

- **Update on Progress in the Fight Against COVID:** Mr. Zients highlighted how, driven by the Delta variant, cases are continuing to rise, especially among the unvaccinated. Zients states that over the past seven days, seven states — among the leaders in unvaccinated percentage — accounted for half of the new cases and hospitalizations despite holding less than a quarter of US population; vaccines are the best way to protect against COVID. Vaccinations are on the rise; the past 24 hours served as the greatest number of vaccinations in a single day since July 3 and the daily average of vaccinations has increased for the fourth week in a row. Zients said that "clearly Americans are seeing the impact of being unvaccinated and unprotected and they respond by doing their part, rolling up their sleeve, and getting vaccinated."
- **Action on Vaccination Requirements:** Mr. Zients reiterated President Biden's call for federal workers and contractors to get vaccinated and notes the further requests for similar requirements in the private sector. Zients stated that over 650 colleges and universities are requiring students and staff on campus to be vaccinated and nationwide, over 100 hospitals and healthcare systems are requiring healthcare professionals to be vaccinated. "America's businesses, large and small, universities and medical schools, and many other institutions are stepping up on vaccination requirements and our message is quite simple: we support these vaccination requirements to protect workers, communities, and the country," Zients said.
- **COVID-19 Surge Response Teams:** Mr. Zients stated that the COVID-19 Surge Response Teams are in 16 states and addressing each state's specific needs, whether that is increased testing, mobile vaccination clinics, or hospital capacity. Zients noted the hundreds of federal employees deployed to the states that are assisting in combatting COVID. "Our whole of government response," Zients said, "will continue its relentless efforts to end this pandemic and deliver progress each and every day."

Dr. Walensky

- **COVID-19 Case Update:** Dr. Walensky stated that on August 3, the CDC reported 103,455 new cases of COVID with a 7-day average of about 89,463 cases per day, representing an increase of 43.3% from last week. Hospitalizations and deaths from this week compared to the last increased significantly; deaths rose 39.3 percent. Walensky stated that 83% of counties within the United States are experiencing moderate or high transmission. Those at high risk remain people who have not yet been vaccinated. Walensky said that "now is the time to get vaccinated. We know these vaccines are working and we know that they save lives."

Dr. Fauci

- **Vaccine Hesitancy and Concern Over Development Speed:** In response to Americans worried about the speed of the development of the vaccine, Dr. Fauci outlined the various ways in which the vaccine is safe and not rushed: the investment of logistics and resources, the decades of prior research (both in platform technology and immunogen), the non-sequential investment in vaccine development, and the reuse of clinical trial sites originally built for HIV and influenza further sped the development. Fauci said that the vaccine "did not go too fast; it was a major investment both in the logistics, the resources, and the clinical and basic research."

Dr. Murthy

- **Vaccine Efficacy:** Dr. Murthy stated that the COVID-19 vaccines protect against the Delta variant, both at reducing the risk of infection and the severity if infected. Murthy said that "breakthrough infections of vaccinated people are the exception, not the rule."
- **Meeting of Living Surgeons General:** Yesterday, Dr. Murthy met with the living former surgeons general to discuss the vaccination effort with equity being at the forefront. The meeting covered health misinformation, ensuring that communities of color and rural areas are not left behind, and engaging with trusted community messengers. Murthy stated that "this gathering of surgeons general reflected the diversity of our nation, and it was emblematic of what we have to do together to defeat the virus."

Testing and Treatment

FDA Testing Updates: As of August 3, 398 tests and sample collection devices are authorized by the FDA under emergency use authorizations (EUAs). These include 279 molecular tests and sample collection devices, 87 antibody and other immune response tests and 32 antigen tests. There are 53 molecular authorizations and one antibody authorization that can be used with home-collected samples. There is one molecular prescription at-home test, three antigen prescription at-home tests, six antigen over-the-counter (OTC) at-home tests and two molecular OTC at-home tests. The FDA has authorized 13 antigen tests and eight molecular tests for serial screening programs. The FDA has also authorized 595 revisions to EUA authorizations.

Funding

FEMA COVID-19 Funeral Assistance Tops $888 Million: FEMA announced that COVID-19 funeral assistance has now increased to over $888 million to more than 135,000 people to assist with COVID-19-related funeral costs for deaths occurring on or after Jan. 20, 2020. The assistance, easing financial stress, comes from the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 and the American Rescue Plan Act of 2021. Eligibility determinations are not driven by state/location; instead, they are based on when the applicant submits all required documentation.

Information for Specific Populations

CDC Issues Eviction Order in Areas of Substantial and High Transmission: CDC announced that Director Dr. Rochelle Walensky signed an order on August 3rd determining the evictions of tenants for failure to make rent or housing payments could be detrimental to public health control measures to slow the spread of SARS-CoV-2, the virus that causes COVID-19. This order will expire on October 3, 2021 and

applies in United States counties experiencing substantial and high levels of community transmission levels of SARS-CoV-2: This temporary protection from eviction in counties with heightened levels of community transmission exists in order to respond to recent, unexpected developments in the trajectory of the COVID-19 pandemic, including the rise of the Delta variant. It is intended to target specific areas of the country where cases are rapidly increasing, which likely would be exacerbated by mass evictions.

CDC Extends Order at the Southern and Northern Land Borders: The Centers for Disease Control and Prevention (CDC) has issued an order under Sections 362 and 365 of the Public Health Service Act, and associated implementing regulations, that temporarily suspends the introduction of certain noncitizens. The order is based on the Director's determination that introduction of such noncitizens, regardless of their country of origin, migrating through Canada and Mexico into the United States creates a serious danger of the introduction of COVID-19 into the United States, and the danger is so increased by the introduction of such noncitizens that a temporary suspension is necessary to protect the public health. Unaccompanied noncitizen children already excepted under a July 16, 2021, order, remain excepted from the order's coverage.

Readout of the Sixth Covid-19 Health Equity Task Force Meeting: HHS released a readout on Friday, July 30's, sixth COVID-19 Health Equity Task Force meeting to consider interim recommendations addressing future pandemic preparedness. Task Force Members discussed and voted favorably on interim recommendations, including but not limited to exploring strategies that meet local and regional staffing needs during pandemic response, expanding adequate and evidence-based healthcare access and funding infrastructure to treat patients in congregate settings, establishing and adjusting national standards as well as strategically target funding for water, sewage, and air quality to where it's needed, based on data from reliable equity indicators.

What to Consider When Planning to Operate a COVID-19 Vaccine Clinic: CDC released information regarding what to consider when planning to operate a COVID-19 vaccine clinic. The informational sheet provides guidance to conduct a gap analysis to determine specific geographic areas and specific populations that may benefit from additional sites to improve access to vaccination, work with community leaders and trusted members of the community to help with the success of vaccination clinics, and assess the optimal time to activate a vaccination site and consider the benefits of focused vaccination efforts. The page also page also provides a checklist of best practices for vaccination clinics held at satellite, temporary, or off-site locations.

Know What to Expect at Your Child's K- 12 School or Child Care Program: CDC released information for parents on what to expect for K-12 school or childcare programs. The page provides information for factors that a child's school or care program may consider, prevention strategies for these programs, and vaccination and masking.

CMS Updates

Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F): CMS announced that, on August 2, 2021, it issued the final rule for fiscal year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The final rule updates Medicare payment policies and rates for operating and capital-related costs of acute care hospitals and for certain

hospitals and hospital units excluded from the IPPS for FY 2022. The policies in this IPPS and LTCH PPS final rule build on key priorities to close health care equity gaps and support greater access to life-saving diagnostics and therapies during the COVID-19 public health emergency (PHE) and beyond. To continue to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments and to minimize any potential payment disruption immediately following the end of the PHE, CMS is extending the New COVID-19 Treatment Add-on Payment for eligible COVID-19 products through the end of the fiscal year in which the PHE ends.

Research

Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings: CDC released an *MMWR* on the outbreak of SARS-CoV-2 infections, including COVID-19 vaccine breakthrough infections, associated with large public gatherings in Barnstable County, Massachusetts in July, 2021. This report was released as an *MMWR* Early Release on July 30. Variants of SARS-CoV-2 continue to emerge. The B.1.617.2 (Delta) variant is highly transmissible. In July 2021, following multiple large public events in a Barnstable County, Massachusetts, town, 469 COVID-19 cases were identified among Massachusetts residents who had traveled to the town during July 3–17; 346 (74%) occurred in fully vaccinated persons. Testing identified the Delta variant in 90% of specimens from 133 patients. Cycle threshold values were similar among specimens from patients who were fully vaccinated and those who were not. Jurisdictions might consider expanded prevention strategies, including universal masking in indoor public settings, particularly for large public gatherings that include travelers from many areas with differing levels of SARS-CoV-2 transmission. CDC Director Rachelle Walensky, MD, MPH, released an accompanying statement on the MMWR.

COVID-19 Vaccine Safety in Adolescents Aged 12–17: CDC released an *MMWR* on COVID-19 vaccine safety in adolescents aged 12–17 in the United States from December 14, 2020 - July 16, 2021. This report was released as an *MMWR* Early Release on July 30. In preauthorization trials of the Pfizer-BioNTech COVID-19 vaccine, adolescents aged 12–17 years reported local and systemic mild and moderate reactions. Myocarditis has been observed after vaccination with mRNA vaccines in post authorization monitoring. Local and systemic reactions after vaccination with Pfizer-BioNTech vaccine were commonly reported by adolescents aged 12–17 years to U.S. vaccine safety monitoring systems, especially after dose 2. A small proportion of these reactions are consistent with myocarditis. Mild local and systemic reactions are common among adolescents following Pfizer-BioNTech vaccine, and serious adverse events are rare. The Advisory Committee on Immunization Practices conducted a risk-benefit assessment and continues to recommend the Pfizer-BioNTech COVID-19 vaccine for all persons aged ≥12 years.

Full-dose Blood Thinners Reduce the Need for Organ Support in Moderately Ill COVID-19 Patients, but Not in Critically Ill Patients: NIH released a report on full-dose blood thinners reducing the need for organ support in moderately ill COVID-19 patients, but not critically ill patients. In April 2020, hospitalized COVID-19 patients received either a low or full dose of heparin, a blood thinner, for up to 14 days after enrollment. By December 2020, interim results indicated that full-dose anticoagulation did not reduce the need for organ support and may even cause harm in critically ill patients. However, one month later, interim results indicated that full doses of heparin likely benefited moderately ill patients. The full study can be viewed here.

Long-Term Study of Brain Development Records Pandemic Life: NIH released a report on the analysis of adolescent brains to examine the long-term health impacts caused by the COVID-19 pandemic and shutdowns. Through surveys and tests, the study, from Adolescent Brain Cognitive Development (ABCD) Study and funded by NIH, is capturing the impact of the COVID-19 pandemic on children using an MRI.

Case Forecasts: This week's national ensemble predicts that 350,000 to 1,800,000 new cases will likely be reported in the week ending August 28, 2021. Over the last several weeks, more reported cases have fallen outside of the forecasted prediction intervals than expected. This suggests that current forecast prediction intervals may not capture the full range of uncertainty. Because of this, case forecasts for the coming weeks should be interpreted with caution. View previous case forecasts.

Hospitalization Forecasts: This week's national ensemble predicts that the number of new daily confirmed COVID-19 hospital admissions will likely increase over the next 4 weeks, with 6,700 to 24,000 new confirmed COVID-19 hospital admissions likely reported on August 30, 2021. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of daily confirmed COVID-19 hospital admissions will likely increase in 38 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported hospital admissions are uncertain or predicted to remain stable in the other states and territories. View previous hospitalization forecasts.

Death Forecasts: This week's national ensemble predicts that the number of newly reported COVID-19 deaths will likely increase over the next 4 weeks, with 2,300 to 9,100 new deaths likely reported in the week ending August 28, 2021. The national ensemble predicts that a total of 624,000 to 642,000 COVID-19 deaths will be reported by this date. The state- and territory-level ensemble forecasts predict that over the next 4 weeks, the number of newly reported deaths per week will likely increase in 17 jurisdictions, which are indicated in the forecast plots below. Trends in numbers of future reported deaths are uncertain or predicted to remain stable in the other states and territories. View previous death forecasts.

Top Military Medical Doctor Predicts Coronavirus Longevity: DoD released a report on the analysis of COVID-19 longevity according to director of Defense Health Agency, Army Lt. Gen. Ronald J. Place. Place stated his belief that COVID-19 and other such coronaviruses likely will stay in the environment and continue to mutate. Vaccines serve as the way to protect oneself from this lingering threat.

Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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Type:	Note

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FOR PLANNING PURPOSES ONLY

Friday, July 16, 2021

HHS Secretary Xavier Becerra To Highlight Biden-Harris Administration Plans to Build Back Better Across Rhode Island

He'll be joined by Governor McKee and Members of the Rhode Island Congressional Delegation

On Friday, July 16, U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra will travel to Rhode Island to highlight Biden-Harris Administration plans to build back better by making bold investments in quality, affordable health care, and home and community-based care.

Joined by Senators Sheldon Whitehouse and Jack Reed, and Representatives David Cicilline and Jim Langevin, Secretary Becerra will begin his day in North Kingstown discussing the American Families Plan, and critical investments in home and community-based care.

After this, Secretary Becerra, Governor Daniel McKee, and the Members of the Rhode Island Congressional Delegation will visit a community health center in Central Falls to discuss the Biden-Harris Administration's "Summer Spring to Coverage" ahead of the

Special Enrollment Period deadline on August 15. Recently, Secretary Becerra announced that more than 2 million Americans have signed up for affordable coverage on HealthCare.gov and state-based marketplaces during the enrollment period.

During the visit to the community health center, Secretary Becerra, Governor McKee, and Members of the Rhode Island Congressional Delegation will hold a media availability where they will discuss the Affordable Care Act, efforts to combat COVID-19 misinformation, and new American Rescue Plan funding for community health centers.

All events will be open press and Secretary Becerra will be available for one-on-one interviews. Timing is subject to change.

LOGISTICAL INFORMATION
Details are subject to change

Home and Community-Based Care Tour and Roundtable

WHO:

Secretary Xavier Becerra

Senator Sheldon Whitehouse

Senator Jack Reed

Representative David Cicilline

Representative Jim Langevin

WHEN: 10:30 AM ET, Friday, July 16, 2021

WHERE: 1130 Ten Rod Road, Suite B201, North Kingstown, RI

Affordable Care Act and Special Enrollment Period Roundtable

WHO:

Secretary Xavier Becerra

Governor Daniel McKee

Senator Sheldon Whitehouse

Senator Jack Reed

Representative David Cicilline

Representative Jim Langevin

WHEN: 12:15 PM ET, Friday, July 16, 2021

WHERE: Blackstone Valley Community Health Center, 1000 Broad St, Central Falls, RI

CONTACT: Press interested in attending any event must RSVP to Kamara.Jones@hhs.gov and zachary.dembner@hhs.gov.

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U.S. Department of Health and Human Services

ALL-HAZARDS EMERGENCY OPERATIONS PLAN
(Re-Aligned, Nov 2019)

DRAFT

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DRAFT

1. Purpose

In the event of a natural or man-made disaster the Department of Health and Human Services (HHS) leads the coordinated Federal mission to provide public health and medical care capabilities to include veterinary and/or animal health issues when appropriate, mortuary services, behavioral health services, and attending to the medical needs of the at-risk populations, primarily as defined in the Public Health Service (PHS) Act and the National Response Framework (NRF), and its Emergency Support Function (ESF) #8 Public Health and Medical Services Annex. The Assistant Secretary for Preparedness and Response (ASPR) coordinates national Public Health and Medical Services actions on behalf of the HHS Secretary.

2. Scope

Public health and medical response to a disaster or emergency event, regardless of cause, will require a coordinated national whole-of-community approach to organize and prioritize prevention, protection, mitigation, response, and recovery; the use of alternative care support; as well as the adjudication and prioritization of resources. These efforts include a coordinated response involving survivors, communities, all levels of government, non-governmental organizations (NGO), private volunteer organizations (PVO) and the private sector industries.

The role of ASPR is to…:

- Lead, coordinate and support Federal public health and medical response and recovery operations for incidents and emergency events.
- Use a phased response approach for response operations.
- Effectively implement public health and medical mission assignments and response actions.

3. Authorities

The ASPR, on behalf of the HHS Secretary, has the authority to take action to prepare for and respond to public health and medical emergencies under several statutes, primarily including the Public Health Service (PHS) Act, Federal Food, Drug and Cosmetic Act, and the Social Security Act.

Federal Statutes, Executive Orders, Presidential Directives, and References

This section lists the Federal statutes, executive orders, presidential directives, and references used to execute Federal Government responsibilities in response to a disaster event.

1. Federal Statutes

- Americans with Disabilities Act (Public Law (Pub. L.)101-336)
- Clean Air Act (42 United States Code (U.S.C.) 7401-7671q)
- Comprehensive Environmental Response, Compensation, and Liability Act (42 U.S.C. 9601-9675)
- Economy Act (31 U.S.C. 1535-1536)
- Endangered Species Act of 1973 (7 U.S.C. § 136, 16 U.S.C. § 1531 et seq., ESA)
- Federal Food Drug and Cosmetic Act (codified at 21 U.S.C. 301, et seq.)
- Federal Hazardous Materials Transportation Law (49 U.S.C. 5101)
- Federal Water Pollution Control Act (33 U.S.C. 1251-1387)
- Homeland Security Act of 2002 (Pub. L. 107-296);)
- National Emergencies Act of 1976 (50 U.S.C. 1601-1651)
- National Environmental Policy Act (Pub. L. 91-190, 42 U.S.C. 4321, 4331-4335)
- National Oil and Hazardous Substances Pollution Contingency Plan (40 CFR 300)
- Native American Grave Protection and Repatriation Act (Pub. L. 101- 601, 104 Stat. 3048
- Occupational Safety and Health Act of 1970 (Pub. L. 91-596, as amended)
- Office of Federal Procurement Policy Act (41 U.S.C. 428a)
- Pandemic and All-Hazards Preparedness Act (Pub. L. 109-417)
- Pets Evacuation and Transportation Standards Act of 2006 (Pub. L. 109-308)
- Post-Katrina Emergency Management Reform Act of 2006 (Pub. L. 109-295)
- Powerplant and Industrial Fuel Use Act of 1978 (42 U.S.C. 8301-8484)
- Public Health Service Act (42 U.S.C. 201, et seq.)
- The Indian Healthcare Improvement Act (Pub. L. 94-437)
- Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121)
- Small Business Act (15 U.S.C. 631-651e)
- Social Security Act (Pub. L. 74-271)
- Superfund Amendments and Reauthorization Act of 1986 (Pub. L. 99-499) and
- Veterans Affairs Emergency Preparedness Act of 2002 (Pub. L. 107-287).

2. Executive Orders and Presidential Directives

- Executive Order 12196, Occupational safety and health programs for Federal employees
- Executive Order 12656, Assignment of emergency preparedness responsibilities
- Federal Continuity Directive – 1, 2017
- Federal Continuity Directive – 2, 2017

- Homeland Security Presidential Directive (HSPD)-5, Management of Domestic Incidents, 2003
- HSPD-7, Critical Infrastructure Identification, Prioritization, and Protection, 2003
- HSPD-10, Biodefense for the 21st Century, 2004
- HSPD-20/National Security Presidential Directive (NSPD)-51 National Continuity Policy, 2007
- HSPD-21, Public Health and Medical Preparedness, 2007
- Presidential Policy Directive (PPD)-1, Organization of the National Security Council System, 2009 and
- Presidential Policy Directive (PPD)-8, National Preparedness, 2011.

3. References

- National Incident Management System (NIMS), October 2017
- National Response Framework (NRF), May 2016
- National Health Security Strategy 2015-2018, and
- National Security Strategy of the United States, December 2017.

4. Situation

A host of potential disasters, regardless of cause, may require national-level public health and medical support. The threat may trigger significant issues relating to environmental and public health needs including mental health services and potential isolation and quarantine, and fatality management services. Medical support may be required at medical facilities, at victim collection and evacuation points, evacuee and refugee points and shelters, and to support field operations and emergency responders. In addition, any contamination dimension may increase the requirement for Federal technical assistance because the impacted public health and medical infrastructure would quickly be taxed.

5. Assumptions and Critical Considerations

The following information represents the planning assumptions and critical considerations used in the development of the HHS All-Hazards Plan. Assumptions and/or considerations that pertain to only a specific core capability or a specific incident/annex are delineated in its respective annex and/or appendix.

Assumptions

Assumptions represent information necessary to continue planning in the absence of fact. During response operations, assumptions are validated as facts when deemed warranted:

a. A catastrophic incident or attack will occur with little or no warning.

b. There is not an additional catastrophic incident(s) occurring.
c. There will be cascading effects associated with the incident.
d. Resources will not reach the entire impacted population.
e. Inter- and intra-state, local, tribal, and territorial mutual aid capabilities will be exhausted.
f. A Presidential Major Disaster Declaration will be issued under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), including concurrent response, recovery, and mitigation activities.
g. The incident response will require specialized equipment and adjustments to processes and procedures, as appropriate to the operational environment.
h. Departments and agencies will coordinate and take action under their own statutory authorities and/or under the Stafford Act as appropriate.
i. Existing Federal department and agency statutory or mission responsibilities will impact the timeliness and capacity of Federal resources.
j. Shared situational awareness of the operational environment will be incomplete.
k. Critical transportation routes and infrastructure will be disrupted by the incident or by secondary effects, such as populace movement and emergency response efforts.
l. Few Federal community-based resources within the impacted area will be able to respond.
m. Deployment-dependent Federal response resources will be unable to arrive and provide significant lifesaving or life-sustaining capabilities until 24 to 72 hours after the incident.
n. Contractor-provided services are limited by the capacity of the private sector to support contract needs.
o. A large number of the affected population will have disabilities or access and functional needs requiring physical, programmatic, and effective communication access.

Critical Considerations

Critical considerations are those elements of information that must be taken into account when developing a plan:

a. Federal departments and agencies are permitted to deploy personnel and resources under their own authority or under the authority of the Stafford Act, if a declaration has been made.
b. Travel restrictions implemented by state, local, tribal, and territorial authorities or the private sector will impact response operations.
c. Personnel deployed by Federal departments and agencies will require temporary housing, food, fuel, sanitation, and water during response operations.
d. Computer and communications systems used within the incident area could potentially include features that preclude Federal, State, local, tribal, and territorial collaboration.
e. Federal departments and agencies are restrained and constrained by statutory authorities.

f. Under the statutory authority of the Stafford Act, the President retains the authority to direct any executive branch department/agency to engage in lifesaving and life-sustaining activities.

6. Roles and Responsibilities

The Secretary of HHS leads the Public Health and Medical response which is coordinated by the ASPR through its Office of Incident Command and Control (OICC). Once activated, public health and medical response functions are initially coordinated by the Secretary's Operations Center (SOC), which then transitions command and control (C2) to the responding Federal Health Coordinating Official (FHCO) and Incident Management Team (IMT). Requests for Federal public health and medical assistance will be submitted to either the SOC or FHCO/IMT depending on the current C2 structure. If HHS requires assistance from other Federal agencies, the SOC will make those requests on behalf of the Secretary. Public health and medical subject-matter experts (including partners representing all appropriate populations, such as pediatric populations, populations with disabilities, the aging, and those with temporary or chronic medical conditions) from HHS and other appropriate organizations are consulted as needed. HHS and its Federal public health and medical partners provide support in the following core functional areas:

Operational Coordination

The Secretary of HHS, through the ASPR, coordinates national – Federal and State, Local, Tribal and Territorial (SLTT) – preparedness, response, and recovery actions. These actions do not alter or impede the existing authorities of any department or agency supporting HHS. Coordination with SLTT authorities is essential in the planning and preparedness phases as well as during the operational response and recovery phase.

Patient Care

Immediate medical response capabilities are provided by assets internal to HHS (e.g., U.S. Public Health Service Commissioned Corps, NDMS, and Federal Civil Service employees) and from ESF #8 supporting organizations.

- HHS may request Department of Defense (DOD) support for casualty clearing and staging, patient treatment, and support services such as surveillance and laboratory diagnostics.
- HHS may seek individual clinical public health and medical care specialists from the Department of Veterans Affairs (VA) to assist SLTT public health and medical personnel.
- HHS may engage civilian volunteers, such as Medical Reserve Corps, to assist SLTT public health and medical personnel.

- HHS may task components to engage Federal civil service personnel, the Officers from the U.S. Public Health Service Commissioned Corps (USPHS), the regional offices, and States to engage civilian volunteers to provide available personnel to support pre-hospital triage and treatment, inpatient hospital care, outpatient services, pharmacy services, to victims who are seriously ill, injured, or suffer from chronic illnesses who need evacuation assistance, regardless of location.

Patient Movement

HHS is responsible for transporting seriously ill (seriously ill describes persons whose illness or injury is of such severity that there is cause for immediate concern, but there is not imminent danger to life) or injured patients and medical needs populations from NDMS- established casualty collection points in the impacted area to designated NDMS safe-haven Federal Coordinating Center (FCC) reception facilities. As reflected in the Patient Movement CONOPS, HHS coordinates the Federal response in support of emergency triage and pre-hospital treatment, patient tracking of NDMS patients, and NDMS patient distribution. This effort is coordinated with Federal, SLTT emergency medical services officials. HHS may request DOD, VA, and DHS/Federal Emergency Management Agency (FEMA), via the national ambulance contract, to provide support for evacuating state-regulated seriously ill or injured patients. Support may include providing transportation assets, and processing and tracking patient movements from collection points to their final destination reception facilities.

Mass Fatality Management

HHS, when requested by SLTT officials, in coordination with its partner organizations, will assist the jurisdictional medico-legal authority and law enforcement agencies in documenting human remains and associated personal effects; reducing the hazard presented by chemical, biological, or radiological contaminated human remains (when indicated and possible); establishing temporary morgue facilities; determining the cause and manner of death; collecting ante-mortem data in a compassionate and culturally competent fashion from authorized individuals; performing postmortem data collection and documentation; identifying human remains using scientific means (e.g., dental, pathology, anthropology, fingerprints, and DNA samples); preparing, processing, and returning human remains and personal effects to the authorized person(s) when possible; providing technical assistance and consultation on fatality management and mortuary affairs. In the event of disinterred/displaced remains, HHS assists in identifying the human remains, re-casketing, and reburial in public cemeteries. HHS may task components and request assistance from other ESF #8 partner organizations, as appropriate, to provide support to families of victims during the victim identification mortuary process.

Assessment of Public Health/Medical Needs

HHS, in collaboration with the Department of Homeland Security (DHS), mobilizes and deploys personnel to support national or regional teams to assess public health and medical needs,

including the needs of at-risk population groups, such as language assistance services for limited English-proficient individuals and accommodations and services for individuals with disabilities. This function includes the assessment of the health care system/facility infrastructure.

Veterinary Medical Support

HHS support will include the amelioration of zoonotic disease and caring for research animals where ESF #11 does not have the requisite expertise to render appropriate assistance. HHS will assist ESF #11 as required to protect the health of livestock and companion and service animals by ensuring the safety of the manufacture and distribution of foods and drugs given to animals used for human food production. HHS supports DHS/FEMA together with Mass Care, Emergency Assistance, Housing, Human Services, and Search and Rescue, to ensure an integrated response is provide for the safety and well-being of household pets and service and companion animals.

Disaster Behavioral Health

HHS may task components to and request assistance from partner organizations in assessing mental health and substance abuse needs, including emotional, psychological, psychological first aid, behavioral, or cognitive limitations requiring assistance or supervision; providing disaster mental health training materials for workers; providing liaisons with assessment, training, and program development activities undertaken by Federal, State, tribal, or local mental health and substance abuse officials; and providing additional consultation as needed.

Disaster behavioral health is an integral part of the overall public health and medical preparedness, response, and recovery systems. It includes the many interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance use/abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events. Effective and well-coordinated behavioral health preparedness, response, and recovery aim to mitigate or prevent more serious behavioral health problems in disaster survivors and responders—as well as address disaster-related needs of people with pre-existing behavioral health conditions and systems that serve them in order to promote individual and community resilience.

Disaster behavioral health actions in the response period often focus on supportive, strengths-based basic interventions such as psychological first aid, crisis counseling, and response worker support. As behavioral health concerns often emerge or evolve over time, planning and activities must react to changing needs, which may include increased access to traditional behavioral health care and treatment in the recovery period.

Some individuals or populations may be at higher risk for more severe reactions. For example, individuals with pre-existing behavioral health conditions or past traumatic exposure may be at

greater risk for exacerbation of symptoms or relapse. Individuals with severe pre-existing behavioral health conditions who rely on the behavioral health care infrastructure for their well-being and independence may be greatly affected by damage to that infrastructure. Children, in particular, can be vulnerable to the behavioral health impact of public health emergencies and disasters as they may lack the experience, skills, and resources to independently meet their own behavioral health needs. Behavioral health is also concerned with influences on decision-making in an affected population. Disaster behavioral health practitioners and approaches can inform risk communication and public health messaging to address anxiety, promote compliance with health directives, and prevent misinformation from gaining credibility.

Blood and Blood Products

HHS may task components to and request assistance from partner organizations to monitor and ensure the safety, availability, and logistical requirements of blood, organs, and tissues. This includes the ability of the existing supply chain resources to meet the manufacturing, testing, storage, and distribution needs of these products.

Health/Medical/Veterinary Equipment and Supplies

In addition to deploying assets from the Strategic National Stockpile (SNS), HHS may request DOD, the VA, or the private sector industry to provide medical equipment, durable medical equipment, and supplies, including medical, diagnostic, and radiation-detecting devices, pharmaceuticals, and biologic products in support of immediate medical response operations and for restocking health care facilities in an area affected by a major disaster or emergency. When a veterinary response is required, assets may be requested from the National Veterinary Stockpile, which is managed by USDA Animal and Plant Health Inspection Service (APHIS).

Health Surveillance

HHS, in coordination with supporting departments and agencies, enhances existing surveillance systems to monitor the impacted population health; carries out field studies and investigations; monitors injury and disease patterns and potential disease outbreaks, blood and blood product bio-vigilance, and blood supply levels; and provides technical assistance and consultations on disease and injury prevention and precautions.

Safety and Security of Drugs, Biologics and Medical Devices

HHS may task components to ensure the safety, security, and efficacy of regulating human and veterinary drugs, biologics (including blood and vaccines), medical devices (including radiation emitting and screening devices), and other HHS-regulated products.

Food Safety & Food Defense

HHS, in cooperation with ESF #11, may task components and request assistance from partner organizations to ensure the safety and security of federally-regulated foods. (Note: HHS, through the Food and Drug Administration (FDA), has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of the USDA Food Safety and Inspection Service. The Environmental Protection Agency establishes tolerance levels for pesticide residues.)

Vector Control

HHS may task components to and request assistance from partner organizations, as appropriate, in assessing the threat of vector-borne diseases; conducting field investigations, including the collection and laboratory analysis of relevant samples; providing vector control equipment and supplies; providing technical assistance and consultation on protective actions regarding vector-borne diseases; and providing technical assistance and consultation on medical treatment of victims of vector-borne diseases.

All-Hazard Public Health & Medical Consultation, Technical Assistance and Support

HHS may task regional offices and request assistance from partner organizations in assessing public health, medical, and veterinary medical effects resulting from all hazards events. Such tasks may include assessing exposures on the general population and on high-risk population groups; conducting field investigations, including collection and analysis of relevant samples; providing advice on protective actions related to direct human and animal exposures, and on indirect exposure through contaminated food, drugs, water supply, and other media; and providing technical assistance and consultation on medical treatment, screening, and decontamination of injured or contaminated individuals. While SLTT officials retain primary responsibility for victim screening and decontamination operations, HHS can request and/or deploy the national medical response teams to assist with victim decontamination.

Potable Water/Wastewater and Solid Waste Disposal

HHS may task components and request assistance from partner organizations to assist in assessing potable water, wastewater, solid waste disposal, and other environmental health issues related to public health in establishments holding, preparing, and/or serving food, drugs, or medical devices at retail and medical facilities, as well as examining and responding to public health effects from contaminated water; conducting field investigations, including collection and laboratory analysis of relevant samples; providing equipment and supplies as needed; and providing technical assistance and consultation.

Agriculture Safety and Security

HHS, in coordination with ESF #11, may task components to ensure the health, safety, and security of food-producing animals, animal feed, and therapeutics. (Note: HHS, through the FDA, has statutory authority for animal feed and for the approval of animal drugs intended for both therapeutic and non-therapeutic use in food animals as well as companion animals.)

Public Health and Medical Information

HHS provides public health, disease, and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected in languages and formats that are understandable to individuals with limited English proficiency and individuals with disabilities. This information can also be analyzed to establish trends in order to forecast of pre-identify future public health and medical support requirements.

Worker Health and Safety

Force Health Protection (FHP) means the security and prevention of injuries and illness from environmental, occupational, operational, biological and chemical threats to Federal personnel, both medical and non-medical, deployed in response to an event. Federal response elements must take special precautions to protect their staff from the effects of the very hazard that they are responding to, and response personnel and their leadership must be acutely aware of the hazard zone and implement mitigating strategies to protect the responders. Protection of deployed personnel is afforded through the required compliance with the US Department of Labor (DOL) Occupational Safety and Health Administration (OSHA) standards (Federal Employee OSHA Protection). Protecting the force not only includes imposing mitigating strategies, but a holistic approach that is comprehensive in terms of responder preparation and appropriate follow-up from a health, safety, and security standpoint, which demands attention before, during, after, and between emergency deployments. FHP is a continuous process, achieved through the cooperative efforts of responders, organizations, agencies and leaders. The objective is a health and fit response force able to provide support within the hazard area and return home safely.

HHS will support DOL, the lead Federal agency responsible for worker health and safety, in ensuring that the responder community's health is protected. HHS is responsible for their deployed responder worker safety and health, and complies with the requirements of the Occupational Safety and Health Act (OSHA) during disaster events, training and exercise regimens, by providing a robust Force Health Protection structure. HHS will commit the necessary health and medical resources and materiel (e.g., SNS assets) to assist with protecting their safety and health as well as conducting related surveillance as deemed appropriate. HHS will utilize the Personnel Accounting Reporting System (PARS) to ensure 100% accountability of all personnel deployed.

Other Roles and Responsibilities

Debris Management – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the US Army Corps of Engineers under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Detection and Monitoring – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from either the US Environmental Protection Agency or the US Coast Guard under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Donation Management – Based on its statutory roles and responsibilities, HHS receives this support for foreign donations from the US State Department, the US Agency for International Development, the FDA and the HHS Office of Global Health Affairs. HHS receives this support domestically from the Federal Emergency Management Agency under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Energy and Utilities Services – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the US Department of Energy under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Firefighting/Fire Protection – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the US Department of the Interior under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Law Enforcement – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the Department of Justice/Bureau of Alcohol, Tobacco and Firearms and Explosives under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Population Protection – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the Federal Emergency Management Agency under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Public Works and Engineering – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the US Army Corps of Engineers under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

Search and Rescue – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the Federal Emergency Management Agency under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

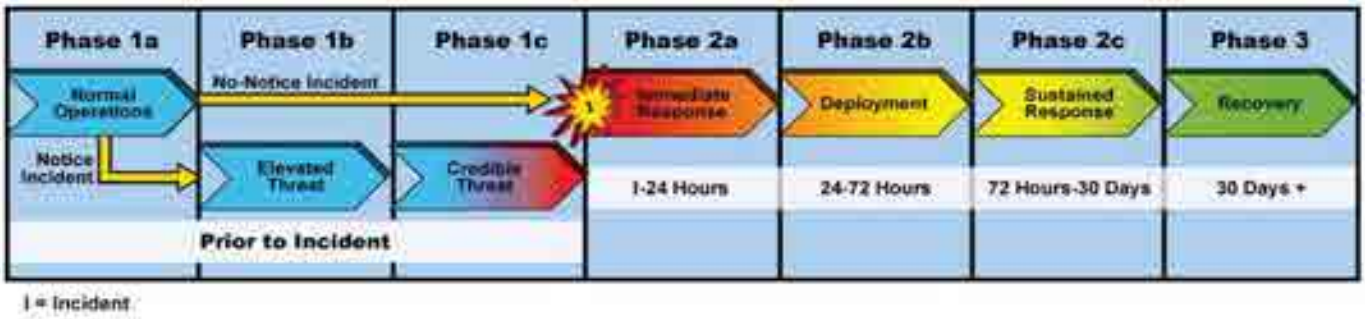
Transportation Systems and Resources – Based on its statutory roles and responsibilities, HHS does not perform this in the execution of its mission, either in a primary or tangential capacity. If required, HHS receives this support from the US Department of Transportation under the auspices of the National Response Framework, the Response Federal Interagency Operational Plan (Stafford Act) and/or through Federal Agency-to-Federal Agency agreement (Economy Act).

7. Concept of Operations

HHS leads and coordinates Federal public health and medical support through the SOC and/or the IMT. Normal procedures for certain contingencies may be expedited or streamlined to address the magnitude of urgent requirements of the incident.

Operational Phases

FIGURE 1 OPERATIONAL PHASES



Public health and medical response to a disaster will occur in three phases, which correspond to Federal interagency planning guidance. The phases are as follows:

Phase 1: PREPARE

- Phase 1a: Normal Operations
- Phase 1b: Elevated Threat
- Phase 1c: Credible Threat

Phase 2: RESPONSE

- Phase 2a: Immediate Response
- Phase 2b: Deployment
- Phase 2c: Sustained Response

Phase 3: RECOVERY

- Phase 3a: Demobilization and Short-term Recovery (Stabilization)
- Phase 3b: Intermediate Recovery
- Phase 3c: Long-term Recovery

PREPARE

Phase 1a: Normal Operations

ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; countermeasures research, advance development, and procurement; and grants to strengthen the capabilities of hospitals and health care systems in public health emergencies and medical disasters. The office provides federal support,

including medical professionals through the National Disaster Medical System (NDMS) to augment state and local capabilities during an emergency or disaster.

The focus of Phase 1 is to ensure that the Secretary of HHS, through the ASPR and the SOC, as well as public health and medical preparedness and response partners, receive the most current and accurate situational awareness information concerning communications relevant to emerging and potential threats and that operational assets are postured to respond in a timely manner. The strategy for this phase is to closely monitor events and ensure the preparations required to facilitate an effective and timely response; and to establish an alert posture for forward deployment and pre-positioning of assets that may be required prior to and immediately after a notice or no-notice event occurs in order to expedite a sustained response.

Phase 1b: Elevated Threat

During this phase, ASPR prepares to activate (and potentially deploy) in support of a threatened event. The SOC will issue a warning order (WO) to supporting departments, agencies, team personnel, and staff that may be required to forward deploy assets, directing them to assume a heightened state of alert in preparation. Initial incident-specific operational planning begins to address surge capacity, anticipated medical requirements and public health functions.

Phase 1c: Credible Threat

Efforts in this stage focus on the activation and initial deployment of public health and medical resources to pre-incident locations. The SOC will issue an execute order (EXORD). It may be necessary to pre-deploy (stage) and/or pre-position enabling assets prior to declaration of an emergency or major disaster using surge account funds. HHS and other federal agencies may operate under their own statutory authorities to pre-position (stage) personnel and resources in locations favorable to providing timely and efficient access to areas of operations.

RESPONSE

Phase 2a: Immediate Response

In this phase, the primary mission of the SOC and supporting interagency partners is to rapidly gather credible situational awareness in order to operationally support life-saving and life-sustaining activities. This includes the ability to gain a common operating picture and then provide public health and medical resources to support response activities.

Phase 2b: Deployment

During this phase, acceleration of the response occurs as improved situational awareness is developed. This phase includes deployment of Federal public health and medical assets, activation of additional lifesaving and life-sustaining resources and maximum use of pre-scripted mission assignments and pre-positioned disaster supplies. As better situational

awareness is gained, and clarity of incident size, scope and complexity is established, the public health and medical response is adjusted to meet requirements.

Phase 2c: Sustained Response

In this phase, operational public health and medical response must be maintained or possibly accelerated, if required. Actions taken during this phase are intended to restore services, continue government operations, and promote recovery. Public health and medical recovery expertise will be required to provide strategic guidance for the transition to recovery operations while continuing to perform response operations.

RECOVERY

Phase 3a: Demobilization and Transition to Short-term Recovery (Stabilization)

As response actions wind down and local capability is re-established, Federal resources will be released by the requesting authority in consultation with SLTT public health officials and the Federal Coordinating Official (FCO). Community resiliency and stabilization activities are primary indicators for demobilization.

Recovery functions begin before a disaster strikes, with preparedness activities such as planning, capability building, exercising, and establishing tools and metrics to evaluate progress and success; mitigation planning and actions; economic development planning, and vital partnership building, all of which contribute to the community's and the nation's resilience. Post-disaster recovery activities begin in the early stages of the response operations. Actions that help recovery, resilience, and sustainability should be built into the steady state operations of governments at all levels. Short-term recovery/stabilization is the process in which the immediate impacts of an event on community systems are managed and contained, thereby creating an environment where recovery activities can begin. The various elements of a community system will stabilize on different time frames, leading to a situation in which response, stabilization, and restoration activities can occur concurrently.

Phase 3b: Intermediate Recovery

Intermediate Recovery involves returning individuals and families, critical infrastructure and essential government or commercial services back to a functional "new-normal" state, if not pre-disaster capability. Such activities are often characterized by temporary actions that provide a bridge to permanent measures.

Phase 3c: Long-term Recovery

Long-term recovery may continue for months to years. Examples include the complete redevelopment and revitalization of the damaged area. Long-term recovery is the process of rebuilding or relocating damaged or destroyed social, economic, natural, and cultural capability in a community to conditions set in a long-term recovery plan. The goal

underlying long-term redevelopment is the impacted community moving toward self-sufficiency, sustainability, and resilience.

Disaster healthcare and public services are beneficial to the community up until the point these services can be provided by local entities in a cost-effective manner. Providing no-cost care and solutions that bypass local providers of services will impair long-term economic recovery and rebuilding of confidence in the health and vital services infrastructure. Any decision to maintain or withdraw services is complex and prone to criticism. However, indecision can be equally harmful. Demobilization is not an-all-or none decision. Each region and locale will be unique. State authorities must be involved and educated on the negative aspects of long-term federal services.

Recovery entails the sustainable restoration of services and service networks essential for affected people and communities to return to their pre-event level of self-sufficiency. The U.S. Department of Health and Human Services (HHS) focuses on services, providers, facilities, and infrastructure within the public health, medical and human services sectors – in order to restore the well-being and health of affected people and communities.

When discussing the criteria and option to demobilize HHS assets, the following must be considered for re-deploying federal assets:

- The healthcare and the public health systems have adequately recovered to have the capacity to provide basic functions Federal resources should not compete with, and impede recovery of, local public and private healthcare entities and vital services.

The decision to demobilize and transition to short term recovery primarily resides with the local public health officials and the federal coordinating officer (FCO). Once activated under a mission assignment, only FEMA can issue authority and orders for demobilization. Established resource release parameters and event criteria will provide insights to drive this decision. A demobilization plan is prepared by the IRCT and forwarded to the EMG manager for approval. Parameters that can help determine if demobilization should be considered are:

a. Local capacity and capabilities

(1) Daily census: outpatients – ER waiting times, admissions, transfers, deaths/births.

- Laboratory services available 24/7
- Radiology services available 24/7
- Medical staff and nursing staff recovered
  - Limited nursing overtime
  - Use of agency nurses at pre-disaster level
- Percent and number of empty beds

b. Daily census at DMATs:

- Outpatient visits,
- Waiting times,
- Admissions,
- Transfers,
- Deaths,
- Births,
- Prescriptions filled – written by non-federal providers.

c. Identify closest unaffected regional hospital systems with excess capacity

Close liaison with local medical, dental, mental health/behavioral health, private sector services e.g., pharmacies, liaison with local county health department, diverse communities and special needs populations may need additional due diligence, and liaison with advocacy groups. The IMT is the entity responsible for monitoring these parameters and report to the HHS Secretary or his or her designee. Every HHS asset is responsible for reporting its observations to the IMT.

As response efforts are completed, demobilization occurs and begins to transition to short term recovery. Transition to long term recovery is not limited to Medical infrastructure repair and re-building. With the recent release of the National Disaster Recovery Framework (NDRF) the transition of response to recovery is done by transitioning response Emergency Support Function (ESF) responsibilities to Recovery Support Functions (RSF). The ESF #8 functions transition to the Health and Social Services RSF of which HHS has primary coordinating agency responsibilities. RSF Health and Social Services mission is for the Federal Government to assist locally-led recovery efforts in the restoration of the public health, health care and social services networks to promote the resilience, health and well-being of affected individuals and communities. The NDRF strongly recommends that State governors as well as local government and Tribal leaders prepare as part of their disaster recovery plans to appoint Local Disaster Recovery Managers (LDRM) and State/Tribal Disaster Recovery Coordinators (SDRC/TDRC) to lead disaster recovery activities for the jurisdiction. In large-scale disasters and catastrophic incidents where a Federal role may be necessary, the SDRC and/or TDRC is the primary interface with the Federal Disaster Recovery Coordinator (FDRC). The FDRC is a focal point for incorporating recovery and mitigation considerations into the early decision making processes. The FDRC monitors the impacts and results of such decisions and evaluates the need for additional assistance and adjustments where necessary and feasible throughout the recovery. In these situations, the FDRC works as a deputy to the federal coordinating official and employs an assessment protocol to ensure a scalable, flexible, adaptable and cost-effective approach and to determine which coordination structures are necessary and appropriate under the circumstances. From this assessment, the FCO, in coordination with the State, activates the appropriate recovery support functions, if necessary. The NDRF is not intended to impose new, additional or unfunded net resource requirements on federal agencies. Instead the NDRF aims to leverage and concentrate the effects of existing federal resources, programs,

projects and activities through an organization of RSFs to promote effective recovery for affected communities before and after disaster strikes. HHS does not have programs and funding designated specifically for recovery efforts. As a result, activities are initially funded through reimbursement under the Stafford Act or as otherwise provided by law and/or through existing HHS programs, authorities, and funding. If significant and/or longer term recovery issues are identified, additional direct appropriations, supplemental appropriations, and/or reimbursements may be required.

- The coordination between the ESFs and RSFs is the responsibility of the FCO, RSF, and FDRC team. Health and Social Services will also include the public health officials. Disaster operations vary based on the nature, scope and complexity of the specific incident. Therefore, the timing of the transition from response to initial recovery operations and then to recovery varies. During response and in the early stages of recovery, RSFs may be deployed while ESFs are still operational and the two coexist until the ESFs fully demobilize. Also, ESF's may transition to RSF's at different times depending on the unique issues and needs of the impacted communities. Working together in collaboration with tribal, State and local authorities, the FCO determines when it is appropriate to begin phasing out the ESF and JFO elements associated with the National Response Framework (NRF).
- Transition involves a conscious effort from day one to the recovery operation, to actively engage and encourage local, State, and Tribal leadership and ownership of the recovery process. It provides coordination support and technical assistance, with the intent to supplement (not substitute) local leadership, ownership and capabilities. *(October 2019 NRF)*

HHS Operating and Staff Divisions (OpDivs/StaffDivs) will also assist locally-driven recovery efforts. These efforts will primarily but may not be limited to their normal statutory authorities/responsibilities and funding sources.

The Regional Advisory Council (RAC) and other relevant OpDiv/StaffDiv representatives, as appropriate, will play a significant role in recovery efforts. The lead Regional Emergency Coordinator (REC) from the impacted region and the OpDivs/StaffDivs are key players in the transition from response to recovery. OpDiv/StaffDiv support will be dependent on the nature of the disaster and recovery effort.

Specific examples of how HHS provides support for recovery includes, but is not limited to:

- Collaboration with Federal and SLT officials on prioritizing the restoration of the public health, medical and human services infrastructure to accelerate community recovery.
- Technical assistance in the form of impact analyses and recovery planning support of public health, medical, and human services infrastructure.
- Technical consultation and expertise on necessary services to meet the long-term physical and behavioral health needs of affected populations.
- Coordination of linking HHS-benefit programs with affected populations.

- Coordination of all potential HHS and other sources of recovery funding.

The Secretary's Operation Center (SOC) supports ASPR by (1) actively monitoring and immediately notifying them of events with recovery implications, and (2) keeping the SOC aware of recovery issues as they manage response operations. The ASPR RECs will provide consultative services to the Office of Recovery Coordination and the RAC on an as-needed basis.

8. Key Federal Decisions

Key Federal-level HHS decisions required during FIOP-Response implementation include:

- HHS will activate and deploy Federal resources or teams to the impacted area. HHS, in coordination with State, local, tribal, and territorial governments and private entities, can act in anticipation of or in response to an incident.
- The President of the United States determines the need to declare an emergency or major disaster declaration invoking the Stafford Act. If a Stafford Act declaration is made, the President will appoint an FCO for each affected State or territory to lead Federal support efforts. The FCO serves in the Joint Field Office and works with the State Coordinating Officer to meet State and local assistance requirements and priorities.
- For a declaration other than the Stafford Act, or a request for Federal-to-Federal support, the President, in coordination with the appropriate heads of Federal departments and agencies, will determine the lead agency for disaster or emergency operations, as necessary.
- When activated, the HHS SOC will coordinate with the Regional Emergency Coordinators to determine and provide needed resources and policy guidance to support the response.
- A Federal Health Coordinating Official (FHCO) may be designated to oversee field operations.
- If an IMT is established, decisions on location, staffing, program priorities, and demobilization will be required.

9. Critical Information Requirements

Critical information requirements (CIR) will be published by the HHS SOC once it is activated. CIRs are gathered facts (and where appropriate, educated assumptions) that when assembled together provide vital insight needed for the successful facilitation of timely information management and decision-making processes that affect a successful disaster response. They provide insight into important details that response personnel need to know to effectively manage and execute their operations. CIRs can be developed through the acquisition and assemblage of one or more essential elements of information. The initial CIRs for a disaster event include:

- Geographic location, scale, projected destruction, and preliminary damage assessments;
- Population effects, including individuals displaced, self-evacuating, and injured as well as fatalities and information on special needs populations;
- State, local, and tribal evacuation plans, timelines, and instructions (including the evacuation of critical facilities, such as hospitals and nursing homes);
- Status of Federal and State coordination centers;
- Ability of government organizations to continue essential functions and services;
- Potential chemical, physical, natural, and biological hazards resulting from a the event that may affect the safety and health of Federal response and recovery workers;
- Damage to, and status of, critical infrastructure (e.g., government facilities, hospitals/healthcare facilities, ground and air transportation, and utilities);
- Weather information, both current and forecast information;
- Possible resource shortages and associated economic impacts;
- Legal and statutory impediments; and
- Potential international impacts.

Common Operating Picture

Information collected and analyzed by the HHS SOC will be used to establish a common operating picture (COP) for Federal public health and medical response and short-term recovery efforts. The COP ensures that information is collected and collated and finally distributed to facilitate Federal, State, local, and tribal incident management coordination. It provides senior leadership with a snapshot of the current or developing situation and the ability to develop courses of action. The COP also facilitates collaborative planning efforts and precise decision-making among Federal response and short-term recovery components.

Situational Awareness

Situational awareness requires continuous monitoring of relevant sources of information regarding actual and developing incidents. For an effective national response, organizations must continuously refine their ability to assess the situation as an incident unfolds and rapidly provide accurate and accessible information to decision-makers. It is essential that all response partners develop a COP and synchronize their response operations and resources.

Situational awareness must start at the incident scene and be effectively communicated to Federal, State, local, and tribal governments as well as the private sector to include CI. Organizations must integrate existing reporting systems to develop an information and knowledge management system that fulfills national information requirements.

After a disaster event, responders will assess the situation, identify and prioritize requirements, and activate available resources and capabilities to save lives, protect property and the environment, and meet basic human needs.

Federal, State, local, and tribal governments have a wide range of operations centers that monitor events and provide situational awareness. Based on their roles and responsibilities, operations centers should identify information requirements, establish reporting thresholds, and be familiar with the expectations of decision-makers and partners.

Reports

At the Federal level, information is collected and disseminated through various reports generated by Federal departments and agencies; States, local, and tribal governments; NGOs; and the private sector. The HHS SOC, RRCC ESF#8 Liaison, JFO ESF#8 Liaison and IMT generate a number of informational products that will be disseminated following an event.

Reporting and documentation procedures should be standardized to enhance situational awareness and provide public health and medical emergency/response personnel with ready access to critical information. Situation reports should contain verified information and explicit details (who, what, where, when, and how) related to the incident. Status reports, which may be contained in situation reports, relay specific information about resources. Based on an analysis of disaster impacts, State, local and tribal governments, through coordination with the Federal Government, should provide emergency public information.

10. Coordinating Instructions

HHS organizes at the national, regional, and field levels to support disaster operations. Effective coordination among Federal, SLTTs, NGOs, and private-sector partners is critical to effective disaster operations. The key to achieving a coordinated and synchronized response is to leverage existing coordination processes and link established hubs of coordination. These linkages include, but are not limited to, the following:

- HHS Secretary's Operations Center (SOC)
- National Response Coordination Staff (NRCS)
- Federal Health Coordinating Official (FHCO)
- Incident Management Team (IMT)
- Regional Response Coordination Center (RRCC)
- Joint Field Office (JFO)

Authority to Initiate

The SOC is the primary HHS element for resource coordination at the national level/ headquarters level. The SOC has the capacity to immediately increase staffing in response to a

disaster through activating and recalling other personnel as required. The SOC provides public health and medical coordination functions to the Regions and/or JFOs, conducts operational planning, deploys national-level resources, and collects and disseminates incident information to maintain a common operating picture (COP).

Federal Priorities

The IMT/REC develops an Incident Action Plan (IAP), which outlines the objectives and priorities at a State level. The RRCC ESF#8 liaison(s) conduct planning to support incident operations. The SOC will issue a Warning Order (WO)/Execution Order (EXORD) and generate an Incident Coordination Plan (ICP) which identifies HHS (ESF#8) primary goals, strategies, objectives, and future planning; looking 48-96 hours beyond a given operational period. The Incident Coordination Plan (ICP) reinforces the incident priorities and objectives and does not replace the IAP.

Direction and Control

The HHS SOC provides primary operational leadership for the coordination of Federal public health and medical resources and capabilities until the IMT assumes operational control.

Coordination with State, Territorial, Tribal and Local Authorities

Coordination with State, local, Tribal and Territorial (SLTT) authorities is essential in the planning and preparedness phases as well as during response and recovery. The Secretary has three means of coordination with SLTT authorities; each one appropriate at different times and for a different purpose.

Prior to Federal deployments, the regional team (Regional Director (RD), Regional Health Administrator (RHA), and Regional Emergency Coordinator (REC)) are the appropriate conduits to State and local officials:

- RD to Governor, Mayor or executive branch officials
- RHA to public health and medical officials
- REC to emergency management officials as well as public health and medical officials

During Federal response operations, after Federal teams are deployed, the Secretary may utilize deployed HHS personnel to contact the State and local officials on response matters. For *operations level* issues, the appropriate conduit is the ESF #8 lead, usually a REC. Table 1 outlines the various roles within HHS and the responsibilities related to working with SLTTs.

TABLE HHS RESPONSIBILITES RELATED TO WORKING WITH SLTT AUTHORITIES

	PREPAREDNESS	RESPONSE	RECOVERY
Regional Emergency Coordinator **Lead for Emergency Preparedness and Response**	• Regional lead for preparedness • Works with all state health department officials and emergency managers • Serves as a focal point for coordinating HHS emergency preparedness activities in the region • Serves as the ASPR representative in the region, co-chairs the Regional Advisory Committee (RAC) • Develops operational plans in coordination with the States and locals	• Regional lead for response • Team leader for the Incident Management Team • Assess and validate requests for Federal health and medical support, coordinates the creation and execution of Mission Assignments • Co-Chair the RAC to coordinate Agency response in the region • Ensures the accurate and timely development of a common operating picture for State and Federal leadership. • May serve as Federal Health Coordinating Official (FHCO)	• Regional lead for coordinating recovery activities by providing technical advice and leveraging existing partnerships to garner support. • Coordinates the development of an HHS Recovery Plan with State and local health jurisdictions, key OpDivs and FEMA.
Regional Director **Political Appointee at Regional Level**	• Primary POC for elected officials in the region • Co-Chairs the Regional Advisory Committee (RAC) • Serves as the Secretary's representative in the region	• Acts as a conduit for elected local, State and tribal officials and Federal public health authorities during a disaster • Proactively engages with elected officials to provide situational awareness	• Proactively engages with elected officials on recovery needs of an affected community as needed
Regional Health Administrator **Principal Public Health Authority**	• Work with state health directors on public health programs • Serves as the senior public health official in the region • Participates in the RAC	• Serves in public health advisory role as requested and in support of the Assistant Secretary for Preparedness and Response • Liaison with state health directors • Serves as a senior public health consultant to the Incident Response Coordination Team	• Assists in the coordination of recovery efforts with state health directors and applicable OASH counterparts
Administration for Children and Families **Lead Agency for Human Services**	• Participates in regional planning activities to plan for human service programs • Enhances preparedness activities for children and special needs populations	• Provides disaster case management services • Assesses and coordinates ACF response • Provide liaison to the IRCT • Provide support to program recipients	• Leads the efforts in coordinating human services support • Recommend program areas which may need support during recovery
CDC Representative **Coordinates Technical Support from CDC to the Region.**	• Co-located with EPA in the regions and represents CDC activities	• Advises regions on the use of CDC assets and provides technical assistance	• Use of CDC assets and technical assistance to support state recovery
Other HHS Regional OpDivs and StaffDivs **(Incl. AoA, CMS, FDA, HRSA, SAMHSA, and other HHS)**	• Located throughout the region • Actively engages with other members of HHS regional offices • Participates in the RAC	• Has a specific agency response mission • Collaborates with the REC/IRCT on missions	• Participates in recovery missions consistent with the Recovery Support Framework

Coordination with the Private Sector

The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Program in the HHS Office of the Assistant Secretary for Preparedness and Response leads a unique

public and private sector partnership known as the Healthcare Sector Coordinating Council (HSCC) in protecting the essential goods, services, and functions of healthcare and public health that, if destroyed or compromised would negatively affect the Nation.

11. Administration, Resources, and Funding

Administration

The Department of Health and Human Services has responsibilities to manage financial activities for emergency operations within its established processes. For response and short-term recovery activities associated with this plan, the Stafford Act establishes management and oversight responsibilities for all administrative and logistical requirements that support response and short-term recovery operations. FEMA is the primary agency for funding associated with Stafford Act declarations.

- The Public Health Service Act provides HHS with the legal authority for responding to public health emergencies.
- The Federal Food, Drug, and Cosmetic Act provides the foundation for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.
- The Social Security Act authorizes Medicare, Medicaid, State Children's Health Insurance (SCHIP), and social services programs of the Department. Among other things, it authorizes the Secretary to temporarily modify or waive certain Medicare, Medicaid, SCHIP, and HIPAA requirements when the Secretary has declared a public health emergency and the President has declared an emergency or a major disaster.
- The Stafford Act provides the legal framework for fiduciary and material support to State, local, and tribal governments.
- Once an emergency declaration has been made, authorized Federal response and recovery operations will be funded under the Disaster Relief Fund (DRF).

Coordination of State Mutual Aid Agreement(s)

If a State anticipates that its public health and medical resources and capabilities will be exceeded, the Governor can request assistance from other States through mutual aid and assistance agreements, such as the Emergency Management Assistance Compact (EMAC). A State does not have to exhaust mutual aid agreements before requesting Federal assistance, but the extent to which the event is beyond the State's capability to respond will be evaluated. State mutual aid and assistance agreements will be coordinated following existing policies and procedures.

Financial Oversight

Current budgetary policies and procedures are not altered by this Plan. The Office of Management, Finance, and Human Capital (MFHC) provides financial management guidance for ASPR as part of a coordinated response.

Personnel Administrative Management Responsibilities

Public health and medical response activities require carefully managed resources (personnel, teams, facilities, equipment, and/or supplies) to meet incident needs. Utilization of the standardized resource management concepts—such as resource typing, inventorying, organizing, and tracking—will facilitate the dispatch, deployment, and recovery of resources before, during, and after an incident. Federal public health and medical resource management should be flexible, scalable, and adaptable in order to support any incident and should be adaptable to changes.

Authorities for and Policy on Personnel Augmentation

HHS is responsible for personnel augmentation to support operational requirements under this Plan. HHS possesses policies for personnel augmentation predicated on its authorities, policies, memorandums of understanding, and mutual aid agreements.

Personnel Training

HHS must ensure that employees who are engaged in disaster response, recovery, and mitigation activities are able to perform under standard resource typing guidelines and operational requirements. As noted in the National Incident Management System (NIMS), training and exercises should be specifically tailored to the responsibilities of the personnel involved in incident management. Mentoring or shadowing opportunities, to allow less-experienced personnel to observe those with more experience should be incorporated to enhance training and exercising. In addition, exercises should be designed to allow personnel to simulate multiple command, supervisory, or leadership roles. Personnel reporting for duty in the SOC, National Response Coordination Center (NRCC), Regional Response Coordination Center (RRCC), or Joint Field Office (JFO) should be fully trained in the appropriate procedures and should be knowledgeable in public health and medical incident management operations.

Funding

For response activities, the following authorities apply:

- The Public Health Service Act provides a general grant of authority for Federal-State cooperation to control epidemics of any disease or condition and to meet other health emergencies and problems.
- The Stafford Act provides the legal framework for fiduciary and material support to Federal departments and agencies and State and local governments for immediate life-saving and life-sustaining activities.

Use of disaster funds is triggered by an emergency or major disaster declaration from the President. However, before a major disaster or emergency declaration, the Stafford Act and/or the Public Health Service Act authorizes the pre-deployment of personnel, who may be from various Federal agencies, and equipment to reduce immediate threats to life and property as well as public, employee, and responder health and safety; and to improve the timeliness of its response.

Initiatives requiring external Federal department or agency action for funding or adjustment of policies will be coordinated pursuant to Presidential Policy Directive (PPD)-1 and submitted to the Office of Management and Budget (OMB) for consideration. In addition, Section 402 of the Stafford Act, General Federal Assistance states: In any major disaster, the President may direct any Federal agency, with or without reimbursement, to use its authorities and the resources granted to it under the Federal law (including personnel, equipment, supplies, facilities, and managerial, technical, and advisory services) in support of State and local assistance response and recovery efforts.

Mission assignments (MA) are issued to order the performance of an operational task (e.g., force protection for Federal responders) or to activate an agency liaison to report to the SOC, NRCC, RRCC, JFO, or other Unified Command operational facility. The MA process is derived from the authority outlined in Section 402 of the Stafford Act, and provides that the President may direct any Federal department or agency to provide personnel, equipment, and resources—with or without reimbursement—to assist State and local disaster relief efforts.

MAs may be issued verbally or in response to an action request form (a verbal MA must be followed by an action request form within 24 hours). Action request forms can be developed manually or use a pre-scripted mission assignment (PSMA) for capabilities and resources of departments and agencies identified in advance.

HHS has responsibility to manage financial activities for preparedness actions within its established processes. Generally, in instances of Federal-to-Federal support, the requesting agency provides funding for the incident consistent with provisions of the Economy Act, unless other statutory authorities exist.

Logistics Management and Resource Support

HHS provides coordinated Federal assistance to supplement SLTT resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. One of the core functions is providing supplemental assistance of health/medical/veterinary equipment and supplies to support medical logistics where HHS has the lead and oversight of this responsibility. The ability to sustain and rapidly deploy medical logistics assets to a Federal response is critical to HHS fulfilling its responsibilities.

The Logistics structure of ASPR/Office of Resource Management (ORM) is responsible for management and implementation of logistics policies and procedures to support the following:

(1) management, deployment, and sustainment of medical cache equipment and supplies; (2) oversight of ASPR Property Management operations; (3) policy guidance for execution of response logistics; and (4) credentialing of public health and medical response logistics personnel for the Assistant Secretary for Preparedness and Response. As the executive agent for ESF #8 response logistics, ORM Logistics is also responsible for coordinating logistics resources and support with internal and external public health and medical, and National Disaster Medical System (NDMS) partners.

12. Oversight and Communications

Oversight

During disaster operations, HHS is responsible for coordinating the Federal Government public health and medical response in support of the affected State(s), reducing the loss of life and property. As such, the HHS Secretary/ASPR has overall responsibility for response operations. The White House National Security Staff (NSS) provide oversight, guidance, and de-confliction, as appropriate.

Communications

Response operations are dependent upon effective communications between HHS staff and operating divisions, and with its supporting ESF#8 departments and agencies —and with SLTT governments and the public. HHS/ESF#8 communications plans and strategies ensure interoperability and minimize the effects of a disaster event through established channels of communication prior to an incident.

Common Operation Picture (COP)

Establishing and maintaining a common operating picture (COP) and ensuring accessibility and interoperability are the principal goals of the Communications and Information Management component of NIMS, and they are essential for Federal public health and medical response and recovery operations. The public health and medical COP will be developed by HHS in coordination with supporting Federal, State, local, tribal, NGOs, and private-sector partners.

13. Evaluation, Maintenance, and Revision

Periodic evaluation, maintenance, and revisions of the updated plan are required to ensure that the various roles, responsibilities, functions and capabilities are kept up-to-date.

Schedule:

- **Evaluation.** The All-Hazards Emergency Operations Plan (AH EOP) will be evaluated during and after all exercises and real-world incidents.
- **Maintenance.** The AH EOP will be updated after each evaluation, as required.

- **Revision.** The AH EOP will be formally reviewed and revised on a four (4) year cycle.

Method

- **Evaluation.** In coordination with the Exercise, Evaluation, and After Action (E2A2) Division, the Planning Division will evaluate the AH EOP during and after all Department exercises and real-world responses. Through the ASPR Corrective Action Program (CAP), E2A2 will provide AAR comments to the Planning Division that will inform the update of ASPR's AH EOP.
- **Maintenance.** The AH EOP project manager will post the approved changes/updates identified through the CAP process, as well as other identified changes to the AH EOP, to the AH EOP. The project manager will maintain a log of all changes/updates. The change log sheet will list the identified change/update, its location, and date of change. The change log sheet will be maintained with the AH EOP.
- **Revision. The formal revision process is a four (4) phase process:**
    - **Phase 1 Identify and establish the planning team.**
    - **Phase 2 Review.** A formal revision process, consisting of the AH EOP project manager and the AH EOP work group, will begin reviewing the plan six (6) months prior to the end of the four (4) year cycle.
    - **Phase 3 Staffing and Adjudication.** AH EOP stakeholders review and provide comment on the plan. THE AH EOP work group will adjudicate the comments and finalize the plan.
    - **Phase 4 Approve and Promulgate.** Plan is approve, signed, and distributed to stakeholders.

DRAFT

Annex I: Tasks (Situational Awareness, Coordination, Resource Execution)

All-hazards encompasses all conditions, environmental or man-made, that have the potential to cause injury, illness, or death; damage to or loss of equipment, infrastructure, services, or property; or alternatively causing functional degradation to social, economic, or environmental aspects.

All-hazard preparedness for response recognizes that, regardless of the cause of a disaster, households, businesses, and community organizations must respond in roughly similar ways. This is not done by compartmentalizing various disaster agents and addressing each separately. Rather, the approach is to begin first by assessing what various events have in common with respect to response demands, and only later focusing on specific contingencies. For example, responsibility for management, direction, and control must be assumed no matter what type of disaster agent is involved. For communities, sheltering, feeding, and providing health care services to victims, restoring essential services, overcoming transportation system disruption, and removing debris are critical regardless of what type of disaster is involved. Addressing the need for appropriate and sufficient resources is a generic preparedness task, even though specific resources needed to deal with different types of disasters vary. In cases in which hazard agents require distinctly different responses, hazard-specific planning, training, and resources are required.

The All-Hazards Tasks Table is focused on functions that HHS and supporting Federal agencies would execute for any event. It addresses both Notice and No-notice Events; however, tasks listed in Phase 2a (Immediate Response) for No-Notice Events may be executed in Phases 1b (Elevated Threat) and 1c (Credible Threat) for Notice Events. A Notice Event would allow for pre-event preparedness/action, while a No-Notice Event would only allow for post-event response. Additionally, the table does not currently utilize specific time markers for execution measurement due to the varying response requirements of diverse scenarios, whether Notice or No-Notice.

The Table is arrayed into six categories, primarily by Function:

Phase	These are divided first by Preparedness (yellow), Response (red), and Recovery (blue); with each phase further delineated into more time/actionable sub-phases.
Function/Task	HHS/ESF#8 executes 18 (including planning/coordination) public health and medical functions in order to accomplish its mission. Each of these functions is further divided into more specific tasks that allow each function to be accomplished.
Resource Provider	Each Task is accomplished by a specific agency/component
Resource	Each Provider utilizes a specific capability to execute the task.
ICP Data Element	Each Task conforms to elements of the Information Collection Plan

Execution Standard for determining whether/when task is to be executed

TASKS TABLE

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R=Recovery (a-Short-term Recovery/Stabilization; b-Intermediate Recovery; c-Long-term Recovery)

Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
			Function: Operational Coordination				
			ICP Data Element 1. Health/Medical/Supporting Critical Infrastructure requirements 2. Strategic/Policy/Planning requirements 3. Health/Medical response requirements 4. Interagency coordination requirements				
a			Review ASPR initiatives, policies or strategies to prepare governments and healthcare organizations to reduce evacuation requirements, mitigate any potential affects, and provide for better preparation.	All		–	Ongoing
a			Review SLTT initiatives strategies to prepare governments and healthcare organizations to reduce evacuation requirements, mitigate any potential affects, and provide for better preparation are: Regional Program initiatives or plans to prepare governments and healthcare organizations to reduce evacuation requirements, mitigate any potential affects, and provide for better preparation.	SLTT Entities		–	Ongoing
a			Review Capabilities Requirements	EMMO	REC	–	Ongoing
a			Define, develop and acquire medical countermeasures	BARDA		–	Ongoing
b			Establish contact through the National Operations Center/National Response Coordination Center (NRCC) to maintain a heightened state of situational awareness	OICC	SOC	4	
b			Review and validate ESF #8 Event/Scenario Plans	SPPR	Plans	2	
b			Review and validate ESF #8 Essential Elements of Information (EEIs), information collection strategies and methodologies, and related decision points	SIIM	Info Mgmt	2	
b			Ensure Pre-Scripted Mission Assignments (PSMAs) and existing interagency and contractual vehicles are available for rapid implementation and execution	MFHC	Finance	3	
b			Review emergency personnel rosters and equipment in support of active and sustainable field response and recovery operations	EMMO	Readiness	3	
b			Establish and maintain required communication and coordination links via normal communication channels with ESF #8 Partners and appropriate Regional and State counterparts	OICC	SOC	4	
b			Establish and maintain additional lines of communication and coordination with non-collocated command, control and coordination entities (e.g., White House Situation Room, National Security Staff)	OICC	SOC	4	
b			Begin coordination with Interagency partners, including DHS, USDA and DOS, and White House • Liaison Officers to DHS and other agencies as requested, • ESF 8 partners Begin coordination with appropriate DHS/FEMA contacts (NRCC, RRCC, RECs, etc.)	OICC/ESF #8 partners		4	

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
b			Review plans to address surge capacity for medical functions such as: • Health care facility staff augmentation • Shelter in place vs. evacuation for threatened health care facilities • Special requirements for treating the aging , at-risk, medical special needs and pediatric patients	EMMO	Readiness ABC HPP CDC	3	
b			Send as requested by DHS and FEMA, pre-identified representatives, authorized to coordinate and make decisions, to multi-agency and multi-jurisdictional groups.	OICC	SOC	4	
b			Initiate tests of communications systems, i.e., Video Teleconference (VTC), emergency contact communications, and cascading call-down lists	OICC	SOC	4	
b			Direct rostered personnel to prepare for deployment by reviewing all deployment requirements, procedures and practices and review alert, activation, and deployment standard operating procedures, practices, and protocols	OPDAS	EMMO	3	
b			Update situational awareness and ensure visibility of the common operating picture is maintained	SIIM	Info Mgmt	4	
b			Begin GIS Modeling	SIIM	Info Mgmt	1	
b			Issue Warning Order to ESF#8 response teams (ESF #8, Rapid Deployment Force (RDF), Applied Public Health (APHT), Mental Health (MHT), At-Risk SMEs, Incident Response Coordination Team (IRCT) and Advance Logistics Reception Team (ALRT) and external agencies	OICC	SOC	3	
b			Begin collecting and collating applicable information for the area. • GIS • Meteorological • Transportation • Intelligence • Law Enforcement	SIIM	Info Mgmt	1	
b			Formalize and distribute ESF#8 response structure, decisional authorities, and trigger points for health & medical interventions	SPPR	Plans	2	
b			Establish contact with key public health, healthcare, and community partners (i.e. State Health Department, State OEM, State Hospital Association, etc)	EMMO/OPDIVs		4	
c			Upon receipt of the NOC/NRCC Operations Order: (Alert Notification), initiate contacts with Federal, Regional, SLTT officials to include private sector representatives in accordance with statutory authorities	SIIM	CIP	4	
c			Ascertain need to request approved or cleared pharmaceuticals, medical supplies, and equipment from foreign countries. As appropriate, request needed resources through the International Assistance System (IAS). Address steps to be taken to determine U.S. regulatory status of any donated product	SPPR/DOS/USAID/OGHA/FDA		2	
c			Determine procedures for uncompensated medical care	EMMO	CMS	2	
c			Ensure that the HHS Secretary is notified of the threat and is receiving regular updates.	ASPR		2	
c			Alert ESF#8 Partners, OPDIVs and STAFFDIVs	OICC	SOC	4	
c			Issue SOC LNO request to ESF #8 Partners to be prepared to (BPT) staff SOC/HHS-EMG	OICC	SOC	4	

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
c			Review staffing of SOC for potential augmentation	OICC	SOC	3	
c			Activate the IMT to support mission	OICC	SOC	3	
c			Lead scheduled National ESF #8 Video Teleconferences to maintain situational awareness and to identify potential issues from the States and/or Regions	OICC	SOC	4	
c			Participate in video teleconferences and other conference calls with DHS/FEMA and ESF # 8 partners concerning the situation, mission, and objectives	OICC	SOC	4	
c			Map projected event and impact on public health & medical infrastructure and initiate geo-spatial imaging	SIIM	Info Mgmt	1	
c			Check on status of FEMA Surge Account funding	MFHC	Finance	2	
c			Alert CDC's EOC for heightened readiness posture.	OICC	SOC	4	
c			Activate logistics infrastructure. • Identify field lodging support for teams/personnel as required • Be prepared to provide all non-medical logistics support	ORM	LOG	3	
c			Identify HHS facilities in potentially affected areas	OICC	COOP	1	
c			Work with regional or National IMAT and RRCC/NRCC to identify potential personnel required to enable ESF #8 to identify public health hazards (e.g., food safety, water quality, waste disposal, vector control, hygiene, and any environmental health support)	EMMO/CDC/ FDA/IHS/ DOD		3	
c			Begin capturing after-action comments	OPDAS	E2A2	2	
c			Alert pre-rostered teams (RDF, Public Health, Mental Health, NDMS, IMT) and interagency ESF#8 teams for possible deployment (Does not indicate formally putting ESF #8 on alert status)	OPDAS	EMMO	3	
c			Place resources (SNS resources, medical assets, equipment caches and supplies etc) in alert posture and prepare for deployment	ORM	Logistics	3	
c			Stage rostered teams (DCCPR, NDMS, other ESF #8 personnel) to designated FEMA logistics bases	OPDAS	EMMO	3	
c			Increase SOC Staffing level to include selected liaisons and specialties Expand Ops, Planning, Log, and SME cells as required • Initiate Administration/Finance section if not already activated • Request LNO from ESF #8 partners as required (DOT, DOD, VA, FEMA, ARC)	OICC	SOC	3	
c			• Issue initial Operations Order • Prepare and possibly deploy ALRT and initial response forces • NVRT Strike Team and cache • Alert advance elements of applicable mission task force(s) • Prepare to deploy rostered teams (RDF, APHT, MHT, IMT, At-Risk subject matter specialists and DOD patient movement enabling teams • Begin to execute PSMAs (as appropriate) in coordination with FEMA Mission Assignment Coordinators RRCC/NRCC	OICC	SOC	3	

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R=Recovery (a-Short-term Recovery/Stabilization; b-Intermediate Recovery; c-Long-term Recovery)

Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
c			Prepare Incident Support Plan and assure plans are coordinated with ESF #8 support agencies, OP/DIVs/Staff DIVs and States.	SPPR	Plans	2	
c			Review FDA guidance to regulated industry and public health and public service messages related to safety of FDA-regulated products – food, medication, medical devices, blood, and pet food.	FDA/AABB TF		2	
c			Analyze vulnerability of key resources, critical infrastructure in the expected impact zone	SIIM	CIP	1	
c			• Be prepared to develop RFA cost estimates • Be prepared to track MA expenditures	MFHC	Finance	2	
c			Utilize HAvBED system to track hospital bed capacity	SIIM	Info Mgmt	1	
c			Increase EMG activation level as necessary	OICC	SOC	2	
c			Initiate deployment actions for FHCO, IMT and appropriate ESF #8 Regional and State resources • Provide representative for Regional IMAT (usually the Regional Emergency Coordinator) • Provide representative to State EOC and or Health Department • Staff the ESF #8 desks in the RRCC	OPDAS	EMMO	4	
c			Deploy ESF#8 Lead to JFO	OPDAS	EMMO	4	
c			Determine Security Requirements for ESF #8 assets	OPDAS	EMMO	3	
c			Stage rostered teams (DCCPR, NDMS, other ESF #8 personnel) as required	OPDAS	EMMO	3	
	a		Ensure that the HHS Secretary is notified of the event and is receiving regular updates.	ASPR		2	
	a		Alert ESF#8 Partners, OPDIVs and STAFFDIVs	OICC	SOC	3	
	a		Issue SOC LNO request to ESF #8 Partners to be prepared to staff SOC	OICC	SOC	4	
	a		Review staffing of SOC for potential augmentation	OICC	SOC	3	
	a		Activate the IRCT to support applicable mission	OEM	Ops	4	
	a		Map projected event and impact on public health & medical infrastructure and initiate geo-spatial imaging	SIIM	Info Mgmt	1	
	a		Identify HHS facilities in potentially affected areas	SIIM	COOP	1	
	a		Alert pre-rostered teams (RDF, Public Health, Mental Health, NDMS, IMT) and interagency ESF#8 teams for possible deployment (Does not indicate formally putting ESF #8 on alert status).	OICC	SOC/DCCPR	3	
	a		Place resources (SNS resources, medical assets, equipment caches and supplies etc) in alert posture and prepare for deployment	ORM	LOG	3	
	a		Increase SOC Staffing level to include selected liaisons and specialties • Expand Ops, Planning, Log, and SME cells as required • Initiate Administration/Finance section if not already activated • Request LNO from ESF #8 partners as required (e.g., DOT, DOD, VA, DHS/FEMA, ARC)	OICC	SOC	3	

TASKS TABLE

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R=Recovery (a-Short-term Recovery/Stabilization; b-Intermediate Recovery; c-Long-term Recovery)

Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
	a		• Issue initial Operations Order • NVRT Strike Team and cache • Alert advance elements of applicable mission task force(s) • Prepare to deploy rostered teams (RDF, APMT, MHT, IMT, At-Risk subject matter specialists and DOD patient movement enabling team. • Begin to execute PSMAs (as appropriate) in coordination with FEMA Mission Assignment Coordinators RRCC/NRCC	OICC	SOC	3	
	a		Prepare Incident Support Plan and assure plans are coordinated with ESF #8 support agencies, OP/OIVs/Staff DIVs and States	SPPR	Plans	2	
	a		Utilize HAvBED system to track hospital bed capacity	SIIM	Info Mgmt	1	
	a		Increase SOC activation level as necessary	OICC	SOC	2	
	a		• Initiate deployment actions for IMT and appropriate ESF #8 Regional and State resources. • Provide representative for Regional IMAT (usually the Regional Emergency Coordinator) • Provide representative to State EOC and or Health Department. • Staff the ESF #8 desks in the RRCC	EMMO	IRCT REC	4	
	a		Deploy ESF#8 Lead to JFO	OPDAS	EMMO	4	
	a		Determine Security Requirements for ESF #8 assets	EMMO	ESF#13	3	
	a		Deploy IMT(s) including SMEs if necessary, including Reps to State EOCs, etc.	OPDAS	EMMO	4	
	a		Stage rostered teams (OFRD, NDMS, other ESF #8 personnel) as required	OPDAS	EMMO	3	
	a		Deploy the FHCO	OPDAS	EMMO	3	
	a		Provide recommendations regarding decontamination and medical management	SPPR		2	
	a		Submit EUA /IND for countermeasures that are not FDA approved (EUA Playbook)	ORM/FDA		2	
	a		Coordinate medical support requirements at mass care shelters	EMMO	ABC/ARC /ACF	3	
	a		Coordinate with the potentially affected states to stage FMS and advance personnel to set-up and install FMS ST	EMMO	IMT	4	
	a		Develop more detailed impact analysis that further defines the impact area based on detailed models	SIIM	Info Mgmt	1	
	a		Deploy rostered teams (DCCPR, NDMS, other ESF #8 personnel) to designated FEMA logistics bases	EMMO	Readiness	3	
	a		Conduct and maintain situational awareness reporting	OICC/EMMO	SOC/IMT	3	
	b		Coordinate rapid needs assessments (public health, medical and at-risk infrastructure)	EMMO	IMT	4	
	b		Determine need for Public Health Emergency and Social Security Act Section 1135 Waivers.	SPPR	DLG	2	
	b		Update situational awareness of hospital and healthcare infrastructure facilities (including power, water and debris) in the impacted areas.	EMMO	IRCT	1	
	b		Determine procedures for uncompensated medical care	OEM	CMS	2	
	b		Capture after-action comments	OPDAS	E2A2	2	
	c		Review damage assessments and consult with FEMA regarding whether activation of Recovery is required.	EMMO	Recovery	3	

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
	c		Develop a scalable demobilization and deactivation plan for the release of appropriate ESF #8 components.	ALL		2	
	c		Begin ESF #8 redeployment/recovery/transition planning	SPPR	Plans	2	
	c		Coordinate the transition to recovery activities with OPDIV/STAFFDIVS	OPDAS/OPDIVS/ STAFFDIVS		4	
	c		At the direction of the JFO/NRCC implement demobilization and deactivation plan for the release of appropriate ESF #8 components	OPDAS		2	
	c		Adjust ESF #8 assets to ensure (a) continued visibility on the execution of longer term Mission Assignments/RFAs and (b) maintain situational awareness to support additional response operations	MFHA	Finance	3	
	c		Coordinate the transition to recovery activities with OPDIVs/STAFFDIVs.	OICC	SOC	4	
	c		Prepare to debrief incident response to HHS Secretary.	ASPR		2	
	c		Capture after-action comments	OPDAS	E2A2	2	
	c		Receive, process, track and sub-task (as needed) MAs	MFHA	Finance	3	
		a	Begin implementing demobilization and deactivation plan for the release of appropriate ESF #8 components.	OICC/OPDAS	SOC/EMMO/ORM	3	
		a	Scale IMT to reduced staffing to ensure (a) continued visibility on the execution of longer term Mission Assignments and (b) maintain situational awareness to support additional response operations	OICC/OPDAS	SOC/EMMO	4	
		a	Complete after-action input	ALL		2	
		b	Demobilize and deactivate specific response assets when appropriate	OICC	SOC	3	
		b	Scale down HHS-EMG operations commensurate with field activities	OICC	SOC	3	
		b	As ESF #8 assets demobilize, prepare for the orderly transfer to recovery	OICC/OPDAS	Recovery ALL	3	
		b	Transition response to SLTT authorities	HHS/ALL		2	
		c	Notify Federally deployed Units/Entities of pending demobilization and redeployment of personnel and equipment.	OICC	SOC	3	
			Function: Assessment of Public Health, Human Services and Medical Needs				
			ICP Data Element 5. Assessment requirements				
	b		Produce ongoing public health, medical, veterinary, and at-risk status assessments post-event	EMMO	IMT	5	
			Function: Health Surveillance				
			ICP Data Element 6. Illness and injury surveillance needs and capabilities of the potentially affected State(s). 7. Outbreaks/reports of abnormal diseases or disease rates.				
c			Receive and assess updated exposure data to monitor event	USDA/FDA/CDC	Team/SME	7	

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Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
c			Continue to ascertain the status of vaccination/immunization requirements in the potentially affected areas.	CDC	EIS	6	
	a		Assist with environmental surveillance	CDC/USDA	Team/SME	7	
	a		Assist SLTT/USDA through direct or technical assistance in the collection and analysis of data from veterinarian surveillance activities	USDA/FDA/CDC	Team/SME	7	
	a		Conduct increased surveillance, detection and review of all adverse event reports related to FDA-regulated products used as part of the response to the emergency	FDA	Team/SME	6	
	a		Assist, as needed, the coordination of lab surge capabilities with the LRN and SLTT authorities	FDA	Team/SME	7	
	a		Monitor available surveillance data	SIIM/CDC	Info Mgmt	7	
	b		Produce EMR Report at regular intervals when available	SIIM	Fusion	7	
	b		Assist States with surveillance efforts to determine product integrity of pharmaceuticals, medical supplies and equipment in aftermath of incident.	FDA	Team/SME	6	
		b	Determine need and requirement for continued assistance in long-term post-event surveillance or investigation and provide assistance to SLTT governments as needed	CDC	Team/SME	6	
		b	Continue to assist states as needed with surveillance efforts to determine product integrity	FDA	Team/SME	6	
		b	Conduct increased surveillance, detection and review of all adverse event reports related to FDA-regulated products used as part of the response to the emergency	FDA	Team/SME	6	
			Function: Patient Care				
			ICP Data Element **8.** Capabilities requirements for medical surge/patient care				
c			Alert medical and public health staff or other civilians as needed to augment Medical and Mass Care Shelters	EMMO	Readiness	8	
c			Stage/Deploy assets to pre-incident locations as necessary	EMMO/ORM		8	
	a		Assess the need to use the Emergency System for Advance Registration of Voluntary Health Professionals (ESAR-VHP)	EMMO	HPP	8	
	a		Alert medical and public health staff or other civilians as needed to augment Medical and Mass Care Shelters	EMMO	Readiness	8	
	a		Activate NDMS response teams	EMMO	Readiness	8	
	a		Stage/deploy public health, medical, veterinary, behavioral health and at-risk personnel assets as needed	HHS/DOD/VA		8	
	a		Stage/deploy NDMS teams and equipment caches to forward to staging locations	EMMO/ORM	Readiness/LOG	8	
	a		Deploy ESF #8 medical and public health and HHS human services teams to provide assistance where needed	EMMO	HSTA Assets	8	
	b		Deploy ESF#8 formulary items, as directed	CDC/OFRD	DSNS	8	
	b		Deploy medical, public health, mental health, at- risk staff or other civilians as needed to augment Mass Care Shelters	EMMO	Readiness	8	
	b		Augment shelter-in-place facilities as required to sustain operations	EMMO	Readiness	8	

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
	b		Deploy additional ESF#8 assets as required	EMMO	Readiness	8	
	b		Determine if medical mass care procedures are required	EMMO	Readiness	8	
		a	Notify Federally deployed Units/Entities of pending demobilization and redeployment of personnel and equipment	EMMO	Readiness	8	
			Function: Health/Medical/Veterinary Equipment and Supplies				
			ICP Data Element **9.** Health/Medical Movement requirements **10.** Health/Medical Supplies requirements **11.** Pharmaceuticals requirements				
b			Ascertain the status of essential medical material for special and emergency at-risk population needs	EMMO	ABC	10	
b			Identify veterinary supplies and equipment which may be used	ORM	LOG	10	
b			Establish procedures for follow-on shipments of necessary veterinary supplies and equipment to affected area	ORM	SNS	10	
b			Verify procedures for Animal SNS shipments of necessary veterinary supplies and equipment from affected area	ORM	SNS	10	
c			Deploy LRAT and initial response force package	EMMO/ORM		9	
c			Prepare to load resources for possible deployment	ORM	LOG	9	
	a		Deploy LRAT and initial response force package	ORM	LOG	9	
	a		Deploy other logistics assets for ESF #8 NDMS teams/personnel to staging locations	ORM	LOG	9	
	a		Verify procedures for Animal SNS shipments of necessary veterinary supplies and equipment from affected area	ORM	SNS	9	
	a		Identify veterinary supplies and equipment which may be used	ORM	LOG	10	
	a		Establish procedures for follow on shipments of necessary veterinary supplies and equipment to affected area	ORM	SNS	9	
	a		Alert VA to be prepared to provide health and medical logistics/supply support via National Acquisition Center (NAC).	OICC	SOC	9	
	b		Coordinate the response to any drug shortages created by damage to manufacturing facilities	FDA		11	
	b		Activate Emergency Prescription Assistance Program (EPAP), if required	ORM	LOG	11	
	c		Begin logistics redeployment/recovery/transition planning as situation warrants	ORM	LOG/IMT	10	
	c		Identify updated countermeasures, medical supplies and equipment	ORM	SME	10	
		a	Inventory and return non-essential equipment for reconstitution	ORM	LRAT	10	
		a	Establish procedures for follow on shipments of necessary veterinary medical supplies and equipment to affected area	ORM	SNS	9	
		a	As situation warrants, begin animal SNS redeployment/recovery/transition planning	ORM	SNS	10	
		b	Inventory and return non-essential equipment for reconstitution	ALL		9	

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Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
			Function: Patient Movement				
			ICP Data Element **12.** Patient Movement response/requirements **13.** DOD patient movement assistance requirements				
b			Identify and coordinate patient movement and enablers	EMMO	Readiness	12	
b			Alert ESF #8 Federal Coordinating Centers (FCC) to be prepared to begin bed counts	EMMO	Readiness	12	
b			Coordinate with the National Guard Bureau for potential evacuation support	EMMO	Readiness	13	
c			Support patient movement efforts, if initiated. Deploy AE components as required to support Mission Assignment(s)	EMMO	DOD	13	
c			Request DOD assistance to provide support for the evacuation of seriously ill or injured patients to pre-identified locations.	EMMO	Readiness	13	
c			Determine which FCCs will be activated for patient movement	EMMO	Readiness	12	
c			Activate ESF #8 patient movement	EMMO	Readiness	12	
	a		Activate the Ambulance contract for medical transportation (ground, air and para-transit ambulances)	EMMO, FEMA	Readiness	12	
	a		Review and adjust patient movement plans.	EMMO/SPPR	Readiness/ Plans	12	
	a		Coordinate public health and medical support requirements	EMMO	IMT	12	
	a		Support patient movement efforts, if initiated. Deploy AE components as required to support Mission Assignment(s)	EMMO	DOD	13	
	a		Determine which FCCs will be activated for patient movement	EMMO	Readiness	12	
	a		Activate ESF #8 patient movement	EMMO	Readiness	12	
	a		Request DOD assistance to provide support for the evacuation of seriously ill or injured patients to pre-identified locations	EMMO	Readiness	13	
	b		Support patient movement efforts, if initiated. Deploy AE components as required to support Mission Assignment(s)	EMMO	DOD	13	
	b		Request DOD assistance to provide support for the evacuation of seriously ill or injured patients to pre-identified locations	EMMO	Readiness	13	
	c		Conduct shelter-in-place assessment of medical facilities to determine patients remaining	EMMO	IMT	12	
			Function: Worker Safety and Health				
			ICP Data Element **14.** Physical/mental health and well-being requirements for emergency workers				
	b		Provide for health and safety of deployed ESF #8 personnel in affected areas.	EMMO	IMT/SME	14	
	c		Maintain accountability for all deployed personnel	OICC	SOC	14	
		c	Continue to monitor worker safety, and physical and mental health	CDC		14	
			Function: Blood and Blood Products				

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
			ICP Data Element **15.** Requirement for blood product support				
c			Ascertain the status of blood supplies in the potentially affected areas	OASH	AABB	15	
c			Activate the American Association of Blood Banks Interagency Task Force on Domestic Disasters and Acts of Terrorism (AABB) to assess the current blood supply levels throughout the country	HHS	OASH	15	
c			Coordinate with AABB Task Force to identify supply levels at the supporting healthcare, critical infrastructure and key resources for the incident. Activate supply distribution plans for affected region(s)	HHS	OASH	15	
	a		Activate the American Association of Blood Banks Interagency Task Force on Domestic Disasters and Acts of Terrorism (AABB) to assess the current blood supply levels throughout the country	HHS	OASH	15	
	a		Coordinate with AABB Task Force to identify supply levels at the supporting healthcare, critical infrastructure and key resources for the incident. Activate supply distribution plans for affected region(s)	HHS	OASH	15	
	a		Ascertain the status of blood supplies in the potentially affected areas	OASH	AABB	15	
			Function: All-Hazard Public Health, Human Services and Medical Consultation, Technical Assistance, and Support				
			ICP Data Element **16.** State public health technical assistance/support requirements				
	a		Provide technical assistance or subject matter expertise to states related to FDA-regulated products (food, drug, medical device and biologics safety) and conduct assessment of food retail establishments in impacted area	FDA	Team/SME	16	
	a		Provide CDC staff to supplement State efforts to address identified public health issues/concerns	CDC	Team/SME	16	
	b		Provide technical assistance specific to event response	OPDIVs/ STAFFDIVs	SME	16	
	b		Deploy human services subject matter experts and/or liaison personnel to IRCT/EOC	ACF	HSTA	16	
	b		Provide CDC staff to supplement State efforts to address identified public health issues/concerns	CDC	Team/SME	16	
	b		Conduct active review of all adverse event reports related to FDA-regulated products	FDA	Team/SME	16	
	c		Coordinate with SLTT health departments to ascertain need and provide for technical assistance, consultation, and support	EMMO	IMT	16	
	c		Assist states through direct or technical assistance in the collection and analysis of data from injury, illness and mortality surveillance activities	SIIM	Info Mgmt	16	
		a	Provide technical assistance specific to event recovery	OPDIVs/ STAFFDIVs	SME	16	
		a	Deploy Disaster Case Management assets for Federal Direct DCM Service	ACF	HSTA	16	
		b	Continue to assist with coordination of SLTT environmental health departments to ascertain ongoing and anticipated need for technical assistance, consultation, and support	CDC	Team/SME	16	
		b	Assist States with transition from Federal Direct DCM service to State-led disaster case management program	ACF	HSTA	16	
		c	Coordinate post-deployment debrief of deployed personnel at home stations	CDC		16	

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Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
		c	Update dose rate data for responders and for potential re-entry into safe regions	EPA, DOE, CDC	SME	16	
		c	Continue and/or assist with inspections of regulated industries	FSA/EPA/NIH/ USDA	Team/SME	16	
			Function: Food Safety & Food Defense				
			ICP Data Element **17.** Food Safety and Security assistance/support requirements.				
	b		Assist states with collection and/or analysis of FDA-regulated product samples from retail food establishments	FDA	Team/SME	17	
	b		Conduct or assist with inspections and assess damage to FDA-regulated industry	FDA	Team/SME	17	
	b		Assist States with collection and/or analysis of regulated product samples	FDA	Team/SME	17	
	b		Provide technical assistance or subject matter expertise to states related to FDA-regulated products (food, drug, medical device and biologics safety) and conduct assessment of food retail establishments in impacted area	FDA	Team/SME	17	
	b		Conduct assessment of food retail establishments and pharmacies in impacted area	FDA	Team/SME	17	
	b		Assist states with collection and/or analysis of FDA-regulated product samples from retail food establishments and pharmacies	FDA	Team/SME	17	
		a	Continue inspections and assessments of FDA regulated industry and products and work with states as needed to assess retail food establishments and pharmacies in impacted areas	FDA	Team/SME	17	
		b	Continue to assist states through collection and/or analysis of FDA-regulated product samples	FDA	Team/SME	17	
			Function: Safety and Security of Drugs, Biologics, and Medical Devices				
			ICP Data Element **18.** Safety/Security of Drugs, Biologics and Medical Devices assistance/support requirements.				
	b		Assist states with collection and analysis of FDA-regulated product samples from pharmacies	FDA	Team/SME	18	
	b		Assist States with surveillance efforts to determine product integrity of pharmaceuticals and medical supplies/equipment in aftermath of incident	FDA	Team/SME	18	
			Function: Vector Control				
			ICP Data Element **19.** Vector Control assistance/support requirements.				
	b		Conduct vector surveillance and be prepared to coordinate vector control measures	CDC	Team/SME	19	
		a	Conduct vector surveillance and be prepared to coordinate vector control measures	CDC	Team/SME	19	
		b	Conduct vector surveillance and be prepared to coordinate vector control measures	CDC	Team/SME	19	
			Function: Potable Water/Wastewater and Solid Waste Disposal				
			ICP Data Element **20.** Potable Water/Wastewater and Solid Waste Disposal assistance/support requirements.				
	c		Provide technical assistance for potable water/wastewater assessment	CDC	Team/SME	20	

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Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
	c		Provide technical assistance to ESFs #3 and #10 to assess potable water/wastewater	CDC	Team/SME	20	
			Function: Agriculture Safety and Security				
			ICP Data Element **21.** Agriculture Safety and Security assistance/support requirements				
	b		Provide technical assistance for protection of animal life in coordination with ESF #11	EMMO	Readiness	21	
			Function: Disaster Behavioral Health				
			ICP Data Element **22.** Behavioral healthcare requirements for the at-risk population				
	b		Ensure provision of appropriate behavioral health services	EMMO	Readiness	22	
	c		Provide mental health and stress management technical assistance	SAMSHA, ABC	Team/SME	22	
	c		Monitor potential behavioral health concerns of affected populations	EMMO	IMT	22	
		a	Assess State human services system capabilities and unmet needs for Disaster Case Management	ACF	HSTA	22	
			Function: Public Health and Medical Information				
			ICP Data Element **23.** Response-related communications requirements (JIC, State EOCs, etc). **24.** Public health/medical public communications requirements.				
b			Coordinate public health messages through PAO (HAN) communication channels	OEA	Communications/OPDIVs	24	
b			Identify SMEs on medical and public health aspects of radiation health	OEA	ASPA	24	
c			Review and update information on HHS websites covering preparedness, response, injury prevention, cleanup activities, etc	HHS	ASPA	24	
c			Communicate special risks and precautions for managing public health threats	HHS	ASPA	24	
	a		Identify SMEs on medical and public health aspects of radiation health	OEA	ASPA	24	
	a		Provide talking points that give protective guidance	HHS/ALL	ASPA	24	
	a		Provide information (when available) for Medical Providers seeking treatment and management guidance and algorithms (REMM)	HHS/ALL	ASPA	24	
	a		Coordinate communications efforts with SLTT Public Health Departments as well as affected foreign governments (for OCONUS or cross-border incidents)	OEA/CDC/FDA/DOS/JIC	ASPA	24	
	b		Coordinate public health messages through PAO (HAN) communication channels	OEA	PIO/OPDIVs	24	
	b		Continue situation briefing/conference calls for ESF partners and OP/Staff	HHS/ALL	ASPA	23	

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Phase P	Phase R	Phase R		Resource Provider	Resource	ICP Data Element	Execution
	b		Continue to participate in National Incident Communications Conference Line (NICCL) • Continue providing information and anticipatory guidance to the public, including the at-risk population • Reiterate rationale for difficult decisions that must be made due to overwhelming need in the context of resource scarcity (e.g. first priority is to save as many lives as possible) • Continue providing talking points on worker health and safety; decontamination, evacuation vs. shelter-in-place); information on the zone of exclusion, and where/how to seek care • Maintain hotline capacity for medical and behavioral health questions • Disseminate information on volunteer opportunities and rostering mechanisms (phone line, internet) decontamination, evacuation vs. shelter-in-place); information on the radiation zone, and where/how to seek care	HHS/ALL	ASPA	23	
	b		Continue assistance in providing information and guidance on worker health and safety; animal depopulation, quarantine; information on contaminated livestock, and where/how to seek care for affected animals	HHS/ALL	ASPA	24	
	b		Maintain the capacity to respond to medical and behavioral health questions	HHS	ASPA	24	
	b		Provide information on medical and public health response activities with as much granularity as possible	HHS	ASPA	24	
		a	Coordinate public health messages through PAO (HAN) communication channels	OEA	PIO/OPDIVs	24	
			Function: Mass Fatality Management				
			ICP Data Element 25. Requirements to provide mortuary affairs/victim identification support, crisis counseling, and services for surviving family members.				
	b		Deploy assets in support of fatality management as requested	EMMO	Readiness	25	
	c		Provide Fatality management capability	EMMO	Readiness	25	
	c		Provide victim identification and mortuary services	EMMO	Readiness	25	
	c		Support the local coroner, provide identification of human remains	EMMO	Readiness	25	
	c		Provide Family Assistance	EMMO	Readiness	25	
			Function: Veterinary Medical Support				
			ICP Data Element 26. Requirements for veterinary support to protect the health of livestock, companion, service animals, and search and rescue animals				
c			Provide assistance in the reviewing, adjustment, and implementation of animal relocation plans with ESF #8 partners	EMMO/DOD/VA/ USDA		26	
c			Assess information available for veterinarian providers and healthcare organizations seeking treatment, management guidance and algorithms for FAD/FMD exposure	EMMO/FDA/IGA/ USDA		26	
	a		Continue to coordinate and collaborate on veterinary medical care support	EMMO/USDA	IMT	26	
	b		Deploy assets in support of depopulation if available and needed	EMMO/USDA	IMT	26	

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Phase				Resource Provider	Resource	ICP Data Element	Execution
P	R	R					
	b		Provide assistance in the reviewing, adjustment, and implementation of animal relocation plans with ESF #8 partners	EMMO/DOD/VA USDA		26	
	b		Deploy veterinary medical team component to support working animals	EMMO	Readiness	26	
	b		Assist coordination of movement of service animals	NDMS	NVRT	26	

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Annex II: Operational Planning
UNDER DEVELOPMENT

Annex III: Incident Management
UNDER DEVELOPMENT

Annex IV: Logistics
UNDER DEVELOPMENT

Annex V: Communications and Warning
UNDER DEVELOPMENT

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Annex VI: Operations

Appendix I: Patient Care

1. Purpose

This appendix provides guidance concerning how the Federal government will provide patient care resources during an incident to support a State, territory, or tribe.

2. Situation

Disasters are threats to healthcare systems, regardless of size, scope, or location. A single emergency can temporarily affect demand for services; however, multiple emergencies that occur concurrently or sequentially can adversely impact patient safety and systems' ability to provide care, treatment, and services for an extended length of time. This is especially true in situations where an affected community cannot adequately support the health care system or key facilities due to power failures, water and fuel shortages, flooding, and communication breakdowns.

The effects of disasters and emergencies may exceed the capacity and capabilities of State and local healthcare resources, creating temporary patient surge and triggering a requirement for federal public health and medical services' response. Such incidents result in SLTT requests for capability and capacity augmentation by Federal resources, with the goal to save lives and alleviate human suffering. HHS has developed a suite of flexible, scalable and sustainable disaster response capabilities that can rapidly integrate into and be interoperable within an affected area's existing healthcare system.

3. Assumptions

See base plan.

4. Mission

Medical Care

Based on the type, extent, magnitude, and nature of an incident, the following categories of medical care that may be encountered range from basic first aid to ICU/trauma critical care.

Figure 1 shows this spectrum and the federal medical resources that can be utilized to provide this support. The following types of medical care are identified in this section:

1. Pre-hospital emergency care
2. Primary healthcare
3. Inpatient and NDMS definitive healthcare
4. Nursing home and other extended healthcare (including medically-supported patient repatriation)

1. Pre-Hospital Emergency Care

Pre-hospital emergency care is based on the standard principles of medicine, but in many operational settings, those principles may be applied in ways different from traditional hospital settings. Pre-hospital emergency care is influenced by three important factors:

- Austere environment
- Limited Resources
- Operational circumstances that influence the degree of medical care provided.

Federal pre-hospital emergency care and stabilization resources will be utilized to supplement State and local resources until all initial victims of an event have been identified, triaged and dispositioned.

2. Primary Healthcare

Defined as the non-urgent or emergent out-patient medical care a patient receives upon contact with the health care system, Federal primary healthcare is aimed at supporting the affected region's primary health care needs focusing on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. Primary healthcare serves a coordination function to ensure continuity and ease of movement across the system, so that care remains coordinated during a period of limited primary care providers.

Primary healthcare infrastructure support is provided through Federal health and medical personnel augmenting and creating additional primary healthcare services. Federal health and medical personnel provide supplemental primary healthcare by augmenting freestanding health clinics (to include community health centers and Federally Qualified Health Centers) and emergency room/outpatient care. Mobile primary care capabilities provide for ongoing primary care needs of the community. ESF #8 partners may also develop additional primary healthcare clinics in shelters of opportunity and/or support federally funded health centers to continue to provide care with additional staff or equipment. Mental health services are also augmented and supported by placing Federal personnel into the existing state and community mental healthcare system and primary care sites. Sources of personnel staffing are discussed in the Annex I – Personnel.

153 **3. Inpatient and NDMS Definitive Healthcare**
154
155 ESF #8 Primary and Support Agencies provide staff to augment existing hospitals and provide
156 and support Federal Medical Stations. The SOC, in coordination with NDMS[1], HHS OPDIVs, ESF
157 #8 Support Agencies, and State and Local health care officials identifies the inpatient care
158 shortfall and determines which assets will be sent to the incident site. All logistical support for
159 deployed ESF-8 health care delivery systems will be coordinated through the IMT operating out
160 of the RRCC or JFO when activated. Deployment of any ESF #8 medical assets may be initiated
161 through a State, territorial, or tribal requested mission assignment, submitted in accordance
162 with NRP guidance.

163 A complement to inpatient care is the forward movement of patients through the Patient
164 Movement and Definitive Care Components of NDMS. This involves the evacuation and
165 reception of patients from the affected area and/or States and subsequent admission to NDMS
166 participating hospitals. This could include either the direct evacuation of disaster victims to
167 medical care made available outside of the State, or movement of hospitalized patients within
168 the area or State to increase the capability and capacity of State and local medical facilities to
169 admit disaster victims. These actions would require activation of the NDMS Patient Movement
170 Component and the NDMS Definitive Care Component.

171 NDMS Definitive Care is provided through a nationwide network of voluntary, pre-identified,
172 non-Federal acute care hospitals. These hospitals have agreed to participate with NDMS and
173 are capable of providing NDMS definitive care for the victims of a domestic disaster or military
174 contingency that exceeds the medical care capabilities of the affected local, State, or Federal
175 medical systems. "Definitive care," and the NDMS Definitive Care Component includes
176 treatment services required or provided for injuries or illnesses resulting directly from a
177 specified disaster or emergency, or for injuries, illnesses, and conditions requiring services
178 temporarily not available as a result of the disaster or emergency.
179
180 DoD and the VA are responsible for coordination of NDMS Patient Reception Area (PRA)
181 through specifically designated military medical treatment facilities and VA hospitals that
182 function as NDMS Federal Coordinating Centers (FCCs). Coordination of patient placement into
183 available, staffed and equipped NDMS hospitals is accomplished through these FCCs.
184
185 The NDMS Executive Secretariat (an organization component of the NDMS with representatives
186 from the four NDMS Federal Partner Departments) may convene a Medical Inter-Agency
187 Coordination Group to advise as to the extent to which NDMS definitive care assets (PRAs)
188 need to be activated, and in what order, as well as provide support for the coordination of
189 patient placement into NDMS participating hospitals. FCCs and their associated PRAs may be
190 activated regionally, incrementally and/or all together, and may similarly be de-activated

[1] NDMS teams for this mission may include Medical Strike Teams, Burn Specialty Teams, Pediatric Specialty Teams, National Nurse Response Teams, and National Pharmacy Response Teams.

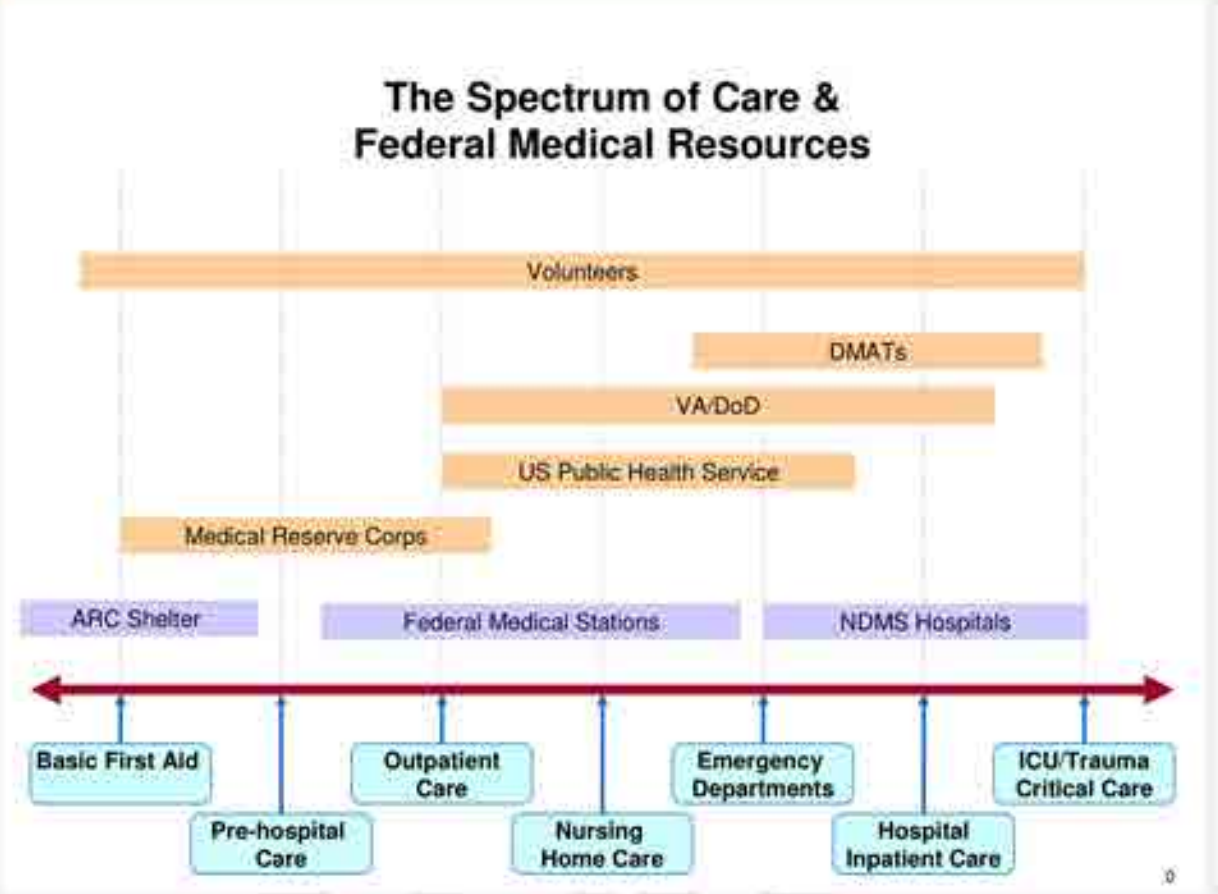
regionally, incrementally and/or all together, as appropriate and as situations evolve and dictate.

NDMS definitive medical care begins upon admission to a participating NDMS hospital. For Non-DOD beneficiaries, NDMS definitive medical care is, to the extent authorized by NDMS in the particular public health emergency, medical treatment or services beyond emergency medical care, initiated upon inpatient admission to an NDMS hospital and provided for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring non-deferrable medical treatment or services to maintain health when such medical treatment or services are temporarily not available as a result of the public health emergency. Payment for such NDMS definitive medical care ends when one of the following occurs, whichever comes first: completion of medically indicated treatment (maximum of 30 days); exhaustion of Diagnosis Related Group payment schedule; voluntary refusal of care; return home or to point of origin/fiscally comparable location or to destination of choice for patient (whichever costs less).

The FCC Director assumes responsibility for tracking patients upon a patient's arrival in the PRA until authorization for NDMS definitive medical care ceases. This may include when the patient is either discharged, deceased, transferred out of the PRA, returned home or, in the case of military patients, returned to the responsible military Service's personnel system for processing and assignment to a military unit, or discharge from active duty, as appropriate. If available, a Military Patient Administration Team may be dispatched to the FCC to assist in coordinating administrative actions for military patients. Additionally, GPMRC Liaisons may be dispatched to the FCC to support the FCC's responsibilities for coordinating with GPMRC, and to ensure that notifications are made and that military patients are tracked.

4. Nursing Home Care and Other Extended Healthcare

Extended care is the fourth broad group of medical care. Extended care refers to individuals who are not sick enough to require medical hospitalization but need skilled nursing and/or supportive residential/medical care. This broad medical care category refers to patients who might be chronically, non-acutely ill or injured individuals not requiring admission to an acute care facility, and individuals discharged from an acute care facility. Nursing homes, long term care facilities (which include skilled nursing facilities, nursing facilities, assisted living facilities and intermediate care facilities for people with permanent or short term cognitive or developmental disabilities) and medical needs shelters are examples of this category. Homebound, medically fragile populations are also included in this category. As the primary agency for ESF #8, HHS coordinates with State, local, territorial, tribal officials and ESF-6 (Mass Care, Housing, and Human Services) to provide augmentation to nursing homes, long term care facilities and special medical/residential needs shelters and federal medical shelters if required by the situation.



5. Resources

Disaster Medical Assistance Team

The Disaster Medical Assistance Team (DMAT), managed under the National Disaster Medical System (NDMS), is the HHS response asset, responsible for providing medical care and support to public health emergencies such as natural disasters, acts of terrorism, or other nationally significant events. These services are rendered in coordination with State, Local and Tribal governments upon official request and when local resources are non-existent, overwhelmed, or otherwise inaccessible.

The DMAT is capable of administering basic to complex medical care to victims of a public health emergency or NSSE. The DMAT can provide a rapidly deployable advance unit, augmentation of existing medical facilities, or establish a stand-alone treatment facility. The capabilities of the DMAT include the ability to provide:

- Basic First Aid and Life Support
- Primary Care
- Acute Care

- Emergency Care
- Critical Care

Public Health Service Commissioned Corps

As one of the seven Uniformed Services of the United States Public Health Service (USPHS) Commissioned Corps is a group of trained and mobile health professionals that can be activated and deployed by order of the Surgeon General, with approval from the Assistant Secretary for Health, or by the HHS Secretary.

The USPHS Rapid Deployment Forces (RDFs) provide resources and assistance to State, Tribal and local health authorities throughout the United States. They may be deployed in response to a public health emergency. There are currently five RDFs, each of which is a workforce comprising 125+ trained USPHS Commissioned Corps officer responders. Each RDF is scalable, and can provide only those resources required.

Federal Medical Stations (FMS)

ASPR has partnered with CDC to develop and field the deployable FMS program to increase bed capacity and aid healthcare response and recovery efforts at the State and local levels. The FMS is standardized, scalable, and adaptable to meet the low-to-mid acuity healthcare needs of patients in the mass casualty care continuum. The FMS is designed to care for patients with acute exacerbations of chronic conditions. Typically, these patients are too sick for general population shelters but not yet sick enough to warrant the attention at a crowded ER. Bed capacity for FMS is scalable between 50 to 250-beds per station allowing HHS flexibility to meet State, local, territorial, or tribal needs. FMS includes base support, base treatment, and pharmacy modules to care for 250 patients for 3 day duration with direct re-supply mechanisms in place to allow HHS to continue to provide care until the local healthcare infrastructure is functional. The U.S. Public Health Service (PHS) Commissioned Corps Rapid Deployment Force Teams will provide the primary clinical staff for the FMS. Other ESF 8 support agencies, such as DoD and VA, and State and local entities will be requested to augment the PHS staff with ancillary and support staff as required. State, local, or territorial officials must identify suitable building or structures to house and FMS. FMS are employed in non-contaminated environments.

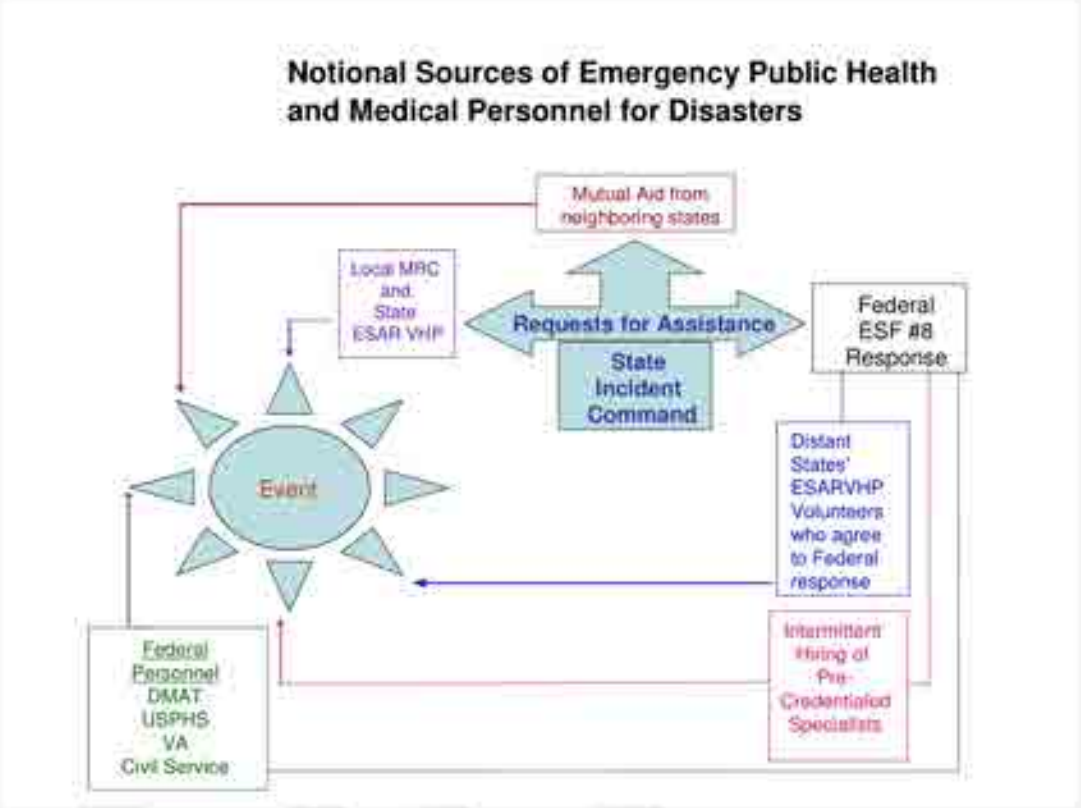
Additional Resources

HHS may request Department of Defense (DOD) support for casualty clearing and staging, patient treatment, and support services such as surveillance and laboratory diagnostics.

HHS may seek individual clinical public health and medical care specialists from the Department of Veterans Affairs (VA) to assist State, tribal, and local public health and medical personnel.

HHS may engage civilian volunteers, such as Medical Reserve Corps, to assist State, tribal, and local public health and medical personnel.

In addition to deploying assets from the Strategic National Stockpile (SNS), HHS may request DOD or the VA to provide medical equipment, durable medical equipment, and supplies, including medical, diagnostic, and radiation-detecting devices, pharmaceuticals, and biologic products in support of immediate medical response operations and for restocking health care facilities in an area affected by a major disaster or emergency.



6. Execution

Concept of Operations

Phase 1 - Preparedness

1. Identify strategies for potential health and medical requirements, including providing medical surge capacity, medical sheltering, and medical evacuations.
2. Alert medical and public health staff or other civilians as needed to augment Medical and Mass Care Shelters
3. Obtain situational awareness of available capacity to treat ill/injured, including state- or facility-level agreements to create room for incident-related ill/injured by moving patients from hospitals to other care facilities.
4. Stage/Deploy assets to pre-incident locations as necessary

317
318 ***Phase 2 – Response***
319
320 **Alerts, Activation and Deployment**
321
322 Upon activation of HHS and subsequent activation of the NDMS, DMAT personnel, as intermittent
323 Federal employees, can be alerted or activated for the purpose of response and deployment. The
324 HHS Secretary's Operations Center (SOC) may initially request the activation of the Incident
325 Management Team (IMT). If the IMT is operational, then a mission request for DMAT support
326 will be sent from the IMT to the SOC. Subsequently approved mission requests and requirements
327 are forwarded to the Office of Emergency Management and Medical Operations (EMMO). The
328 EMMO will process the NDMS Activation Order to cover the period of preparation, deployment
329 and demobilization.
330
331 A DMAT can deploy within 24 hours of notification. The DMAT can achieve initial operational
332 capability (IOC) within 3-6 hours of arrival to a disaster or emergency site. Advance elements of
333 the DMAT can deploy within 12 hours of notification and can achieve IOC within 30 minutes of
334 arrival at a shelter of opportunity.
335
336 **Employment**
337
338 DMAT personnel are trained, equipped and prepared to carry out the following missions:
339
340 • ED Decompression
341 • Inpatient Care Augmentation
342 • Transfer of Patients from Local Critical Care Units
343 • Delivery of Direct Patient Care
344 • Stabilization and Transfer of Critically Ill Patients
345 • Staffing Casualty/Patient Collection Points
346 • Triage Services for Isolation and Quarantine Stations
347 • Mass Prophylaxis
348 • Federal Medical Station Support
349 • Medical Support for ESF #9
350 • Force Health Protection for Federal Responders
351
352 DMAT personnel may also be tasked to augment existing medical resources such as a definitive
353 care facility or state-based response team. In these situations, overall strategic command and
354 control will be retained by the IRCT.
355
356 Federal agencies may request medical services from the DMAT in support of special activities and
357 events via agreements (MOU, IAA, and/or MOA) between the respective agencies and HHS.
358

When necessary a DMAT may be augmented by assets from the United States Public Health Service (USPHS) Commissioned Corps, the Medical Reserve Corps, or the Department of Defense (DoD). The IRCT or EMG, will facilitate coordination of USPHS and DoD assets. Additional support entities, to be included but not limited to, are: security, local and state entities and force health protection.

Phase 2a: Immediate Response

1. Assess the need to use the Emergency System for Advance Registration of Voluntary Health Professionals (ESAR-VHP)
2. Alert medical and public health staff or other civilians as needed to augment Medical and Mass Care Shelters
3. Activate NDMS response teams
4. Stage/deploy public health, medical, veterinary, behavioral health and at-risk personnel assets as needed
5. Stage/deploy NDMS teams and equipment caches to forward to staging locations
6. Coordinate with ESF-9 to move the rescued and injured to medical facilities
7. Coordinate with ESF-6 to provide medical support, and support medical requirements related to mass evacuations and mass care shelters
8. Coordinate with jurisdictional authorities and ESF #6 for potential needs for ESF #8 support to mass care operations, to include HHS/SAMHSA Crisis Counseling Support and HHS/ACF Disaster Case Management
9. Deploy HHS medical and public health and HHS human services teams to provide assistance where needed

Phase 2b: Deployment

1. Deploy HHS formulary items, as directed
2. Deploy medical field teams (with the necessary logistical resources) to support search and rescue, triage, treatment, medical surge and transportation
3. Consider the deployment of Federal Medical Stations (FMS)
4. Provide medical support to State decontamination teams, or other federal partners
5. U.S. Public Health teams to provide primary care, mental health, public health services; mass prophylaxis and vaccination; Medical surge; Isolation and quarantine; Epidemiology/surveillance, Environmental Health
6. ESF 8 immediately deploy/employ field medical platform capable of general surgery, casualty care management and patient holding
7. ESF 8 deploy/employ mobile treatment teams capable of providing ATLS (Advanced Trauma Life Support), sick call, patient holding and basic ancillary services.
8. ESF 8 deploy/employ surgical treatment teams to augment fixed or field treatment sites
9. ESF 8 deploys/employs medical professionals, volunteers, and international support to support hospital decompression
10. Support disabled individuals with acute medical needs, in obtaining medical treatment and reconnection to durable medical equipment, medications, and consumable medical supplies

11. Assess the short-term medical treatment needs of incident-area population evacuees and those sheltering in place
12. Deploy one or more FMSs, an FMS Installation Team (FIT), and/or medical personnel (e.g., DMAT, Rapid Deployment Force (RDF) teams) to support and/or establish medical sheltering operations
13. Deploy, stage, and integrate additional Federal medical teams and personnel (i.e. DMAT, International Medical Surgical Response Team (IMSuRT), NMRT, RDF) to support life-saving and life-sustaining medical/surgical operations.
14. Provide resources for pre-hospital triage and initial stabilization
15. Ensure coordination with jurisdictional authorities and ESF #9 to identify triage and treatment sites to support SAR operations
16. Deploy appropriate HHS personnel and/or request ESF #8 partner deployment of health and medical personnel, equipment, and supplies in response to requests for public health, behavioral health, and medical assistance
17. Deploy medical, public health, mental health, at- risk staff or other civilians as needed to augment Mass Care Shelters
18. Coordinate the movement of survivors into the medical triage/treatment system post-rescue
19. Coordinate the staging of medical resources/capabilities and the medical evacuation of patients
20. Augment shelter-in-place facilities as required to sustain operations
21. Deploy additional HHS assets as required
22. Determine if medical mass care procedures are required

Phase 2c: Sustained Response

1. ESF 8 participates in follow-on public health and patient care as required by local and State health officials
2. Coordinate with ESFs #1 and #5 for the relocation of individuals with acute medical needs whose medical care cannot be sustained in the impacted area to communities that can provide required services in the most integrated setting appropriate

Phase 3 - Recovery

Redeployment/Demobilization: Redeployment or demobilization of the DMAT will begin when medical services are no longer needed as indicated by the FHCO. However, planning for demobilization begins at the onset of the mission.

DMAT personnel will be deployed for a maximum of 21 days per deployment cycle. If there is an ongoing mission requirement, the deployment may be extended, within limits, with the concurrence of the DMAT Team Commander, the IMT Commander, the FHCO, EMMO, and the approval of the Director of NDMS.

1. Continue Federal medical care operations support

2. Notify Federally deployed Units/Entities of pending demobilization and redeployment of personnel and equipment

7. Interdependencies

HHS may request Department of Defense (DOD) support for casualty clearing and staging, patient treatment, and support services such as surveillance and laboratory diagnostics.

HHS may seek individual clinical public health and medical care specialists from the Department of Veterans Affairs (VA) to assist State, tribal, and local public health and medical personnel.

HHS may engage civilian volunteers, such as Medical Reserve Corps, to assist State, tribal, and local public health and medical personnel.

8. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and Departmental policies.

DRAFT

Appendix II: Patient Movement

1. Purpose

This appendix provides guidance concerning how the Federal government will provide patient movement resources, which includes the reporting, validation of patients, medical regulating, and evacuation of patients during an incident to support a State, territory, or tribe.

2. Situation

In an event in which the medical systems within a domestic disaster area are overwhelmed, there may be a need to move patients out of the disaster area. If State or local authorities are unable to provide patient movement capability, Federal authorities may deploy appropriate assets to assist. If State or local authorities determine that resources are inadequate to transport or care for all patients, a request for Federal medical evacuation assistance can be initiated.

3. Assumptions

1) Local, municipal, and/or State medical assets (augmented by Federal assets if available) may provide pre-hospital emergency medical services and initial hospital services during early phases of disasters and emergencies.
2) Health and medical resources available within an affected disaster area may be inadequate to provide more than initial emergency assessment and care.
3) Patients require follow-on, supportive medical services beyond what can be made available in a timely manner within a disaster area.
4) A local, municipal or State Emergency Medical Services Agency, Public Health office, and/or other agency may be in place to regulate both the pre-hospital and the inter-hospital movement of patients in the immediate environs of the disaster area.
5) Unless specified otherwise, the medical regulating policy may be to transport disaster related patients to the nearest DoD or VA managed Federal Coordinating Center (FCC) Patient Reception Area (PRA) capable of distributing patient evacuees to appropriate definitive medical care.
6) Contaminated patients generally will not be transported
7) Contagious patients may not generally be transported over State lines in the patient movement system.
8) State and local law enforcement resources to secure FCCs/PRAs may be limited due to other priority missions.

4. Mission

The mission of the ESF #8 patient movement and evacuation function is to insure the safe, effective and timely transport, utilizing a broad spectrum of modalities, of individuals residing in

a geographic location that will be, or has been, adversely impacted by either an incident of a such a nature that would place the affected population at risk by remaining in place.

5. Execution

Concept of Operations

Patient movement is defined as the process of moving sick, injured, or wounded persons within a given population from a dangerous area due to the threat or occurrence of a natural or man-made incident to a safer area, in order to obtain needed medical and/or dental care. Also included are individuals in the community with special medical needs, such as those with chronic illness or disability, who under normal conditions require assistance to obtain medical care or to have their health care needs met in the community. Patient movement starts with movement from point of origin, which can include hospitals, long-term care facilities and other types of healthcare facilities; in the field at the point of injury; or in the homes of home-based patients. Usually the individual is moved to a State-identified casualty collection point or medical treatment facility for initial care and stabilization.

Patient movement is comprised of five functions:

- Patient evacuation (to include patient reception and management)
- Medical regulating
- En-route medical care
- Patient tracking that is integrated with tracking of the general population evacuees
- Re-entry

Phase 1 – Preparedness

Once it has been determined that there exists a need to move a vulnerable population out of an area that will be (or has been) adversely impacted by a significant event, several actions need to be initiated; starting at the local level and involving the collaboration and cooperation among various agencies, jurisdictions, and levels of government. These actions include:

- Threat Recognition
- Threat and Vulnerability Assessment
- Needs Analysis
- Local/State Resource Allocation
- Appropriate Declaration Request
- Requisition and Acquisition of Appropriate Federal and DoD Resources
- Implementation of ESF #8 Patient Movement and Evacuation Plan

As the need for evacuation is identified, it is incumbent upon the public health and medical community at the local, State and Federal levels to coordinate the appropriate resources so that a safe and orderly movement can begin. A primary responsibility is the identification of

individuals requiring medical care or who have medical special needs that cannot be provided for either in general population movement or a shelter. The public health and medical partner community will:

- Provide appropriate medical care for identified individuals through all phases of the patient movement continuum
- Determine the best method of transportation based on nature of the medical need or acuity level
- Determine the most appropriate destination facility available
- Track these individuals from point of first contact through release back to their residence of record or final disposition

Various modes of transportation can be utilized and are determined by the specific needs of the individuals being transported, including:

- Ground (surface and rail)
- Military and civil air (rotor and fixed wing)
- Marine (ferries, cruise ships, hospital ships, etc.)

Regardless of the type of conveyance, these individuals will be under the direct care of medical providers and clinicians from point to point until they are transferred to tertiary facilities, designated Alternate Medical Treatment Sites (AMTS) or returned home.

Phase 2 – Response

1. **Movement of Patients from Point of Origin to First Receiver**

During an incident, consideration should be given for areas of limited access based on estimates of roadway delays due to debris, evacuee traffic congestion, great distance, and limited traffic arteries, air mobilization of medical assets and available personnel. Ground entry to the area by large numbers of ambulances may be latent, cumbersome, and could potentially cause delays and negatively impact patient and special medical needs post-incident evacuation. Additionally, forward communication may be reasonably anticipated to be limited and compromised; therefore, close working arrangements with National Guard and other State entities, and staff within forward coordination points is also recommended. Local dispatching capabilities should be expected to be heavily tasked and reasonably compromised by the impact of the incident, thus coordinating through the forward coordinating points established by the State/Federal points of contact may be necessary. This would allow the feasible staging of ambulances at areas that provide tertiary or advanced and specialized care. First responder medical personnel and assets could be mobilized immediately post event into the forward area, vice waiting for ambulances to enter the area. Patients and special medical needs evacuees would then be moved to evacuation points for transfer to the next levels – either to destinations that provide more tertiary or advanced care, and/or subsequent transport by

ground/surface or air to definitive care/originating facility institutions. In addition to providing care to patients and special medical needs evacuees identified for medical transport, ESF #8 may be requested to provide the transportation assets from either the type of area mentioned above or from other collection points. Local/State authorities will normally transport patients and special medical needs evacuees to collection points. ESF #8 may support the transportation of medically at-risk evacuees from point of injury to the initial receiving medical facility (hospitals or field facilities). Medical transportation assets will provide for the medical requirements of the special medical needs evacuee(s) based on resources available.

Tasks

1. Conduct ground/surface movement (includes rail) with basic/advanced emergency medical services
2. Conduct ground/surface movement (to include rail) with critical care support
3. Conduct rotary wing movement with basic/advanced emergency medical services
4. Conduct rotary wing w/ critical care support
5. Ensure continuity of medical records (initiate electronic medical record)
6. Communicate with local EOC and/or State/Federal/Local Coordination Hub

2. Hold/Care at Originating Facility Support

Patients and those with special medical needs may shelter-in-place. Decisions to shelter-in-place must be made by the individual facilities or as directed by State or local authorities based on their preparedness, expected impact, availability of evacuation resources, ability to continue operations, historical experience, and patient safety. There are others who will be identified by local authorities as requiring transportation from a healthcare facility (hospital or nursing home), or their residence or other location in the impact area. In most cases, these evacuees are too frail or ill to travel by normal means. In addition to movement, many of these evacuees will require some en-route medical care (e.g., cardiac monitor, intravenous infusion pumps, ventilation, etc.). ESF #8 personnel may be requested to provide medical support for the movement of these patients by ambulance, para-transit, train, boat/ship, or air. The medical regulating and patient tracking should begin as early in the process as possible. Patient tracking should be integrated with general population evacuation tracking (coordination hub). Triage tags should include the minimum amount of patient information to facilitate patient tracking. Subject to the availability of resources and funding, and consistent with the VA mission to provide priority services to veterans, when requested VA might be able to designate and deploy available medical, surgical, mental health, and other health service support assets to support this phase.

Tasks

1. Provide basic/advanced emergency medical services to shelterees
2. Provide critical care support for shelterees
3. Support patients in place in case transport not available (Support may include the need for availability of oxygen)

4. Enter shelterees in designated tracking system such as Joint Patient Asset Tracking System (JPATS), TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES), and/or the Electronic Medical Record (EMR).
5. Conduct medical regulating coordination, if transport is required.
6. Support extended sheltering with fluctuating census.
7. Coordinate discharge planning with other patient movement.
8. Communicate with Local/State/Federal Coordinating Hub

3. Movement and Care to Medical Special Needs Shelters

The State may request Federal ESF #8 resources to assist in the movement of at-risk/medically fragile populations to shelter areas and with the sheltering of the special medical needs population that exceeds the State capacity. (NOTE: The movement of jailed patients/inmates is not an ESF #8 responsibility). Federal resources will be used for both the overflow of special medical needs residents and for special needs patients with higher level of care requirements (similar to what may be needed in a skilled nursing facility). The latter patients may be handled through the establishment and operation of Federal Medical Stations (FMS) or equivalent with the understanding that an FMS by itself is very limited in its ability to provide appropriate emergent or urgent medical interventions. If there is a need or potential need to accommodate such high acuity patients, then the FMS should be coupled with a Disaster Medical Assistance Team (DMAT) cache and team, which will allow for the short term care and stabilization of high acuity patients prior to their transport to a tertiary facility capable of the appropriate level of care.

Tasks

1. Conduct basic/advanced emergency medical services for evacuees traveling by ground/surface movement and rotary-wing
2. Conduct critical care support for evacuees traveling by ground/surface movement
3. Enter medical evacuees (patient and special medical needs evacuees) in designated tracking and regulating systems (e.g., JPATS, TRAC2ES, and/or the EMR) as required
4. Conduct medical regulating coordination
5. Support extended sheltering with fluctuating census
6. Coordinate discharge planning with other patient movement
7. Communicate with local/State/Federal Coordinating Hub
8. Report patient information according to established State and Federal guidelines
9. Provide for patient and responder safety
10. Ensure medical force protection

4. Movement from Originating Facility to another Facility or to Point of Embarkation

Large healthcare chains or hospitals with prearranged agreements may choose to transfer patients from one facility to another without State/Regional/Federal involvement. This could be a move out of the affected area or even a move within the same geographic region but simply to a more secure facility. Hospitals that have plans, receiving facilities, and

transportation assets in place to self-evacuate should not need State/Federal support. However, if their contracted transportation assets are not available at the time of an evacuation, State, Regional, and Federal ESF #8 partners may be requested to assist with ground and/or air transportation.

Nursing homes/licensed assisted living facility/licensed personal home care normally have transportation agreements in place to evacuate their residents in case of emergency. Many of these plans entail contacting the local EMS provider(s) through the 911 or equivalent call center as the need is recognized, from personal experience, this can take place within a time frame as short as hours prior to event impact. Note that nursing homes or skilled nursing facilities (SNFs) have a much different client base than an assisted living facility (ALF). ALFs as a rule do not have residents that require around-the-clock care or those that require medications other than what would normally be prescribed for them if they were still on their own. These two distinctly different care providers should not be treated the same when determining transportation needs. Additionally, State/local authorities may or may not have complete visibility of all ALFs and home-based residents that have the potential need for evacuation.

In general, most nursing home, licensed ALF, licensed personal home care patients, and those in special rehabilitation centers and other types of health care facilities will be transported to alternate shelter facilities with which the facility has a pre-arranged agreement. The only residents that will not be transported to an alternate shelter facility are those who decompensate, or whose current medical condition warrants transfer to a hospital. This transfer will normally be done by ambulance, but will be determined and carried out to the best ability of the local medical on-scene commander or medical transportation officer. Non-ambulatory patients may be transferred to partner institutions via ambulance or equivalent means; ambulatory patients may be transferred via coach bus/para-transit or equivalent means, and those who use wheelchairs will be transported by appropriate vehicles. The best possible and available resources will be used to support patients and individuals with special medical needs. This transportation, while normally provided by the State/local assets, can be provided Federally if required to augment them during catastrophic incidents. Having available staff to prepare patients, load and unload patients, and provide in-transit care for nursing home residents is a vital part of a safe and effective evacuation. In addition to the nursing staff, augmentation may be required.

If hospitals are unable to evacuate with pre-identified assets, they will request evacuation assistance from their Disaster Recovery Center (DRC). Hospitals will inform their DRC on the status of the facility, the number of patients that require evacuation, they type of patient, and whether they are ambulatory or non-ambulatory. With this, the DRC will typically contact the EMS coordinator through the State EOC to facilitate patient movement.

If State and State contracted transportation resources for SNF or ALF populations become overwhelmed the State may require the use of Federally-contracted ambulances and buses. If needed, transportation will be coach buses with drivers and medical personnel on each bus, as well as Federally-contracted ambulances with drivers and medical personnel.

720
721 Using a combination of available transportation assets (from FEMA, DOT, United States Coast
722 Guard, and/or National Guard (State Active Duty (SAD) or Title 32 status), ESF #8 will manage
723 the transportation of medically fragile evacuees from healthcare facilities (hospitals or nursing
724 homes), or home of residences to collection/staging/points of embarkation. Transportation
725 assets will meet the medical requirements of the evacuee(s).
726
727 In the event that hospitals request assistance and should the decision be made to move
728 patients outs of an affected area, it is likely that hospital patients would be taken to a
729 collection/staging/point of embarkation area to be queued, awaiting evacuation assets
730 (aircraft, ambulances, trains, ships, etc.). It should be noted that patients are medically
731 assessed at each stage in patient movement and possibly re-triaged as either waiting time or
732 situation warrants. Individual facilities coordinate with local and possibly State governments for
733 the conveying of patients from their facilities to collection points/points of embarkation. It
734 must also be noted that not all patients will come from hospitals or nursing homes. Local
735 governments or other entities may coordinate patient movement from other settings which
736 may include senior centers, ALFs, rehabilitation centers, or individual homes. Also, there may
737 be ad hoc, improvised/impromptu, or uncoordinated patient movement of individual patients
738 by a variety of means. These individuals may not gain visibility within the patient movement
739 system until they present at a marshalling point. Private hospitals that have contracted for
740 private air and ground ambulance assets will execute their plans without State and/or Federal
741 assistance. Early on in the response phase, hospitals typically evacuate their Obstetrics,
742 Neonatal ICU, and Nursery units and this will normally be accomplished utilizing private and
743 contracted transportation assets to bring patients to pre-designated receiving facilities.
744
745 **Tasks**
746 1. Conduct ground/surface (includes rail) and rotary-wing movement with basic/advanced
747 emergency medical services
748 2. Conduct ground/surface (to include rail) and rotary-wing movement with critical care
749 support
750 3. Conduct medical regulating to destination facilities
751 4. Manage patient evacuation requests
752 5. Initiate designated tracking and regulating systems (e.g., JPATS, TRAC2ES, and/or the EMR)
753 and coordinate/synchronize with State EOC/Coordinating Officer
754 6. Provide contingencies for sheltering/AMTS when/if transportation breaks down, or is
755 overwhelmed by sheer numbers.
756 7. Report patient information according to established State and Federal guidelines
757 8. Provide for patient and responder safety
758
759 **5. Reception, Hold, Care at Point of Embarkation or Aeromedical Marshalling Point**
760
761 Patients or special medical needs evacuees will arrive at the embarkation site/aeromedical
762 marshalling point and be briefly assessed by a trained a trained flight surgeon (or similarly
763 trained healthcare provider) to determine if they have any medical/psychological issues that

require immediate treatment or that would prohibit the patient from enduring a four to eight hour evacuation/movement transportation time. Prior to boarding DoD aircraft, evacuees will be processed through a patient staging facility, to facilitate movement to the appropriate debarkation site.

For those arriving independently (i.e., on their own or self-referred) at an embarkation site, they will be referred to healthcare personnel for an evaluation prior to transport. If an evacuee's medical condition cannot be stabilized by ESF #8 medical personnel, a process will be established to transport that evacuee by ground/surface to appropriate medical facility out of the impact site.

It is important to note that patient staging facilities is not designed nor manned to provide advanced medical care prior to aeromedical evacuation (AE). Rather, it serves as a holding facility providing medical support until suitable fixed-wing airlift arrives at the airfield to transport the patient. If advanced medical care is required at the aeromedical marshalling point, ESF #8 may augment the patient staging facility with critical care providers.

Tasks

1. Contact participating NDMS accepting facilities to determine capacity to accept evacuees with significant medical needs
2. Contact destination facilities to reconfirm capacity to accept evacuees with significant medical needs
3. Receive evacuee from ground/surface medical transport and reassess/triage medical condition to determine best and most expedient transportation mode
4. Determine medical suitability for aeromedical transport
5. Provide holding capability for those awaiting continuation of evacuation, either by aeromedical evacuation or by ground transport
6. Conduct basic/advanced emergency medical services or critical care as required for those awaiting transportation
7. Prepare medical evacuees for air travel (fixed or rotary wing)
8. Load patients on fixed-wing aircraft; litter bearing teams must be provided at APOE
9. Coordinate with medical regulating assets
10. Enter evacuee into designated tracking and regulating systems (e.g., JPATS, TRAC2ES, and/or the EMR) as required
11. Report patient information according to established State and Federal guidelines
12. Provide for patient and responder safety
13. Ensure medical force protection
14. Manage patient evacuation requests

6. Movement and In-Transit Medical Care from Point of Embarkation to Point of Debarkation

Although this stage is typically thought of as AE conducted through NDMS with military aircraft, it should be noted that there may be non-federal air movements (State/EMAC Air National

Guard or private charters) as well as other means of conveyance (rail, ground, or watercraft). The bulk of air transportation support for patient movement will come from State, the national FEMA ambulance contract, EMAC Air National Guard and DoD. ESF #1 may be able to source commercial air support but these assets would have limited applicability for patient movement. Other Federal support can come from Federal ambulance or air-ambulance contacts; although these assets typically have smaller lift capacity. The Federal government has little or no means to regulate any private movement operations. State movement operations will generally be conducted by the Air National Guard on State activation (or units activated by another State and responding under EMAC).

Tasks

1. Conduct ground/surface (includes rail) and rotary/fixed-wing movement with basic/advanced emergency medical services
2. Conduct ground/surface (to include rail) and rotary/fixed-wing movement with critical care support
3. Update designated tracking and regulating systems (e.g., JPATS, TRAC2ES, and/or the EMR) as required
4. Verify manifest accuracy with the JPMT co-located with the originating State EOC (or Theater Patient Movement Requirements Center – Americas (TPMRC-A)GPMIC, if no JPMT is established)
5. Report patient information according to established State and Federal guidelines
6. Provide for patient and responder safety
7. Ensure medical force protection

7. Reception, Hold, Care at Point of Debarkation Area

Patients and special medical needs evacuees will arrive at the debarkation site, and if not pre-determined to be a patient on a designed patient movement flight, be briefly assessed to determine if they have developed any medical issues en route that requires immediate treatment. If evacuees self-identify as having a medical/mental health issue, they will be referred to healthcare personnel for an evaluation.

Patients evacuated from a disaster area for definitive medical care should arrive at a debarkation site that has been pre-identified as a patient reception area. A *patient reception area* (PRA) is a geographic locale containing one or more airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to local voluntary, pre-identified, non-Federal, acute care hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. The PRA generally operates from a pre-identified airfield, bus station or railhead. Patients are off-loaded, triaged and staged pending further regulating and ground transport to a local definitive care hospital, medical special needs shelters, or long term healthcare facility.

Those already pre-designated as patients arriving from aeromedical marshalling points will be re-triaged at the PRA, and then transferred to the appropriate healthcare facility for further evaluation and care. Patients and special medical needs evacuees may be re-triaged and determined that they do not require inpatient hospitalization. These individuals could be transferred to a shelter, if established, and with the approval of the shelter manager.

Tasks

1. Unload patients from fixed-wing aircraft; litter bearing teams must be provided at APOD
2. Reassess/re-triage patients and special medical needs evacuees' condition post-travel
3. Determine/reaffirm the evacuee destination based on current condition
    a. Communicate with patient regulating asset to facilitate movement using appropriate transportation and to the appropriate level of care, and to confirm destination facility is ready to receive
4. Provide appropriate medical care for patient and/or special medical needs evacuees while processing through a patient reception center and until the patients and/or special medical needs evacuee has been transferred to the next transportation asset
    a. Ensure appropriate level of care is available during the next transportation leg (medical evaluation)
    b. Hold evacuee at reception center if follow-on transportation is not sufficient for the evacuee's medical condition, or if a receiving facility is not immediately available
5. Update designated tracking system such as JPATS, TRAC2ES, and/or the EMR

8. Movement from Reception Area to Definitive Care or Healthcare Facility

Patient movement from the reception area/site to the receiving facilities is traditionally thought of as an NDMS movement utilizing a developed and exercised FCC plan; moving patient with local assets to civilian NDMS hospitals. The application of this process will likely be somewhat different. First, the patient population will include a mixed array of hospital patients, nursing home patients, special medical needs populations, and others. Their destinations will correspondingly be as diverse, including both special needs and general shelters, and possibly receiving nursing homes. Non-medical attendants and service animals may be accompanying transported patients. (NOTE: Household pets are not included in the transport of patients. Other arrangements will need to be made to move household pets with the general population.) There will be attempts made to shelter low acuity patients with attendees at appropriate shelters. Triage at the point of debarkation will be needed to establish the best receiving locations for the arriving patients. Note that nursing homes are not normally incorporated into the NDMS system as a receiving facility. State Nursing Home Associations can assist in matching patients with available beds. Coordination between ESF #6 shelters and ESF #8 medical triage and treatment personnel should occur; whereby a screening process will establish which of the evacuees meet the criteria to be housed in general shelters and receive limited 'outpatient' care or assistance, rather than being placed in medical special needs shelters.

In most cases, it is expected that more than one destination medical facility will be available to support patients' needs. Patients who require treatment not available in a local disaster area are generally regulated to nearest appropriate facility capable of supporting the patient, contingent on the availability of transportation.

Tasks

1. Contact participating NDMS accepting facilities to determine capacity to accept evacuees with significant medical needs
2. Contact destination facilities to reconfirm capacity to accept evacuees with significant medical needs
3. Coordinate follow-up movement with medical regulating assets
    a. Ensure transportation mode and en-route care is appropriate to the medical condition of the evacuee
4. Perform thorough hand-off communication with the next level of care (i.e., transportation asset and/or healthcare facility)
5. Provide manifests of ESF #8 patients to include their destination facility to HHS/EMG (re-entry requirement)
6. Augment local medical transportation assets with staff or vehicles as directed
7. Update designated tracking system such as JPATS, TRAC2ES, and/or the EMR

9. Hold, Care at Definitive Care Facility

Definitive medical care generally begins upon admission to a participating destination hospital. If this is an NDMS patient, this facility will normally be an NDMS participating hospital. There may be instances that NDMS participating hospitals may not have the needed specialty or expertise to care for a patient. An example would be in the case of burn patients. If there is not enough capacity within the NDMS network to provide burn bed capacity, burn patients may be sent to non-NDMS hospitals within the burn bed network.

Within NDMS, the FCC Director assumes responsibility for tracking patients upon a patient's arrival in the PRA until patients are moved to the first accepting NDMS hospital. If available, a JPATS Team or ESF #8 Service Access Team (SAT) may be dispatched to the FCC to assist in coordinating administrative actions for medical evacuees. Additionally, Global Patient Movement Integration Center (GPMIC) Liaisons may be dispatched to the FCC to support the FCC's responsibilities for coordinating with GPMIC, and to ensure that notifications are made and that military patients are tracked. FCCs may assist in coordinating some fiscal information to support the processing of financial claims reimbursement programs.

Tasks

1. Ensure continued communication with evacuation coordination hub in sending the state and/or receiving state (or county/city, if transported in state) ongoing status of evacuees.
2. Work with receiving definitive care facilities to coordinate discharge planning
3. Update designated tracking system such as JPATS, TRAC2ES, and/or the EMR

938 **Phase 3 – Recovery**
939
940 **10. Movement from Healthcare Facility to Final Disposition – Home of Record**
941 Once authorities have determined the originating home of record is safe for re-entry, evacuees
942 will be allowed to return. For those placed in medical special needs shelters, or healthcare
943 facilities (i.e., hospitals, mental health facilities, assisted living facilities, rehabilitation facilities,
944 or nursing homes), it will become necessary to arrange transportation back to their home of
945 record or original facility. Some of the patients or special medical needs evacuees may not be
946 medically/cleared for immediate return travel. It will be important to coordinate closely with
947 case managers to ensure movement occurs when medically/psychiatrically indicated.
948 Transportation to home of record may be through a variety of transport modes (e.g., air, rail,
949 and ground), which will be coordinated by/with appropriate local and State
950 representatives/authorities. When requested, ESF #8 will assist with re-entry/repatriation of
951 medically fragile evacuees. The HHS, in its role as Primary Agency for "Federal" ESF #8 of the
952 NRF shall assure the return of ESF #8 patients and special medical needs evacuees that require
953 en-route medical care and therefore cannot travel via commercial air or without medical
954 assistance.
955
956 Re-entry/repatriation of discharged patients is not the responsibility of ESF #8. However, these
957 individuals may be returned with the general population under the guidance of FEMA DRC.
958 Additionally, general population evacuees who become ill during their movement or once they
959 arrive at their evacuation location are not an ESF #8 responsibility. One exception is the return
960 of remains should an ESF #8 patient become deceased during the response operations. ESF #8
961 will utilize the Disaster Mortuary Operational Response Teams (DMORT) to assist in the safe
962 return of remains.
963 1. Facilitate transport of ESF #8 patients who require en-route medical care back to their
964 home of record, original medical facility, originating nursing home, or other suitable
965 location to be determined by the discharge planner and evacuee
966 2. Conduct ground/surface movement (includes rail) with basic/advanced appropriate
967 emergency medical services
968 3. Conduct ground/surface movement (to include rail) with critical care support
969 4. Conduct rotary/fixed wing movement with appropriate basic/advanced emergency medical
970 services
971 5. Conduct rotary/fixed wing with critical care nurse support
972 6. Conduct return movement of NDMS evacuated patients
973 7. Conduct return movement of non-NDMS evacuated patients (NOTE: HHS does not conduct
974 return of self-evacuated individuals. They are not patients.)
975 8. Conduct return movement of shelterees and other at-risk populations that were moved and
976 continue to require care
977 9. Update designated tracking systems such as JPATS, TRAC2ES, and/or the EMR
978 10. Identify patients who decide to remain in evacuation state
979 11. Communicate this information to receiving state and sending state
980 12. Facilitate the return of deceased who were processed as an NDMS/ESF #8 patient
981

6. Interdependencies

Patient Movement Coordination Cell (PMCC)

- Comprised of representatives from HHS, DoD, DHS, VA and other ESF #8 support agencies
- Determines the medical regulating policy as well as which FCC PRAs should be alerted and/or activated for medical regulation purposes
- Ensures that the operations of the USTRANSCOM GPMIC are in concert with those of Regional, State or other medical regulating agencies
- Coordinates the planning, alert, activation and de-activation of select FCCs in support of an operation

Department of Defense (DoD)

Following an ESF #8 mission assignment, activation of NDMS, and approval by the Secretary of Defense (SECDEF), DoD coordinates with local, regional, State and other authorities to support the evacuation of patients to locations where NDMS hospital care is available.

USTRANSCOM

Once NDMS is activated, DoD (if approved by the SECDEF) will support regulation of evacuated patients via DoD assets, to the FCC responsible for the nearest or most readily assessable PRAs. When DoD resources are available and approved by SECDEF, DoD can provide patient evacuation. DoD will be responsible for regulation of patients transported by DoD assets. DoD may provide transportation by air or by ground, as available and as applicable. DoD provides Active Duty, Reserve and/or National Guard units, as available, to support patient staging and evacuation, when authorized and necessary. DoD ensures the integration of DoD patient movement operations with those of regional and/or local medical regulating agencies, as applicable.

USNORTHCOM

Tasking authority to mobilize DoD patient movement enablers and aircraft. Coordinates the operation of DoD managed FCCs. FCCs, in turn, coordinate with NDMS civilian hospitals that may be available to provide appropriate care. NDMS participating civilian hospitals will be notified by DoD FCCs of a potential need to receive incident victims for definitive care.

Department of Transportation

Supports disaster patient evacuation operations of local, regional and/or DoD medical regulating agencies (e.g., the GPMIC). Assists in the coordination of alternate modes of transportation if needed

Department of Veterans Affairs

Coordinates the operation of VA managed FCCs. FCCs, in turn, coordinate with NDMS civilian hospitals that may be available to provide appropriate care. NDMS participating civilian hospitals will be notified by VA of a potential need to receive incident victims for definitive care.

Department of Justice
Coordinates security plans associated with ESF #8 activities, to include patient movements. The level of ESF #13 involvement will depend on the threat environment and mission priorities.

Local Medical Regulating Agency
The local, municipal or State Emergency Management agency, Public Health and/or other agency responsible for regulating the inter-hospital movement of patients in the immediate environment of the disaster area. Coordinates with the ESF #8 lead/federal health official and DoD medical regulators (if applicable) to ensure integration of effort.

7. Administration and Support

Federal resources required for patient movement will be dependent on the mode of transportation and the level of care needed en-route. Federal partners may be utilized for patient movement and include:

- FEMA National Ambulance Contracts;
- VA and DoD Federal Coordinating Centers; and
- DoD and Air National Guard aeromedical evacuation assets.

It is also feasible that should the situation require, alternate modes of transport, to include commercial aviation and rail assets may also be employed to move patients.

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Appendix III: Mass Fatality Management

1. Purpose

The purpose of this appendix is to describe the delivery of the federal support during a mass fatality incident. Mass fatality management is an integral part of the overall public health and medical preparedness, response, and recovery system. It includes scene management and investigation, remains and personal effects recovery, victim identification, death certification, collection and documentation of evidence, remains preparation, and the reunification of victims with the next of kin for final disposition. State, local, territorial and tribal jurisdictions must plan for mass fatality incidents, respond during the incident, and effectively contribute to the recovery of the affected community.

2. Situation

Mass fatalities incidents can be local, sudden, and catastrophic (e.g. aircraft mishap), or global, prolonged, and chronic (e.g. pandemic). During a sudden catastrophic incident, local capacity may be suddenly overwhelmed and require temporary supplementation in their staff, additional support from forensic specialists, and expanded facilities. During a prolonged increase in fatality rate, local authorities may experience depletion of supplies and fatality management services that require augmentation. In any event, mass fatality incidents will require assessment to determine capacity and shortfalls that require local, regional or federal assistance.

3. Assumptions

The following assumptions and priorities apply to the mass fatality management response to disasters and public health emergencies:

1) Interventions during mass fatality incident response and recovery will be based on accepted professional and scientific standards for the compassionate and respectful handling of human remains.

2) The ultimate goal of the mass fatality response will be the efficient recovery of human remains and return of those remains to responsible parties for final disposition with the accurate completion of all required documentation and minimal delay.

3) The recovery, movement and disposition of human remains are local responsibilities, under local jurisdictional authority, and federal resources will be deployed exclusively in support of local response and recovery efforts.

4) Federal response will depend upon factors such as local capacity, number of fatalities, fatality rate, rate of remains recovery, presence or absence of hazardous material associated with the scene and/or remains, and requirements for a criminal or safety investigation.

5) Under certain circumstances, remains may accumulate in homes, at disaster scenes, in hospitals, at morgues, at funeral homes or at crematories. Movement of remains is regulated by local authorities and modifications in local policies and procedures may be required.

6) Security measures may be required to protect the disaster scene during remains recovery and to prevent loss of personal effects (looting of bodies or removal of evidence).

7) Normal procedures for recovery and processing of remains may be modified due to the presence of hazardous substances at the scene or on the remains.

8) Equipment and personnel deployed under ESF #8 are federal assets and will operate under the authority of NDMS and adhere to NDMS policies, procedures and standards while supporting local incident command.

4. Mission

Federal interagency partners will provide fatality management assistance based on the requirements of state, local, tribal, and territorial authorities. Federal interagency partners will also ensure synchronization of deployed federal, regional, local, and international equipment and personnel to reinforce fatality management response efforts and transition to recovery. Fatality management response addresses the need for the identification of deceased victims, the recovery and return of human remains to authorized individuals for final disposition, the collection and documentation of necessary evidence to generate accurate death certification and support investigations, support grieving individuals, and the safe conduct of fatality management operations.

5. Execution

Phase 1 - Preparedness

Fatality management planning and capacity building promote community resilience and are an essential part of public health and medical emergency response and recovery. Fatality management must be integrated into plans and preparedness activities in order to promote effective and comprehensive response, recovery, and national health security.

1. **Maintenance of Disaster Mortuary Operational Response Teams (DMORT):** The Assistant Secretary for Preparedness and Response (ASPR), through the National Disaster Medical System (NDMS) maintains DMORTs in each of the 10 FEMA regions. Each team can deploy approximately 40 specialists in fatality response and includes funeral directors, forensic dentists and dental assistants, fingerprint technicians, forensic anthropologists, forensic pathologist, photographers, radiologists and radiology technicians, forensic investigators/technicians, other forensic science specialists, administrative and logistics support personnel and other technical specialists to assist operations.
2. **Maintenance of Disaster Portable Mortuary Units (DPMU):** NDMS maintains three (3) palletized transportable equipment sets to establish remains processing in a 10,000 – 12,000 sq. ft. facility of opportunity with adequate utilities and wrap around services.
3. **Maintenance of Victim Information Center Team (VIC):** NDMS maintains a team that can deploy approximately 20 members to provide caring and compassionate guidance to grieving families and friends seeking information about those who have possibly died in a mass fatality incident. The Victim Information Center Team maintains the capacity to collect information using the Victim Information Program information management program and to collect biological specimens to assist in matching possible victims through DNA analysis.
4. **Maintain Fatality Management Assessment Teams:** NDMS maintains ten (one team in each FEMA region), six (6) member teams who can quickly deploy, assess the need for fatality management support and make recommendations to the local authorities and the Secretary's Operations Center (SOC) on appropriate federal response.
5. **Plans, Drills, and After-Action Meetings:** HHS NDMS Fatality Management components (DMORT, DMORT Victim Information Center) participate in preparedness activities such as disaster response and recovery planning and plan development, training sessions, and—in coordination with the ASPR Office of Emergency Management Training, Exercise, and Lessons Learned (TELL) Division—exercises (including team training exercises and training in conjunction with federal supporting agencies (e.g. DOD), federal partners (e.g. NTSB) and non federal partners (state DMORT, state National Guard)), after-action meetings, and lessons-learned sessions.
6. **Resilience Development and Special Topics:** DMORT members with special expertise are available for outreach and consultation to communities developing, modifying, or evaluating their fatality management plans. NDMS Fatality Management participates in collaborative activities to establish scientific standards,

guides, and best practices in the field of fatality management. NDMS Fatality Management personnel participate in meetings and make presentations to interested parties on topics related to fatality management. The US Department of Health and Human Services, Hospital Preparedness Program provides assistance to healthcare organizations to develop capacity to respond to mass fatality incidents. The US Department of Homeland Security, Federal Emergency Management Agency (FEMA) provides assistance to organizations to develop their mass fatality response capabilities.

7. **Coordination with other Federal Departments and Agencies:** The ESF #8 Fatality Management Working Group includes all ESF #8 partners to work on, and resolve issues concerning fatality management.
8. **Coordination with other Non-Federal Governmental Agencies and Non-Governmental Partners:** HHS NDMS and Fatality Management components will consult with and provide assistance in developing plans in coordination with international organizations, allied nations, state, local, territorial, and tribal authorities on plans and preparations for mass fatality incidents. HHS NDMS and Fatality Management components will also work with nongovernmental organizations (e.g. American Red Cross, International Red Cross, etc.) to prepare to collaborate during response and recovery from mass fatality incidents.

Phase 2 - Response

Assessment, deployment of personnel and equipment, and operations may be initiated during the response phase. Initially, response activities will involve efforts to recover and store human remains, secure personal effects and preserve evidence associated with the fatality. Full spectrum fatality management assistance may be required during the response phase, especially during a global, prolonged, chronic disaster (e.g. pandemic).

1. **Federal Activation**

   (a) **State, local, territorial and tribal authorities activate:** Requests for fatality management assistance will generally be routed to the SOC, through the Regional Emergency Coordinators (REC), or the Incident Management Team (IMT) if it is in operational control.

   (b) **Activation by supported agencies:** Requests for support from HHS Fatality Management from other federal agencies will conform to the parameters outlined in existing Memoranda of Agreement (MOA). Agencies without MOAs will forward requests to the SOC for evaluation and action.

1199 **2. Assessment and Initial Response Activity**

1200 (a) **Fatality Management Assessment Teams:** If necessary, an assessment team will
1201 deploy to the affected area to identify opportunities for federal assistance due to
1202 imbalances in demands and resources. The Fatality Management Assessment Team
1203 may also provide subject matter expert advice to local authorities on procedures
1204 and resources that may be used to address increased demands for services. The
1205 assessment team will make recommendations to the SOC or IMT.
1206 (b) **Equipment and Personnel Mobilization:** DMORT and VIC personnel will be
1207 identified for mobilization to address fatality management needs. DPMU equipment
1208 movement to support local needs will be determined as information is developed
1209 about local requirements.
1210 (c) **Contaminated Environment and Contaminated Remains:** DMORT procedures may
1211 be modified due to the presence of hazardous substances (biological, radiological,
1212 chemical, or explosive) in the environment, at a scene where remains recovery is
1213 required, or in the area of morgue operations. DMORT personnel with special
1214 training, equipment, and safety procedures may be deployed to address hazardous
1215 material concerns. In hazardous material incidents, monitoring of the environment,
1216 the remains, and DMORT personnel will be required and procedures will vary,
1217 depending on the contaminant.
1218 (d) **Deployment of Personnel and Coordination of Federal Assistance:** NDMS will
1219 deploy fatality management personnel and equipment during initial response
1220 according to validated requests. Personnel deployment may range from sending
1221 entire DMORT teams and or VIC, to the deployment of a limited number of subject
1222 matter experts to supplement local operations. Requests for assistance that cannot
1223 be provided by NDMS assets will be referred to other supporting federal
1224 departments and agencies.
1225
1226 **3. Partner Organizations in Initial Response Activity**

1227 (a) Initial response will most likely involve the recovery of human remains. Scene
1228 control, investigation, remains recovery, remains and personal effects disposition
1229 and funeral arrangements will be performed by non NDMS personnel and units.
1230 However, DMORT has subject matter experts that can advise local authorities and
1231 other agencies regarding task organization and procedures, if requested.
1232 (b) Other supporting federal departments and agencies, as designated under ESF #8,
1233 may be tasked with providing assistance. Nongovernmental organizations may also
1234 be involved in response activities in coordination with NDMS Fatality Management.
1235

Phase 3 - Recovery

Assessment, deployment of personnel and equipment, and operations may be initiated or continue during the recovery phase.

1. **Assessment and Recovery Activity.** Requests for fatality management assistance during the recovery phase will be evaluated and, depending upon the existing command structure, will be forwarded through the REC or IMT, SOC for assessment, validation and appropriate action.

2. **Coordination, Assessment, and Analysis.** The DMORT team leader and/or the IMT Fatalities Management liaison will:

   (a) Maintain bi-directional communication through relevant local agencies to assess and address locally-driven recovery needs and gaps and share governmental information;
   (b) Provide information to the SOC, through the REC and/or IMT if appropriate, to inform recovery assessments and to guide EMG decisions relating to support and recovery mission assignments;
   (c) Identify personnel and equipment resources related to disaster recovery and resilience and mobilize access to these resources through liaison with local authorities; and
   (d) Plan for and implement the transition from recovery operations to steady-state activity.

3. **Resources and Technical Assistance**

   (a) NDMS Fatality Management assets available for the initial response will remain available for assistance during the recovery phase. Assets range from the deployment of individual subject matter experts, to DMORTs, VIC, and DPMU. NDMS will provide logistical support for their deployed assets. Requests for aid that cannot be provided directly through use of NDMS assets will be addressed on a case-by-case basis and possibly assigned to other federal departments, agencies or cooperating nongovernmental groups.
   (b) DMORT and NDMS Activities will:
      - Partner with STT and local entities to examine fatality management recovery needs and recommend ways to transition federal response supports into existing structures (e.g., local hospital and government operated morgue facilities, local funeral homes and crematoria, etc.); and
      - Work with state, local, territorial and tribal authorities to continue to carry out fatality management services to promote community resilience and recovery.

4. **Research Opportunities.** NDMS, placing the care and safety of disaster survivors above all else and remaining sensitive to the complexities associated with disaster research, seeks opportunities to examine the performance of personnel, equipment, and procedures through analysis and research on fatality management, to promote improved understanding and performance.

5. **Transition from Recovery to Steady-State.** Transition from DMORT and DPMU operations to local operations will be coordinated with local authorities. DMORT personnel will continuously assess the need for federal assistance based upon local capacity, other resources available, and the required rate of processing of remains. Consultation with local authorities on continued need for DMORT personnel and DPMU assets will be conducted and recommendations will be forwarded to the SOC (via the IMT if necessary).

6. **Records.** Copies of all DMORT records, both paper and electronic, relating to remains identification and the examination of remains, will be provided to the local medico legal jurisdiction. Records required for investigations will be provided to investigative agencies, as approved by the controlling jurisdiction. Copies of records may be kept within NDMS for administrative reviews and analysis.

6. Interdependencies

a. **Coordination with Professional Organizations.** The Public Health and Medical (ESF#8) fatality management response, and the transition from response to recovery, requires close coordination with local, state, regional and national funeral directors organizations to assure that the increased numbers of remains are respectfully processed and prepared for release to families, next of kin, or other responsible individuals for final disposition. DMORT and the Victim Identification Center (VIC) Team routinely interact with the American Red Cross and the National Center for Missing and Exploited Children in support of their identification efforts. Religious organizations and mental health provider organizations are often involved to provide grief counseling and mental health services.

b. **Coordination with law enforcement and investigative agencies**: Mass fatality incidents where crime is suspected or incidents involving occupational safety or accident investigations (e.g. transportation accident investigated under the authority of the National Transportation Safety Board (NTSB)), require close coordination with local, state, territorial, tribal and federal investigators to recover and document evidence at the scene and associated with the remains.

c. **Coordination with other federal departments and agencies**: The Department of Health and Human Services has the primary responsibility for federal assistance in mass fatality incidents. According to the National Response Framework, Emergency Support Function #8 (ESF#8), federal departments and agencies provide support.

Mass Fatality Incident Response Function	Federal Department/Agency Support
Scene Control and Investigation	Department of Justice (DOJ) Federal Bureau of Investigation (FBI) National Transportation Safety Board (NTSB)
Recovery of Remains and Personal Effects	Air National Guard (contaminated remains), Army National Guard Department of Defense Mortuary Affairs US Coast Guard (remains recovery in water)
Evidence Collection	Federal Bureau of Investigation (FBI)
Identification	Federal Bureau of Investigation Department of Defense
Death Certification	Department of Defense
Remains Preparation	Department of Defense
Disposition of Remains and Personal Effects	Department of Defense

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and departmental policies.

Appendix IV: Assessment of Public Health and Medical Needs

1. Purpose

The purpose of this Appendix is to describe the delivery of Public Health and Needs Assessments.

2. Situation

In the event of emergencies or disaster events, a public health and needs assessment must be conducted so that supporting Federal resources are applied quickly and efficiently for both response and recovery.

3. Assumptions

- Public health departments and healthcare organizations will establish close working relationships and mutual aid agreements with State, regional, and tribal public health response coordinators, neighboring health jurisdictions, humanitarian and volunteer organizations, and the local Medical Reserve Corps.
- Local public health departments and healthcare organizations will conduct hazard vulnerability and risk assessments for their area.
- Capacity assessments will be conducted to define the resources of the community's public health system and the resources available through mutual aid agreements.
- Plans will be developed to outline continuity of public health operations and healthcare organizations during disasters and emergencies, and include procedures to request and incorporate surge capacity resources necessary to perform basic public health missions.

4. Mission

HHS mobilizes and deploys personnel to support national or regional teams to assess public health and medical needs, including the needs of at-risk population groups, such as language assistance services for limited English-proficient individuals and accommodations and services for individuals with disabilities. This function includes the assessment of the health care system/facility infrastructure.

5. Execution

General

The ASPR Regional Administrator (RA) normally leads the overall public health and medical needs assessment process. The initial assessment is conducted by the immediate response cadre within the impacted region. It is led by the Regional Emergency Coordinators (REC), complemented by available Federal public health and medical personnel. This generally includes the US Public Health Service (PHS) Regional Incident Support Team (RIST) team members, other ASPR regional staff (HPP, MRC Coordinator) and HHS regional staff. The assessment is developed and executed through a liaison network at multiple operational centers and locations. A variety of on-site and web based monitoring is utilized to conduct the assessment.

IMT-Forward

The IMT-Forward (F) is the first team to arrive on-site, ideally within 12 hours. The assessment done by the IMT-F is specifically focused upon the response mission to be executed. It also provides support to the RA and immediate response staff at assessing the situation to the extent possible, but it is not staffed as a disaster assessment team.

The IMT-F must be able to deploy upon verbal approval by the DAS or designee. The IMT OSC and LSC closest to the incident may be authorized to move immediately upon notification to an agreed upon location on their own to meet up with the rest of the initial response group and the FHCO to facilitate the assessment of the operating location and the reception of personnel and equipment.

Applied Public Health Teams

HHS also has Applied Public Health Teams (APHT) that can be used to conduct focused public health assessments post-disaster. The assessments may either be focused on a specific issue (e.g., mold, food) or have a much broader focus.

Administration for Children and Families

Regional Emergency Managers (REM) for the Administration for Children and Families (ACF) deploy to the human services branch of the Regional Response Coordination Center (RRCC) and work with the various Human Service partners to assess the needs of special needs populations.

SAMHSA

The SAMHSA Regional Administrator supports the response by assessing the behavioral health needs of the impacted populations. SAMHSA maintains regular communication with the HHS response structure, and sometime provides direct support inside the IRCT.

Regional Advisory Committee

The Regional Advisory Committee (RAC) is comprised of all HHS leadership in the Region. The RAC convenes during an incident and meets regularly to coordinate Regional HHS support. The ASPR RA is a co-chair of the RAC, and maintains constant communication and information exchange, bringing together all HHS operating and staff divisions. The RAC is an important forum for assessing regional impacts to public health, medical and special populations.

Support to States

CDC has developed the CASPER tool for community based post-disaster assessment. This can be offered to the state/locals for use. Federal Public Health and Medical Responders have also been used to support these assessments in the past.

6. Interdependencies

HHS can coordinate assistance from National and Regional personnel and teams to supplement state (and local) capabilities.

7. Administration and Support

Activities performed under this Appendix will be carried out in accordance with applicable laws, regulations, and Departmental policies.

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Appendix V: Veterinary Medical Support

1. Purpose

The purpose of this Appendix is to describe the delivery of HHS Veterinary Medical Support to State, local, tribal, and territorial authorities, in collaboration with other Federal Agencies, Private Volunteer Organizations (PVOs) and Non-governmental Organizations (NGOs) that provide national capabilities for animal response and recovery.

2. Situation

During and after an emergency event, it is common for animals to be both affected and/or utilized as responders. Impacted animal populations can include: household pets, service and assistance animals, working animals, horses, poultry and livestock, wildlife, exotic animals, zoo animals, laboratory animals, and animals housed in shelters. A disaster of any magnitude may cause animals to become displaced, voluntarily or involuntarily separated from their owner, chemically or radiologically contaminated, sick, or injured. Many hazards and disasters also impact the local veterinary medical infrastructure thus making it unavailable for immediate emergency response.

In addition, working dogs and horses may be deployed in the response. These valuable animals require access to veterinary medical care to maintain their medical readiness and/or treat work-related injuries and illnesses and return them to duty.

Local veterinary medical providers may face personnel, equipment and infrastructure challenges during disasters due to gaps in resources, unanticipated events, and lack of knowledge or planning. Loss of local veterinary capabilities puts impacted animal populations at risk.

Evidence has shown that private practitioners who offer their clinics in response to a disaster risk financial loss and credibility. Clinics can become overwhelmed by wild and domestic animals presented for care and quickly run out of resources and personnel. To make matters worse, private practitioners often lose credibility when they try to recoup their costs by charging disaster victims for their services. Furthermore, during events with contaminated animals, private practitioners may be reluctant to support decontamination and treatment of these animals in their hospitals due to public misperceptions that the facility may become persistently contaminated thus negatively impacting the practitioner's future livelihood.

During and after a disaster, veterinary public health issues often arise due to the degradation of local infrastructure and breakdown of the normal human-animal interface. The result is

increased risk of exposure to zoonotic and vector-borne diseases, and environmental health threats such as food borne or waterborne diseases.

3. Assumptions

The following assumptions and priorities apply to the veterinary medical response to disasters and public health emergencies:

1) Ownership of domestic animals for companionship and service needs is important to humans and will have a significant impact on disaster management.

    a. For an urban population such as that in Washington DC, the average is 1 pet per household and over half of owners consider pets to be family members nationally.

    b. Animals will be affected similarly to people in the impacted area, i.e., becoming displaced, injured, contaminated or ill because of the physical infrastructure damage, health threat exposures and the environmental situation.

    c. Evacuation, decontamination, and sheltering plans for people only work as well as the adjunct animal plans that support them.

    d. Animal evacuation will be conducted in conjunction with human evacuation efforts. Animals will be sheltered near their owners to the greatest extent possible.

2) Veterinary Medical Support reinforces the human response in disaster situations by giving survivors the peace of mind that their pets and service animals will be evacuated, sheltered and cared for.

3) Animal first responders will conduct aggressive search and rescue operations, and veterinary public health risks will be mitigated.

4) For a human infectious disease with a strong zoonotic nexus, control of the disease in people is more readily accomplished if appropriate measures are taken to control the incidence among animal populations, thus reducing the susceptible animal species' ability to serve as a natural reservoir and source of human exposure to the pathogen.

4. Mission

In emergencies and disasters, HHS and its Federal interagency partners conduct Veterinary Medical Support based on the requirements of State, local, tribal, and territorial authorities, in collaboration with the numerous Private Volunteer Organizations (PVOs) and Non-governmental Organizations (NGOs) that provide national capabilities for animal response and recovery.

Federal Veterinary Medical Support bridges state and local response and recovery capability gaps, and supports state and local resiliency to regain capacity for responding to future animal issues.

In certain infectious disease outbreaks, HHS may implement veterinary medical control measures under its own authorities and in support of State, local, tribal, and territorial authorities to reduce the disease threat to the human population.

HHS, through its National Veterinary Response Team (NVRT), veterinary officers of the Commissioned Corps of the US Public Health Service (USPHS), and other veterinary medical professionals within its divisions such as the CDC, FDA, and NIH, is the primary Federal resource for treatment of displaced, injured and ill, service animals, companion animals, working animals, laboratory animals, and in certain circumstances, horses and livestock. The capabilities of the U.S. Department of Agriculture (USDA), Department of Defense (DOD) and other Federal partners align to support HHS in this effort. HHS can similarly provide veterinary public health technical support to States, local, tribal and territorial communities upon request.

Under its own statutory authority, HHS manages and conducts zoonotic disease response and control programs in order to protect human health. Examples include certain animal influenzas, exotic animal diseases, and emerging and re-emerging diseases.

HHS supports other Federal lead agencies for responses under their authorities for livestock, equine, poultry, and wildlife. This encompasses the spectrum of biological, radiological and chemical events, to include oil and other hazardous substance spills (ESF 10), as well as U.S. response to international animal emergencies and disasters.

HHS and its partners are also prepared to provide Veterinary Medical Support to animals during evacuation and sheltering operations, to working animals deployed for search and rescue, to poultry and livestock during disease outbreaks of agricultural importance, and to working animals supporting Special Events (SE)/National Special Security Events (NSSE) and other law enforcement missions

5. Execution

Concept of Operations

<u>Phase 1 - Preparedness</u>

The HHS Veterinary Medical Support strategy supports both national health security and local community resilience. Veterinary Medical Support is an essential component of medical and public health emergency response and recovery activities. Veterinary Medical Support must be integrated into preparedness plans at all levels. HHS collaborates and synchronizes planning with the interagency community in order to promote effective and comprehensive response, recovery, and resilience.

Preparedness

1. **NATIONAL ANIMAL RESPONSE COALITIONS:** The national non-Federal response capabilities and entities are organized into two primary coalitions – the National Animal Rescue and Sheltering Coalition (NARSC) and the National Alliance of State Animal and Agricultural Emergency Programs (NASAAEP). As Veterinary Medical Support represents only a fraction of the animal issues in emergency management, HHS and its Federal partners will:
    a) Share information, training opportunities, and best practices.
    b) Leverage opportunities for synchronized planning, interagency projects, training and exercises, and active participation in national and regional conferences.
    c) Incorporate exercise and operational lessons learned in preparedness plans.
    d) Gather external stakeholder input through listening sessions, meetings, working groups, summits and workshops.
    e) Promote shared objectives (i.e., National Health Security Strategy, National Mitigation Framework, National Response Framework (NRF), National Disaster Recovery Framework (NDRF), Whole Community, and Grant Alignment).

2. **STATE AND REGIONAL ASSESSMENT:** ASPR Regional Emergency Coordinators (ASPR-RECs) conduct, with the assistance of NVRT leaders in their region or the NDMS Chief Veterinary Officer, a *Veterinary Medical Capacity Assessment* for each state in their region to establish capacity, address gaps, and promote resilient animal health systems in support of of state veterinary medical leaders.

3. **NATIONAL VETERINARY RESPONSE TEAM:** The NVRT is the primary Federal resource for veterinary medical treatment of displaced, injured and ill pets, service animals, working animals, laboratory animals, horses and some circumstances livestock. The NVRT plans, equips, and trains in preparation for these potential missions.

5. **VETERINARY CATEGORY OFFICERS OF THE USPHS COMMISSIONED CORPS:** Although not a significant clinical medical capability provider, this group contributes a wealth of veterinary public health and laboratory animal medical expertise to the HHS veterinary capability set and are integrated in HHS veterinary medical training and exercises whenever possible.

6. **U.S. ARMY VETERINARY SERVICE:** U.S. Army veterinary capabilities serve as the primary Federal level clinical and veterinary public health backup to HHS. To meet anticipated Defense Support of Civil Authorities (DSCA) missions in support of HHS (ESF8), DOD and HHS veterinary/medical planners will collaborate and synchronize civil support planning efforts. To promulgate unity of effort, planners will identify potential capability gaps that may result in HHS requests for assistance, and define specific requirements for subsequent mission assignments. Whenever possible, veterinary pre-scripted mission assignments (PSMAs) and/or formal interagency agreements will be developed. HHS and DOD veterinary capabilities that may be leveraged for DSCA will establish lines of communication and conduct exercises with interagency partners and stakeholders whenever possible.

7. **VETERINARY CAPABILITIES AND OFFICERS OF OTHER HHS AND FEDERAL AGENCIES:** The CDC and other HHS divisions, as well as other Federal agencies, who mobilize personnel and resources in support of a national veterinary medical response requirement, write synchronized response plans, and train personnel to fill their respective emergency response roles.

8. **PLANNING:** Animal responses for which HHS has the Federal lead, such as significant zoonotic disease outbreaks, compel HHS to develop plans and exercise them as there is limited experience with such contingencies in the United States. ASPR will support the development of these plans at the Regional and State level. ASPR and the CDC develop a national framework for how such a response would be executed.

9. **DRILLS, EXERCISES, AND AFTER-ACTION MEETINGS:** HHS operational and staff divisions, with Veterinary Medical Support expertise (such as ASPR and CDC), participate in preparedness activities such as disaster response and recovery plan development, and, in coordination with the ASPR Exercise, Evaluations, and After Actions (E2A2) Division, exercises, after-action meetings, and lessons-learned sessions. The NDMS NVRT, USPHS Officers in the Veterinary Category, other HHS veterinarians, and our Federal veterinary medical partners such as the U.S. Army Veterinary Service participate in operations-based exercises of our own or preferably with those of our State and PVO/NGO partners which more closely models how such a response would be executed

Resources, Technical Assistance, and Information Dissemination

10. **STATE ANIMAL RESPONSE ORGANIZATIONS:** States have various models for organizing and training their animal response personnel. These include State Animal Response Teams (SARTs), Veterinary Medical Reserve Corps (VMRCs), and other organizational constructs. State animal planning is typically conducted by the State Veterinarian's office. Zoonotic disease response planning typically resides in the state health department. ASPR and the CDC

participate in these preparedness efforts to exchange information, resources, and best practices.

11. **Dissemination of Information and Training:**
    a) Training Modules: In order to train its responders and those of its response partners, the National Disaster Medical System developed on-line training for veterinary medical response issues, tactics, techniques, and procedures. These training modules are accessible by the interagency community for inclusion in partners' and stakeholders' training programs.
    b) Concepts of operations, tactics, techniques and procedures development: ASPR-OEM identifies national veterinary medical response gaps and develops requirements for capability development; ASPR-OEM develops operational concepts, tactics, techniques and procedures for execution by HHS Veterinary Medical Support assets.
    c) Protocols and reporting: ASPR-OEM works with its interagency response partners to develop a common operational picture (COP), methods of sharing communications, reporting and record-keeping, and inter-operational veterinary medical protocols. The goal of these efforts is to synchronize and synergize the interagency veterinary medical response.

12. **Federal Animal Coordination Programs:**
    a) ASPR-OEM participates in animal emergency management policy development and planning with its Federal agency partners.
    b) A formally-recognized Federal Animal Emergency Management Working Group (FAEMWG) is under development by DHS and relevant Federal agencies that will improve collaboration, coordination, program development, and policymaking across Federal agencies. ASPR, the CDC, the FDA, and the NIH are HHS divisions that have a stake in this working group.

13. **Scientific Preparedness and Research:** Although most veterinary critical care and emergency medical procedures are well developed, numerous gaps exist in the science of the treatment of animals in a contaminated environment (chemical/biological/radiological); there is no Federal entity with the mandate to close these knowledge and capability gaps.

Phase 2 - Response

Veterinary Medical Support efforts address the needs of three population groups:

- Animals affected by emergencies and disasters.
- Animal disaster responders.

- Human populations facing veterinary public health threats due to emergencies and disasters.

Federal Activation

1. **SUPPORTING AGENCIES ACTIVATION:** The HHS Secretary's Operations Center (SOC) and the Emergency Management Group (EMG) that activate during emergency and disaster operations coordinate the deployment of Veterinary Medical Support capabilities by HHS and its supporting agencies; if Veterinary Medical Support gaps remain, a DSCA request for assistance may be made to DOD under the authorities of the Economy Act or the Stafford Act.

Coordination, Assessment, and Analysis

2. **ANIMAL MULTI-AGENCY COORDINATION GROUP (AMAC):** FEMA hosts an informal multi-agency coordination group upon activation of the NRCC to serve as a national clearing house for assessing animal response needs identified by the states and identifying potential resources to fill them.

3. **NATIONAL ANIMAL RESCUE AND SHELTERING COALITION (NARSC):** During disaster responses, NARSC hosts daily teleconferences with their members (national animal PVO/NGOs), national response partners and stakeholders, and the affected states to help identify and fill needs with the appropriate resource.

Resources, Technical Assistance, and Information Dissemination

4. **MISSION ASSIGNMENTS:** ASPR, along with the USPHS Division of Commissioned Corps Personnel and Readiness (DCCPR), creates rosters of NVRT and USPHS responders eligible for mission assignments that HHS receives from DHS/FEMA in accordance with the Stafford Act. ASPR executes mission assignments and deploys Veterinary Medical Support assets based on State and local needs and requests. If additional veterinary gaps and requirements exist, DOD veterinary capabilities may be requested by HHS, and upon approval by the Secretary of Defense (SECDEF), employed in support of HHS following receipt of a Veterinary Medical Support mission assignment (MA) from FEMA.

5. **VETERINARY MEDICAL LNO:** In anticipation of deployment of ASPR-NDMS or DCCPR veterinary medical resources, the ASPR-EMG assigns a Veterinary Medical LNO to the Incident Management Team (IMT) to identify needs and facilitate coordination of federal veterinary medical assets, including staged DOD veterinary capabilities, with local and voluntary assets. When the Veterinary Medical Branch Director position (below) is activated it may assume the coordination duties of the LNO or be an additional position in the IMT depending on the scope of the veterinary medical response.

1686 6. **Veterinary medical Branch Director:** Once ASPR-NDMS, DCCPR, or supporting agency
1687 veterinary medical resources are deployed, the ASPR-EMG assigns a Veterinary Medical
1688 Branch Director (VMBD) who serves under the IMT Operations Section Chief and provides
1689 tactical supervision of deployed veterinary resources. The VMBD is the conduit for
1690 information between deployed resources and the IMT. The VMBD informs all relevant IMT
1691 members of issues or concerns, helps define resource requests, and serves as the subject
1692 matter expert within the IMT on veterinary issues and oversight. When required, the VMBD
1693 (with a supporting staff) conducts branch tactical planning to meet the veterinary medical
1694 objectives of the HHS response.
1695
1696 7. **Sustained Response:** Requirements for sustained Veterinary Medical Support, such as
1697 support to animal sheltering, often go well beyond the traditional Response phase and
1698 overlap with HHS activities in the Recovery phase; sustained Veterinary Medical Support
1699 must be planned for during Preparedness, Response and Recovery phases. Under ideal
1700 conditions in the late Response phase, the States, Local governments, and PVO/NGOs will
1701 be able to meet the impacted area's veterinary needs thus allowing HHS Veterinary Medical
1702 Support assets to demobilize. For events that generate massive damage to the local/state
1703 veterinary medical infrastructure, long-term animal sheltering requirements, or result in a
1704 persistently contaminated environment, HHS must be prepared to meet Veterinary Medical
1705 Support requirements on a long-term horizon.

1706
1707 **Phase 3 - Recovery**
1708
1709 (c) **Transition:** The transition from Federal response to recovery for Veterinary Medical
1710 Support is marked by several organizational changes:

1711 a) State and local immediate response needs diminish. Response assets demobilize and the
1712 national coordinating structure transitions from the NRF to the NDRF; and

1713 b) At HHS, coordination passes from NRF Emergency Support Function #8 (Health and
1714 Medical) to NDRF Recovery Support Function for Health & Social Services (H&SS RSF)

1715 **Resources, Technical Assistance, and Information Dissemination**
1716 **(d) Missions:** Veterinary Medical Support in this phase is primarily technical in nature and
1717 requirements are filled using the appropriate resources from those previously described
1718 under Response
1719
1720 **(e) Whole of Community:** The animal welfare and veterinary medical communities benefit from
1721 the generosity of the public and the organizations and foundations that represent them.

Many of these organizations represented by NARSC and other animal health and welfare coalitions offer grants and other support to help the animal and veterinary medical infrastructure recover.

Transition from Recovery to Steady-State

(f) **PHASE-DOWN AND TRANSITION TO STEADY-STATE:** Transition from NDRF-coordinated recovery Veterinary Medical Support to steady-state Federal and community resources is a key planning consideration throughout the H&SS RSF operational period. The NDRF provides guidance for assessing the progress of this transition. Prior to the transition, phase-down planning is conducted by the H&SS RSF. For Veterinary Medical Support this involves:

- Ensuring the disaster-impacted community is aware of any changes in provision of external veterinary medical services; local authorities and veterinary medical providers are engaged in the transition to steady-state activity, working through H&SS RSF and regional agency personnel, as indicated; and
- Documenting and applying Veterinary Medical Support lessons learned through engaging in after-action reviews (AAR) and revising related planning, response and recovery documents, including capturing the new organizational and interagency relationships, best practices, approaches, knowledge, and resources that can assist communities to prepare, respond, recover and become more resilient.

6. Interdependencies

HHS Veterinary Medical Support serves a role in numerous other Emergency Support Functions.

- **Transportation** – Animals pre and post transport should be examined and treated as required.
- **Public Works (Debris Management)** – There are public health issues that need to be defined and managed when disposing of animal carcasses; public health issues and carcass disposal methods vary by disaster and state.
- **Mass Care** – Animals sheltered-in-place, evacuated and sheltered with their owners, or evacuated and sheltered with other unfamiliar animals have increased medical requirements caused by stress, environmental exposures, food and water contamination or deprivation, injuries and contagious diseases.
- **Urban Search and Rescue (US&R)** – US&R working dogs have increased medical needs while deployed to damaged, hazardous, contaminated, and stressful environments.

Animals rescued from collapsed buildings or other circumstances requiring their extrication generally have immediate emergency medical needs.

- **Oil and Hazardous Materials Response** – Animals that have been contaminated/decontaminated have specific veterinary medical and rehabilitation needs that can rarely be met by private or public veterinary clinics and hospitals.

- **Agriculture and Natural Resources** – Diseases that affect horses, livestock, poultry, and wildlife may require HHS assistance for their response and will very often require HHS assistance in defining and communicating the threat to human health.

- **Security and Law Enforcement** – Working dogs and horses used for security and law enforcement have increased veterinary medical needs to keep them in duty status. This is true for both emergencies and planned special events when these animals are working longer hours, in environmentally stressful conditions, and may be subjected to intentional or incidental contamination with hazardous materials and chemicals.

7. Administration and Support

Activities performed under this Appendix will be carried out in accordance with applicable laws, regulations, and Departmental policies.

DRAFT

Appendix – Disaster Behavioral Health

1. Purpose

The purpose of this Appendix is to describe the delivery of the Disaster Behavioral Healthcare. Disaster behavioral health is an integral part of the overall public health and medical preparedness, response, and recovery system. It includes the many interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events. Behavioral factors directly and indirectly influence individual and community risks, health, resilience, and the success of emergency response strategies and public health directives.

2. Situation

During and after an emergency event, it is common for people—including response workers—in the affected region to experience distress and anxiety about safety, health, and recovery, as well as grief and loss. Some people may experience more severe behavioral health reactions that hinder their recovery. In a smaller subset, psychological conditions or substance use/abuse may develop or worsen if not addressed. Disaster behavioral health aims to provide a continuum of services and activities—ranging from communication, education, and basic support to promoting access to behavioral health treatment—in order to mitigate the progression of adverse reactions into more serious behavioral health conditions.

3. Assumptions

The following assumptions and priorities apply to the behavioral health response to disasters and public health emergencies:

1) Interventions during disaster response and recovery should be based on accepted professional standards, founded on empirical knowledge, and delivered by trained volunteers, paraprofessionals, and when appropriate, professional personnel.

2) Individuals with pre-existing behavioral health issues may be among survivors receiving medical services.

3) Some individuals or populations may be at higher risk for more severe reactions.

4) Primary care providers and emergency responders delivering behavioral health support in the affected community, as well as early care and school age providers and educators, may

benefit from technical assistance, support, and referral points for disaster behavioral health services.

5) In certain incidents, such as biologic events or terrorist incidents, emergency departments and health care facilities may experience an influx of patients with psychologically-based complaints or unexplained physical symptoms, as well as more severe behavioral health symptomology than is experienced in other natural disasters, requiring targeted preparedness and response activities.

4. Mission

Federal interagency partners will initiate and conduct Disaster Behavioral Healthcare based on the requirements of State, local, tribal, and territorial authorities. These Federal interagency partners will also ensure synchronization of deployed Federal, Regional, local, and international teams to reinforce Disaster Behavioral Health response efforts and transition to recovery.

5. Execution

a) Concept of Operations

Phase 1 - Preparedness

Disaster behavioral health strategies and actions promote community resilience and are an essential part of public health and medical emergency response and recovery. Disaster behavioral health must be integrated into plans and preparedness activities in order to promote effective and comprehensive response, recovery, and national health security.

Preparedness

4. **Quarterly Preparedness Forums:** ASPR-ABC and SAMHSA will establish and convene quarterly Disaster Behavioral Health and Community Resilience Preparedness Forums. The format of these forums will be flexible to meet current preparedness needs, and may include in-person meetings, teleconferences, or web-based venues. At these forums, federal partners with responsibilities in disaster behavioral health preparedness and the psychological and behavioral aspects of community resilience will:
    a) Share information and best practices;
    b) Leverage opportunities for coordinated efforts, joint projects, and presentations at national and regional conferences;
    c) Incorporate lessons learned in preparedness plans;
    d) Gather external stakeholder input through listening sessions;
    e) Promote shared objectives (i.e., NHSS, NDRF, Whole Community, and Grant Alignment)

5. **State and Regional Assessment:** ASPR Regional Emergency Coordinators (ASPR-RECs) conduct, if applicable, a *Disaster Behavioral Health Capacity Assessment* for each state in their region to establish capacity, address gaps, and promote resilient systems. ASPR-ABC and SAMHSA will provide technical assistance to ASPR-RECs for this process.
6. **GeoHealth:** GeoHealth will be populated with information about the behavioral health infrastructure in each state, territory, or tribal area, such as availability of STT, community, and private providers of mental health and substance abuse services as well as pertinent federal grantees.
7. **Plans, Drills, and After-Action Meetings:** HHS OPDIVs and STAFFDIVs with disaster behavioral health expertise (such as ACF, ASPR, CDC, and SAMHSA) participate in preparedness activities such as disaster response and recovery plan and plan development, and—in coordination with the ASPR Exercises, Evaluations, and After Action Division (E2A2) Division—exercises, after-action meetings, and lessons-learned sessions.
8. **Resilience and Special Topics:** Agencies participating in Preparedness Forums foster the principles of individual and community psychological resilience in preparedness plans and approaches and ensure that special topics with a role in overall well-being and safety (such as family disaster planning, out-of-home caregiver/educator training to react and respond to needs of children, and disaster preparedness in relation to pets) are included in preparedness materials and training.

Resources, Technical Assistance, and Information Dissemination

9. **Cooperative Agreements/Grants:** CDC and ASPR educate STT stakeholders and grantees participating in the CDC's Public Health Emergency Preparedness (PHEP) program and ASPR's Hospital Preparedness Program (HPP) on the importance of including behavioral health as part of public health and hospital preparedness and response.
10. **State Disaster Behavioral Health Consortium:** ASPR-ABC and SAMHSA participate in State Disaster Behavioral Health Consortium meetings to exchange information, resources, and best practices.
11. **Dissemination of Information:**
    a) The disaster behavioral health preparedness forum group works to identify existing behavioral health training opportunities and educational materials to ensure that they are accessible and cross-linked on pertinent government websites, to identify electronic and print dissemination mechanisms, and to address knowledge gaps that require new information development.
    b) ASPR-ABC creates assessment tools, educational resources, and factsheets and disseminates them to ESF #8 and STT partners to enhance response capacity and resilience.

1877 c) The SAMHSA Disaster Behavioral Health Information Series (DBHIS) contains themed
1878 resource collections and toolkits pertinent to the disaster behavioral health field.
1879 (See Appendix D).

1880 d) The SAMHSA Disaster Kit contains SAMHSA disaster behavioral health publications
1881 (see Appendix D) for professionals and the general public. Materials may be used to
1882 support immediate disaster behavioral health response efforts.

1883 12. **Behavioral Health Programs:**
1884 a) SAMHSA's 24/7 Disaster Distress Helpline connects those experiencing emotional
1885 distress related to a disaster with crisis center counselors who can provide support
1886 and referrals to local resources by calling 1-800-985-5990 or texting TalkWithUs to
1887 66746.
1888 b) SAMHSA's National Child Traumatic Stress Network is dedicated to improving access
1889 to care, treatment, and services for children and adolescents exposed to traumatic
1890 events.
1891 c) The DHS-FEMA/SAMHSA CCP provides crisis counseling services to disaster
1892 survivors, develops partnerships with local organizations to promote resilience and
1893 recovery capabilities, trains and educates community partners and grant recipients,
1894 and collects data to evaluate and improve CCP services (see Appendix C).
1895 d) SAMHSA's Disaster Technical Assistance Center (DTAC) provides resources that help
1896 STT and local entities deliver an effective mental health and substance abuse
1897 response to disasters.
1898 e) ACF's Administration on Children, Youth, and Families' National Domestic Violence
1899 Hotline provides support, information, referrals, safety planning, and crisis
1900 intervention in 170 languages to domestic violence victims.
1901 f) SAMHSA's National Center for Trauma Informed Care is dedicated to building
1902 awareness of trauma-informed care and promoting the implementation of trauma-
1903 informed practices in programs and services.
1904
1905 13. **Scientific Preparedness and Research:** The National Institutes of Health (NIH) and the
1906 National Library of Medicine (NLM) conduct research and literature reviews to determine
1907 best practices and evidence-informed approaches to disaster behavioral health and
1908 resilience. This includes collecting and disseminating information on disasters and
1909 behavioral health from NIMH, SAMSHSA and other agencies via MedlinePlus, PubMed,
1910 and the Disaster Information Management Research Center. Awareness of the most up to
1911 date findings of the scientific community supports HHS training, guidance, and
1912 educational and policy documents.
1913

1914 **Phase 2 - Response**
1915 Disaster behavioral health response efforts address the needs of three population groups:
1916 • Survivors affected by the emergency who require support
1917 • Incident responders/workers
1918 • Existing recipients of behavioral health services provided by the behavioral health care
1919 infrastructure

1920 **Federal Activation**
1921 **8. Supporting Agencies Activate:** The CDC Emergency Operations Center (EOC)
1922 Mental/Behavioral Health Functional Desk, ACF Emergency Operations and SOC Liaison,
1923 ASPR-ABC SOC liaison and EMG seat, ARC Mental Health, and SAMHSA Emergency
1924 Coordination functions activate in response mode and coordinate any immediate outreach
1925 to STT partners to address urgent needs.
1926

1927 **Coordination, Assessment, and Analysis**
1928 **9. Federal Disaster Behavioral Health Group** (FDBHG): ASPR-ABC convenes the FDBHG, which
1929 includes participants indicated by the needs of the disaster such as SAMHSA, ACF, ARC,
1930 ASPR, CDC, FOH EAP, HHS Recovery staff, and IRCT and/or ASPR-REC field representatives.
1931 The FDBHG provides behavioral health information analysis and coordination in support of
1932 ESF #8 operations. The FDBHG does not replace or supersede OPDIV and STAFFDIV
1933 authorities, responsibilities, or reporting. Operating until activities transition to recovery
1934 operations, the FDBHG:
1935 a) Implements a coordinated outreach approach so that outreach to state and local
1936 behavioral health stakeholders is targeted, appropriate, and non-duplicative;
1937 b) Establishes bi-directional communication through relevant agency programs and
1938 grants to identify needs, share governmental information, gather essential elements
1939 of information, and develop a common operating picture (Appendix B summarizes
1940 the Essential Elements of Information (EEI) that are needed to guide the behavioral
1941 health response);
1942 c) Analyzes information to identify capabilities, gaps, and response recommendations;
1943 d) Identifies informational and psycho-educational resources related to the disaster
1944 event and mobilizes access to this information through public information systems;
1945 and
1946 e) Generates information to inform long-term recovery and after-action/lessons-
1947 learned activities.
1948 **10. ESF #8 Reporting:** ASPR-ABC summarizes pertinent information from the FDBHG for ESF #8
1949 situation reports to the SOC and ASPR leadership, and for the Incident Action Plan (IAP) and
1950 HHS policy response coordination meetings.

11. **MRC Coordination:** OASH-OSG-DCVMRC assists ESF #8 partners in integrating OASH-OSG-DCVMRC members into their response activities, and works with the coordinator of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP; see Appendix D) to provide liaison to ESF #8 partners on civilian deployment.

Resources, Technical Assistance, and Information Dissemination

12. **Human Services:** ACF contacts program grantees and regional coordinators in affected areas to determine the impact of the disaster on human services provision and related behavioral health needs. ACF can also make use of flexibilities and waivers in its routine grantee programs to provide services as necessary.
13. **Mission Assignments:** ASPR, along with OFRD, creates rosters of responders eligible for mission assignments that HHS receives from DHS/FEMA in accordance with the Stafford Act. ASPR executes mission assignments and deploys behavioral health assets based on STT and local requests and needs. ASPR-ABC assists by analyzing and vetting complex behavioral health mission assignments.
14. **Behavioral Health LNO:** Upon deployment of ASPR-NDMS or OFRD teams, the ASPR-SOC assigns a Behavioral Health LNO to the IMT to help coordinate federal behavioral health assets with local and voluntary assets, identify needs, and monitor federal behavioral health force protection efforts. ASPR-ABC serves as a reach-back resource on disaster behavioral health for the IMT, the LNO, and for leadership in the field.
15. **MedMap:** The ASPR-SOC compiles and analyzes Behavioral Health MedMap data to inform the response, target resources, and address gaps.
16. **Information Promulgation:** ASPR-ABC works with SAMHSA, CDC, ASPR Public Information Officer, and pertinent stakeholders—using information identified through the FDBHG—to coordinate dissemination of relevant behavioral health information and psycho-educational resources. Activities include providing information on behavioral health, coping, resilience, and resources through HHS social media (e.g., Twitter and Facebook) accounts.
17. **Behavioral Health Programs/Activities:** SAMHSA:
    a) Contacts grantees and response partners to determine impact and coordinates with the State Disaster Behavioral Health Coordinator and stakeholders or other entities holding disaster-related projects or grants in affected region to assess need and offer technical assistance and resources. Examples of relevant projects and grants include the National Child Traumatic Stress Network, Suicide Prevention, block grants, tribal programs, and mental health and substance abuse prevention and treatment programs.
    b) Provides technical assistance on CCP (a Stafford Act program) and the SAMHSA Emergency Response Grant (SERG) program to STT and local entities. CCP assists individuals and communities in recovering from the challenging effects of disasters

1989 through the provision of community-based outreach and psycho-educational
1990 services. Services are typically provided by behavioral health organizations through
1991 contracts with a state's department of mental health.
1992 c) Disseminates resource materials via the SAMHSA website, Information Clearance
1993 Center, and DTAC.
1994 d) Connects those experiencing emotional distress related to a disaster with crisis
1995 center counselors who can provide support and referrals to local resources by calling
1996 SAMHSA's 24/7 Disaster Distress Helpline at 1-800-985-5990 or texting TalkWithUs
1997 to 66746.
1998 e) Helps VOADs and professional guilds, such as the American Psychological
1999 Association, the National Association of Social Workers and the American Counseling
2000 Association, who provide behavioral health services, to coordinate their activities
2001 with federal and STT activity.
2002 **18. Medicaid/Medicare:** CMS works with states to maximize flexibility in Medicaid/Medicare
2003 payment and coverage in the disaster or emergency affected region.
2004 **19. Surveillance:** Agencies query existing surveillance systems for information about behavioral
2005 health and resilience. CDC and SAMHSA, if indicated, tailor existing surveillance systems,
2006 such as the Behavioral Risk Factor Surveillance System, to ascertain disaster-related
2007 behavioral health trends.
2008 **20. Research Findings and Subject Matter Expert (SME) input:** NIH and its NLM identify pertinent
2009 research findings and scientific evidence relevant to behavioral health and resilience
2010 concerns of the disaster event in order to inform policy and response decisions. NIH, ASPR-
2011 ABC, and ASPR's National Biodefense Science Board (ASPR-NBSB) obtain input from
2012 additional behavioral health and resilience SMEs when indicated.

2013 **21. Research Opportunities:** NIH examines the response environment for opportunities to
2014 promote research on behavioral health through existing programs, through specialized
2015 funding announcements or the NIH unsolicited parent grant announcement.
2016 **Responder Behavioral Health**
2017 **22. Behavioral Health Force Protection:** The ASPR SOC and IMT integrate behavioral health
2018 force protection assets and materials in federally deployed teams. In catastrophic, complex,
2019 or large scale events, behavioral health providers and materials are integrated into the
2020 ASPR-NDMS Mobilization Processing Center to provide information, pre- and post-
2021 deployment briefings, and informal one-on-one supportive interventions to ASPR
2022 responders.
2023 **23. DCCPR Mental Health Teams (MHTs):** DCCPR MHTs may be deployed to provide force health
2024 protection services, stress mitigation/management, and counseling services for responding
2025 agencies' personnel and their family members, crisis intervention including PFA and triage

for disaster survivors and incident responders/workers, and public behavioral health agency/community assistance.

24. **CDC Responder Resiliency:** Through its Responder Resiliency Program, CDC provides trained team members to monitor and support the well-being and resilience of CDC emergency response personnel and enhance their awareness of psychosocial conditions in the populations they serve.
25. **CDC Responder Health Monitoring:** CDC's National Institute for Occupational Safety and Health (NIOSH) offers guidance for emergency responder health monitoring and provides communication products and technical consultation to employers and worker organizations following requests submitted either through routine channels or through the CDC EOC Worker Safety and Health Function Desk.
26. **FOH EAP Services:** FOH EAP Emergency Response Team reports to impacted agencies requesting services and can provide post-deployment education, support and referrals to responders. Information on how to access the EAP is provided to responders during the mission and after their return home.

Additional Partners: By reaching out and facilitating coordination, ASPR, localities, STTs, and other organizations may expand their respective responses by maximizing potential surge resources for behavioral health, such as:

- HHS behavioral health professionals beyond those normally engaged in response activities;
- VA and DoD;
- State volunteer behavioral health responders from the OASH-OSG-DCVMRC and the ESAR-VHP network outside the affected area;
- National VOADs and community and faith-based organizations with behavioral health capabilities from outside the affected area;
- Behavioral health and health professional associations such as the American Psychological Association's Disaster Response Network, the National Association of County & City Health Officials, the National Association of Social Workers, the American Psychiatric Association, the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, the American Academy of Pediatrics, the American Medical Association, etc.;
- State-to-state behavioral health resources available through EMAC;
- Behavioral health professionals tracked through ESAR-VHP systems; and
- Behavioral health professionals from other countries and international organizations made available through established international structures.

Deployment of Tools and Resources: With assistance from the FDBHG, HHS can draw on a number mechanisms and assets to expand the disaster response effort:

a) Facilitating the provision of just-in-time disaster behavioral health training (such as psychological first aid) for additional federally-sponsored volunteers or other responders who may be put on rosters and deployed;
b) Assisting STTs with access to critical psychiatric or substance abuse treatment medications;
c) Using science-based tools to prioritize use of scarce clinical resources;
d) Offering evidence-based interventions at the population and community level to reduce morbidity or severity of psychological illness and injury in situations that hamper or prevent provision of behavioral health treatment to significant numbers of individuals; and

WAIVERS AND SUPPLEMENTAL FUNDING: The federal role in disaster response may be broadened through utilization of statutory authorities or new authorities enacted by Congress:

a) Exercise of allowable federal program and grant flexibility or waivers to broaden provision of behavioral health services; and
b) Securing supplemental appropriations from Congress to fund critical disaster behavioral health services and determining delivery mechanisms for funding (such as the SERG program, which may also be used without Stafford Act declaration).

Phase 3 - Recovery

(g) **RECOVERY IN PREPAREDNESS & RESPONSE:** H&SS RSF staff participate in the FDBHG during the disaster response phase as well as in quarterly Disaster Behavioral Health and Community Resilience Preparedness Forums to promote a smooth transition from response to recovery.

(h) **FDBHG RECOVERY FOCUS:** ASPR-ABC ensures that FDBHG meetings include behavioral health issues relating to the transition to recovery. The final meeting(s) of the FDBHG are dedicated to the transition to recovery, and involve additional recovery stakeholders, as needed.

(i) **TRANSITION:** The transition from federal response to recovery for disaster behavioral health is marked by several organizational changes:

a) Response assets demobilize and the national coordinating structure transitions from the NRF to the NDRF;

b) At HHS, coordination passes from NRF ESF #8 to NDRF H&SS RSF; and

c) The FDBHG stands down, with behavioral health recovery representatives integrating directly into the H&SS RSF under the H&SS National Recovery Coordinator in support of the Field Recovery Coordinator and Departmental recovery efforts.

2100 **Coordination, Assessment, and Analysis**

2101 (j) **H&SS RSF Support Agencies:** H&SS RSF support agencies with behavioral health
2102 responsibilities:

2103 a) Maintain bi-directional communication through relevant agency programs and
2104 grants to assess and address locally-driven recovery needs and gaps and share
2105 governmental information;

2106 b) Provide information to the H&SS RSF to inform recovery assessments and to guide
2107 H&SS RSF activities (including requests for support or recovery mission
2108 assignments);

2109 c) Identify informational and psycho-educational resources related to disaster recovery
2110 and resilience and mobilize access to this information through recovery information
2111 channels; and

2112 d) Plan for and implement the transition from recovery operations to steady-state
2113 activity.

2114 **Resources, Technical Assistance, and Information Dissemination**

2115 (k) **MedMap in Recovery:** The ASPR-SOC compiles and analyzes Behavioral Health MedMap
2116 data to inform recovery efforts and track reconstituted infrastructure.

2117 (l) **Support for Recovery Coordinators:** ASPR-ABC provides subject matter expertise and reach-
2118 back support to ASPR National and Field Recovery Coordinators.

2119 (m) **Behavioral Health Programs/Activities:** SAMHSA:

2120 a) Partners with STT and local entities to examine behavioral health recovery needs
2121 and recommend ways to transition federal response supports into existing
2122 structures (e.g., CCP or SERG and/or VOAD or community behavioral health efforts);

2123 b) Offers technical assistance and resources from existing SAMHSA-sponsored
2124 programs and grantees such as DTAC, National Child Traumatic Stress Network,
2125 Suicide Prevention, block grants, tribal programs, and mental health and substance
2126 abuse prevention and treatment programs; and

2127 c) Works in partnership with STT CCP grantees to continue to carry out crisis
2128 counseling services to promote individual and community resilience and recovery;
2129 compiles and analyzes data from CCP to inform the H&SS recovery.

2130 (n) **Human Services:** ACF provides recovery-related technical assistance for ACF programs.

2131 (o) **Medicare/Medicaid:** CMS works with STTs to maximize flexibility in Medicaid/Medicare
2132 payment and coverage in the disaster or emergency affected region.

2133 (p) **SURVEILLANCE:** Agencies query existing surveillance systems for information to track trends in
2134 behavioral health recovery in the affected region. CDC, if indicated, tailors existing
2135 surveillance systems to continue to ascertain disaster-related behavioral health trends.

2136 (q) **RESEARCH OPPORTUNITIES:** NIH, placing the care and safety of disaster survivors above all else
2137 and remaining sensitive to the complexities associated with disaster research, examines the
2138 recovery environment for opportunities to promote research on behavioral health through
2139 existing programs, through specialized funding announcements, or through the NIH
2140 unsolicited parent grant announcement.

2141 (r) **RESEARCH AND SME INPUT:** NIH and its NLM provide literature reviews and gather pertinent
2142 research on recovery and resilience issues. NIH, ASPR-ABC, and ASPR-NBSB obtain input
2143 from additional behavioral health, recovery, and resilience subject matter experts when
2144 indicated.

2145 (s) **FOH EAP SUPPORT:** The FOH EAP and Work/Life program offer information and transition
2146 services for qualified individual federal employees, their families, and supervisors after an
2147 event. Assistance might include provision of psychological support sessions, information
2148 about what to expect in the aftermath of an event, including expectations about work
2149 performance, and coaching on specific issues.

2150 **Transition from Recovery to Steady-State**

2151 (t) **PHASE-DOWN AND TRANSITION TO STEADY-STATE:** Transition from NDRF coordinated recovery
2152 activity to steady-state federal, STT, and community resources is a key planning
2153 consideration throughout the H&SS RSF operational period. The NDRF provides guidance
2154 for assessing the progress of this transition. Prior to the transition, phase-down planning is
2155 conducted by the H&SS RSF. For behavioral health this involves:

2156 a) Ensuring the disaster-impacted community is aware of any changes in behavioral
2157 health service provision and engaged in the transition to steady-state activity,
2158 working through H&SS RSF and regional agency personnel, as indicated; and

2159 b) Documenting and applying behavioral health lessons learned through engaging in
2160 after-action review activity and revising related recovery documents, including
2161 documenting the new organizational relationships, best practices, approaches,
2162 knowledge, and resources concerning behavioral health developed though the
2163 recovery process that can assist communities to recover and become more resilient.

2164 6. Interdependencies

2165 **Coordination with Mass Care**

The Public Health and Medical (ESF#8) behavioral health response, and the transition from response to recovery, requires close coordination with certain aspects of Mass Care, Emergency Assistance, Housing, and Human Services (ESF#6).

The Administration for Children and Families (ACF):

- Leads the HHS ESF #6 Human Services response and administers the Disaster Case Management (DCM) program for the DHS Federal Emergency Management Agency (DHS-FEMA).

- Assists with strategic leveraging of federal human services programs, including program flexibilities and waivers, establishes human services liaisons to state, regional, and national emergency operations centers, and advises on the needs of children and at-risk individuals.

- Addresses the needs of victims of domestic violence and their children through emergency shelter, statewide services coordination, tribal services, and administering the National Domestic Violence Hotline.

Additionally, its Office of Human Services Emergency Preparedness and Response (ACF-OHSEPR) works with ASPR's Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ASPR-ABC) to coordinate human services preparedness, response, and recovery activities across HHS.

Other HHS divisions provide human services-related support, though not necessarily as part of ESF#6 response activities. The Administration on Aging (AoA) works with ACF and ASPR-ABC to address the needs of seniors and persons with disabilities. Behavioral health personnel staged in ASPR National Disaster Medical System (ASPR-NDMS) treatment areas provide community information and referrals for at-risk individuals, e.g., displaced residents of extended care facilities, individuals with special medical needs, and individuals requiring home health care or durable medical equipment. The Centers for Disease Control and Prevention (CDC) advises on human services aspects of communication, surveillance, field investigation, clinical guidance and other issues.

Mass Care and Housing

ASPR-ABC works with federal partners (such as FEMA and HUD) and NGOs (such as ARC) to promote the inclusion of behavioral health support in shelters and disaster housing. ACF, AoA, and the Office on Disability (OD) provide subject matter expertise and technical assistance to meet the needs of children and at-risk individuals in mass care and congregate shelters. ASPR-NDMS behavioral health personnel can provide psychological first aid and referral services to shelter residents. Several OPDIVs and STAFFDIVs (including ASPR-ABC and ACF) participate in the National Disaster Housing Task Force, which may be called upon to provide guidance on disaster housing following a major event.

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and Departmental policies.

DRAFT

Appendix VII: Blood and Blood Products

1. Purpose

The purpose of this Appendix is to describe the delivery of Blood and Blood Products as an integral part of the overall public health and medical preparedness, response, and recovery system.

2. Situation

In the event of large-scale and catastrophic incidents the Federal Government response may be required to ensure resources are applied quickly and efficiently for both response and recovery. This occurs in coordination with private sector entities, non-governmental organizations, local governments, states and Federal departments and agencies. Before, during, and after an emergency event, the U.S. blood supply owners and operators (99% of U.S. supply is from non-governmental sources) collectively organize under the auspices of the American Association of Blood Banks (AABB) Task Force on Domestic Disasters and Acts of Terrorism, to ensure appropriate collection, distribution, and utilization of blood and blood products, including relevant and related interaction with the inherently governmental duties of corollary blood safety and availability offices within the Federal Government (i.e., HHS Office of the Assistant Secretary for Health, FDA, CDC, and the DoD).

3. Assumptions

The following assumptions and priorities apply to the U.S. Blood Supply response to disasters and public health emergencies:

1. Hospitals may require increased amounts of blood products, especially during emergency surges (e.g., operating rooms, emergency rooms, etc.)

2. Blood and blood products (e.g., packed red blood cells, platelets, plasma, etc.) may be required as necessary medical countermeasures for a wide variety of CBRNE incidents

3. Treating disaster victims may require a range of blood products using varying quantities (e.g., average of 3 units/patient, some could require 100+ units)

4. Blood products are typically always in good supply (as a national aggregate) within hospitals and blood collection centers; however, effective and efficient cold-chain shipment of blood products from areas of supply to areas of demand may be required and shipments may be prone to logistical challenges (i.e., routes, methods, and gridlock)

5. It is anticipated some situations of CBRNE incidents may require regulatory deferral of donations (e.g., depending on agent and population exposure)

6. It is anticipated some situations of CBRNE incidents may involve an emergency use authorization request(s) (i.e., to FDA) for an unanticipated exception to federal safety policy

7. Providing necessary cold-chain for existing blood products (500,000+ units nationwide) may be required and could quickly become challenging during certain incidents (e.g., large-scale power outage, hurricane/flood, and Cyber attacks).

4. Mission

The HHS Office of the Assistant Secretary for Health (OASH), through its Division of Blood & Tissue Safety & Availability (DBTSA), serves as the lead federal agent for coordination of blood and blood products for All-Hazards planning, response, and recovery. It provides U.S. blood supply preparedness and response support to local, state, and federal government offices and the private health care industry, through formal liaison with the AABB Task Force, for a comprehensive suite of planning, logistics, and emergency operations services before, during, and after all-hazards incidents and exercises.

5. Execution

b) Concept of Operations

Phase 1 - Preparedness

U.S. blood supply strategies and actions promote blood industry resilience (99% of U.S. blood supply is from non-governmental sources) and are an essential part of public health and medical emergency response (e.g., hospital surge capacity) and recovery. The U.S. blood supply must be integrated into plans and preparedness activities in order to promote effective and comprehensive response, recovery, and national health security.

Preparedness

1. **Periodic Preparedness Forums:** HHS/OASH/OHAIDP/DBTSA participates in several preparedness and emergency exercise teleconferences and in-person meetings throughout the year to exercise, challenge, and develop standard operating procedures aimed at preparing, responding to, and recovering from all-hazard incidents, including:
    - Sharing information and best practices;

- Leverage opportunities for coordinated efforts, joint projects, and presentations at national and regional conferences;
- Incorporate lessons learned in preparedness plans;
- Gather external stakeholder input at national conferences (i.e., AABB, ABC, ARC);
- Promote shared objectives

2. **State, Regional, And National Assessment:** OASH Division of Blood & Tissue Safety & Availability prepares and distributes to public and private sector partners periodic, routine, and ad-hoc assessments of U.S. blood supply inventories covering various levels of geographic reach, depending on the circumstance.
3. **HHS Basis Program:** the Blood Availability & Safety Information System (BASIS) is managed by OASH-DBTSA as a U.S. Dept. of Homeland Security Protection of Critical Infrastructure Information (PCII) accredited web-based platform capturing blood supply inventories at U.S. hospitals and blood centers.
4. **Plans, Drills, And After-Action Meetings:** HHS OPDIVs and STAFFDIVs with interest in the U.S. blood supply (e.g., HHS/OASH, CDC, and FDA) participate in preparedness activities such as disaster response and recovery plan and plan development, and—in coordination with the ASPR/Exercises, Evaluations, and After Actions (E2A2) Division—exercises, after-action meetings, and lessons-learned sessions.
5. **Resilience And Special Topics:** OASH-DBTSA participates in the activities of ASPR-CIP GCC/SCC, including annual, semi-annual, and subcommittee working groups

Resources, Technical Assistance, and Information Dissemination

6. **Federal Cooperative Forums:** OASH-DBTSA participates with ASPR as the blood and blood products liaison member of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Enterprise Executive Committee (PHEMCE/EEC).
7. **AABB Task Force on Domestic Disasters and Acts of Terrorism:** OASH-DBTSA participates as a Level-1 member of the AABB Task Force, providing technical and logistical assistance at meetings to exchange information, resources, and best practices.
8. **Dissemination of Information:** OASH-DBTSA coordinates public messaging regarding the safety and availability (including the need for blood donations) with HHS/ASPA personnel and other federal stakeholders (e.g., FDA and CDC) and the communications branch of the AABB Task Force on Domestic Disasters.
9. **Scientific Preparedness and Research:** The National Institutes of Health (NIH/NHLBI), the FDA (CBER/OBRR and OBE), OASH-DBTSA, and ASPR-BARDA conduct and foster research and public/private sector symposiums to determine best practices and evidence-informed

approaches to disaster blood supply resilience, including innovations in blood products, alternatives, and elements of the U.S. blood supply chain.

Phase 2 - Response

U.S. Blood Supply response efforts address blood products safety and availability for the collection (U.S. blood collection centers) and utilization (U.S. hospitals) of blood and blood products:

- Maintenance of regulatory good manufacturing practices (i.e., FDA safety regulations)
- Maintenance of an effective supply chain infrastructure (e.g., distribution and logistical requirements)
- Maintenance of appropriate supplies (e.g., laboratory reagents, durable/disposable medical supplies, and testing analyzers)
- Maintenance of emergency communications and information sharing channels (i.e., within the industry and to the U.S. public)

Federal Activation

27. Supporting Agencies Activate: OASH-DBTSA activates as the U.S. blood supply liaison for the ASPR-SOC and as the coordinator for the Agencies within the HHS-BOTS group (Blood, Organs, and Tissues Safety, i.e., CDC, FDA, HRSA, OASH, and CMS).

Coordination, Assessment, and Analysis

28. Federal Blood, Organ, and Tissue Safety (BOTS) working group: OASH-DBTSA convenes the monthly (and ad-hoc) meeting of the HHS BOTS Agencies, also including external federal stakeholders (DOD/ASBPO and Veterans Affairs)

29. AABB task force on domestic disasters and acts of terrorism: OASH-DBTSA participates as a Level-1 member of the task force to coordinate public-private sector requirements, including logistics, data, and communication.

30. ESF #8 Reporting: OASH-DBTSA summarizes pertinent information from the AABB Task Force ESF #8 situation reports to the SOC and ASPR leadership, and for the Incident Action Plan (IAP) and HHS policy response coordination meetings.

31. U.S. blood supply availability: OASH-DBTSA assists ESF #8 partners with reports and analysis of affected and surrounding area blood supplies (including relevant national distributions).

Resources, Technical Assistance, and Information Dissemination

32. Logistical requirements: OASH-DBTSA coordinates public-private sector logistical needs with the ASPR-ORM-LOGS division (through ASPR-SOC).

2361 **33. Mission Assignments:** OASH-DBTSA fields ASPR-SOC mission assignments related to blood
2362 and blood products throughout the public and private health sector via service as the ASPR-
2363 SOC liaison for the U.S. blood supply.
2364 **34. HHS BASIS:** Along with U.S. blood collection center inventory reports from the AABB Task
2365 Force, OASH-DBTSA uses the Blood Availability & Safety Information System (BASIS)
2366 program to produce reports on U.S. blood supply inventories.
2367 **35. Information Promulgation:** OASH-DBTSA coordinates public messaging with the OASH-
2368 ASPA office and the AABB Task Force regarding the safety and availability of the U.S. blood
2369 supply (e.g., the need for donors and/or the importance of donor deferrals).
2370 **36. U.S. Blood Supply Programs/Activities:** 99% of the U.S. blood supply obtained through a
2371 myriad of private sector federally licensed businesses (mostly non-profit). During disasters
2372 these blood products collection centers gather under the auspices of the AABB Task Force
2373 on Domestic Disasters and Acts of Terrorism.
2374 **37. Surveillance:** U.S. blood supply availability (inventory) surveillance is performed through
2375 the HHS BASIS program and through the AABB Task Force. Other surveillance on blood
2376 safety is performed through the CDC's National Healthcare Safety Network (NHSN – blood
2377 recipient adverse events) and the OASH-DBTSA DonorHART program (blood donor adverse
2378 events).
2379
2380 **Deployment of Tools and Resources**: OASH-DBTSA serves as the U.S. blood supply liaison on the
2381 ASPR-SOC and utilizes the federal tools and resources available within the framework of the
2382 ASPR-SOC (e.g., logistics, planning, and operations); additionally, OASH-DBTSA serves as a level-
2383 I Task Force member and leverages the resources of the AABB Task Force on Domestic Disasters
2384 and Acts of Terrorism (a private sector coordinating body for the U.S. blood supply).
2385
2386 **Waivers** : during disasters, circumstances could arise lending to agents of the private sector
2387 blood industry to apply for exceptions (waivers) to current federal regulatory safety policy (i.e.,
2388 FDA Emergency Use Authorization – EUA) in order to provide for the availability of blood
2389 products.
2390
2391 **Supplemental Funding:** Past disaster response events (e.g., Hurricane Katrina, Haiti and others)
2392 have required emergency supplemental funding to provide for the movement (transport) of
2393 blood products via military and private aircraft, as well as ships.
2394
2395 **Phase 3 - Recovery**
2396
2397 (u) **Recovery in Preparedness & Response:** OASH-DBTSA staff participate in the activation of
2398 ESF#8 as LNO to the ASPR-SOC and the AABB Task Force (Level-1) and upon deactivation of
2399 ESF#8 – OASH-DBTSA staff focus on the AABB Task Force efforts for recovery of the U.S.

2400 blood supply in terms of blood products redistribution (from/to contributing blood
2401 collection centers and regions) and appropriate donor recruitment (e.g., public messaging).

2402 (v) **U.S. Blood Supply Recovery Focus:** OASH-DBTSA coordinates federal interest in the recovery
2403 of safety and availability of the U.S. blood supply and works with the AABB Task Force to
2404 assess needs and requirements, including the availability of supply chain logistics (cold chain
2405 transportation).

2406 (w) **Transition:** The transition from federal response to recovery for the U.S. blood supply is
2407 marked by several organizational changes:

2408 • Response assets demobilize and the national coordinating structure transitions from the
2409 NRF to the NDRF;

2410 • At HHS, coordination passes from NRF ESF #8 to NDRF H&SS RSF; and

2411 • The ASPR-EMG stands down, with blood supply LNOs integrating directly into the H&SS
2412 RSF under the H&SS National Recovery Coordinator in support of the Field Recovery
2413 Coordinator and Departmental recovery efforts.

2414 **Coordination, Assessment, and Analysis**

2415 (x) **H&SS RSF Support Agencies:** H&SS RSF support agencies with U.S. blood supply
2416 responsibilities:
2417 (a) Maintain bi-directional communication with the AABB Task Force (and federal
2418 programs) to assess and address locally-driven recovery needs and gaps and share
2419 governmental information;
2420 (b) Provide information to the H&SS RSF to inform recovery assessments and to guide
2421 H&SS RSF activities (including requests for support or recovery mission
2422 assignments);
2423 (c) Identify blood donor resources related to disaster recovery and resilience and
2424 mobilize access to this information through recovery information channels; and
2425 (d) Plan for and implement the transition from recovery operations to steady-state
2426 activity.

2427 **Resources, Technical Assistance, and Information Dissemination**

2428 (y) **BASIS in Recovery:** OASH-DBTSA compiles and analyzes U.S. blood products inventories data
2429 to inform recovery efforts and track reconstituted infrastructure.

2430 (z) **Support for Recovery Coordinators:** OASH-DBTSA provides subject matter expertise and
2431 reach-back support to ASPR National and Field Recovery Coordinators.

2432 (aa) **Surveillance:** Agencies query existing surveillance systems for information to track
2433 trends in blood safety (adverse events for donors and recipients) in the affected region.

Transition from Recovery to Steady-State

(bb) **PHASE-DOWN AND TRANSITION TO STEADY-STATE:** Transition from NDRF coordinated recovery activity to steady-state federal, STT, and community resources are key planning considerations throughout the H&SS RSF operational period. The NDRF provides guidance for assessing the progress of this transition. Prior to the transition, phase-down planning is conducted by the H&SS RSF.

(cc) **DOCUMENTING AND APPLYING LESSONS LEARNED:** OASH-DBTSA coordinates lessons learned with the ASPR-E2A2 office and the AABB Task Force through engaging in after-action review activity and revising related recovery documents, including documenting the new organizational relationships, best practices, approaches, knowledge, and resources concerning the U.S. blood supply though the recovery process that can assist communities to recover and become more resilient.

6. Interdependencies

IMPORTANT RELATED INDUSTRY STANDARD OPERATING PROCEDURES: the most relevant interdependency is the relationship between the government and the AABB Task Force on Domestic Disasters and Acts of Terrorism (AABB Task Force). This task force has been in place for 10 years and maintains 99% of the U.S. blood supply (non-governmental). Important considerations include:

- AABB Task Force membership includes federal partners (HHS, FDA, CDC, DOD)
- The Task Force has mature/developed Standard Operating Procedures (SOPs)
- Industry-wide resources, including the movement of blood products during disasters, are coordinated by Level-1 Task Force members
- The AABB Task Force relies heavily on the HHS-DBTSA liaison on the ASPR-SOC (and visa-versa)

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and Departmental policies.

Appendix VIII: Health/Medical/Veterinary Equipment and Supplies

1. Purpose

The purpose of this Appendix is to describe the delivery of Federal Public Health/Medical/Veterinary Equipment and Supplies as a result of the implementation of the All Hazards Plan. The ASPR-ORM Logistics Division is responsible for the management and implementation of logistics policies and procedures to support the following: (1) management, deployment, and sustainment of equipment caches and supplies; (2) oversight of ASPR Property Management program; (3) coordination and policy guidance for execution of response logistics; and (4) credentialing of response logistics personnel for the ASPR. As the executive agent for Federal public health and medical response logistics, ORM Logistics is also responsible for coordinating logistics resources and support with internal and external, and National Disaster Medical System (NDMS) partners. The ability to sustain and rapidly deploy medical logistics assets to a federal response is critical to HHS fulfilling its disaster preparedness, response and recovery responsibilities.

2. Situation

The Department of Health and Human Services (HHS) is the lead agency for providing Federal public health and medical support. HHS authorities and the National Response Framework's Emergency Support Function (ESF) #8 - Public Health and Medical Services - provide the mechanism for coordinated federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated federal response, and/or during a developing potential health and medical emergency. One of the core functions of the ORM Logistics Division is providing supplemental assistance of health/medical/veterinary equipment and supplies to support medical logistics where HHS has the lead and oversight of this responsibility.

3. Assumptions

The following assumptions and priorities apply to the logistics response to disasters and public health emergencies:

1. Transportation infrastructure is affected, making distribution challenging and requiring coordination of external logistics resources with federal and state partners to maximize efficiency of resources.

2. Competing demands and priorities for interoperable communications assets and access to communication services will affect logistics operations at all levels.

3. All impacted jurisdictions will utilize single-point ordering to avoid duplication and overlap in resource management.

4. Prioritization of resources will be granted based on life-saving and life-sustaining tasks.

5. Strategic partnerships with Federal and commercial supply vendors and distributors are necessary to create communication channels required to share critical information regarding capabilities at the strategic and operational levels of supply chain management.

4. Mission

Based on the requirements of State, local, tribal, and territorial authorities, ORM Logistics and its Federal interagency partners will initiate and conduct logistics operations to support the movement, maintenance, sustainment, and recovery of deployed health, medical, and veterinary equipment and supplies.

5. Execution

Concept of Operations

Phase 1 – Preparedness

Pre-deployment activities are taken to prepare medical caches, equipment, and logistics personnel for deployment. Logistics personnel plan, train, exercise, and evaluate their pre-deployment activities. Maintenance and standardization of cache equipment and supplies are critical to public health and medical preparedness. During the planning stages, logistical planners consider (1) the lead time required for various scenarios, including no-notice and forewarned events; (2) weather contingencies; (3) transportation; and (4) infrastructure.

Preparedness Tasks

1. Verify readiness of logistics requirements.

2. Verify readiness status of HHS/ESF #8 response, assets, caches.

3. Ascertain the status of vaccination supplies in the potentially affected areas.

4. Ascertain the status of blood supplies in the potentially affected areas.

5. Ascertain need to request pharmaceuticals, medical supplies, and equipment from foreign countries.

6. As appropriate, request needed resources through the International Assistance System (IAS).

7. Activate logistics infrastructure.

8. Identifies field lodging support for teams/personnel as required.

9. Be prepared to provide all non-medical logistics support.

10. Ascertain the status of vaccination requirements in the potentially affected areas.

11. Notify ORM Logistics to begin preparations to load resources (FMS, equipment caches and supplies) for possible deployment.

12. Work with regional or National IMAT, and RRCC/NRCC to identify and prioritize assembly areas of pre-deployment of medical supplies to strategic locations.

13. Pre-identify and prioritize assembly areas of pre-deployment of medical supplies to strategic locations.

14. Work with regional or National IMAT and RRCC/NRCC to pre-identify any potential DOD requirements to provide military medical logistics support (medical equipment/supplies, medical diagnostics/blood products).

15. Prepare and possibly deploy ALRT and initial response forces (two DMATs and associated caches.

16. NVRT Strike Team and cache.

17. Coordinate non-medical support with FEMA.

18. Refine medical supply concept support plan.

19. Prepare supplies and equipment packages (logistics support) for all HHS/ESF#8 teams/personnel (note that CDC supports FMS).

20. Stage/Deploy assets to pre-incident locations as necessary (under surge account funding): ALRT Cache, HHS/ESF #8 personnel, Federal Coordinating Center (FCC) points of contact, and others as appropriate. It is imperative that the ALRT and LRAT is moved first and in place to receive additional assets listed here and elsewhere.

21. Continue to ascertain status of vaccination requirements in potentially affected areas.

22. Continue ORM Logistics preparations to load resources (FMS, equipment caches and supplies) for possible deployment.

23. Continue to work with Regional/National IMAT and RRCC/NRCC to identify and prioritize assembly areas of pre-deployed of medical supplies to strategic locations.

24. Continue to pre-identify and prioritize assembly areas of pre-deployment of medical supplies to strategic locations.

25. Continue to work with regional or National IMAT and RRCC/NRCC to pre-identify any potential DOD requirements to provide military medical logistics support (medical equipment/supplies, medical diagnostics/blood products)

Phase 2 – Response

The disaster logistics response consists of the mobilization and deployment of response logistics assets, and the subsequent sustainment of those assets.

Mobilization is the process of assembling and organizing resources to support response objectives and other incidents, and includes coordinating resources from all or part of the National Disaster Medical System and its partner resources to meet the requirements of the response. Mobilization of personnel is outlined in the ASPR Mobilization CONOPs. Mobilization of equipment and caches will be outlined in the Execution Order published by the Emergency Management Group. Activities associated with the mobilization processes include personnel readiness processing, preparation of required documentation for personnel and cargo movement, identification and processing of hazardous cargo, vehicle preparation, preparation of sensitive cargo, building of pallets for airlift, issuance of additional supplies and equipment, and containerization of equipment.

Deployment is the movement of resources to an operational area in response to an execution order or mission assignment, and encompasses all logistics activities from origin through destination, including pre-deployment events, as well as CONUS and OCONUS movements. During large-scale responses, ASPR's goal is to deploy medical resources to arrive anywhere within CONUS within 12 hours and OCONUS within 48 hours after notification. To meet this aggressive timeline, SOC Resource Management (RM) develops a multimodal movement plan, in coordination with HHS/ESF #8 partners, which contains a sufficient amount of detail to prepare the logistics structure to execute strategic and tactical transportation operations. These movement plans define responsibilities, functions, and details the deployment process and resources from origin to destination. More than one deployment plan may be required depending on whether ASPR is using organic, commercial, or Department of Defense transportation, or a combination thereof.

Sustainment is the provision of personnel, logistics, and other support necessary to support a response until successful accomplishment, or revision of the mission or response objective. All personnel and cache equipment required to conduct medical response operations are initially deployed with three days of supply, to facilitate initial operations and allow for re-supply operations to be established. Subsequent re-supply pushes will be deployed in increments of 14 days unless otherwise directed by the Incident Commander or Manager.

Response Tasks

1. Stage/deploy NDMS teams and equipment caches to forward to staging locations.

2. Validate communications infrastructure.

3. Alert VA to be prepared to provide health and medical logistics/supply support via National Acquisition Center (NAC).

4. Deploy other logistics assets for HHS/ESF #8/NDMS teams/personnel to staging locations.

5. Provide real time requirements for new pharmacy, medical supplies, and equipment to ORM LOGS.

6. Activate Emergency Prescription Assistance Program (EPAP), if required.

Phase 3 –Recovery (and Demobilization)

Recovery and demobilization involves the return of responders and caches to home station or demobilization station. Redeployment priorities are outlined in the Demobilization Execution Order published by the IMT and SOC. Logistics personnel must provide accountability and adjust the equipment and supply quantities to reflect the gains and losses that have occurred while in theater. Such changes are normally attributed to operational losses, maintenance, or supply. Other key redeployment activities that must be considered include transfer of equipment (stay behind equipment); basic load turn-in; security of the responders while in transition; availability of transportation assets; availability of material handling equipment as the theater draws down; and the availability of strategic lift. The theater logistics structure may be required to contract for additional logistics resources in order to effectively and efficiently redeploy and demobilize.

Recovery (and Demobilization) Tasks

1. Demobilize and deactivate specific response assets when this specific task or Mission Assignment is completed or when it is determined the magnitude of the event does not warrant continued use of the asset.

2. Coordinate, with IMT and HHS/ESF#8 supporting agencies, the demobilization of resources when all operational objectives contained in the Incident Coordination Plan has been met or affected State, or DHS, determines that resources are no longer needed.

3. Demobilize personnel as required in accordance with MA completion.

4. Establish procedures for follow on shipments of necessary pharmaceuticals, medical supplies, and equipment to affected area.

5. Inventory and return non-essential equipment for reconstitution.

6. Interdependencies

A. Coordination with the Department of Defense. When deploying via the Defense Transportation System (DTS), ASPR must integrate its strategic and operational movement plans into the U.S. Transportation Command (USTRANSCOM), Joint Operation Planning and Execution System (JOPES) operations plan. This requires establishment and submission of a

Time Phased Force Deployment Data (TPFDD) worksheet, which outlines movement priority of personnel and equipment. ASPR ORM must also establish and acquire a unit line number (ULN) from USTRANSCOM to utilize the Defense Transportation System (DTS) and track the movement of all material by DoD. To facilitate integrating ASPR's requirement into DoD's movement plan, SOC RM embeds a liaison officer with the respective Combatant Commander (USTRANSCOM, NORTHCOM, SOUTHCOM, CENTCOM, or PACOM, etc.) to accomplish JOPES requirements. All personnel and cargo transported via Defense Transportation System must meet requirement of the Defense Transportation Regulation (www.transcom.mil/dtr/part-i/). TPFDD development will also help identify DoD contracted or private sector commercial transportation requirements.

B. Deployment by Commercial Transportation. When deploying by commercial carriers, ASPR/ORM must ensure all cargo and personnel meet requirements of commercial carrier, Code of Federal Regulation (CFR 49), and the International Air Transport Association (IATA) as it pertains to airlift. ASPR ORM will use established contracts or Third Party Logistics (3PL) Contracts to execute deployment of medical supplies and equipment. All contracting actions will be coordinated through SOC RM to the Logistics Support Branch for processing. EMGLOG will evaluate all modes of transportation (highway, rail, air, and sealift) to determine modes that meet mission requirements.

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and Departmental policies.

Appendix IX: Health Surveillance

1. Purpose

Public health surveillance is a critical component for a public health response to a biological incident. The information and data generated by surveillance is used by other focus areas (*e.g.*, epidemiology, environmental evaluation, and medical care and countermeasures) to identify, implement and/or evaluate public health response activities.

2. Situation

HHS, in coordination with supporting departments and agencies, enhances existing surveillance systems to monitor the impacted population health of the general and medical needs; carries out field studies and investigations; monitors injury and disease patterns and potential disease outbreaks, blood and blood product bio-vigilance, and blood supply levels; and provides technical assistance and consultations on disease and injury prevention and precautions.

3. Assumptions

The following assumptions apply to the Health Surveillance response to disasters and emergencies:

- Public health departments will establish close working relationships and mutual aid agreements with State, regional, and tribal public health response coordinators, neighboring health jurisdictions, humanitarian and volunteer organizations, and the local Medical Reserve Corps.
- Local public health departments will conduct hazard vulnerability and risk assessments for their area.
- Capacity assessments will be conducted to define the resources of the community's public health system and the resources available through mutual aid agreements.
- Plans will be developed to outline continuity of public health operations during disasters and emergencies, and include procedures to request and incorporate surge capacity resources necessary to perform basic public health missions.
- The local public health department will have a system in place to capture health surveillance information (morbidity, mortality, syndromic and behavioral) during emergency situations.

4. Mission

Public health surveillance is "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice."[2] Surveillance is the cornerstone of public health practice, providing the scientific and evidence-based data needed for informed decision-making. It is essential to establishing public health priorities and determining appropriate actions. In general, public health surveillance provides the data that can be used to:

- Estimate the magnitude of a health problem in a population at risk;
- Detect outbreaks or epidemics;
- Test hypotheses about etiology;
- Identify and evaluate control strategies;
- Assess the safety of medical countermeasures (MCM);
- Provide information to plan and conduct research; or
- Define strategies for planning and response.

5. Execution

Types of Surveillance

Historically, surveillance is classified as either passive or active. Passive surveillance refers to data that is voluntarily supplied to a SLTT health authority. For example, most routine notifiable disease surveillance in the United States is passive. While passive surveillance systems are simple and more affordable to operate, they can dramatically underreport the occurrence of a disease or condition. Conversely, active surveillance relies on SLTT health authorities to regularly solicit reports from various healthcare providers to stimulate the reporting of specific diseases. Active surveillance systems can be used to validate passive data and assure more complete reporting of disease conditions, and is often used in conjunction with specific epidemiologic investigations. While active surveillance may allow for accurate and complete reporting, it is a complex, time intensive process.

During a biological incident, CDC, in conjunction with its federal, state/local, and international partners, will likely utilize a combination of both passive and active surveillance to collect health-related information.

Detection of a biological incident

[2] Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev* 1988;10:164-90.

Generally, SLTT health authorities track relevant environmental, animal, and human health data for specific exposures and diseases, which may be indicative of a biological incident in their jurisdiction. Identification of a natural or intentional biological incident may occur through notification of:

- A probable/confirmed case of a notifiable illness;
- A probable/confirmed case of a highly infectious, life-threatening illness;
- A death from unknown causes;
- An aberration in an illness indicator using a syndromic surveillance system; or
- A highly credible threat involving a bioterrorism agent.

Federal, SLTT and international health authorities utilize a number of different surveillance and reporting systems that support efforts to detect biological incidents.

Traditional disease reporting (clinical and laboratory)
In the United States, the Council of State and Territorial Epidemiologist (CSTE) annually recommends which health conditions should be considered notifiable. Once a list of notifiable conditions is developed, each state determines which diseases and conditions require notification to its state public health authorities. Identification/recognition of a case on the notifiable disease or condition list should prompt a clinician or laboratory to follow its state-based and CSTE guidelines for reporting. For some diseases or conditions, reporting may be immediate, daily, or weekly, utilizing a variety of reporting mechanisms (*e.g.,* telephone, mail or electronic). Traditional clinical and laboratory reporting is a passive surveillance system and the completeness and accuracy vary due to physician and laboratory reporting practices.

Depending on the biological agent, SLTT health authorities may report notifiable diseases or conditions to CDC. In certain instances, CDC may receive notification directly from the treating physician or laboratory upon recognition of a disease or condition in order to receive guidance for the clinical management of the case or technical assistance with the laboratory testing. When this occurs, the agent-specific SME will refer the clinician to their SLTT health authorities, as well as contact the affected health authorities to ensure that they have been notified. The CDC may also contact public health officials in surrounding jurisdictions to ensure situational awareness and provide assistance with active surveillance, if requested, to look for potentially related cases.

During the response to a biological incident, the collection of clinical and laboratory reports provides the necessary data for epidemiologists to determine whether an incident involving a biological agent (*e.g.,* outbreak or bioterrorism) has occurred, identify the etiological agent, and initiate investigations in the source of the exposure.

Syndromic Surveillance

Strategies used for the early detection of a biological incident have been designed around the increasing availability of electronic medical data.[3] Syndromic surveillance tools are used to collect, aggregate and evaluate data from health-related sources to identify aberrations (*i.e.*, significant changes) from the expected numbers of pre-identified syndromes. Syndromic surveillance systems can evaluate chief complaints and primary diagnoses from medical facilities (*e.g.*, hospitals, emergency clinics) and first-responders, prescription or over-the-counter medication sales, veterinary data, environmental data, or Medicare and Medicaid laboratory test cost-reimbursement data. Aberrations in the data can suggest the occurrence of an outbreak that warrants further public health investigation.

While syndromic surveillance systems cannot definitively identify the occurrence of a biological incident, they can still provide timely access to health data for immediate analysis and feedback. Syndromic surveillance compliments traditional passive surveillance systems by providing incident-related information that may assist in defining the scope and progression of the outbreak. However, syndromic surveillance does not replace the gold standard of clinical diagnosis with laboratory confirmation for detecting a biological incident.

Syndromic surveillance is currently used by federal, SLTT and international health authorities. For example, BioSense, managed by CDC, is a national program intended to improve the nation's capabilities to conduct real-time biosurveillance, and enables health situational awareness through access to existing data from healthcare organizations across the country. The data, based on automated reporting, are available in near real time. Sources of data include participating hospitals; the Department of Veterans Affairs (VA) health care system; the Department of Defense (DoD) health care facilities, treatment centers, and hospitals; poison control centers; and a clearinghouse database for laboratory test orders. Surveillance through BioSense is limited because of the lack of comprehensive national coverage and disease-specific data. An additional limitation is that data collection methods preclude the calculation of probability estimates.

In addition to BioSense, there are numerous syndromic surveillance tools (*e.g.*, EARS[4], ESSENCE[5] and RODS[6]) that are used by federal, SLTT health authorities, and international partners for early event detection.

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[3] Rotz L, Hughes J. Advances in detecting and responding to threats from bioterrorism and emerging infectious disease. *Nat Med.* 2004Dec;10(12 Suppl):S130-6.

[4] Developed by CDC to be utilized by SLTT health authorities, the Early Aberration Reporting System (EARS) is a tool for detecting a case, cluster, or significant trend by analyzing pre-diagnostic health information (categorized into syndromes) from hospital emergency departments, poison control centers, or other early-detection data sources.

[5] The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) provides worldwide surveillance for military personnel and their dependents. Johns Hopkins University Applied Physics Laboratory developed ESSENCE in collaboration with the Maryland Department of Health and Mental Hygiene, the District of Columbia Department of Health, and the Virginia Department of Health.

[6] The Real-time Outbreak and Disease Surveillance system (RODS) was developed by the University of Pittsburgh https://www.rods.pitt.edu/site/content/view/13/78/.

During a response to a biological incident, CDC collaborates with SLTT health authorities to integrate its capacity and capabilities for syndromic surveillance with the affected jurisdiction(s).

Animal Health Surveillance

Surveillance of animal health allows for the detection of diseases or conditions affecting animals, as well as identifies the potential for zoonotic disease outbreaks that may affect human populations. Animal health surveillance activities in companion animals (*i.e.,* pets), the food supply, or wildlife is the responsibility of a number of agencies and entities at the federal and state/local level. Depending on the laws governing the jurisdiction, either the agriculture and/or public health authorities are responsible for conducting animal health surveillance. At the federal level, the Animal and Plant Health Inspection Service (APHIS) of the U.S. Department of Agriculture (USDA) is the lead federal agency for health surveillance activities for domestic animals and the co-lead with the Department of the Interior for surveillance activities for wildlife.

Environmental Monitoring

Environmental monitoring involves routine or targeted sampling of the environment to detect the presence of an intentionally released biological agent. Environmental monitoring attempts to detect the presence of a biological agent before the onset of symptoms in exposed subjects. However, environmental monitoring systems have limitations; they can be affected by many factors, including the specificity of the testing methods, weather patterns, location and placement of the monitors, and the concentration of the agent in the environmental media tested (*e.g.,* air, water). These and other technical factors must be considered when deploying an environmental monitoring system and responding to a signal indicating that a biological agent has been detected in the environment[7]. Some environmental surveillance systems currently in use include:

- BioWatch: A Department of Homeland Security (DHS) program, BioWatch is implemented in selected sites to sample ambient air for aerosolized releases of specific biological threat agents; or
- BioHazard Detection Systems (BDS): A system used by the U.S. Postal Service (USPS) to detect the presence of *B. anthracis* in the mail.

Local authorities with environmental monitoring systems in their jurisdiction will work with the managing agency of the environmental monitoring program to address the public health response following detection. As part of this response, the jurisdiction may request that CDC assist with the environmental assessment and investigation of a contaminated or potentially contaminated area.

<u>Identification of Relevant Surveillance Systems</u>

[7] Rotz L, Hughes J. Advances in detecting and responding to threats from bioterrorism and emerging infectious disease. *Nat Med.* 2004Dec;10(12 Suppl):S130-6

There are multiple surveillance systems across the various CIOs at CDC. These surveillance systems may be agent-specific and managed by SMEs (*e.g.,* FluView), while others may not be traditionally involved with the response to a biological incident (*e.g.,* Behavioral Risk Factor Surveillance System). Specific surveillance systems can be deployed and utilized for many different purposes. During a biological incident, multiple surveillance systems from different CDC programs may be utilized for a comprehensive and effective response.

As part of agency preparedness for a biological incident, SMEs should identify surveillance systems that may be utilized for a response to a specific biological agent. This process can be facilitated by the Office of Public Health Scientific Standards (OPHSS). During the preparedness for and response to a biological incident, OPHSS/Health Information Technology and Surveillance Strategy (HITSS) can provide coordination across CDC programs to identify, adapt and utilize agency surveillance systems. Additionally, the Center for Surveillance, Epidemiology and Laboratory Services/Division of Health Informatics and Surveillance (CSELS/DHIS) can provide direct assistance for a response by collecting and analyzing data from the surveillance systems that it maintains. The following surveillance systems are maintained by OSELS:

- BioSense
- Countermeasures and Response System (CRA)
- Distribute
- National Electronic Disease Surveillance System (NEDSS)

Analysis, interpretation, and display of surveillance information

Data must be analyzed and presented so that agency and response leadership can easily identify current or emerging public health issues. Reports should include analyses and interpretations of surveillance information, as well as recommendations for public health actions that are based on available data.

The Situational Awareness Section (SA) in DEO or the CDC IMS coordinates and collaborates with all IMS sections to obtain data, validate information, and produce automated visualizations, databases, reports, assessments, graphics, and briefings. For example, SA can provide assistance to agent-specific SMEs to develop databases and geospatial information products for surveillance information. The geospatial products serve as a visual reference for the biological incident and can be used to provide information to agency and incident leadership, as well as the general public.

Surveillance assistance to Subject Matter Experts

During the response to a biological incident, surveillance activities are not solely limited to the identification and reporting of case counts. It will be necessary to provide surveillance expertise to other response functions (*e.g.,* MCM, Environmental Evaluation) for collection, analysis and interpretation of their data. For example, CDC may be asked to monitor the distribution, effectiveness and potential adverse events associated with the use of MCMs during the response to a biological incident. This activity requires coordination between surveillance and

MCM SMEs to identify, adapt/develop, and implement multiple surveillance systems to collect the required public health information.

Creation of databases to manage surveillance information

Depending on the circumstances of a biological incident, surveillance activities may generate a large amount of data that will need to be stored and maintained not only for current response activities, but also for future analyses. Surveillance information needs to be maintained in a central database so that the data is accessible to multiple individuals during a response.

Pre-existing surveillance systems use established databases and protocols to manage the collection, review and dissemination of surveillance information. However, there may be a need to develop new databases to manage surveillance information. These new databases may support an existing surveillance system or may contain information for another public health function (*e.g.,* medical countermeasure distribution).

NOTE: It is important to ensure that databases created for the management of surveillance information are consistent with current ethical practices and legal statutes. Division- and center-level ADS should be involved at the beginning of database creation. If additional assistance is needed, then the Office of the Associate Director for Science (OADS) and Office of General Counsel (OGC) may be engaged.

Creation of surveillance databases requires personnel that are familiar with the principles and practices of informatics. CDC expertise in data management or informatics is located within the various programs conducting surveillance activities or may be located in a specific CIO informatics office.

Modeling

Mathematical and simulation modeling can provide critical tools for policy and operations in a biological incident, especially when resources are limited. During a response, models have three basic analytical functions: interpretation and interpolation of existing epidemiological data; prediction of the potential course of events given explicitly defined assumptions and knowledge of disease processes; and quantitative evaluation of potential intervention strategies to guide operations.

For example, predictive modeling can provide CDC decision-makers with quantitative information about possible risks and outcomes of prevention and mitigation activities. Mathematical modeling can represent biological processes, such as the spread of an infectious disease in susceptible populations, utilizing systems of equations.

CDC's modeling capability is distributed among several CDC programs, with particular strength in communicable disease transmission (NCHHSTP and NCIRD), response logistics simulation (DSNS), and spreadsheet/economic analysis (NCEZID/DPEI). CDC is also viewed within the federal interagency community and by the public at large as the definitive source for clinical and surveillance information during public health emergencies. Generating this information in a

timely manner requires both rapid access to appropriately organized primary data and analytical modeling capability (*i.e.*, to calculate the reproduction number of transmissible diseases).

Develop and disseminate communication materials

The development and dissemination of surveillance communication materials is coordinated with ERCB/JIC or the Division of News and Electronic Media (media only). ERCB/JIC works with surveillance SMEs to ensure that the communication materials are appropriate for intended audiences and contain relevant guidance and recommendations. Development and clearance[8] of surveillance communication materials may require input from appropriate partners (*e.g.*, SLTT health authorities, non-governmental organizations). Therefore, surveillance SMEs should assist ERCB/JIC to coordinate with partner agencies. Once the materials have been cleared, ERCB/JIC uses a number of communication methods (*e.g.*, HAN Alert, Epi-X, Clinician Outreach Calls, Laboratory Outreach Communications System (LOCS), state coordination calls and CDC.gov) to disseminate the information.

6. Interdependencies

CDC will coordinate with federal, state, and local health agencies on health surveillance issues.

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and HHS Departmental policies.

[8] Additional information on clearance procedures is located in the Health Communications section

Appendix X: Safety & Security of Drugs, Biologics and Medical Devices

1. Purpose

The purpose of this Appendix is to describe the role and functions of FDA in assuring the safety and efficacy of FDA-regulated medical products, including drugs, biologics, and devices, as an integral part of the overall public health and medical preparedness, response, and recovery system. During emergency and disaster situations, FDA must continue to meet its mission to protect the public health by assuring the safety and security of FDA-regulated medical products. This Appendix describes the agency's specific, incident-related functions which support the agency's public health and regulatory mission.

As part of its Emergency Support Function #8 functions, FDA can provide State, tribal, territorial, and local agencies with activities related to regulated product support. For example, FDA can assist State and local agencies in ensuring the safety of drug and medical products in pharmacies.

2. Situation

Emergencies and disasters, whether natural or manmade, accidental or intentional, have the potential to cause adverse health and safety effects for large segments of the human and animal populations. In order to mitigate the consequences of such incidents, FDA must possess the resources and capabilities necessary to prevent, prepare for, protect against, and rapidly and effectively respond to and recover from all hazards. A planned and coordinated approach to emergency operations by FDA organizational components in support of Federal, State, tribal, territorial, and local government, with assistance, when appropriate from foreign counterparts and international partners, can save lives and ensure that critical public health and medical needs are met.

Contamination of the Nation's human and animal food or medical products supply may initially be indistinguishable from a naturally occurring event. Moreover, depending upon the particular agent and associated signs or symptoms, several days or weeks could pass before authorities suspect terrorism may be the cause.

The *FDA Emergency Operations Plan and Annexes (EOP)* is an all-discipline, all-hazards plan that establishes a single, comprehensive framework for the agency's management of incidents. It provides the measures, operating structures, roles and responsibilities, and mechanisms for direction and coordination of FDA resources before, during, and after disease outbreaks, terrorist attacks and other criminal acts, natural disasters, and any other incidents associated with FDA-regulated products that pose a risk to human or animal health.

3016
3017
3018 ## 3. Assumptions

3019 Emergency Authorities:
3020
3021 Statutory authorities relevant to FDA emergency preparedness and response are described
3022 below under the general categories of safety and medical countermeasures. In addition, certain
3023 FDA regulations in Title 21 of the Code of Federal Regulations may apply in an emergency
3024 situation.
3025
3026 • Under the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 301 et seq., as
3027 amended, FDA regulates the safety of, among other things, food, including dietary
3028 supplements, infant formula, and animal feed; human and animal drugs; medical
3029 devices; electronic products emitting radiation; and tobacco products. FDA is charged
3030 with ensuring that safe and effective drugs, biologics, and devices are available for
3031 emergency use.

3032 • Under the Public Health Service Act (PHSA), 42 U.S.C. 262, FDA will only approve a
3033 biologics license application upon a demonstration that the biological product is safe,
3034 pure, and potent. In addition, under the PHSA, 42 U.S.C. 264, FDA may issue and enforce
3035 regulations necessary to prevent the spread of communicable disease.

3036 • Under the FFDCA, FDA generally approves drugs and devices that have been shown to
3037 be safe and effective. Under the PHSA, FDA licenses biological products based upon a
3038 determination that they are safe, pure, and potent.

3039 • Section 561 of the FFDCA: Expanded Access to Unapproved Therapies and Diagnostics
3040 allows FDA to permit the treatment of a patient with an investigational medical
3041 countermeasure under certain circumstances, even though the safety and effectiveness
3042 of the drug have not been fully established.

3043 • Section 564 of the FFDCA, as amended by the Project BioShield Act of 2004, allows FDA
3044 to authorize the emergency use of drug(s), device(s), or biological product(s) during a
3045 declared emergency under certain circumstances.

3046 • The Public Readiness and Emergency Preparedness Act (PREP Act) of 2005, "PREP Act,"
3047 (42 U.S.C. 247d-6d), concerns, among other things, liability protection for the use of
3048 designated medical countermeasures.

3049

The National Infrastructure Protection Plan and its supporting Sector-Specific Plans (SSP), provide the means by which the NIPP is implemented across all 18 Critical Infrastructure and Key Resource (CIKR) sectors, as well as a national framework for each sector to address its unique characteristics and risk landscape. FDA supports HHS in fulfilling its responsibilities for the SSP for the public health and medical sector.

4. Mission

The Secretary of the HHS (the Secretary) has directed FDA to provide emergency support to maintain the safety, efficacy, and security of drugs, biologics, medical devices, radiation-emitting devices, the food supply, or cosmetics.

5. Execution

Concept of Operations

The scope of FDA emergency operations is as wide as the array of products the agency regulates. FDA actions impact the Nation's quality of life on a daily basis through its regulation of food, drugs, medical devices, radiation emitting products, biologics, veterinary drugs, and tobacco products. For this reason, FDA's successful and efficient handling of emergencies and disasters is especially important in fulfilling its mission to maintain not only the public's health, but also its trust and confidence.

Phase 1 – Preparedness

Prior to confirmation of an incident, FDA may conduct a number of activities designed to deter intentional and unintentional acts affecting FDA-regulated products and protect consumers from potential public health hazards.[9] Through heightened and targeted preventive measures at various points in the processing and distribution chains, and by exercising the systems and networks to be used during emergency response operations, FDA can protect the safety and security of regulated products and protect consumers from harm. Activities in support of this effort, conducted in cooperation and collaboration with applicable FDA organizational components; Federal, State, territorial, tribal, and local partners; industry; academia; foreign governments; and, international organizations include, but are not limited to, the following:

- Implementing risk communications with government and industry partners
- Facilitating coordination of medical product investigations between FDA and the States
- Providing FDA guidance to regulated industry and public health and public service messages related to safety of FDA-regulated products

[9] Incident confirmation includes conclusive laboratory analysis, field investigations, epidemiological data, or reliable information from other government agencies that triggers emergency response operations.

3088 • Conducting targeted inspections and investigations and collecting samples
3089 • Preparing laboratory response and other scientific capabilities to analyze/test for
3090 chemical and microbiological agents
3091 • Tracing and intercepting specific imported and domestic products
3092 • Protecting public health through regulatory, legal, and administrative actions.
3093 • Requesting that firms recall drugs, biologics, and medical devices that predictably could
3094 cause serious health problems or death ("Class I") or such products that might cause a
3095 temporary health problem or pose only a slight threat of a serious nature ("Class II")10
3096 • Working, as appropriate, with Federal, State, territorial, tribal, and local government
3097 agencies, and international partners
3098 • Issuing warnings, alerts, advisories, and other advice to consumers, industry, foreign
3099 counterparts, and other international partners regarding drug, medical device, and
3100 biological product safety.
3101
3102 The FDA system for responding to the increased risk of an emergency or disaster affecting FDA-
3103 regulated products provides a significant increase in coverage, awareness, and preparedness
3104 through targeted preventive measures implemented by both headquarters and field offices and
3105 in coordination with other intergovernmental public health and medical partners. Collectively,
3106 these additional consumer protection activities provide for more protected supply and
3107 distribution chains and a better prepared national network capable of responding to an
3108 identified threat or hazard.[11]
3109
3110 **Phase 2 – Response**
3111
3112 Requests for support from State and local agencies can be made directly to the agency or, in
3113 the case of a Presidential declaration of a major disaster or emergency under the Stafford Act.
3114 In order to assist States and local agencies with such requests, FDA has developed Pre-Scripted
3115 Mission Assignments (PSMAs), which can be used to expedite the submission of requests when
3116 a major disaster or emergency has been declared. These requests include laboratory analysis,
3117 investigational, sampling collection, subject matter expertise, and training related to drugs,
3118 biologics, medical devices, radiation-emitting devices, tobacco, the food supply, or cosmetics.
3119
3120 During response to an incident, FDA may perform the following functions related to medical
3121 product safety, as needed:
3122

[10] Recalls of products that are unlikely to cause any adverse health reaction, but that violate FDA labeling or manufacturing laws ("Class III"), will not by themselves activate this Plan.

[11] For more information on FDA protection measures as part of the Nation's larger critical infrastructure protection efforts, refer to the "Agriculture and Food Critical Infrastructure and Key Resources Sector-Specific Plan" to the *National Infrastructure Protection Plan*, located at: www.dhs.gov/xlibrary/assets/nipp-ssp-ag-food.pdf.

3123 • Inspecting or investigating FDA-regulated facilities and collecting and analyzing samples
3124 of FDA-regulated products, as needed

3125 • Providing clear and consistent information to assist industry in understanding and
3126 complying with regulations in a post-disaster environment

3127 • Assessing the availability, production capacity, and surge capacity of medical products,
3128 and providing information on alternative sources of critical products during shortage
3129 situations

3130 • Identifying key facilities that manufacture/process, pack, or hold medical products and
3131 determine if any are critically impacted

3132 • Ensuring the safety and efficacy of medical products

3133 • Using import controls to prevent unsafe products from entering the United States

3134 • Posting vital and important information, emergency messages, and other
3135 communication information quickly to the FDA.gov web site

3136 • Conducting inspection, sample collection and laboratory analysis activities in support of
3137 SLTT agencies specifically related to the incident

3138 • Overseeing product destruction and disposal, as appropriate.

3139

3140 For certain events, the FDA Commissioner may authorize the use of an unapproved medical
3141 product or the unapproved use of an approved medical product during a declared emergency,
3142 which may involve a heightened risk of attack against the public or U.S. military forces or has a
3143 significant potential to affect national security. This can be due to a naturally occurring disease
3144 or a Chemical, Biological, Radiological, or Nuclear (CBRN) agent.[12, 13] An Emergency Use
3145 Authorization (EUA) may be issued only after the Secretary has declared an emergency
3146 justifying the authorization to use a product, based on an appropriate determination made by
3147 the Secretary of Homeland Security, Secretary of Defense, or Secretary of the HHS, as required
3148 by the Project BioShield Act of 2004.[14, 15]

3149

3150 When a countermeasure has not yet been approved, licensed, or cleared because the safety,
3151 effectiveness, and/or quality have not been fully established, FDA may permit the treatment of

[12] The Biomedical Advanced Research and Development Authority (BARDA), within HHS's Office of the Assistant Secretary for Preparedness and Response, provides an integrated, systematic approach to the development and purchase of the necessary vaccines, drugs, therapies, and diagnostic tools for public health medical emergencies. www.hhs.gov/aspr/barda/

[13] MedicalCountermeasures.gov facilitates communication between Federal Government Agencies and public stakeholders to enhance the Nation's public health emergency preparedness. www.medicalcountermeasures.gov/

[14] The most current FDA guidance on EUAs can be found at www.fda.gov/RegulatoryInformation/Guidances/ucm125127.htm.

[15] Federal Food, Drug, and Cosmetic Act, Section564: Authorization for Medical Products for Use in Emergencies.

patients with the medical countermeasure under expanded access mechanisms of Investigational New Drug (IND) or Investigational Device Exemption (IDE)[16].

During high-risk or threat situations, the FDA may perform the following general functions related to medical countermeasures:

- Monitoring and updating the status of product availability and relevant manufacturing information
- Facilitating the availability of safe and effective drugs, therapeutic biologics, vaccines, cellular- and tissue-based therapies, diagnostic devices, and other biological products to be used as countermeasures
- Posting vital and important information, emergency messages, and other communication information quickly to the FDA.gov web site.
- Collaborating with, as permitted, Federal, State, tribal, territorial, and local public health agencies and regulated industry regarding product stockpile issues, including labeling, appropriate usage, product performance, monitoring, use in special populations, and other evolving issues
- Conducting prospective discussions about emergency use of products, the appropriate regulatory mechanism for their use, and the submission of data (e.g., EUA, IND, IDE, or Master File) on the product
- Ensuring that product recipients will be provided with information that is:
    - adequate to obtain informed consent (for IND and IDE products)
    - required by the EUA (e.g., that the product is under EUA and the known and potential risks and benefits of taking or refusing the product)
- Providing advice on identifying potential contaminants of drugs and therapeutic biological products and advising how to test for quality and purity

Phase 3 - Recovery

The "recovery" phase for FDA emergency operations includes short- and long-term actions to ensure and restore the safety, efficacy, and availability of FDA-regulated products and protect the public's health. To accomplish this, FDA supports HHS in the execution of the National Disaster Recovery Framework (NDRF) and the two Recovery Support Functions (RSFs) that require HHS coordination or support: Health and Social Services and Infrastructure Systems. As federal response operations conclude, requests for more detailed assessments, technical assistance, and longer-term coordination fall under the recovery mission. Subject matter expertise and technical assistance can be provided to address issues that affect FDA-regulated industries. FDA and federal supporting agencies will work with State, local, tribal, and/or

[16] Federal Food, Drug, and Cosmetic Act, Section 561, (b) and (c): Expanded Access to Unapproved Therapies and Diagnostics.

territory (SLTT) entities to provide a coordinated and consistent approach to recover from an incident. FDA will collaborate and maintain communication with other government agencies, industry, the public, and the media particularly concerning any long-term effects associated with the event.

- Inspecting or investigating FDA-regulated facilities and collect and analyze samples of FDA regulated products for the overall recovery operation, as needed
- Conducting prolonged inspection, sample collection and laboratory analysis activities in support of State, territorial, tribal, or local agencies that are specifically related to a disaster but deemed ineligible under the Stafford Act (e.g., inspections of retail food establishments and pharmacies)
- Managing a potentially large number of samples of FDA-regulated products, including long-term sampling associated with the health effects of natural and man-made disasters
- Overseeing product destruction and disposal, as appropriate.
- Identifying key pharmaceutical and medical device facilities and determine if any supplies of drugs, biologics, or medical equipment have been or will be critically impacted
- Facilitating the availability of critically needed medical products by identifying alternate products or sources of products.
- Providing clear and consistent information to assist industry in understanding and complying with regulations in a post-disaster environment
- Collaborating with public health agencies regarding drug and therapeutic biologic product stockpile issues, including labeling, appropriate usage, product performance, monitoring, use in special populations, product expiry (e.g., the Shelf Life Extension Program), and other evolving issues
- Processing EUA requests for drugs and therapeutic biologic agents after a public health emergency is declared by the Secretary
- Assessing the availability, production capacity, and surge capacity of drugs and therapeutic biologic products used as countermeasures and providing information on alternative sources of critical medical countermeasures in shortage situations
- Monitoring media and marketplace for counterfeit or violative drugs (or advertising) of particular relevance to the emergency

Dependent on the recovery objectives and the level of coordination needed, FDA will determine resources needed to support recovery efforts. As the need for recovery coordination wanes, FDA will assess whether consumer product safety and security and public health protection objectives were achieved. The transition back to a steady-state operation will occur

in stages and will correspond to the re-establishment of public confidence in FDA-regulated products.

6. Interdependencies

Although FDA is a regulatory agency responsible for protecting the public health through the regulation of medical products, including drugs, biological products, and medical devices, it works in coordination with other Federal Agencies (e.g. CDC) and in cooperation with State, tribal, and local officials to ensure safety and efficacy of FDA-regulated medical products.

The FDA Emergency Operations Center (EOC) is responsible for coordinating Federal interagency liaison activities and establishing communications with the headquarters emergency operations centers and staff of other federal agencies during incidents of varying nature and scope. Through the use of dedicated communications channels, standardized reporting mechanisms, and the deployment of internal and external liaisons when needed, the FDA EOC is able to maintain contact with the HHS Secretary's Operations Center (SOC), the CDC's EOC, the USDA/FSIS, and other Federal Department/Agency EOCs, as appropriate. The FDA EOC will assign liaison officers (LNOs), as appropriate, to interface with or report from other departments and agencies (i.e., HHS, CDC, USDA, EPA, DHS) during an incident. These LNOs serve as direct links between FDA and their assigned agency, to provide input on their agency's policies, activities, concerns, resource availability, and other incident-related matters.

FDA has Memoranda of Understanding (MOU) with other Federal agencies, including, but not limited to the CDC. These MOUs provide a framework for coordination and collaborative efforts between Federal agencies. The FDA/CDC MOU facilitates the exchange of information between agencies to protect the public health where FDA and CDC's respective missions may overlap. This exchange of information permits more efficient use of both agencies' resources and will contribute to improved public health protection.

FDA works closely with DHS and other federal agencies to coordinate the overall national effort to enhance the protection of critical infrastructure and key resources of the nation, including the safety of medical products. Healthcare and Public Health was identified as one of 16 critical infrastructure sectors for the United States. HHS serves as the Sector Specific Agency for the Healthcare and Public Health Sector. HHS Chairs the associated Government Coordinating Council (GCC), which is comprised of representatives from Federal, State, local, tribal and territorial governments. The GCC is the public sector segment of the health care and public health public-private framework. The Sector Coordinating Council (SCC) represents the health care and public health industry and provides a forum for the private sector to discuss infrastructure protection issues or to communicate with the government through the GCC.

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and agency policies.

DRAFT

Appendix XI: Food Safety & Food Defense

1. Purpose

The purpose of this Appendix is to describe the role and functions of FDA related to food safety and food defense as an integral part of the overall public health and medical preparedness, response, and recovery system. During emergency and disaster situations, FDA must continue to meet its mission to protect the public health by assuring human food safety and food defense. This Appendix describes the agency's specific, incident-related functions which support the agency's public health and regulatory mission.

As part of its Emergency Support Function #8 functions, FDA can provide State, tribal, territorial, and local agencies with support for activities related to FDA-regulated products. For example, FDA can assist State and local agencies in inspecting retail food establishments impacted by a disaster.

2. Situation

Emergencies and disasters, whether natural or manmade, accidental or intentional, have the potential to cause adverse health and safety effects for large segments of the human and animal populations. In order to mitigate the consequences of such incidents, FDA must possess the resources and capabilities necessary to prevent, prepare for, protect against, and rapidly and effectively respond to and recover from all hazards. A planned and coordinated approach to emergency operations by FDA organizational components in support of Federal, State, tribal, territorial, and local (SLTT) government, with assistance, when appropriate from foreign counterparts and international partners, can save lives and ensure that critical public health and medical needs are met.

Contamination of the Nation's human food supply may initially be indistinguishable from a naturally occurring event. Moreover, depending upon the particular agent and associated signs or symptoms, several days or weeks could pass before authorities suspect terrorism may be the cause.

The *FDA Emergency Operations Plan and Annexes (EOP)* is an all-discipline, all-hazards plan that establishes a single, comprehensive framework for the agency's management of incidents. It provides the measures, operating structures, roles and responsibilities, and mechanisms for direction and coordination of FDA resources before, during, and after disease outbreaks, terrorist attacks and other criminal acts, natural disasters, and any other incidents associated with FDA-regulated products that pose a risk to human or animal health.

3. Assumptions

The following assumptions and priorities apply to a food safety and food defense response to disasters and public health emergencies:

a) Homeland Security Presidential Directive 9, Defense of United States Agriculture and Food, establishes a national policy to defend the agriculture and food system against terrorist attacks, major disasters, and other emergencies.
http://www.dhs.gov/xabout/laws/gc_1217449547663.shtm

b) The National Infrastructure Protection Plan (NIPP) and its supporting Sector-Specific Plans (SSP), provide the means by which critical infrastructure protection is implemented across all 18 Critical Infrastructure and Key Resource sectors, as well as a national framework for each sector to address its unique characteristics and risk landscape. FDA co-chairs the Food and Agriculture sector with USDA, and has regulatory responsibility for most food products, except meat, poultry, and frozen, dried, and liquid eggs, which are under the authority of the USDA/FSIS. FDA also supports HHS, which is responsible for the Sector-Specific Plan (SSP) for the Public Health and Medical sector.

c) Statutory authorities relevant to FDA emergency preparedness and response are described below. In addition, certain FDA regulations in Title 21 of the Code of Federal Regulations may apply in an emergency situation.

- Under the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 301 *et seq.*, as amended, FDA regulates the safety of, among other things, food, including dietary supplements, infant formula, and animal feed; human and animal drugs; medical devices; electronic products emitting radiation; and tobacco products.

4. Mission

The Secretary of the HHS (the Secretary) has directed FDA to provide emergency support to maintain the safety and security of the food supply.

5. Execution

Concept of Operations

The scope of FDA emergency operations is as wide as the array of products the agency regulates. FDA actions impact the Nation's quality of life on a daily basis through its regulation of food, drugs, medical devices, radiation emitting products, biologics, veterinary drugs, and tobacco products. FDA's successful and efficient handling of emergencies and disasters is especially important in fulfilling its mission to maintain not only the public's health, but also its trust and confidence.

3368
3369 **Phase 1 – Preparedness**
3370
3371 Prior to confirmation of an incident, FDA may conduct a number of activities designed to deter
3372 intentional and unintentional acts affecting FDA-regulated products, and protect consumers
3373 from potential public health hazards.[17] Through heightened and targeted preventive measures
3374 at various points in the processing and distribution chains, and by exercising the systems and
3375 networks to be used during emergency response operations, FDA can protect the safety and
3376 security of regulated products and protect consumers from harm. Activities in support of this
3377 effort, conducted in cooperation and collaboration with applicable FDA organizational
3378 components, Federal, and SLTT partners, industry, academia, foreign governments, and
3379 international organizations include, but are not limited to, the following:
3380
3381 1. Implementing risk communications with government and industry partners
3382 2. Facilitating coordination of food contamination investigations between FDA and the
3383 States
3384 3. Providing critical information on food safety and regulatory issues to consumers,
3385 industry, and other Federal/SLTT governmental and international entities (all levels of
3386 the food chain)
3387 4. Providing FDA guidance to regulated industry and public health and public service
3388 messages related to safety of FDA-regulated products
3389 5. Conducting targeted inspections and investigations and collecting samples
3390 6. Preparing laboratory response and other scientific capabilities to analyze/test for
3391 chemical and microbiological agents.
3392 7. Tracing and intercepting specific imported and domestic products
3393 8. Requesting the recall of food products that predictably could cause serious health
3394 problems or death ("Class I") or such products that might cause a temporary health
3395 problem or pose only a slight threat of a serious nature ("Class II")[18]
3396 9. Working, as appropriate, with Federal, SLTT agencies, and international partners

[17] Incident confirmation includes conclusive laboratory analysis, field investigations, epidemiological data, or reliable information from other government agencies that triggers emergency response operations.
[18] Recalls of products that are unlikely to cause any adverse health reaction, but that violate FDA labeling or manufacturing laws ("Class III"), will not by themselves activate this Plan.

10. Issuing warnings, alerts, advisories, and other advice to consumers, industry, foreign counterparts, and other international partners regarding food safety and soliciting feedback
11. Identifying foods that are at elevated risk of contamination and investigating the effectiveness of food processing and preparation practices
12. Developing and disseminating recommendations on measures to prevent the contamination of FDA-regulated foods
13. Developing and evaluating analytical methods for identifying food contaminants
14. Heightening consumer product protection measures against the adverse effects of naturally occurring and man-made hazards
15. Ensuring the safety of foods for humans, including dietary supplements
16. Setting science-based standards for preventing foodborne illness and ensuring compliance with these standards
17. Protecting the food supply from intentional contamination

The FDA system for responding to the increased risk of an emergency or disaster affecting FDA-regulated products provides a significant increase in coverage, awareness, and preparedness through targeted preventive measures implemented by both headquarters and field offices, in coordination with other intergovernmental public health and medical partners. Collectively, these additional consumer protection activities provide for more protected supply and distribution chains and a better prepared national network capable of responding to an identified threat or hazard.

Phase 2 – Response

Requests for support from State and local agencies can be made directly to the agency or, in the case of a Presidential declaration of a major disaster or emergency under the Stafford Act. In order to assist States and local agencies with such requests, FDA has developed Pre-scripted Mission Assignments, which can be used to expedite the submission of requests when a major disaster or emergency has been declared. These requests include laboratory analysis, investigational, sample collection, subject matter expertise, and training related to safety of the food supply.

During response to an incident, FDA may perform the following functions related to food safety and food defense:

1. Inspecting or investigating FDA-regulated facilities and collecting and analyzing samples of FDA-regulated products as needed
2. Monitoring and updating the status of product availability and relevant manufacturing information
3. Identifying key food related facilities and determining if any food supplies have been or will be critically impacted
4. Facilitating the availability of critically-needed food products, including infant formula, by identifying alternate products or sources of products.
5. Providing an assessment on the diversion of contaminated human food
6. Conducting surveillance efforts to determine food product integrity
7. Providing clear and consistent information to assist industry in understanding and complying with regulations in a post-disaster environment
8. Collaborating with other public health agencies and industry regarding food contaminants and other monitoring programs for foodborne illness
9. Using import controls to prevent unsafe food products from entering the United States
10. Posting vital and important information, emergency messages, and other communication information quickly to the FDA.gov web site
11. Providing states and others technical assistance or subject matter expertise related to food safety and defense
12. Conducting inspectional, sample collection, and laboratory analysis activities in support of SLTT agencies specifically related to the incident (e.g., inspections of retail food establishments)
13. Overseeing product destruction and product reconditioning or rendering, as appropriate.

Phase 3 - Recovery

The "recovery" phase for FDA includes short- and long-term actions to ensure and restore the safety, efficacy, and availability of FDA-regulated products and protect public health. To accomplish this, FDA supports HHS in the execution of the National Disaster Recovery Framework and the two Recovery Support Functions that require HHS coordination or support: Health and Social Services, and Infrastructure Systems. As federal response operations

conclude, requests for more detailed assessments, technical assistance, and longer-term coordination fall under the recovery mission. Subject matter expertise and technical assistance can be provided to address issues that affect FDA-regulated industries. FDA and federal supporting agencies will work with SLTT entities to provide a coordinated and consistent approach to recover from an incident. FDA will collaborate and maintain communication with other government agencies, industry, the public, and the media particularly concerning any long-term effects associated with the event.

1. Inspecting or investigating FDA-regulated facilities and collecting and analyzing samples of FDA-regulated products for the overall recovery operation, as needed
2. Conducting prolonged inspection, sample collection and laboratory analysis activities in support of State, territorial, tribal, or local agencies that are specifically related to a disaster (e.g., inspections of retail food establishments)
3. Managing a potentially large number of samples of FDA-regulated products, including long-term sampling associated with the health effects of natural and man-made disasters
4. Overseeing product destruction and product reconditioning or rendering, as appropriate.
5. Identifying key food-related facilities and determining if any food supplies have been or will be critically impacted
6. Facilitating the availability of critically-needed food products, including infant formula, by identifying alternate products or sources of products.
7. Providing clear and consistent information to assist industry in understanding and complying with regulations in a post-disaster environment

Dependent on the recovery objectives and the level of coordination needed, FDA will determine resources needed to support recovery efforts. As the need for recovery coordination wanes, FDA will assess whether consumer product safety and security and public health protection objectives were achieved. The transition back to a steady-state operation will occur in stages and will correspond to the re-establishment of public confidence in FDA-regulated products.

6. Interdependencies

FDA ensures the safety and security of food in coordination with other responsible federal agencies (e.g., USDA) and in cooperation with State, tribal, and local officials, assesses whether

food manufacturing, food processing, food distribution, food service, and food retail establishments in the affected area are able to provide safe food. FDA regulates the safety and truthful labeling of all food products, including venison and other game meat, bottled water, food additives, infant formula, and dietary supplements (except for meat, poultry, and frozen, dried, and liquid eggs, which are regulated by the USDA).

The FDA Emergency Operations Center (EOC) is responsible for coordinating Federal interagency liaison activities and establishing communications with the headquarters emergency operations centers and staff of other federal agencies during incidents of varying nature and scope. Through the use of dedicated communications channels, standardized reporting mechanisms, and the deployment of internal and external liaisons when needed, the FDA EOC is able to maintain contact with the HHS Secretary's Operations Center (SOC), the CDC's EOC, the USDA/FSIS, and other Federal Department/Agency EOCs, as appropriate. The FDA EOC will assign liaison officers (LNOs), as appropriate, to interface with or report from other departments and agencies (i.e., HHS, CDC, USDA, EPA, DHS) during an incident. These LNOs serve as direct links between FDA and their assigned agency, to provide input on their agency's policies, activities, concerns, resource availability, and other incident-related matters.

FDA has Memoranda of Understanding (MOU) with other Federal agencies, to include but not limited to, USDA and EPA. FDA also has an MOU in place with USDA/FSIS to facilitate the exchange of information between agencies for establishments and operations that are subject to the jurisdiction of both agencies. This exchange of information permits more efficient use of both agencies' resources and contributes to improved public health protection. FDA has an MOU in place with EPA that coordinates agency regulatory activities with respect to the suitability of potable water intended for drinking and culinary purposes onboard Interstate Carrier Conveyances.

FDA works closely with DHS and other federal agencies to coordinate the overall national effort to enhance the protection of critical infrastructure and key resources of the nation, including food and agriculture defense. Food and Agriculture was identified as one of 16 critical infrastructure sectors for the United States. The Sector Specific Agencies for the Food and Agriculture Sector are USDA, HHS, and FDA. FDA and USDA Co-Chair the Government Coordinating Council (GCC), which is comprised of representatives from Federal, State, local, tribal and territorial governments. The GCC is the public sector segment of the food and agriculture public-private framework. The Sector Coordinating Council (SCC) represents the food and agriculture industry and provides a forum for the private sector to discuss infrastructure protection issues or to communicate with the government through the GCC.

7. Administration and Support

Activities performed under this Appendix will be carried out in accordance with applicable laws, regulations, and agency policies.

Appendix XII: Vector Control

1. Purpose

Vector-borne diseases are among the most complex of all infectious diseases to prevent and control. This appendix provides an overview of the process involved in navigating vector related issues into the proper CDC CIO with the most appropriate SMEs. CDC has two primary roles and responsibilities as it relates to the vector issues. First, CDC provides technical assistance to perform environmental surveillance that can be used in conjunction with epidemiologic data. Second, CDC provides help in vector identification, incrimination and biology. The vector and reservoir host control, identification of vector control activities, and location/geography are factors that influence which CDC CIO handles each specific vector issue.

NOTE: CDC does not possess equipment to conduct vector activities. During an incident or emergency response, HHS/CDC can coordinate assistance from federal or private vector control entities to supplement state and local capabilities

2. Situation

Vector-borne diseases are infectious diseases transmitted among human, animal or plant populations by arthropods, usually insects or ticks. The most significant mode of vector-borne disease transmission is by blood-feeding arthropods, in which mosquitoes and ticks are the most notable disease vectors. Arthropod-borne viruses are 40% of all virus species pathogenic to humans and arthropod-borne parasites (e.g., malaria, leishmania, and filaria) affect more people than any other category of parasites. Arthropods may also affect human health either directly by bites, stings, or infestation of tissues. However, other species may serve as sources of disease by harboring pathogens that cause disease in susceptible populations, including humans. These "reservoirs" of disease may include invertebrates, other than arthropods (e.g., snails), rodents[19] and other mammals (e.g., foxes, raccoons, and skunks). Some vector-borne diseases, such as malaria and dengue, use humans are the major host, with no significant animal reservoirs.

For most vector-borne diseases, intermediary animal hosts often serve as a reservoir for the pathogens until susceptible human populations are exposed. The vector acquires the pathogen from an infected host, typically through feeding on the host's blood, and later transmits it either to an intermediary host that might be a natural reservoir of the pathogen or directly to humans. The different stages of a pathogen's life cycle occur during this process and are intimately dependent upon the availability of suitable vectors and hosts. In some instances, humans or other hosts become infected but are not the natural reservoir for a particular pathogen. Infection of such "dead end" or accidental hosts rarely, if

[19] Worldwide, rats and mice spread over 35 diseases. These diseases can be spread to humans directly, through handling of rodents, through contact with rodent feces, urine, or saliva, or through rodent bites. Diseases carried by rodents can also be spread to humans indirectly, through ticks, mites or fleas that have fed on an infected rodent.

ever, contribute significantly to the natural transmission of the pathogen, but can result in serious disease.

Vector-borne diseases are especially prevalent in the tropics and subtropics, but can also be found in temperate zones (e.g., Lyme disease, West Nile virus). Climate change could create conditions suitable for outbreaks of now exotic vector-borne diseases in temperate regions. Patterns of vector-borne disease occurrence differ depending on the characteristics of the pathogen, its hosts or vectors, ecological circumstances, and human behavioral and cultural factors. For example, mosquito-borne pathogens are more likely to cause explosive epidemics than are tick-borne.

Vaccines are available for only a few of the major vector-borne viruses (e.g., yellow fever, Japanese encephalitis) and not at all for the bacteria and parasites. This limits prevention and control to vector suppression; reservoir host suppression is usually practical only for house dwelling rodents. Vector and reservoir host control measures most likely to be used in response to a biological incident

3. Assumptions

The following assumptions are made for vector–borne response to disasters and public health emergencies:

1) States have requested assistance thru appropriate and established communication channels.
2) A disaster or public health declaration has been declared by appropriate federal senior leader(HHS secretary or POTUS)
3) CDC activation of IMS and use of EOC facilities
4) Susceptibility of population
5) Migrations of people from different areas living together in temporary housing
6) Inability to exercise minimal personal hygiene and personal protection
7) General breakdown in sanitation
8) Effective control measures exist for the identified vector
9) Adequately trained medical personnel are available
10) Emergency funding will be provided
11) Media coverage is heightened
12) Abundance of vectors and intermediate and reservoir hosts
13) Prevalence of disease-causing pathogens suitably adapted to the vectors and the human or animal host
14) Local environmental conditions, especially temperature and humidity are susceptible to vectors
15) Resilience behavior and immune status of the human population requires assistance.
16) Proportion of the host population that is susceptible to infection and development of clinically detectable illness
17) Proximity of humans to vectors and conditions that influence exposure

4. Mission

HHS/CDC will support the local and /or state with environmental surveillance and research, and identification of vector control activities and options; provide science based leadership and guidance; determine the most effective method of environmental management and provide individual guidance, including vulnerable populations, for personal hygiene and protection in an impacted area during an emergency response.

5. Execution

Concept of Operations

The response to a biological incident is initially a state/local responsibility. In providing assistance to state/local authorities, CDC can contribute personnel and resources to assist with epidemiologic investigations, laboratory diagnosis, environmental sampling and testing, treatment protocols and other technical information, public health risk communication as well as coordinating a larger-scale (*e.g.*, multi-state) or national public health response, or support international responses. The CDC may become involved at any point in preceding public health response as requested by state/local authorities.

CDC's response to a biological incident can be categorized into 4 phases: Notification, Initiation, Response, and Recovery. In general, CDC's response to a biological incident may involve elements from each of the phases during the course of a response. The Concept of Operations identifies essential public health functions, activities and specific tasks that may be performed as part of a response.

Phase 1: Preparedness

CDC may be notified of a biological incident from a number of external or internal (if the incident occurs on CDC property) sources. The initiation phase covers the activities conducted by CDC once the agency is notified of a biological incident. The initiation phase describes activities conducted by CDC as the agency and subject matter experts (SMEs) respond to the initial notification, validate and collect additional incident information and determine initial response operations. Following the initial follow-up with the reporting entity, the agent-specific SME should determine CDC's involvement, in conjunction with appropriate division and CIO leadership, and begin the implementation of the appropriate response activities. Depending on the circumstance of the incident, it is possible that the agent-specific SME will need additional expertise from across the agency to coordinate and conduct response activities. A Preliminary Assessment Team (PAT) may be convened to determine initial agency response activities to the biological incident. The purpose of forming a PAT is to gather a group of technical and health-related SMEs who are responsible for:

- Conducting an initial assessment of an incident or event; and,
- Providing guidance and recommendations to CDC leadership in order to determine CDC's level of involvement in or response to the incident.

Phase 2: Response

Once activated, CDC utilizes an Incident Management System (IMS) to manage and coordinate the agency's response activities

At the initiation of a response, leadership (CIO or IMS) should establish clear goals and objectives for the response (e.g., develop surveillance case definition, provision of medical countermeasures), as well as develop criteria to indicate when a response should be terminated (e.g., no new cases are reported for a determined time frame). This should be conducted in coordination with the SLTT or international health authority requesting CDC assistance. The creation of goals and objectives allows CDC to manage response activities by directing resources to the areas of greatest need. Early prioritization and allocation of resources based on agency goals and objectives is especially important during a response to extended duration or increasing complexity (e.g., pandemic influenza, bioterrorism incident).

The goals and objectives should be agent-and site-specific and may be developed as part of preparedness activities. However, they should be reevaluated at the onset of a response and modified according to the circumstances of the biological incident. Once goals and objectives of the response are established, benchmarks or performance measures will need to be established, with data collected on a regular (*e.g.*, daily) basis to determine whether the initials goals/objectives were reasonable and achievable.

a. **Epidemiology**: An epidemiologic investigation will help determine the nature and scope of the outbreak. During a biologic incident, agent-specific subject matter expert (SME), on request, provides guidance and assistance on surveillance issues and epidemiologic investigations to SLTT health authorities.
b. **Surveillance**: Surveillance is essential to establishing public health priorities and determining appropriate actions. In general, public health surveillance provides the data that can be used to:
    1. Estimate the magnitude of a health problem in a population at risk;
    2. Detect outbreaks or epidemics;
    3. Test hypotheses about etiology;
    4. Identify and evaluate control strategies;
    5. Assess the safety of medical countermeasures (MCMs);
    6. Provide information to plan and conduct research; and,
    7. Define strategies for planning and response.
c. **Laboratory**: From the first indication that a biological incident has occurred, CDC laboratory subject matter experts (SMEs) provide technical consultation directly to SLTT health authorities regarding issues such as sample collection and processing, agent/disease-specific test procedures, laboratory equipment, test reagents, testing algorithms, results interpretation and data management. Technical consultation occurs through established relationships with SLTT health authorities and CDC laboratory SMEs; however notifying the CDC Emergency Operations Center (EOC) is preferred since the EOC maintains real-time point of contact information for both infectious and chronic disease agents and is available 24/7.
d. **Medical Care and Countermeasures**: During the response to a biological incident, CDC uses the basic sciences of public health (*e.g.*, surveillance, epidemiology, laboratory, and health communication) to recognize, identify, and characterize diseases, agents, and affected populations.

These functions allow CDC to provide clinical guidance on treatment and prophylaxis recommendations and determine if, when, where and to whom stockpiles of medical countermeasures (MCMs) will be provided. Information provided from the epidemiologic or environmental evaluations, as well as laboratory testing, may guide countermeasures utilization strategies, including allocation and prioritization decisions.

Phase 3: Recovery

Recovery involves termination of CDC's response activities and implementation of operations to recover CDC assets. Recovery may also signal deactivation of the CDC IMS and a transition of response operations back to oversight and management by the lead CIO.

Mitigation programs continue. Data collection continues to help predict future outbreaks; and frame research, preparedness and prevention plans; develop more refined surveillance systems develop human and animal vaccines, research novel approaches to control vectors and their ability to transmit disease while increasing public and health care provider education.

6. Interdependencies

HHS/CDC can coordinate assistance from federal or private vector control entities to supplement state and local capabilities. Official communication channels exist from local level through the state network to the federal level for support and supplies. HHS can request assistance from DOD to assist in vector control activities to supplement local and /or state resources.

7. Administration and Support

THE CDC All Hazards Plan (AHP) is the base document for establishing the emergency incident response.

OID/NCEZID is considered the primary lead agency for CDC in promoting health and quality of life by preventing and controlling vector-borne disease. Other CDC CIOs could potentially lead a response dependent on reservoir host and location

OPHPR and the Division of Emergency Operations within OPHP support the activated IMS structure with people, equipment and processes. The full resources of CDC are available to support a response

Appendix XIII: All Hazard Public Health and Medical Consultation, Technical Assistance, and Support

1. Purpose

The purpose of this appendix is to describe the coordination of All Hazard Public Health and Medical Consultation, Technical Assistance, and Support in response to State or local requests for assistance during disasters or emergencies as part of the overall public health and medical preparedness, response, and recovery system.

2. Situation

During and after a disaster or emergency, State or local health agencies may be unable to execute their full responsibilities due to a disruption of service in communications, transportation, power, or facilities. The State or local public health and medical agencies may require and request federal assistance in community outreach and assessment; humanitarian assistance, public health needs assessment; epidemiological investigations and surveillance; preventive medical services; environmental health; or worker health. Assistance can include advising public health decision makers, providing technical assistance, plan actions for restoring or improving the public health infrastructure, or augmenting the local public health work force. All Hazard Public Health and Medical Consultation, Technical Assistance, and Support aims to provide a continuum of services (ranging from assessment and consultation of public health needs to direct support of public health infrastructure) to mitigate an incident's effects before developing into more serious medical conditions.

3. Assumptions

The following assumptions apply to the All Hazard Public Health and Medical Consultation, Technical Assistance, and Support response to disasters and emergencies:

1. Public health departments will establish close working relationships and mutual aid agreements with State, regional, and tribal public health response coordinators, neighboring health jurisdictions, humanitarian and volunteer organizations, and the local Medical Reserve Corps.

2. Local public health departments will conduct hazard vulnerability and risk assessments for their area.

3. Capacity assessments will be conducted to define the resources of the community's public health system and the resources available through mutual aid agreements.

4. Plans will be developed to outline continuity of public health operations during disasters and emergencies, and include procedures to request and incorporate surge capacity resources necessary to perform basic public health missions.

5. The local public health department will have a system in place to capture health surveillance information (morbidity, mortality, syndromic and behavioral) during emergency situations.

6. Local public health personnel and augments from humanitarian and volunteer organizations, and the Medical Reserve Corps will be trained in local public health procedures.

7. Public health and medical exercises are conducted to evaluate preparedness for response and short term recovery activities, in order to improve response and recovery plans and identify mitigation and corrective actions needed.

8. Federal teams will augment the local public health department or function as an area public health department to provide the necessary services until the local public health departments are able to resume their normal roles and responsibilities.

4. Mission

Federal interagency partners will initiate and conduct All Hazard Public Health and Medical Consultation, Technical Assistance, and Support based on the requirements of State, local, tribal, and territorial authorities. ESF #8 may task HHS components and regional offices, as well as request assistance from other ESF #8 partner organizations, to assess public health and medical effects resulting from all hazards. Such tasks may include assessing exposures to the population; conducting field investigations including collection and analysis of relevant samples; providing advice for protective actions related to direct human and animal exposures, and the indirect exposure through contaminated food, drugs, water supply, and other media; and providing technical assistance and consultation for the medical treatment, screening, and decontamination of injured or contaminated individuals. ESF #8 will ensure synchronization of deployed Federal Public Health and Medical teams to reinforce State and local response efforts and transition to recovery.

5. Execution

Concept of Operations

c) <u>Phase 1 – Preparedness</u>

All Hazard Public Health and Medical Consultation, Technical Assistance, and Support strategies and actions promote community resilience and are an essential part of public health and medical emergency response and recovery. All Hazard Public Health and Medical Consultation, Technical Assistance, and Support must be integrated into plans and preparedness activities in order to promote effective response, recovery, and national health security.

(1) **National Healthcare Preparedness Program (NHPP):** The NHPP provides funding through grants and cooperative agreements to States, territories, and eligible municipalities to improve surge capacity and enhance community, hospital, and other health care organizations medical surge capability preparedness for public health emergencies. For more information, view the following document: http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf

(2) **Public Health Emergency Preparedness Cooperative Agreement (PHEP):** The PHEP cooperative agreement supports preparedness nationwide in state, local, tribal, and territorial public health departments. The PHEP cooperative agreement provides funding to build and upgrade the preparedness infrastructure of public health departments to improve their ability to respond to the public health consequences of not only terrorist threats, but also infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies.

(3) **Centers for Disease Control and Prevention (CDC):** CDC provides annual guidance and technical assistance to assist state, territorial, and local health departments with their strategic planning to strengthen their public health preparedness capabilities. Technical assistance includes CDC public health expertise, standards for developing priority preparedness capabilities, and expertise for conducting exercises and meeting performance goals.

(4) **CDC's Clinician Outreach Communication Activity (COCA):** COCA is designed to provide two-way communication between clinicians and the CDC about emerging health threats, such as pandemics, natural disasters, and terrorism. COCA operates in order to help clinicians provide the best possible care to patients by supplying them with the most current and reliable information; disseminate evidence-based health information and public health emergency messages to clinicians; provide and promote emergency preparedness and response training opportunities; obtain feedback from healthcare provider audiences to help improve emergency communications to clinicians; and identify clinical issues during emergencies to help direct communication strategy and outreach to clinicians.

(5) **CDC's Cities Readiness Initiative (CRI):** The CRI is designed to enhance preparedness in the nation's largest cities and metropolitan statistical areas. Through CRI, state and large metropolitan public health departments have developed plans to respond to a large-scale bioterrorist event by dispensing antibiotics to the entire population of an

3830 identified MSA with 48 hours. CDC provides technical assistance to the participating 72
3831 MSAs for the development of their plans to receive, distribute, and dispense medical
3832 assets received from CDC's Strategic National Stockpile. To ensure continued readiness,
3833 CDC and state public health personnel conduct annual technical assistance reviews to
3834 assess the plans for each local jurisdiction.

3835 (6) **Association of State and Territorial health Officials (ASTHO):** ASTHO is the national,
3836 non-profit organization representing the state and territorial public health agencies of
3837 the United States, the U.S. territories, and the District of Columbia. ASTHO's members
3838 are the chief health officials of these jurisdictions, and are dedicated to formulating and
3839 influencing sound public health policy and assuring excellence in state-based public
3840 health practice.

3841 (7) **National Association of County and City Health Officials (NACCHO):** NACCHO is a
3842 national membership organization representing the 2,800 local public health
3843 departments. NACCHO helps local public health departments continuously improve
3844 their work and workforce, infrastructure, and services to their communities through a
3845 variety of technical assistance and tools promoting health and equity, combating
3846 disease, and improving the quality and length of all lives.

3847 (8) **Federal Drug Administration** provides technical guidance and assistance to States and
3848 industry to ensure foods are safe, wholesome, sanitary and properly labeled; ensuring
3849 that human and veterinary drugs, and vaccines and other biological products and
3850 medical devices intended for human use are safe and effective.

3851 (9) **Coordinated Outbreak Response and Evaluation Network (FDA)** was created to
3852 manage not just outbreak response, but surveillance and post-response activities
3853 related to incidents involving multiple illnesses linked to FDA-regulated human and
3854 animal food and cosmetic products

3855 (10) **FDA's Office of Crisis Management (OCM)** serves as the agency focal point for
3856 coordinating emergency and crisis response activities involving FDA regulated
3857 products or in situations when FDA regulated products need to be utilized or
3858 deployed. It coordinates intra-agency and inter-agency activities related to crisis
3859 management, emergency preparedness and response, and security operations.

3860 (11) **FDA's Office of Counterterrorism and Emerging Threats (OCET)** mission is to facilitate
3861 the development and availability of safe and effective public health emergency
3862 medical countermeasures and establish policies to safeguard medical products from
3863 adulteration and prevent disruption of supplies as a result of terrorist activities. OCET
3864 also coordinates FDA's Medical Countermeasures initiative (MCMi); facilitates relevant
3865 intra-and inter-agency counterterrorism communications; and coordinates emergency
3866 use authorization.

(12) **FDA's Center for Drug Evaluation and Research (CDER)** takes an active role in helping prepare the nation for terrorist events, emerging health threats, and emergency response to natural and man-made crises.

(13) **Centers for Medicare and Medicaid Services (CMS)**

(14) **Health Resources and Services Administration (HRSA)**

(15) **Administration for Children and Families (ACF)**

b. Phase 2 – Response

When State or local health agencies may be unable to execute their full health responsibilities due to a disruption of communications, transportation, power services, or facilities caused by a disaster or emergency, the State or local public health and medical agencies may require and request federal assistance in All Hazard Public Health and Medical Consultation, Technical Assistance, and Support functional mission area.

(1) **Federal Coordination:** The HHS Secretary's Operations Center (SOC) and the CDC Emergency Operations Center (EOC) activate the necessary coordination entities to support State requests for All Hazard Public Health and Medical Consultation, Technical Assistance, and Support needs.

(2) **Regional Coordination:** The ASPR Regional Emergency Coordinators (REC) and the ASPR Incident Management Team (IMT) provide regional and State level coordination of Federal ESF #8 operations; situational awareness, assessment, and reporting; and communication with State and local health organizations.

(3) **MRC Coordination**: OASH-OSG-DCVMRC assists ESF #8 partners in integrating OASH-OSG-DCVMRC members into their response activities, and works with the coordinator of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to provide liaison to ESF #8 partners on civilian deployment.

(4) **Applied Public Health Team (APHT):** APHT can assist local officials with planning and with proposals for restoring public health infrastructure, for improving that infrastructure, or for both. Further, each APHT can collect and analyze information for evaluating and for improving local programs' effectiveness or service delivery. APHT members have the technical consultation skills and abilities to preserve and to safeguard local public health, especially during emergencies.

3902
3903 (5) **Rapid Deployment Force (RDF):** If a State, Tribal or local health infrastructure suffers
3904 damage from a natural disaster or other event, RDF teams can assist officials in response
3905 and/or recovery efforts. Assistance can include augmenting the local health work force to
3906 speed up response or recovery, or, with especially difficult matters, assisting or advising health
3907 decision-makers. Each RDF can also provide essential services to preserve the lives and the
3908 health of affected and returning populations.
3909
3910 (6) **Health Alert Network (HAN):** The Health Alert Network is CDC's primary method of
3911 sharing cleared information about urgent public health incidents with public information
3912 officers; federal, state, territorial, and local public health practitioners; clinicians; and public
3913 health laboratories. HAN is a robust interoperable platform for the rapid distribution of public
3914 health information.
3915 (7) **Laboratory Response Network (LRN):** The LRN is an integrated national and
3916 international network of laboratories that are fully equipped to provide technical assistance
3917 and support by responding quickly to acts of chemical or biological threats, emerging infectious
3918 diseases, and other public health threats and emergencies.
3919
3920 (8) **Strategic National Stockpile (SNS):** The SNS has large quantities of medicine and
3921 medical supplies to protect the American public if there is a public health emergency (e.g.
3922 terrorist attack, flu outbreak, and earthquake) severe enough to cause local supplies to run out.
3923 Once Federal and local authorities agree that the SNS is needed, medicines will be delivered to
3924 any state in the U.S. in time for them to be effective. Each state has plans to receive and
3925 distribute SNS medicine and medical supplies to local communities as quickly as possible.
3926
3927 (9) **Additional Interagency Partners:** ESF #8 coordinates additional response actions
3928 through other Federal interagency partners, other ESF partners, nongovernmental
3929 organizations, volunteer organizations, and State health resources.
3930
3931 c. **Phase 3 - Recovery**

3932 Health and Social Services (H&SS) Recovery Support Function (RSF) staff participates in the ESF
3933 #8 Response phase to promote a smooth transition from response to recovery. The transition
3934 from federal response to recovery is marked by the following organizational changes:
3935 • Response assets demobilize, the HHS Secretary's Operations Center (SOC) adjusts its
3936 alert status, and the national coordinating structure transitions from the NRF to the
3937 NDRF; and

3938 • ESF #8 passes coordination, under the NRF, to the H&SS RSF, under the NDRF.

During Recovery, H&SS RSF support agencies:

- Maintain bi-directional communication through relevant agency programs and grants to assess and address locally-driven recovery needs and gaps and share governmental information,
- Provide information to the H&SS RSF to inform recovery assessments and to guide H&SS RSF activities (including requests for support or recovery mission assignments),
- Identify informational related to disaster recovery and resilience and mobilize access to this information through recovery information channels,
- Plan for and implement the transition from recovery operations to steady-state activity, and
- Transition from NDRF coordinated recovery activity to community resources are a key planning consideration throughout the H&SS RSF operational period. The NDRF provides guidance for assessing the progress of this transition.

6. Interdependencies

ESF #8 provides guidance, technical assistance, and support to Mass Care, Emergency Assistance, Housing, and Human Services (ESF #6) to ensure adequate services are provided within congregate shelters and disaster housing.

7. Administration and Support

Activities performed under this appendix will be carried out in accordance with applicable laws, regulations, and departmental policies.

Appendix XIV: Potable Water, Wastewater, and Solid Waste Disposal

1. Purpose

This Appendix describes the US Department of Health and Human Services (HHS) strategy and actions to address issues relating to Potable Water, Wastewater, and Solid Waste issues following a disaster or incident. The management of these activities is an environmental health priority that will need to be addressed in most disasters. Community perceptions of water shortages, unreliable or unsafe water sources needed for consumption or clean-up activities could prove to be a source of anxiety and mistrust of governmental authorities. As such, a priority following large incidents must be to quickly assess and restore water and environmental safety in the affected areas.

As such, those agencies with responsibility regarding water issues must ensure the water made available meets established chemical and biological standards and is safe for consumption and available in enough quantities to the survivors. The proper handling of any wastewater, as well as the disposal of solid waste generated, is also important in order to protect the public's health. As any waste tends to create other environmental hazards and threats to those most susceptible and at risk for injury or death.

During and following disaster none of these functions concerning water and solid waste are the primary responsibility of HHS. The US Environmental Protection Agency (EPA) along with state and local water and wastes disposal operators are responsible for protecting the environment and leading these post disaster activities. However, HHS Operational divisions can be expected to provide support for these lead agencies and partners in ensuring the on-going monitoring, testing, health surveillance, pathogen identification, and response to environmental health hazards. HHS may also be called upon at a request from health officials in the affected areas or other partners to provide technical support and consultation along with deploying subject matter experts knowledgeable about these issues.

Background

Following an incident in which damage to the water, sewage and waste management systems occurs, the proper handling of the water supply, waste water and solid waste are critical to ensuring the protection of the health not only of the affected populations but also the emergency responders and recovery workers.

The two main sources of water in the US are surface water (68%) and groundwater (32%). Water is provided through public water systems, private wells, or bottled water. There are approximately 160,000 public drinking water systems (PWS) in the United States. These systems provide potable drinking water to approximately 84% of the US population. The other 16 % of Americans are served primarily by private wells.

Public and private water systems have various components. These include the distribution system/network, and the technical processes which render water safe for consumption. The PWS are composed of intricate piping systems that allow water to be delivered to customers. Regulation of water systems is not a function of HHS. The US Environmental Protection Agency (EPA) and State environmental and public health agencies regulate water systems. This regulation is conducted through data monitoring and chemical standards. The EPA is the lead agency for addressing concerns regarding treatment of water systems and waste infrastructure. The EPA water staff works together with local, state and federal groups during all phases of a disaster to ensure the safety of water systems.

Wastewater is a byproduct of water that has been used in some way either by residential or commercial customers (e.g., industrial, agricultural, food services, healthcare facilities, etc.). Wastewater is "treated" or processed in states by public and private wastewater treatment operators licensed by the EPA. Approximately 16,000 publicly owned treatment plants in the United States process over 32 billion gallons of wastewater every day. Much of this wastewater is collected using sewer systems lines. It is estimated there are more than 600,000 miles of publicly owned (sewage) collection lines used by sewer systems in the U.S.

Other systems that collect wastewater are onsite/decentralized wastewater systems (e.g., septic tanks). EPA estimates that nearly one in four individual households depends on individual septic systems. There are also commercial septic systems known as "cluster systems" capable of processing smaller amounts of both household and commercial sewage. Disasters such as flooding and hurricanes can disable, damage, or destroy both of these types of wastewater systems. This damage in turn could result in potential releases of untreated wastewater and dangerous contaminants into the environment.

Solid waste disposal is a term used to describe the process that waste no liquid waste undergoes. This process includes the: collection, transport, processing, disposal and monitoring of waste materials. According to the EPA, the statutory definition of solid waste is: "Any garbage, refuse, or sludge from a wastewater treatment plant, water supply treatment plant, or air pollution control facility, and other discarded material, including solid, liquid, semisolid, or contained gaseous material, resulting from industrial, commercial, mining, and agricultural operations and from community activities." Commercial or household waste may include dangerous chemicals including household cleaning chemicals and pesticides, or the by-products of manufacturing processes.

2. Situation

Potable Water

Water is a resource essential for all living things. It is also a resource that is often in short supply, even in a non-disaster situation. Lack of water can affect all sectors of a community and services including the health care, food, industry, and agricultural and result in human and economic losses. It can also pose a risk to public safety and the public's health.

Following any emergency or disaster, and especially after flooding, potable water may not be available or safe to drink or use for cooking or personal use (cooking, washing). Floods and

other disasters can damage or deposit hazardous substances in drinking water wells intake sites, which can also lead to contamination of aquifers and wells.

Flood waters can contaminate well water with livestock waste, human sewage, chemicals, and other contaminants which can lead to illness if used for drinking, cooking, bathing, and personal use. As a result, residents may have to find reliable and safe sources of drinking water. In the interim, water will have to be obtained or transported to the affected areas from external or non-traditional sources. In many instances, the affected communities may be instructed by local or state public health authorities on how to treat and store available water in order to make it safer for consumption.

Large amounts of potable water will be needed for meeting demands of households and commercial businesses during clean-up activities. The lack of adequate and safe amounts of water may have indirect effects; such as impacting farm animals, crops, healthcare facilities, and the trust community residents have in their government officials and regulators. Having potable water available is also a sign of resilience and community recovery.

Wastewater:

Septic systems and community wastewater systems play important roles in maintaining adequate levels of sanitation and contribute to communicable disease prevention by removing and safely disposing of harmful viruses, bacteria, and parasites. However, these systems can be vulnerable during disasters caused by either natural or manmade means. In the past, water systems have been damaged, destroyed or rendered inoperable during emergencies such as floods, hurricanes, or earthquakes. This damage can not only lead to contamination of water systems, but also create additional environmental hazards and increase the risk or likelihood for communicable disease or injury.

Solid Waste:

Large amounts of solid waste can be generated during disasters and emergency incidents. For example, during an earthquake large amounts of building construction material debris could be generated. During floods, large amounts of household material, household goods, perishable resources, and commodities may have to be disposed of during clean up or remediation. In addition, potentially hazardous substances such as industrial and household chemicals may be released, requiring proper cleaning and disposal on special sites.

3. Assumptions

The following general assumptions and priorities apply to the availability of potable water and the proper handling of wastewater and solid waste.

- Local water utilities will be partially or completely destroyed, rendered inoperable, or forced to operate at a lower capacity than usual following disaster incidents.
- Disasters or incidents will generate large amounts of various types of waste including waste water and solid waste. Handling solid waste will also require considerable amounts of water to be used during cleanup and rebuilding efforts. Large amounts of wastewater that

could be contaminated with dangerous chemical or biological hazardous substances will be generated during disasters and their cleanup.

- Flood waters or standing waters will contain contaminants from agricultural industrial or household chemicals that are capable of entering and contaminating the water supply during disaster events.

4. Mission

Water is essential for hygiene and sanitation, household use, and cleanup activities. The lack of water clean could create unrest, mistrust, or lack of confidence in the quality of the water and delay recovery operations. During and following a disaster or incident Federal interagency partners will assist state and local water, waste water and solid waste disposal agencies in reducing the impact of damaged drinking water and wastewater systems. Federal assistance can help in monitoring and ensuring that the available water in a disaster area, whether transported or distributed in bulk from local sources, is suitable for consumption. HHS staff will work with the respective Operating Divisions (OPDIVs) to provide jurisdictions affected with access to subject matter experts knowledgeable in issues that can affect water systems during as part of a disasters or incident. A coordinated approach is also required in the delivery of public health communications or health recommendations issued to the public. HHS will support and deploy the necessary staff to augment state and local communications staffs as required.

Through the Incident Management Team (IMT), HHS maintains situational awareness in the field. This team is in best position to immediately obtain the necessary monitors and to support a response addressing emerging public health issues including those related to safety of the water supply. HHS staff deployed to disaster-affected areas must be aware of these environmental concerns and should ensure all HHS activities are appropriately coordinated with the lead federal agencies (e.g. EPA), state/local authorities, and any HHS OPDIVs.

5. Execution

Concept of Operations

Several Federal entities may be engaged in the response to a disaster incident, including HHS, the Department of Homeland Security (FEMA), and the EPA. As part of HHS's Concept of Operations, involvement may include, but is not limited to: the Centers for Disease Control and Prevention (CDC), the Indian Health Service, the Food and Drug Administration, the Assistant Secretary for Preparedness and Response, the Office of the Surgeon General, and the US Public Health Service (USPHS).

Assistance will be provided as requested for addressing the broad spectrum of threats to water, wastewater, and solid waste systems. During the various phases of a disaster or incident, CDC's National Center for Environmental Health (NCEH), Office of Infectious Diseases (OID), National Institute for Occupational Safety and Health (NIOSH), and the Agency for Toxic Substances and Disease Registry (ATSDR) may provide technical consultation and assistance with emergent water, wastewater and waste issues during a disaster or emergency.

4126 This assistance may include, but is not limited to: advanced laboratory testing and
4127 interpretation, waterborne disease surveillance, waterborne outbreak detection and
4128 investigation/response, health risk communications, and deployment of technical staff with
4129 epidemiologic, environmental health, and/or engineering expertise in water, wastewater, and
4130 sanitation to the affected areas to provide guidance regarding drinking water and wastewater
4131 issues.

4132 Others types of assistance may include providing occupational health surveillance, safety health
4133 and information for disaster workers who are carrying out this work. The USPHS has both
4134 environmental health and engineering professionals that are specially trained in disaster
4135 response and can focus on water, wastewater, and solid waste issues. USPHS officers are
4136 considered rapid deployable assets for HHS. In addition, there are other HHS OPDIV civilian staff
4137 members with similar experience and expertise in these issues that may also be available for
4138 deployment.

4139 **Phase 1 - Preparedness** – During the preparedness phase, HHS through CDC, ASTDR, and NIOSH
4140 can plan for addressing some of the issues concerning water, wastewater, handling of solid
4141 waste, and safety aspects of those workers performing the work. In preparation for dealing
4142 with issues concerning potable water, wastewater, and solid waste management, the CDC has
4143 developed and maintains a portfolio of information products concerning the safety and use of
4144 water in disaster situations. These products are informational in nature and can be provided, as
4145 needed, to assist state and local authorities' public information efforts. This information is
4146 available via the CDC web site and is deployable via social media. In addition, CDC participates
4147 in workgroup and planning activities with all partners concerned with water issues, including
4148 communications staff from other agencies involved in preparedness work for disasters.

4149 **Phase 2 – Response** - During the response phase, HHS through CDC, NIOSH, and ATSDR are
4150 prepared to support federal, state, and local partners by:

4151

4152 **Potable Water**

4153 1. Providing technical assistance and support for the establishment of surveillance systems for
4154 monitoring health issues associated with waterborne disease.

4155 2. Providing Geographical Information Systems in support of the jurisdictions affected.

4156 3. Providing links to health information about water safety for the public, response workers,
4157 and public health officials.

4158 4. Providing public health content and public health messaging related to water issues for
4159 website and social media (Twitter, Facebook).

4160 5. Deploying environmental health personnel to assist federal, state, and local staff in the
4161 rapid assessments and evaluation of water systems damage that may occur as a result of a
4162 disaster or large scale incident.

6. Deploying environmental health staff to provide consultation and recommendations on the effects of potential hazards and contaminants (chemical, radiological, sanitation).
7. Providing consultation and technical assistance to public health and emergency response partners on issues related to consequence management of issues specific to water systems.
8. Coordinating with federal, state, and local public health and environmental agencies in the development of guidance on water-related issues.
9. Providing educational materials and training on the safety and use of water (including drinking water, flood water exposure, and post-disaster cleanup activities).
10. Coordinating with EPA and partner programs having responsibility for addressing issues with potable water

Wastewater

1. Providing technical consultation regarding common hazards associated with standing flood water that contains wastewater.
2. Providing awareness education as well as health and safety information to the responders and disaster volunteers on issues related to exposure to wastewater.
3. Providing technical consultation and assistance regarding chemical or biological contaminants found in wastewater and providing recommendations to prevent, reduce, and/or control exposure to wastewater during disasters.
4. Participating in discussions regarding remediation of damaged wastewater systems.
5. Providing public health and safety guidelines to prevent injuries associated with standing water including drowning.
6. Providing technical guidance for clean-up and decontamination of objects, surfaces, and/or facilities previously contaminated with wastewater.
7. Providing guidance for determining the potential effects on, and long-term monitoring of, exposed populations.
8. Providing technical assistance with establishing health surveillance for illnesses that may occur as a result of exposure to contaminants in wastewater.
9. Providing assistance in conducting Risk Assessments, including: Hazard Identification, Dose-Response Assessment, Exposure Assessment, and Risk Characterization.

Solid Waste

1. Providing technical assistance and support in establishing surveillance systems for monitoring potential environmental health hazards and exposures that may occur during the clean-up and removal of waste generated during an event.

2. Coordinating with federal, state, and local health and environmental agencies on solid waste issues.
3. Coordinating the assessment of hazardous waste sites affected by hurricanes, floods, and other disaster events.
4. Providing technical consultation and support during monitoring for potential vectors and nuisances that may occur as a result of large amounts of waste been generated.

Phase 3 - Recovery – During the recovery phase of the incident, HHS may sub-task CDC, NIOSH, and ATSDR to:

1. Continue to provide information via CDC web content of special media pages for use by the public and public officials.
2. Provide clinical guidelines on prevention and control of water-related illness and injuries for community residents and disaster recovery workers.
3. Provide technical support for vector and pest control issues arising during clean up, debris removal, and waste storage.
4. Ensure staff is available for consultation regarding environmental health hazards associated during the recovery or reconstruction process.

6. Interdependencies

CDC and ATSDR will coordinate with federal, state, and local health and environmental protection agencies on potable water, wastewater and solid waste issues

7. Administration and Support

Activities performed under this Annex will be carried out in accordance with applicable laws, regulations, and HHS Departmental policies.

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Appendix XV: Agriculture Safety & Security

1. Purpose

The purpose of this Appendix is to describe the role and functions of FDA in assuring the safety and security of agriculture as an integral part of the overall public health and medical preparedness, response, and recovery system. During emergency and disaster situations, FDA must continue to meet its mission to protect the public health by assuring the safety and security of agriculture. This Appendix describes the agency's specific, incident-related functions which support the agency's public health and regulatory mission.

As part of its Emergency Support Function #8 functions, FDA can provide State, tribal, territorial, and local agencies with support for activities related to FDA-regulated products. For example, FDA can assist State and local agencies in collecting and/or analyzing food samples.

2. Situation

Emergencies and disasters, whether natural or manmade, accidental or intentional, have the potential to cause adverse health and safety effects for large segments of the human and animal populations. In order to mitigate the consequences of such incidents, FDA must possess the resources and capabilities necessary to prevent, prepare for, protect against, and rapidly and effectively respond to and recover from all hazards. A planned and coordinated approach to emergency operations by FDA organizational components in support of Federal, State, tribal, territorial, and local government (SLTT), with assistance, when appropriate from foreign counterparts and international partners, can save lives and ensure that critical public health and medical needs are met.

Contamination of the Nation's human and animal food supply may initially be indistinguishable from a naturally occurring event. Moreover, depending upon the particular agent and associated signs or symptoms, several days or weeks could pass before authorities suspect terrorism may be the cause.

The *FDA Emergency Operations Plan and Annexes (EOP)* is an all-discipline, all-hazards plan that establishes a single, comprehensive framework for the agency's management of incidents. It provides the measures, operating structures, roles and responsibilities, and mechanisms for direction and coordination of FDA resources before, during, and after disease outbreaks, terrorist attacks and other criminal acts, natural disasters, and any other incidents associated with FDA-regulated products that pose a risk to human or animal health.

3. Assumptions

The following assumptions and priorities apply to agriculture safety and security response to disasters and public health emergencies:

a) Homeland Security Presidential Directive 9, Defense of United States Agriculture and Food, establishes a national policy to defend the agriculture and food system against terrorist attacks, major disasters, and other emergencies

http://www.dhs.gov/xabout/laws/gc_1217449547663.shtm

b) The National Infrastructure Protection Plan and its supporting Sector-Specific Plans (SSP), provide the means by which critical infrastructure protection is implemented across all 18 Critical Infrastructure and Key Resource (CIKR) sectors, as well as a national framework for each sector to address its unique characteristics and risk landscape. FDA co-chairs the Food and Agriculture sector with USDA, and has regulatory responsibility for most food products, except meat, poultry, and frozen, dried, and liquid eggs, which are under the authority of the USDA/FSIS. FDA also supports HHS, which is responsible for the Sector-Specific Plan (SSP) for the Public Health and Medical sector.

c) Statutory authorities relevant to FDA emergency preparedness and response are described below. In addition, certain FDA regulations in Title 21 of the Code of Federal Regulations may apply in an emergency situation.

- Under the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 301 *et seq.*, as amended, FDA regulates the safety of, among other things, food, including dietary supplements, infant formula, and animal feed; human and animal drugs; medical devices; electronic products emitting radiation; and tobacco products.

4. Mission

The Secretary of the HHS (the Secretary) has directed FDA to provide emergency support to maintain the safety and security of the food supply, including agricultural products under FDA's regulatory authority.

5. Execution

Concept of Operations

The scope of FDA emergency operations is as wide as the array of products the agency regulates. FDA actions impact the Nation's quality of life on a daily basis through its regulation of food, drugs, medical devices, radiation emitting products, biologics, veterinary drugs, and

tobacco products. FDA's successful and efficient handling of emergencies and disasters is especially important in fulfilling its mission to maintain not only the public's health, but also its trust and confidence.

Phase 1 – Preparedness

Prior to confirmation of an incident, FDA may conduct a number of activities designed to deter intentional and unintentional acts affecting FDA-regulated products and protect consumers from potential public health hazards.[20] Through heightened and targeted preventive measures at various points in the processing and distribution chains, and by exercising the systems and networks to be used during emergency response operations, FDA can protect the safety and security of regulated products and protect consumers from harm. Activities in support of this effort, conducted in cooperation and collaboration with: applicable FDA organizational components; SLTT, and local partners; industry; academia; foreign governments; and, international organizations include, but are not limited to, the following:

- Implementing risk communications with government and industry partners
- Facilitating coordination of feed and animal drug contamination investigations between FDA and the States
- Providing guidance to regulated industry and public health and public service messages related to safety of FDA-regulated products
- Conducting targeted inspections and investigations and collecting samples
- Preparing laboratory response and other scientific capabilities to analyze/test for chemical and microbiological agents.
- Requesting that firms recall animal feed and drugs that predictably could cause serious health problems or death.
- Working, as appropriate, with Federal, SLTT agencies, and international partners
- Issuing warnings, alerts, advisories, and other advice to consumers, industry, foreign counterparts, and other international partners regarding the safety of animal feed, drugs, and devices and soliciting feedback
- Identifying feed that is at elevated risk of contamination and investigating the effectiveness of feed processing and preparation practices

[20] Incident confirmation includes conclusive laboratory analysis, field investigations, epidemiological data, or reliable information from other government agencies that triggers emergency response operations.

- Protecting animal and human health through regulatory, legal, and administrative actions
- Actively participating in legal proceedings critical to the safety of the food and feed supply
- Using import controls to prevent unsafe products from entering the United States
- Facilitating coordination of meat and milk drug residue investigations between FDA and the States
- Collaborating with public health agencies regarding feed contaminant and tissue residue programs, and other monitoring programs for meat and poultry products

The FDA system for responding to the increased risk of an emergency or disaster affecting FDA-regulated products provides a significant increase in coverage, awareness, and preparedness through targeted preventive measures implemented by both headquarters and field offices, in coordination with other intergovernmental partners. Collectively, these additional consumer protection activities provide for more protected supply and distribution chains and a better prepared national network capable of responding to an identified threat or hazard.

Phase 2 – Response

Requests for support from State and local agencies can be made directly to the agency or, in the case of a Presidential declaration of a major disaster or emergency under the Stafford Act. In order to assist States and local agencies with such requests, FDA has developed Pre-scripted Mission Assignments (PSMAs), which can be used to expedite the submission of requests when a major disaster or emergency has been declared. These requests include laboratory analysis, investigational, sample collection and subject matter expertise.

During response to an incident, FDA may perform the following functions related to agriculture safety and security as needed:

- Inspecting or investigating FDA-regulated facilities and collecting and analyzing samples of FDA-regulated products as needed
- Providing clear and consistent information to assist industry in understanding and complying with regulations in a post-disaster environment
- Collaborating with public health agencies regarding feed contaminant, tissue residue programs, and other monitoring programs for meat and poultry products
- Assessing the availability, production capacity, and surge capacity of animal drugs, and providing information on alternative sources of critical products during shortage situations

4397 • Providing an assessment on the diversion of contaminated human food for use as animal
4398 feed

4399 • Providing technical advice and assistance for assessing potentially affected animal drug or
4400 feed product

4401 • Providing sponsors and other stakeholders with guidance on the use of animal drugs that
4402 serve as potential medical countermeasures in animals

4403 • Identifying key facilities that manufacture/process, pack, or hold food for human or animal
4404 consumption and determining if any are critically impacted

4405 • Ensuring the safety of animal feed and the safety and effectiveness of animal drugs

4406 • Using import controls to prevent unsafe products from entering the United States

4407 • Posting vital and important information, emergency messages, and other communication
4408 information quickly to the FDA.gov web site

4409 • Conducting inspection, sample collection and laboratory analysis activities in support of
4410 SLTT agencies specifically related to the incident

4411 • Overseeing product destruction and product reconditioning or rendering, as appropriate.

4412

4413 **Phase 3 – Recovery**

4414

4415 The "recovery" phase for FDA includes short- and long-term actions to ensure and restore the
4416 safety, efficacy, and availability of FDA-regulated products and protect the public's health. To
4417 accomplish this, FDA supports HHS in the execution of the National Disaster Recovery
4418 Framework (NDRF) and the two Recovery Support Functions (RSFs) that require HHS
4419 coordination or support: Health and Social Services and Infrastructure Systems.
4420 As federal response operations conclude, requests for more detailed assessments, technical
4421 assistance, and longer-term coordination fall under the recovery mission. Subject matter
4422 expertise and technical assistance can be provided to address issues that affect FDA-regulated
4423 industries. FDA and federal supporting agencies will work with SLTT entities to provide a
4424 coordinated and consistent approach to recover from an incident. FDA will collaborate and
4425 maintain communication with other government agencies, industry, the public, and the media
4426 particularly concerning any long-term effects associated with the event.

4427

4428 • Inspecting or investigating FDA-regulated facilities and collecting and analyzing samples of
4429 FDA-regulated products for the overall recovery operation, as needed

- Conducting prolonged inspection, sample collection and laboratory analysis activities in support of SLTT that are specifically related to a disaster
- Managing a potentially large number of samples of FDA-regulated products, including long-term sampling associated with the health effects of natural and man-made disasters
- Overseeing product destruction and product reconditioning or rendering as appropriate.
- Identifying key human and/or animal food/feed related facilities and determining if any food/feed supplies have been or will be critically impacted
- Facilitating the availability of critically needed human and animal food/feed products, by identifying alternate products or sources of products.
- Providing clear and consistent information to assist industry in understanding and complying with regulations in a post-disaster environment
- Providing advice to pet owners regarding animal safety measures

Dependent on the recovery objectives and the level of coordination needed, FDA will determine resources needed to support recovery efforts. As the need for recovery coordination wanes, FDA will assess whether consumer product safety and security and public health protection objectives were achieved. The transition back to a steady-state operation will occur in stages and will correspond to the re-establishment of public confidence in FDA-regulated products.

6. Interdependencies

FDA regulates all animal feed, drugs, and medical devices for veterinary use. USDA regulates all vaccines and blood derivatives for animal veterinary use.

The FDA Emergency Operations Center (EOC) is responsible for coordinating Federal interagency liaison activities and establishing communications with the headquarters emergency operations centers and staff of other federal agencies during incidents of varying nature and scope. Through the use of dedicated communications channels, standardized reporting mechanisms, and the deployment of internal and external liaisons when needed, the FDA EOC is able to maintain contact with the HHS Secretary's Operations Center (SOC), the CDC's EOC, the USDA/FSIS, and other Federal Department/Agency EOCs, as appropriate. The FDA EOC will assign liaison officers (LNOs), as appropriate, to interface with or report from other departments and agencies (i.e., HHS, CDC, USDA, EPA, DHS) during an incident. These LNOs serve as direct links between FDA and their assigned agency, to provide input on their agency's policies, activities, concerns, resource availability, and other incident-related matters.

FDA has Memoranda of Understanding (MOU) with other Federal agencies, including but not limited to, USDA and EPA. These MOUs coordinate Federal activities applicable to food safety and potable water. FDA also has an MOU in place with USDA/FSIS to facilitate the exchange of information between agencies for establishments and operations that are subject to the jurisdiction of both agencies. This exchange of information permits more efficient use of both agencies' resources and contributes to improved public health protection.

FDA works closely with DHS and other federal agencies to coordinate the overall national effort to enhance the protection of critical infrastructure and key resources of the nation, including food and agriculture defense. Food and Agriculture was identified as one of 16 critical infrastructure sectors for the United States. The Sector Specific Agencies for the Food and Agriculture Sector are USDA, HHS, and FDA. FDA and USDA Co-Chair the Government Coordinating Council (GCC), which is comprised of representatives from Federal, State, local, tribal and territorial governments. The GCC is the public sector segment of the food and agriculture public-private framework. The Sector Coordinating Council (SCC) represents the food and agriculture industry and provides a forum for the private sector to discuss infrastructure protection issues or to communicate with the government through the GCC.

7. Administration and Support

Activities performed under this Appendix will be carried out in accordance with applicable laws, regulations, and agency policies.

Appendix XVI: Public Health and Medical Information

1. Purpose

The Public Health and Medical annex to ESF #15 – External Affairs provides a framework for the U.S. Department of Health and Human Services (HHS), its agencies, and partners working under Emergency Support Function #8, to educate and inform the public, health care professionals, policy makers, partner organizations, and the media in a timely, accurate, and coordinated way during the response and recovery phases of an incident requiring a coordinated federal response. This annex outlines the roles and responsibilities of the public affairs function of the HHS, its agencies and partners in support of ESF #8 and ESF #15.

2. Situation

Under the NRF, HHS is the primary federal agency for coordination of ESF #8 – Public Health and Medical Services. Given the unique requirements for the external affairs response during a national public health emergency, HHS and DHS, as the respective leads for ESF #8 and ESF #15, will team together to coordinate and disseminate critical health information and guidance.

3. Assumptions

Operational

1) The HHS Office of the Assistant Secretary for Public Affairs (OASPA) will lead the overall federal public health and medical communications response under ESF #15 with support from all relevant HHS agencies and offices.

2) The Office of the Assistant Secretary for Public Affairs, Department of Homeland Security, will lead communications for non-health effects of an incident (e.g., transportation, commerce, economy, education).

3) White House Communications will guide overall communications strategy and policy for the U.S. Government.

4) Risk communication principles will be incorporated into all public health and medical information activities.

5) Access to communication channels and business destinations may be hindered, so staffs may need to work remotely.

6) Traditional communications channels (e.g., telephone, e-mail, Internet) may be unavailable or inaccessible, which will create difficulties for internal communications within

departments/agencies and across the USG, resulting in delays or barriers to the timely release of information to the public.

7) The first public announcement of a potential public health or medical emergency will come through social media, followed by announcements in traditional news media.

Strategic

1) The public affected by the incident will need to be informed quickly about the measures they can take to protect their health and the health of their families. Regardless of the type of incident, people will be concerned about real or perceived health impacts and will raise questions about protecting health.

2) There will be incomplete information, misinformation, rumors, and misconceptions among the public.

3) There will be an insatiable demand for information from the public and from domestic and international media.

4) There will be overwhelming public pressure on government to provide facts quickly.

4. Mission

During an incident requiring a coordinated federal response, HHS will:

- Coordinate public health and medical messages across the federal government to ensure accuracy and consistency and timely information so that affected individuals and communities can make sound decisions about protecting health.
- Coordinate communications activities with state and local public health, medical, and emergency response agency communications staffs, including regional or local communications centers as appropriate.
- Communicate with members of the public, particularly in affected communities, on the real and perceived public health and medical impacts of the emergency.
- Promptly respond to rumors and inaccurate information to minimize concern, social disruption, and stigmatization.
- Coordinate international information exchange and communication strategies.

5. Execution

Concept of Operations

The Office of the Assistant Secretary for Public Affairs (OASPA) is the central authority within HHS that will manage and coordinate the public health and medical communications for incidents requiring a coordinated federal response. OASPA will work closely with HHS agencies including the Office of the Assistant Secretary for Preparedness and Response, the Centers for Disease Control and Prevention, the Food and Drug Administration (FDA), the Centers for Medicare and Medicaid Services, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Administration for Children and Families, and the Administration on Aging. Certain functions may be delegated to agency personnel at the discretion of OASPA.

1. HHS Virtual Emergency Communications Center

When the Plan is activated, HHS communications efforts will be orchestrated using a virtual Emergency Communications Center with the capability of originating or accessing social media posts; video feeds; coordinating news conferences with in-house and other federal studio/broadcast staff; posting mass electronic mailings; responding to media calls; clearing and vetting messaging among HHS divisions, other federal agencies, and state and local agencies. Primary methods of coordination include conference call and e-mail. ASPA, ASPR, CDC, SAMHSA, FDA, other HHS divisions involved in the response, and ESF #8 partners will each assign an agency public affairs staff member as a liaison.

2. HHS Public Affairs Conference Line

Central to the HHS communications coordinating effort will be a conference line to allow telephone connectivity for public affairs staff supporting ESF #8. This conference line will allow HHS public affairs personnel to work from dispersed sites during the crisis yet be able to receive guidance or direction or to provide information to those needing it.

3. National Incident Communications Conference Line (NICCL)

The DHS NICCL will be used for transmission and exchange of critical and timely [e.g., "breaking"] *incident* information among federal authorities. DHS will turn over control of the NICCL conference calls to HHS, when needed, to coordinate communications information related to the public health and medical aspects of a response, particularly in a public health specific emergency such as a pandemic disease.

4. National Public Health Information Coalition

HHS will leverage a network of state and local health public health communicators to exchange information and increase the likelihood of consistent messaging and communication activities between federal and state or local governments regarding the emergency and its impact on health.

5. ESF #15 – External Affairs

HHS will support the activation and management of ESF #15 – External Affairs, which will be under the leadership of the DHS Office of Public Affairs. This function could involve a Washington, D.C. area and/or deployed site to support a Unified Coordination in a state, U.S. territory, the District of Columbia, or an international area.

6. HHS Secretary's Operations Center (SOC)

SOC serves as HHS's official notification point for operational/non-media aspects of an impending or actual disaster or emergency. The SOC is staffed 24 hours a day, 7 days a week. This facility maintains a 24-hour capability to monitor all sources of warning/disaster information, including other federal agencies, DHS regions, and the news media. The SOC reports disaster events to DHS key officials, DHS regions, and NRF signatory agencies. An HHS public affairs staff member occupies a seat in the SOC during emergencies and serves as POC and liaison to virtual emergency communications center the OASPA headquarters office and other HHS division public affairs offices.

The public health or medical impacts of an emergency may be confined locally or may have a non-specific geographic focus, which may require a very comprehensive and inclusive communications strategy. This plan recognizes that many players, especially non-governmental, have and will play a key role in communicating preparedness and lifesaving information on a rapid and mass scale.

6. Interdependencies

- **Strategic Communications**

  White House will direct strategic communications activities and efforts.

- **Medical and Public Health Communications**

  HHS will coordinate and direct all medical and public health federal communications activities, with support from ESF #8 partners. These efforts will enhance state and local public health and medical communications activities and messaging.

- **Incident Communications**

  DHS will coordinate and, with HHS, direct appropriate elements of the federal incident communications activities.

7. Administration and Support

Activities performed under this Appendix will be carried out in accordance with applicable laws, regulations, and Departmental policies.

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4651 # Annex VII: Acronyms

ACRONYMM	DEFINITION
AABB	American Association of Blood Banks
AAR	After Action Review
ACF	Administration for Children and Families
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
ARF	Action Request Form
ASPA	Assistant Secretary for Public Affairs
ASPR	Assistant Secretary for Preparedness and Response
ARC	American Red Cross
BARDA	Biomedical Advanced Research Development Authority
C2	Command and Control
CDC	Centers for Disease Control and Prevention
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CO	Commissioned Officer
COA	Course of Action
CONOP	Concept of Operation
CONUS	Continental United States
COOP	Continuity of Operations Plan
DASF	Disaster Aero-medical Staging Facility
DCO	Defense Coordinating Officer
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOD	Department of Defense
DOL	Department of Labor
DOS	Department of State
DOT	Department of Transportation
DPMU	Disaster Portable Mortuary Unit
DPTS	Deployment Personnel Tracking System
DSCA	Defense Support to Civilian Authorities
DSNS	Division of Strategic National Stockpile
EIS	Epidemic Intelligence Service
EMAC	Emergency Mutual Aid Compact

ACRONYMM	DEFINITION
EMMO	Office of Emergency Management and Medical Operations
EMR	Emergency Medical Record
EMS	Emergency Medical Services
EMSHG	Emergency Management Strategic Healthcare Group (VA)
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
ESAR-VHP	Emergency Systems for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
EUA	Emergency Use Authorization
EXORD	Execution Order
FCC	Federal Coordination Center
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FFDCA	Federal Food, Drug and Cosmetic Act
FHCO	Federal Health Coordinating Official
FIOP	Federal Interagency Operations Plan
FMS	Federal Medical Station
FOH	Federal Occupational Health
GPMRC	Global Patient Movement and Requirements Center (DOD)
GSA	General Services Administration
HAZMAT	Hazardous Materials
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources Services Administration
IA/IAA	Interagency Agreement
IAW	In Accordance With
IC	Incident Command
ICC	Incident Communications Center
ICP	Incident Coordination Plan
ICP	Information Collection Plan
ICS	Incident Command System
ICU	Intensive Care Unit
IDE	Investigational Device Exemption
IGA	Office of Intergovernmental Affairs
IMT	Incident Management Team
IO	Immediate Office

ACRONYMM	DEFINITION
IRAT	Immediate Response Assessment Team (Part of GPMRC/DOD)
JFO	Joint Field Office
JIC	Joint Information Center
JPATS	Joint Patient Asset Tracking System
MA	Mission Assignment
MCE	Mass Casualty Event
MD	Medical Doctor
ME/C	Medical Examiner/Coroner
MLA	Medico-legal Authority
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSC	Medical Service Corps
NDMS	National Disaster Medical System
NIH	National Institutes of Health
NIMS	National Incident Management System
NIOSH	National Institute for Occupational Safety and Health (HHS)
NIPRNET	Non-classified Internet Protocol Router Network
NMA	Non-Medical Attendant
NRCS	National Response Coordination Staff
NRF	National Response Framework
NSS	National Security Staff
NSSE	National Special Security Event
NTSB	National Transportation Safety Board
OCONUS	Outside the Continental United States
OFRD	Office of Force Readiness and Deployment (HHS)
OGC	Office of General Counsel (HHS)
OICC	Office of Incident Command and Control
OMSPH	Office of Medicine, Science and Public Health (HHS)
OPCON	Operational Control
OPDAS	Office of the Principal Deputy Assistant Secretary
OPDIV	Operational Division
OPM	Office of Personnel Management
ORM	Office of Resource Management
OS	Office of the Secretary (HHS)
OSG	Office of the Surgeon General

ACRONYMM	DEFINITION
OSHA	Occupational Safety and Health Administration
OSHP	Occupational Safety and Health Plan
PHS	Public Health Service
PHS CC	Public Health Service Commissioned Corps
POC	Point of Contact
PPE	Personal Protective Equipment
PSMA	Pre-Scripted Mission Assignment
PSSW	Pre-Scripted Statement of Work
RDF	Rapid Deployment Force
REC	Regional Emergency Coordinator
RFA	Request for Federal Assistance
RHA	Regional Health Administrator
RM	Risk Manager
RNA	Rapid Needs Assessment
RRCC	Regional Response Coordination Center
RSO&I	Reception, Staging, Onward Movement and Integration
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SIIM	Office of Security, Intelligence, and Information Management
SIPRNET	Secret Internet Protocol Router Network
SITREP	Situation Report
SME	Subject Matter Expert
SMO	Senior Medical/Management Official
SNS	Strategic National Stockpile
SOC	Secretary's Operations Center (HHS)
SOC RM	Secretary's Operations Center Resource Management
SOP	Standard Operating Procedure
SPPR	Office of Strategy, Policy, Plans, and Requirements
SSO	Senior Staff Officer (HHS)
TARU	Technical Advisory Response Unit (HHS)
TPFDD	Time Phased Force Deployment Data
TRAC2ES	TRANSCOM Regulating Command and Control Evacuation System
USCG	United States Coast Guard
USDA	United States Department of Agriculture
USERRA	Uniformed Services Employment and Reemployment Rights Act
USDA	United States Department of Agriculture

ACRONYMM	DEFINITION
USNORTHCOM	United States Northern Command
USPHS	United States Public Health Service (HHS)
USTRANSCOM	United States Transportation Command
VA	Department of Veterans Administration
VHA	Veteran Health Administration (VA)
VTC	Video Teleconference

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Annex VII: Distribution

This document will have the overall designation of For Official Use Only. This annex provides instructions on how to ensure the proper protection of the information that is found in the US Department of Health and Human Services (HHS) Emergency Operations Plan. Distribution is authorized to HHS partners and, as appropriate, can be distributed by the HHS RECs to State medical/public health/emergency officials only. Distribution of this plan to other SLTT is not authorized without prior approval from HHS/ASPR/SPPR.

Information contained in this plan is not authorized to be published on any non-governmental website, and is not releasable to the public or media.

Distribution, transmission, and destruction of the HHS Emergency Operations Plan, as a full document, will follow applicable HHS Management Directives relating to official use only and sensitive documents. Questions pertaining to the distribution, transmission, or destruction of this plan, or requests for information on how to obtain a copy of any applicable HHS Management Directive, should be submitted in writing to the ASPR Plans Division at SOC.Plans@hhs.gov or the HHS Office of Public Affairs.

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OFFICE OF THE SURGEON GENERAL

DAILY COVID-19 SITUATIONAL
MORNING "CATCH-ALL"
03-25-2021
Author: Adam Beckman

Internal, pre-decisional
Content may be embargoed or confidential

HAPPENING TODAY

- White House
  - POTUS will be giving his first press conference as president at 1:15 p.m. ET. (Per CNN, President Biden is expected to announce his new vaccination goal today, according to two sources familiar with the plans.)
- HHS
  - Ongoing inquires about AstraZeneca data; pointing to FDA application process
  - Health Equity Taskforce Meeting tomorrow 3/26
  - Tracking report from the WHO about the origins of COVID; will be released under embargoed at noon today for member states to review, public release 3/26 midday
  - State-by-state update on community health center relief funding later today (of the $6b)
- CDC
  - Announcement: CDC Plans to Provide $332 Million to Support Community Health Workers for COVID-19 Prevention and Control
  - 2 MMWRs being released today (less COVID relevant)
    - Rapid scale up of anti-retroviral therapy in Nigeria
    - Yesterday was international tuberculosis day; an article about TB
- OASH
  - Swearing-in ceremony today for the Surgeon General at 9 am EST by Sec. Becerra (www.hhs.gov/live)
  - RADM Collins will participate with CDC in tri-caucus briefing related to health equity
- CMS
  - Preparing for recently announced special enrollment period
- FEMA
  - Federal pilot CVCs in Mass and Virginia tomorrow
  - Meeting with Missouri and New Jersey for openings for their sites soon
  - Nominee for FEMA Administrator (Deanne Criswell) hearing today; she would be the first female Administrator
- DHS
  - Press briefing on the border today and COVD likely to come up
- VA
  - Secretary testifying on the Hill today

    - President signed Save Lives Act expanding vaccinated population yesterday
- USDA
    - Secretary testifying on the Hill today
- Other
    - The CEOs of Twitter, Facebook and Google will testify today before the House Energy and Commerce Committee including about misinformation on COVID.
- Agencies not listed either had no updates or were not present

MORNING HEADLINES

- **Pushing back against U.S. health officials, AstraZeneca says new analysis confirms efficacy of its Covid-19 vaccine**
    - Rejecting sharp criticism from U.S. government scientists, AstraZeneca said Wednesday night that its Covid-19 vaccine was 76% effective at reducing the risk of symptomatic Covid-19, and 100% effective against severe disease, in a new analysis of its large U.S.-based clinical trial.
    - Those estimates were just a few percentage points lower than much more sparse results the company released Monday from an earlier analysis of the study, despite dramatic statements from government scientists that AstraZeneca's initial release may have used "outdated information" that could have been overly favorable.
    - Eric Topol, director of the Scripps Research Translational Institute, said that the results were "better than expected" given the clash between the DSMB and AstraZeneca. He added that he is "relieved since the world needs the vaccine badly."
    - Or, as Nahid Bhadelia, the director of the special pathogens unit at Boston Medical Center, put it on Twitter: "At this point, I will wait for the FDA submission packet just to avoid any further roller coaster rides.
- **More than 40 states plan to meet President Biden's goal of making all adults eligible for the coronavirus vaccine by May 1, and at least 30 plan to open up eligibility before then**, per NYT.
- **Seven out of 10 people across the U.S. ages 65 and older — totaling 38 million — have received at least one dose of a COVID-19 vaccine,** according to the Centers for Disease Control and Prevention.
- **Nearly 2,900 unaccompanied minors tested positive for COVID-19 on arrival at U.S. government shelters over the past year** — including around 300 currently in the system — a Department of Health and Human Services official tells Axios' Stef Kight.
- **Biden administration adds $10 billion to vaccine effort**
    - The next phase of the federal government's Covid-19 immunization campaign involves a $3 billion effort to promote vaccine confidence, $6 billion to expand vaccine access for community health center workers and patients, and a new partnership with dialysis clinics to provide vaccines directly, the Biden administration announced this morning.
    - With funding in large part from the American Rescue Plan, the U.S. Department of Health and Human Services (HHS) will invest nearly $10 billion to expand access to vaccines and better serve communities of color, rural areas, low-income populations, and other underserved communities in the COVID-19 response. This funding will expand access to vaccines for vulnerable populations and increase vaccine confidence across the country.
- **Hospitals still in "survival mode"**

- A year into the pandemic, hospitals say they're still in "survival mode," according to a new report from the Health and Human Services Department's inspector general.
- Alarm over the potential of COVID-19 misinformation to cause harm spread first from public heath officials to tech firms and then moved to legislators.

- **Stop Blaming Tuskegee, Critics Say. It's Not an 'Excuse' for Current Medical Racism.**
  - For months, journalists, politicians and health officials — including New York Gov. Andrew Cuomo and Dr. Anthony Fauci — have invoked the infamous Tuskegee syphilis study to explain why Black Americans are more hesitant than white Americans to get the coronavirus vaccine.
  - When she asks Black seniors in Los Angeles about the vaccine, Tuskegee rarely comes up. People in the community talk about contemporary racism and barriers to health care, she said, while it seems to be mainly academics and officials who are preoccupied with the history of Tuskegee.
- **Nearly half of public schools are open full time for face-to-face classes**
  - The first federal data on education during the pandemic finds that White children are far more likely than Black or Asian American students to be attending school in person, The Post's Laura Meckler reports.
  - Overall, the survey found that 47 percent of schools serving fourth-graders and 46 percent serving eighth-graders were open for full in-person instruction. But millions of students either don't have access to full-time in-person school or are opting for remote education. Overall, 60 percent of fourth-graders and 68 percent of eighth-graders were learning at home for at least part of the week, under either fully remote or hybrid models.
  - "The survey also raised questions about the quality of education being delivered to those learning from home. About one-third of schools offer two hours or less of live instruction per day for those learning either full or part time at home. Some offer none," Laura writes.
- **Non-fatal opioid overdoses on the rise during the pandemic.**
  - In a new paper published in the *Annals of Emergency Medicine*, researchers investigated the rate of non-fatal opioid overdoses arriving at emergency departments (EDs) during 2020.
  - Emergency department treatment of opioid overdoses increased substantially in 2020 compared to 2018-2019 in four of the six health systems. The overall non-fatal overdose visit rate increased by 28.5 percent in 2020 compared to 2018-2019. Meanwhile, across these health systems, there was a 14 percent decline in ED visits for all reasons in 2020.

Note: Media headline may be direct excerpts from news articles and are intended for informational updates, not as original writing.

Internal | Pre-decisional | Confidential | Deliberative

OFFICE OF THE SURGEON GENERAL

DAILY COVID-19 A.M. SITUATIONAL
03-31-2021
Author: Adam Beckman

UPCOMING TODAY
(8:30 AM EST COMMS CALL)

- White House
  - **FLAG:** WH COVID Briefing 11:15 AM
    - Tennessee, Wisconsin, Maryland CVCs being announced
    - Possibly mentioning Peace Corps partnership w/FEMA around CVC sites
  - **FLAG:** 3:30 PM Jeff, Fauci, Murthy to talk w/all political appointees re: Q&A
  - VPOTUS to do Faith Leader event re: vaccines
  - Pre-recorded Dr. Nunez-Smith and Fauci interview will air
- HHS
  - **FLAG:** Pfizer and children announcements (see headlines below) and talking points:
    - Encouraging to see this announcement
    - Looking forward to seeing the data and to FDA reviewing and moving forward in that process
  - Today likely release of bimonthly GAO oversight CARES Act Reports report, including HHS recs for COVID response
- CDC
  - **FLAG:** 2 MMWRs today as below
    - Mortality rate: Context: In Feb, issued MMWR on life expectancy, showing dramatic impact w/communities of color. Today's looks at provisional data and shows COVID is third leading cause of death (~11% of deaths in US were COVID related). Death rate is double in communities of color nearly. Takeaways around equity and magnitude of pandemic impact.
    - ICD codes and overreporting of COVID deaths: There has been some accusation that we are attributing too many deaths to COVID-19. Finding: ICD-10 codes, only small % listed COVID u code; 95% included other ICD codes which are supportive of COVID as underlying cause of death (e.g. septecemia, cardiac arrest). Reassuring that we are capturing these correctly. Takeaway that little evidence to suggest CDC inflating CDC Deaths
- NIH
  - 9 AM EST: Roll out of 2 area at-home testing in NC and Tennessee to see if it can reduce community transmission
  - Moderna Phase 1 Variant vaccine trial is to start at Emory today

- Fauci: PSA w/Ricky Martin on vaccines as part of Latin Grammys, CNN w/Coumo this evening

- FDA
  - Launched a call center yesterday for monoclonal antibodies (I.e. to find out where they can get, providers to get more information)
- OASH
  - **FLAG:** Dr. Levine receiving J&J vaccine tomorrow 8 AM; NPR All Things Considered afterwards
- FEMA
  - CVCs as above
- Agencies not listed either had no relevant updates or were not present

MORNING HEADLINES

Note: The summary below intends to capture headlines that may otherwise be missed or lower down in other COVID-19 updates the Surgeon General is receiving.

- **A Pfizer-BioNTech trial found the vaccine extremely effective in 12- to 15-year-olds, with no coronavirus infections among children who received it.**
  - In short: Pfizer provided 100% protection in 12-15 year olds for symptomatic infection (18 cases of infection in placebo, 0 among children who received vaccine). Strong antibody response was seen in addition to case reduction. Small N but promising news and next step is FDA EUA submission and review.
  - Pfizer and BioNTech said this morning that their Covid-19 vaccine prevented symptomatic disease and was well-tolerated in a Phase 3 study of 2,260 adolescents aged 12-15 who were randomly assigned to receive two doses of the vaccine or placebo. There were 18 cases of Covid-19 among patients who received placebo and none in those who received the vaccine, the companies said. The data will now be submitted to the FDA as an amendment to the vaccine's emergency use authorization for people 16 and up, in addition to other regulators around the world. Pfizer CEO Albert Bourla said in a press release that the companies hope it will be possible to begin vaccinating adolescents in this age group before the start of the next school year.
  - "The vaccine was 100 percent effective at preventing symptomatic illness within the trial and it triggered immune responses that were even more robust than those seen in young adults," Erin writes.
  - Currently authorized for people 16 yo +
- **it's clearer than ever before that fully vaccinated people can't spread the virus to others.**
  - CDC Director Rochelle Walensky said on MSNBC that the data "suggests that vaccinated people do not carry the virus, don't get sick, and that it's not just in the clinical trials, but it's also in real-world data."
- **'We're Skating On A Knife's Edge Right Now': Scientists Worry US Could Be Headed For Yet Another COVID-19 Surge**
  - Several factors are fueling the upturn, Apoorva Mandavilli, a Times science reporter, told us. A more contagious variant (the one first identified in Britain, called B.1.1.7) is spreading. Some mayors and governors have continued to lift restrictions and mask rules. Many Americans are behaving less cautiously. And vaccinations have not gotten the country near herd immunity.

    - The increase is not distributed equally. "New York and New Jersey have been bad and are not getting better, and Michigan's cases are rising at an explosive rate," Mitch Smith, a Times reporter covering the pandemic, said.
    - Hospitalizations are also rising rapidly in Michigan, with Jackson, Detroit and Flint among the metro areas experiencing the highest rates of new cases in the country.
    - USA Today reports that "as COVID-19 cases creep up again across the country, federal officials and epidemiologists say they're worried we could hit another tipping point, leading to a fourth significant surge of infections, hospitalizations and deaths." Nicholas Reich, a biostatistician at the University of Massachusetts Amherst, said, "We're skating on a knife's edge right now." In the US, "average daily reported cases are up 10% compared to a week earlier, data from the" CDC show. CDC Director Rochelle Walensky "said in a White House briefing with media Monday that she's anxious about what the next few weeks could bring."
- **Biden Administration Allows Media Inside Texas Border Tent Packed With Minors**
    - The Washington Post reports "the Biden administration allowed reporters for the first time Tuesday to go inside the crowded border tents where record numbers of [immigrant] teenagers and children have been held in recent weeks after crossing into the United States without their parents." Department of Homeland Security officials allowed "the Associated Press and a camera crew to tour the Donna, Texas, temporary processing facility run by U.S. Customs and Border Protection, where 3,400 unaccompanied minors were in custody Tuesday along with 700 members of" immigrant families. The reporters "described extreme levels of overcrowding, including one detention 'pod' with 516 minors despite a pandemic-rated capacity of 32 people."
- **Demand for vaccines is waning in some parts of the U.S.**
    - Vaccine appointments "are not being snapped up in 10 minutes like they were a month ago," Nirav Shah, director of Maine's Center for Disease Control and Prevention and the president of the Association of State and Territorial Health Officials, told the Washington Post.
    - "This I take as the very earliest sign that we are shifting from urgency to hesitancy," he added.
- **Advocates warn the variant clock is ticking**
    - In a survey of 77 epidemiologists, about two-thirds said the world likely has a year or less before the virus changes so much that existing vaccines wouldn't be effective against the new strains.
    - The survey was sponsored by the People's Vaccine Alliance, an organization that wants to strip some intellectual property protections from vaccine makers in the hopes of producing more doses.
- **W.H.O. Inquiry On The Pandemic's Origin: What We Know**
    - The Wall Street Journal reports more than a dozen countries, including the US, said in statement that they were concerned about a WHO-led investigation into the origins of COVID-19. The countries called for an independent and transparent evaluation and analysis, without interference or undue influence.
    - The New York Times reports, "More than a year after the coronavirus pandemic began, the World Health Organization released a report on Tuesday laying out theories on how

the virus first spread to humans – but it is already raising more questions than answers, including from the health body's own leader." The Times says, "The experts had said that officials at the Wuhan Institute of Virology, which houses a state-of-the-art laboratory known for its research on bat coronaviruses, assured them that they were not handling any viruses that appeared to be closely related to the coronavirus that caused the recent pandemic."
    - World Health Organization director-general Tedros Adhanom Ghebreyesus welcomed the joint WHO-China report on the origins of the coronavirus on Tuesday, but he noted that scientists had difficulty "accessing raw data" from China and called for further investigation of the lab leak theory.
- **Republicans Seek To Make Vaccine Passports The Next Battle In The Pandemic Culture Wars**
    - The Washington Post reports on its front page, "Republicans are opening a new front in the pandemic culture wars, attacking efforts by the Biden administration to develop guidelines for covid-19 vaccination passports that businesses can use to determine who can safely participate in activities such as flights, concerts and indoor dining."
- **Biden administration builds volunteer network to boost vaccine confidence**
    - Politico reports, "The Biden Administration is creating a network of outside health experts and community leaders charged with building trust in coronavirus vaccines, as the shots become available to the entire adult population, according to documents obtained by POLITICO." The COVID-19 Community Corps program is expected to be unveiled on Thursday with the aim of amplifying "the government's vaccine messaging within their own communities, and lead on-the-ground efforts to combat skepticism and misinformation." The article says HHS and the CDC will oversee this initiative

Note: Media headline and content may be direct excerpts from news articles and are intended for informational updates, not as original writing.

COVID TEAM UPDATES
(9:30 AM EST DEPUTIES)

Note: To be completed in the SharePoint during the 9:30 AM call.

- **CDC (Walensky)**
- **FEMA (David Bibo)**
- **Pharmacy (Sonya Sackner-B)**
- **Supply (Tim Manning)**

OFFICE OF THE SURGEON GENERAL

DAILY COVID-19 A.M. SITUATIONAL
04-9-2021
Author: Adam Beckman

UPCOMING TODAY
(8:30 AM EST COMMS CALL)

- TBD
- Agencies not listed either had no relevant updates or were not present

Notes not from call but from emails last night:

- **FLAG:** Department of Education is releasing Volume 2 of its "Roadmap to Reopening Safely and Meeting All Students Needs" (Embargo lifts at 9am ET on 4/9/21)
  - p. 12-14 focuses on "supporting student mental health needs" - relevant excerpts here:
    - For example, data from CDC shows that the proportion of student emergency department visits related to mental health has increased dramatically during the pandemic. A National Association of Elementary School Principals survey reported in December that 84% of elementary school principals are very concerned about student mental health needs and 68% report that they do not have sufficient school-based mental health professionals to adequately meet those needs.2 Further, during the pandemic, since many underserved students rely on school-based mental health services, it is likely that many went without these mental health services if their schools were not able to provide telehealth services.
    - An example of a state-wide mental health program is the SafeUT program in Utah. The free app, SafeUT, is a statewide service that provides real-time crisis intervention to youth through live chat and a confidential tip program from a smartphone.
    - Students with disabilities who are eligible under IDEA or Section 504 of the Rehabilitation Act of 1973 (Section 504), regardless of the student's disability classification, can also receive a range of mental health-related services, such as counseling services, psychological services, and social work services in schools, if included in their IEP or 504 plan, as appropriate.
  - Talking points (via Department of Ed) may include:
    - This is initial guidance. The Department of Education is putting out separate mental health guidance within the upcoming months.
    - The administration's efforts to double the number of mental health providers in schools will serve to help provide students access to these services.

        - We must also remove the stigma that can be associated with mental health so that where these services are provided, students are willing and able to access them.
- **FLAG:** Tim / Supply team updated that there is a "Transition from Reusing Decontaminated Respirators - Letter to Health Care Personnel and Facilities" going live (DATE TBD – I messaged Tim this morning)
    - Relevant excerpts:
        - The FDA recommends that health care personnel and facilities:
        - Limit decontaminating respirators for reuse. Decontaminated respirators should be used only when there are insufficient supplies of new FFRs or if you are unable to obtain any new respirators
        - Transition away from a crisis capacity strategy for respirators, such as decontamination of N95 and other FFRs
        - Increase inventory of available NIOSH-approved respirators—including N95s and other FFRs, elastomeric respirators, including new elastomeric respirators without an exhalation valve that can be used in the operating room, and PAPRs. That is, even if you are unable to obtain the respirator model that you would prefer, you should obtain and use a new respirator before decontaminating a preferred respirator.

MORNING HEADLINES

Note: The summary below intends to capture headlines that may otherwise be missed or lower down in other COVID-19 updates the Surgeon General is receiving.

Data Insights

- The number of new COVID-19 cases has consistently increased for approximately 3 weeks; the 7-day daily average of new COVID-19 cases **increased 2%** for the week ending April 7, 2021 compared with the previous week (from 62,869 to 64,152 cases/day, 7-day average)
    - Since the trough observed on March 14, 2021, the 7-day daily average of new COVID-19 cases has increased 22% (from 52,736 to 64,152 cases/day, 7-day average)
- In the past week, **Michigan** and **Minnesota** have seen >15% increase in the 7-day daily average number of cases reported, a ≥1.5 percentage point increase in test positivity, and a >30% increase in the 7-day daily average confirmed COVID-19 hospital admissions per 100 patient beds
    - **Michigan** continues to see worsening metrics. In the last 7 days, Michigan had a case rate of 492 cases per 100,000 population; RT-PCR test positivity increased from 12.1% to 15.6%; and confirmed COVID-19 admissions per 100 patient beds increased 47%
        - The 40-49 year old and 50-59 year old age groups had the greatest % increases in confirmed COVID-19 admissions (both + 60%)
    - In the last 7 days, **Minnesota** had a case rate of 233 cases per 100,000 population; RT-PCR test positivity increased from 5.7% to 7.2%; and confirmed COVID-19 admissions per 100 patient beds increased 34%
        - The 30-39 year old and 50-59 year old age groups had the greatest % increase in confirmed COVID-19 admissions (+60% and +58%, respectively)
- Overall, **174,879,716** COVID-19 vaccine doses have been administered in the United States
    - In total, **34%** of the population (112.0 million people) has received at least one dose and **20%** of the population (66.2 million people) are fully vaccinated
    - **77%** of **adults 65 and older** have received at least 1 dose and **58%** have been fully vaccinated
    - Progress toward 200M dose target (doses reported since January 20, 2021; Day 78): **158,354,435 doses (79%)**

Media Headlines

- CDC Director Dr. Walensky announced on April 7th that the B.1.1.7 variant (first identified in the UK) is the most common SARS-CoV-2 lineage in the U.S.
  - All three vaccines currently authorized for use in the U.S. have been proven to be effective against this variant which appears to have increased transmissibility and likely an increased severity based on hospitalizations and deaths
- In response to surging COVID-19 cases in Michigan, the CDC will help to increase testing, address outbreaks in jails and prisons, and increase genomic sequencing in the state. The federal government continues to allocate vaccines to states based on population rather than hotspot status
- Vaccination sites in Commerce City, Colorado and Raleigh, North Carolina temporarily paused vaccinations after several people had adverse reactions, including nausea and dizziness, soon after receiving the Johnson & Johnson vaccine.
  - The Colorado Department of Public Health and Environment on Wednesday night issued a statement stressing that the side effects experienced by patients were "consistent with what can be expected."
- CDC Director Dr. Walensky anticipates that schools will be fully in-person by September 2021, regardless of whether children are vaccinated
- CDC reports released on April 8th focused on COVID-19 in American Indian/Alaskan Native communities
  - In Montana, between March and November 2020, COVID-19 incidence was more than twice as likely and mortality was nearly four times as likely among American Indian/Alaskan Native persons than among White persons, highlighting the need for culturally appropriate public health measures and evidence-based vaccine allocation strategies
  - Enforcement of stay-at-home orders and mask mandates were linked to a 33-fold decrease in SARS-CoV-2 incidence in Montana's Blackfeet Tribal Reservation
- Due to uneven production, the U.S government will allot only 785,500 Johnson & Johnson doses next week, nearly 85% less than this week; the company is reportedly still on track to deliver approximately 100 million doses by the of May

- **America may be close to hitting a vaccine wall**
  - Red states in the South are administering the lowest portion of the vaccine doses that they receive from the federal government — a sign of low demand, slow public health systems, or both.
  - An analysis released by Surgo Ventures yesterday concluded that "the supply-demand shift for the vaccine will happen earlier than expected — as early as the end of April — and before the nation reaches the 70–90% threshold for achieving herd immunity."
  - A separate survey of rural Americans, released by KFF this morning, found that while they're more likely to have already been vaccinated than urban and suburban Americans, there are fewer remaining rural residents who are eager to get their shots.
    - 39% have already gotten at least one dose of the vaccine, 16% say they'll get it as soon as possible, and 15% said they want to "wait and see."
    - Another 9% said they'll only get vaccinated if required, and 21% said they definitely won't.
    - The bottom line: Rural, Republican-heavy states are likely blowing through their vaccine-eager populations.
    - "Based on interviews of 1,001 adults living in rural America, the Monitor finds four in ten (39%) saying they have already gotten at least one dose of a COVID-

19 vaccine, larger than the shares of adults living in urban or suburban areas who say the same (31% each)."
        - "Three in ten rural residents say they will get vaccinated as soon as possible (16%) or are waiting to see how it is working for other people (15%), compared to about half of urban and suburban residents who say the same."
- **North Carolina Sites Halt J&J Shots After Adverse Reactions**
    - The AP reports that "North Carolina health officials said on Thursday that they stopped administering Johnson & Johnson doses at a mass vaccination site in Raleigh and at clinics in Hillsborough and Chapel Hill after at least 26 people experienced adverse reactions, including fainting. Four people were taken to hospitals for further examination, and state and federal health officials are reviewing the matter." The CDC "noted that reactions like fainting are not uncommon after someone is vaccinated, though it is reviewing reports of adverse reactions in North Carolina and three other states," including Georgia.
- **Headline summaries**
    - **Florida Sues Federal Government To Allow Cruises To Sail**
    - **As More Americans Get COVID-19 Vaccine, Number Of New Daily Cases Rises, Especially Among Young People**
    - **1 In 4 US Adults Fully Vaccinated Against COVID-19, CDC Data Shows**
    - **New COVID-19 Cases Associated With Youth Sports, Daycare Centers Could Hinder**
    - **Lawmakers From Michigan Ask Biden To Increase Vaccine Allocation To The State In Light Of Rising Number Of COVID-19 Cases. School Reopening Efforts.**
    - **Tens of thousands of vaccine appointments remain unclaimed in Mississippi, a sign the state is already encountering hesitancy.**
    - **Rochelle Walensky, director of the Centers for Disease Control and Prevention, on Thursday declared racism "a serious public health threat."**
- **Fauci And Walensky Can Start Being Candid**
    - Ramesh Ponnuru writes in Bloomberg Opinion that CDC Director Dr. Rochelle Walensky has been providing "confusing" information about the COVID-19 pandemic. He says, "Walensky is not alone in providing whiplash along with Covid guidance." NIAID Director Dr. Anthony Fauci "notoriously went from discouraging mask use early in 2020 ('people keep fiddling with the mask and they keep touching their face') to encouraging it later." Ponnuru says "these experts deserve some slack. The stakes and the scrutiny have been higher than ever. They have had to convey information about a little-understood virus to tens of millions of people with less scientific literacy than themselves. Errors and miscommunication were inevitable." Nevertheless, "there is a troubling through line to many of the most damaging episodes of public-health messaging in the pandemic: a fear of candor."
- **Fauci Thanks US Health Workers for Sacrifices but Admits PPE Shortages Drove Up Death Toll**
    - Nevertheless, the U.S. government has failed to systematically count health worker deaths. Members of Congress, the Health and Human Services Department and academic reports have cited The Guardian and KHN's reporting as the most comprehensive. A growing chorus of policy experts and unions have called for a comprehensive count of health worker deaths.

- "We certainly want to find an accurate count of the people who die," said Fauci, without noting when the government should undertake such an effort. "Certainly, that's something I think would fall under the auspices of the federal government."

- **The Health 202: AstraZeneca's Vaccine Is Still Considered Safe To Take**
  - The Washington Post reports, "The available science still indicates the AstraZeneca coronavirus vaccine is safe for people to take, even as regulators investigate a potential red flag," according to vaccine experts, who are "frustrated by the recent barrage of negative headlines." Former FDA scientist Luciana Borio said she feels that "in general the press has not been doing a good job." She said the coverage of AstraZeneca's COVID-19 vaccine feels "alarmist." Borio said, "People do not want to take the vaccine in Europe now, and if that's because of misinformation, then the pandemic's going to continue to remain very active globally, which means everybody is vulnerable."
- **US Suicides Fell Almost 6% Last Year Amid Coronavirus Pandemic, Data Indicate.**
  - The AP (4/8, Stobbe) says, "The number of U.S. suicides fell nearly 6% last year amid the coronavirus pandemic – the largest annual decline in at least four decades, according to preliminary government data." The piece adds that it is "hard to say exactly why suicide deaths dropped so much, but one factor may be a phenomenon seen in the early stages of wars and national disasters, some experts suggested."
- **One Third Of People Recovered From COVID-19 Diagnosed With Psychiatric, Neurological Disorders, Research Suggests.**
  - The Los Angeles Times (4/8, Healy, 3.37M) reports, "New research highlights COVID-19's lingering effects on the brain, finding that in the six months after becoming ill, roughly a third of surviving patients were diagnosed with at least one neurological or psychiatric disorder." Dr. Avindra Nath, who leads research on the brain and immune system at the National Institute of Neurological Disorders and Stroke, said, "This paper is important because it's the largest data set anyone has looked at. ... In that sense, it's huge."
- **White House Vaccinations Coordinator Touts Progress On COVID-19 Vaccine Rollout.**
  - r. Bechara Choucair, White House Vaccinations Coordinator. Choucair said, "11 weeks ago, the US was averaging less than one million vaccinations per day. Our current seven-day average is over three million vaccinations per day. This weekend, we reported for the very first time ever four million shots administered in one day. As of today, we have administered over 168 million doses as a country, and for people 65 and older, where we know 80% of the deaths from COVID are occurring, more than 75% of" them "have had at least one shot of the vaccine. That's up from 8% 11 weeks ago. So, when you look at the numbers, this is really impressive, and I continue to be in awe on how this country is coming together to get us all vaccinated, and getting us past this pandemic."
- **Here's a silver lining: Veterans report post-traumatic growth during the pandemic**
  - Given their previous line of work, it's not surprising that veterans are more likely to experience PTSD and think about suicide than the civilian population. But a new study that surveyed veterans about the pandemic early last year and followed up a year later reveals a happier twist in the story. While 13% of veterans said they had Covid-related PTSD symptoms and 8% considered suicide, many more — 43% — said the pandemic brought positive psychological side effects. Among those whose answers added up to PTSD, more than 70% reported positive changes, tied to a 40% lower likelihood of

contemplating suicide. Their appreciation of life was greater, their interpersonal relationships were closer, and their sense of personal strength was higher.

Additional talk points for WH Pressor:

- **Here's What Will Actually Convince People to Get Vaccinated**
  - 59% having a conversation with family/friends, 56% a family or friend receiving the vaccine. This came out on the 2nd so very current.
- **Changing the Covid Conversation**
  - Stick to the facts. Stories about the randomness and unpredictability of COVID can be compelling, but when it comes to the vaccine, facts and data are most important. Emotional appeals are much less likely to be persuasive.
  - Choose the right messengers. The most effective sources will be doctors, family, and other people who are already trusted. Young Republicans (18-49) are more likely than older Republicans to be influenced by their peers and their parents. But the most important messengers for all Republicans are doctors -- and specifically their own doctor.
- **Via NIMH: JAMA study** (Ettman CK, Abdalla SM, Cohen GH, Sampson L, Vivier PM, Galea S. Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. JAMA Netw Open. 2020;3(9):e2019686. DOI: http://dx.doi.org/10.1001/jamanetworkopen.2020.19686) **that has the stats below**
  - Depression symptom prevalence was higher in every category during COVID-19 compared with before[with an average increase across severity of about 7% ALTERNATE: an increase of about 5% of moderately severe to severe symptoms] DATA: (mild: 24.6% [95% CI, 21.8%-27.7%] vs 16.2% [95% CI, 15.1%-17.4%]; moderate: 14.8% [95% CI, 12.6%-17.4%] vs 5.7% [95% CI, 4.8%-6.9%]; moderately severe: 7.9% [95% CI, 6.3%-9.8%] vs 2.1% [95% CI, 1.6%-2.8%]; severe: 5.1% [95% CI, 3.8%-6.9%] vs 0.7% [95% CI, 0.5%-0.9%]).
  - • A higher risk of depression symptoms during COVID-19 was associated with having lower income [doubling the probability, and exposure to more stressors tripling it] DATA: (odds ratio, 2.37 [95% CI, 1.26-4.43]), having less than $5000 in savings (odds ratio, 1.52 [95% CI, 1.02-2.26]), and exposure to more stressors (odds ratio, 3.05 [95% CI, 1.95-4.77]).
  - **If you want to go with the CDC info**, our SME recommends the following language based on this:
    - **41.5%** of adults reported symptoms of an anxiety or depressive disorder in January-February 2021– **57%** of young adults reported these symptoms (18-29 years). **11.7%** reported they needed but did not receive mental health counseling

Note: Media headline and content may be direct excerpts from news articles and are intended for informational updates, not as original writing.

COVID TEAM UPDATES
[9:30 AM EST DEPUTIES]

Note: To be completed in the SharePoint during the 9:30 AM call.

- TBD

From:	Murthy, Vivek (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV>
SentVia:	Atkins, Melea (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0128346FCB6A4E438D3FE9273424ED9F-ATKINS, MEL>
To:	Murthy, Vivek (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV <Vivek.Murthy@hhs.gov>; Waldo, Eric (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=7ead25012182469b9fbca545d1eb2a0d-Waldo, Eric <Eric.Waldo@hhs.gov>
Subject:	HOLD: Call with Secretary Cardona
Date:	2021/07/27 13:22:37
Start Date:	2021/08/09 15:00:00
End Date:	2021/08/09 15:30:00
Priority:	Normal
Type:	Appointment
Location:	Zoom

Sec. Cardona's team to send invite.

From: Waldo, Eric (HHS/OASH) <Eric.Waldo@hhs.gov>
Sent: Monday, July 26, 2021 4:42:24 PM
To: Nix, Sheila <Sheila.Nix@ed.gov>
Subject: Getting Vivek and Secretary Cardona together

Hey Sheila!

Thank you again for your team's help on the health misinformation launch. So helpful.

I know a lot's happening, but we'd love to get Vivek on the line with Secretary Cardona next week or the week after. He's been wanting to connect for a while, so I'm hoping we can find a time that works for their schedules. Happy to work with your scheduling team, but wanted to raise with you first.

Thanks so much!
Eric

Eric W. Waldo [He/Him]
Director of Engagement
Office of the U.S. Surgeon General, Dr. Vivek Murthy
U.S. Department of Health & Human Services

Sender:	Murthy, Vivek (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV>;

	Atkins, Melea (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0128346FCB6A4E43BD3FE9273424ED9F-ATKINS, MEL>
Recipient:	Murthy, Vivek (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV <Vivek.Murthy@hhs.gov>; Waldo, Eric (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=7ead25012182469b9fbca545d1eb2a0d-Waldo, Eric <Eric.Waldo@hhs.gov>
Sent Date:	2021/07/27 13:22:37

From:	Murthy, Vivek (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV <Vivek.Murthy@hhs.gov>
To:	Beckman, Adam (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=2a00f6fceac04289866d64b3d44f8187-Beckman, Ad <Adam.Beckman@hhs.gov>; Phillips, Alexandria (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=823b656fc11443c3b97471899535d819-Phillips, A <Alexandria.Phillips@hhs.gov>; Lesko, Max (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4f2cc293a2714518acf3b8f1fe98d057-Lesko, Max <Max.Lesko@hhs.gov>
Subject:	HOLD: Possible moot with OS on misinformation
Date:	2021/07/08 13:08:29
Start Date:	2021/07/12 10:30:00
End Date:	2021/07/12 11:30:00
Priority:	Normal
Type:	Schedule.Meeting.Request
Attendees:	Beckman, Adam (HHS/OASH); Phillips, Alexandria (HHS/OASH); Lesko, Max (HHS/OASH)

Alex to guide

Sender:	Murthy, Vivek (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1967C-MURTHY, VIV <Vivek.Murthy@hhs.gov>
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Identifying Credible Sources of Health Information in Social Media: Principles and Attributes

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Disclaimer: The views expressed in this paper are those of the authors and not necessarily of the authors' organizations, the National Academy of Medicine (NAM), the National Academies of Sciences, Engineering, and Medicine (the National Academies), or the National Institutes of Health (NIH). The paper is intended to help inform and stimulate discussion; it is not a report of the NAM or the National Academies.

ABSTRACT | *Social media is widely used as a source of health information for the general public. The potential for information shared through social media to influence health outcomes necessitates action by social media platforms to enhance access and exposure to high-quality, science-based information. This paper summarizes the work of an independent advisory group convened by the National Academy of Medicine that deliberated and gathered information to develop a set of initial principles and attributes that could inform platforms' identification and possible elevation of credible sources of health information. Using these principles and attributes as a framework, the authors discuss the likelihood of credibility among major categories and types of nonprofit and government organizations that share health information through social media. The authors also emphasize the need for parallel strategies in addition to source evaluation, including assessment of content, as well as important ethical considerations such as the protection of free speech and individual autonomy. The paper also stresses that, in order to be considered credible themselves, social media platforms should share data with behavioral and public health researchers to understand the effects of such policies on both online and offline behaviors.*

Introduction

People seek, share, and receive health information from a wide variety of sources, such as health care professionals, insurance and pharmaceutical companies, family and friends, media, educational materials, advertisements, and the internet—including social media. Increasing numbers of Americans have turned to internet sources for health and medical information in recent years, with approximately three out of four searching for health information online today, and similar rates among Europeans [1,2]. However, both high- and low-quality health information can be found online, and few social media platforms (SMPs) [a] differentiate between credible and non-credible sources of information. Consequentially, consumers must make their own judgments about how much trust to place in a source and the quality of the information it shares. These judgments are influenced by their level of health and digital literacy, prior knowledge, personal situations, and personal beliefs [3].

"Misinformation" is that which conflicts with the best scientific evidence available at the time. "Disinforma-

tion" describes a "coordinated or deliberate" effort to spread misinformation in order to gain "money, power, or reputation" [1]. Social media allows both misinformation and disinformation to be disseminated much more rapidly and broadly than ever before [4]. The ability for people to tailor their preferences on SMPs to see information from only the sources they select raises concerns about "bubbles" or "echo chambers" that could reinforce existing beliefs (although recent research has challenged this notion [5]). However, consumers do not have to proactively seek information that confirms their beliefs; algorithms used by SMPs and other web platforms often recommend content on the basis of users' past behaviors and expressed interests, leading to passive or incidental exposure [6]. In the case of low-quality health information, such reinforcement loops can be harmful.

The coronavirus disease 2019 (COVID-19) pandemic has demonstrated the potentially malign outcomes of this aspect of social media. Misinformation about the disease spread through social media and other online forums—often fueled by politicization of scientific information—has considerably harmed the adoption of recommended prevention and control behaviors and has decreased support for vital policies, such as vaccination [7]. Therefore, SMPs are capable of amplifying misinformation and disinformation in harmful ways, including those that may lead to poor outcomes for individual as well as population health [8]. The authors believe that these platforms have an important opportunity—and a growing responsibility—to intervene, not only to counteract these harmful trends but also to enhance consumers' access and exposure to high-quality, science-based health information. Proactive interventions by SMPs are one potential approach, although not a sole solution, to the challenge of "platform governance," an issue that has been the subject of increasing policy debate [9].

The tremendous reach of SMPs among broad and diverse audiences affords them unique potential to support health-promoting behaviors amid the COVID-19 pandemic, as well as other current and future health challenges. For example, the two current most popular SMPs used by organizations to share health information—Facebook and YouTube—reach 2.85 billion [10] and "over 2 billion," [11] monthly active users, respectively [b]. This represents a significant portion of the world's population, estimated by the U.S. Census Bureau to be nearly 7.8 billion people in June 2021 [12]. Harnessing the power of social media to elevate high-quality information could therefore have a truly transformative effect on health and well-being worldwide.

However, determining what constitutes high-quality health information is a complex and multidimensional process. Although SMPs are beginning to pilot strategies to elevate and label high-quality information, there are no public data available to demonstrate what works and no scientific or technical consensus about the most effective approach. Nevertheless, the urgency of ensuring access to high-quality health information necessitates action, even if such action is initially imperfect. The challenge will require collaboration among public and private actors to develop incremental and iterative solutions, with attention to transparency, accountability, and incorporation of feedback from a diverse set of stakeholders.

This paper focuses specifically on the evaluation of *sources* of health information, rather than content or design (discussed further under "Scope"). The authors offer initial principles and attributes for consideration by SMPs in their efforts to identify credible sources—with the ultimate goal of promoting access to high-quality health information. The guidance in this paper is therefore limited in scope and is offered as a starting point in what should be an ongoing process. This guidance will also need to be regularly revisited and updated according to changes in the online information ecosystem. SMPs should invest in ongoing, rigorous research and analysis of this subject; commit to transparency and continuous quality improvement; and build and sustain collaborations with scientific, health, ethical, and other communities to ensure an effective and accountable approach.

Although this paper is intended to inform the policies of SMPs, organizations that share health information through social media may find the principles and credibility attributes useful in assessing their own approach. Importantly, members of the public might also use this guidance to inform their personal evaluation of sources. Both groups should be engaged by SMPs and others seeking to improve the accessibility of high-quality health information in social media.

Background

In March 2021, the National Academy of Medicine (NAM) launched a project to help identify principles for identifying credible sources of health information in social media, of which this paper is the principal output. Sponsored by YouTube's Healthcare and Public Health Partnerships arm [c], the project was inspired

by the goal of enhancing public access to evidence-based health information during the COVID-19 pandemic, although the issue has relevance beyond the current crisis.

The project involved an independent expert advisory group composed of multi-disciplinary experts in information governance, health information development, public health and health equity, social media and misinformation, and science communication (members of which also authored this paper), a public webinar, a public comment period, and other information-gathering activities. **This paper does not constitute official recommendations from the NAM or the National Academies of Sciences, Engineering, and Medicine (NASEM), nor does it represent an endorsement of any actions taken by YouTube or other SMPs following its publication.**

Methods

Managing Conflict of Interest

The NAM is an organization whose influence stems in part from its reputation as a credible source of health information. Further, the NAM disseminates this information in part through social media [d]. To minimize conflict of interest (COI), the NAM took steps to ensure the independence and objectivity of the advisory group and this paper. This paper represents the opinions of the authors and does not reflect a consensus position of the NAM, NASEM, or the authors' organizations. The authors did not receive payment from the NAM, NASEM, or YouTube for their contributions to this paper, and the authors' declared individual COIs are included in this paper's back matter. This paper has been revised in response to scientific peer review by individuals who were chosen for their expertise in social media, ethics, health literacy, law, communications, and policy but are unknown to the authors.

Box 1 | Takeaway Points from the NAM Webinar on "Defining the Authority of Online Providers of Health Information"

- Scientific and medical collaborations with social media companies offer a unique opportunity to share high-quality health information with a broad audience.
- People are resourceful when seeking health information, meaning that they consult many sources and often will not settle for the word of a single, "authoritative" entity.
- High-quality health information must be understandable, engaging, and culturally competent [a] to be influential. Health and medical organizations must work hard to gain the trust of people at the community level.
- Inter-science debate and evolving information makes social media content moderation very challenging. For example, during the COVID-19 pandemic, information shared by "authoritative" sources such as the World Health Organization and the Centers for Disease Control and Prevention quickly became outdated.
- A perfect solution to this challenge may not exist, but achieving something "better than" the status quo is a worthy goal.

NOTE: Webinar speakers included Garth Graham, director and global head of healthcare and public health partnerships at YouTube; Brendan J. Nyhan, professor of government at Dartmouth College; Lisa Fitzpatrick, founder and CEO of the Grapevine Health; and Zeynep Tufekci, McColl Term Associate Professor, University of North Carolina-Chapel Hill School of Information and Library Science (see https://nam.edu/event/defining-the-authority-of-online-providers-of-health-information/).

[a] "Cultural competence" refers to the ability to interact effectively with diverse audiences by recognizing and responding to variations in social, cultural, and linguistic needs (see https://psnet.ahrq.gov/perspective/cultural-competence-and-patient-safety#_ednref4).

Deliberative Sessions

The authors met for four closed, deliberative sessions between March and June 2021. Representatives from YouTube attended the first 60 minutes of the initial session in order to explain the company's current policies and future goals with regard to elevating high-quality health information and to answer questions from the authors. Representatives from YouTube did not attend any part of the subsequent deliberative sessions. Notes from all three sessions are available to the public on the project webpage: NAM.edu/AuthoritativeHealthSources.

Information-Gathering Public Webinar

On April 5, 2021, the NAM hosted a public webinar to gather information to inform the authors' deliberations. The webinar was planned with the input of the authors, and all authors attended. The topics covered included background on YouTube's goals with regard to elevating credible sources of health information; the health and social consequences of social media misinformation and disinformation; how health information is received at the community level; and unintended consequences of social media content moderation strategies. The session concluded with a question-and-answer session among the authors and presenters (see *Box 1*). The webinar was attended by approximately 400 members of the public. The webinar recording, transcript, slide presentations, and a written summary are available on the project webpage, along with a synthesis of questions and comments submitted by public attendees.

Preliminary Discussion Document and Public Comment Period

The authors created a four-page preliminary discussion document to solicit feedback on the project from interested parties, including researchers, providers of online health information, and members of the public. The document contained background on the project; preliminary definitions and source categories; and ethical, logistical, and public health considerations. The document was posted on the project webpage on April 5, 2021, where it remains available [13].

The NAM hosted a questionnaire to collect comments on the discussion document between 12:00 pm ET on April 5, 2021, and 11:59 pm ET on April 9, 2021 (see *Appendix C*). The comment opportunity was

Box 2 | Key Themes Among Feedback Received During the Public Comment Period

- **The need for parallel strategies to supplement elevation of credible health sources,** including content analysis; reduction of misinformation; consumer education/efforts to increase health and digital literacy; and efforts to improve the communication skills of credible sources, including a focus on cultural competence [a].
- **The need to consider the evolving nature of science and health and medical practice;** the necessity of experimentation and iteration should not impact perception of a source's credibility. On the other hand, steps must be taken to increase consumers' understanding of the limitations of information, particularly primary or preliminary research.
- **The importance of conflict of interest disclosures;** even the most credible sources have conflicts, and no organization should be exempt from disclosing them.
- **The need to protect free speech and personal autonomy;** efforts to elevate credible health sources should not amount to censorship of any other sources, and individual consumers should retain the ability to make their own judgments.
- **The desire for a simple system by which users can evaluate source credibility,** such as a "visual seal of approval" or a "1-5 rating system."

NOTE: See a detailed summary of comments at https://nam.edu/wp-content/uploads/2021/04/PUBLIC-COMMENT-SYNTHESIS.pdf.

[a] "Cultural competence" refers to the ability to interact effectively with diverse audiences by recognizing and responding to variations in social, cultural, and linguistic needs (see https://psnet.ahrq.gov/perspective/cultural-competence-and-patient-safety#_ednref4).

Box 3 | Models for Evaluation of Source Credibility

Clinical Practice Guidelines We Can Trust. This 2011 Institute of Medicine consensus report made recommendations for identifying high-quality clinical practice guidelines (CPGs) among the nearly 27,000 then contained in the National Guideline Clearinghouse. The report committee concluded that certifying organizations with trustworthy CPG development procedures, rather than evaluating the content each individual CPG, was a reasonable (although not the only) approach to the challenge.

The CRAP Test. Developed by librarian Molly Beestrum, the CRAP Test is a system for evaluating the credibility of a website according to four major attributes: **C**urrency/**C**redibility, **R**eliability, **A**uthority, and **P**urpose/**P**oint of View. Embedded within each of these attributes are questions such as, *How recent is the information? Does the website include citations? What are the author's credentials? Does the author seem to be trying to push an agenda or sell you something?* Educator Mike Caulfield has developed an alternative to the CRAP model called SIFT (**S**top. **I**nvestigate the Source. **F**ind Better Coverage. **T**race claims, quotes, and media to the original context), which is designed to help "students get better at sorting truth from fiction from everything in between" [a].

Health on the Net (HON) Foundation Certification. HON is an international nonprofit organization based in Switzerland. HON certification holds health and medical websites accountable to basic ethical standards in the presentation of information, including sharing information from only trained and qualified professionals, respecting patient and consumer privacy, providing evidence in support claims, and disclosing financial interests, among others. Websites with HON certification earn the right to display a visual seal as an indication of their integrity.

MEDLINE and MedlinePlus (National Library of Medicine [NLM]). MEDLINE is an NLM database with over 27 million references to journal articles in the life sciences. To decide which journals (i.e., article sources) to include, MEDLINE applies a set of criteria including scope and coverage, editorial policies and processes, scientific and methodological rigor, production and administration, and impact. MEDLINE selection also depends on the judgment of an independent Literature Selection Technical Review Committee, a Federal Advisory Committee.

MedlinePlus is an NLM website designed to share health information with the public. MedlinePlus primarily links to other government websites but will consider inclusion of nongovernment websites (i.e., information sources) if they demonstrate a mission to share high-quality health information; display transparency and trustworthiness; provide unbiased content for the purpose of education; and ensure the accessibility of information, among other criteria. MedlinePlus also gives preference to websites that do not host advertisements.

URAC Certification for Health Content Providers and Health Websites. URAC is an accreditor that offers certifications for health information sources that meet standards for disclosures, editorial and content review processes, privacy and security, external linking policies, consumer complaint processes, and more.

NOTE: See *Appendix A* for more detailed discussions of each of these models.

[a] See https://hapgood.us/2019/06/19/sift-the-four-moves/.

promoted via email to approximately 1,000 individuals who had registered to attend the webinar and/or signed up for the project mailing list, as well as shared through the NAM's social media channels. In total, the NAM received 49 comments. Fourteen of the commenters provided feedback on behalf of an organization, while the remainder commented as individuals. Three commenters were from Canada, one was from Mexico, one was from Egypt, and the remainder were from the United States. The comments were analyzed, sorted into themes, and summarized by a contractor [e]; this synthesis is available on the project webpage and presented more briefly in *Box 2*. The authors reviewed all comments received and considered them in developing this paper.

Review of Existing Models for Evaluation of Source Credibility

The authors performed a scan of existing models for evaluating source credibility and/or information quality (see *Box 3* and *Appendix A*). Major themes that emerge across these models include the importance of independence from profit motivations and bias; rigorous content review processes; transparency and accountability; and mission-driven policies.

Scope

Given the complexity of the task—including the volume of health information shared through social media and the controversial nature of evolving content moderation policies—the authors limit their guidance to what they believe is a feasible first step toward enhancing access to high-quality health information. Therefore, this paper focuses on the credibility of *sources* of health information, rather than the information shared by these sources. Source evaluation is a common means of curating a large volume of content because it eliminates the need to evaluate every piece of information individually (although advances in machine learning may soon increase the feasibility of large-scale content evaluation).

However, although a reasonable place to begin, source evaluation cannot yield a complete solution to the challenge of increasing access to high-quality health information in social media. The credibility of a source is, at most, an indicator of information quality and by no means a guarantee. Furthermore, even organizations with strong reputations for credibility are not infallible. For example, the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) were slow to acknowledge the role of airborne transmission in the COVID-19 pandemic, and the CDC recently removed three pieces of guidance related to the virus from its website for failing to adhere to the agency's scientific standards [14, 15]. Therefore, the authors stress that identifying credible sources of information is a starting point only and must be supplemented by ongoing and iterative efforts to assess the quality of information.

The authors further limit their consideration in this paper to *government and nonprofit organizations* (including nonprofit news sources that share health information), not individuals (e.g., independent physicians with Facebook pages) or for-profit companies. Individuals require separate analysis because they lack the organizational infrastructure that is the basis of the authors' approach to source evaluation in this paper. For-profits have a unique set of financial interests that, likewise, require a separate assessment.

However, the authors' decision to omit consideration of individual and for-profit sources from this paper does not reflect a judgment of their credibility. Individuals and for-profits may be highly credible and are influential sources of health information in social media. Therefore, an assessment of their credibility, as well as the quality of the information they share, should be the focus of future analysis. It also should be noted that demarcations between individuals and organizations and between nonprofit and for-profit organizations are not always clear. Many of the principles laid out in this paper can apply to for-profits.

Finally, the authors have limited their present focus to *organizations based in the United States*, including those that provide information in languages other than English. While some of the guidance in this paper can be applicable to organizations outside the United States, additional research and the engagement of global partners will be needed for this work in the international context.

Key Terms

Terminological precision is critical to this task and was the subject of careful deliberation by the authors. The following are definitions and discussions of the key terms used in this paper.

Credible

For the purposes of this paper, the authors present their own definition of *credible* in the context of sources of online health information: "offering information that is consistent with the best scientific evidence available at the time and employing processes to reduce

conflict of interest and promote transparency and accountability." The principles that inform this definition are explained in the following section.

High-Quality Information

As noted in the Introduction, *high-quality information* is that which is "science-based" or consistent with the best scientific evidence available at the time. The state of science and knowledge is always evolving, so the marker of time is an important component of this definition. The evolution of knowledge is also the reason that more absolute terms, such as *accurate*, are less appropriate. Although this paper does not consider information quality directly, increasing access to high-quality information is the goal of the approach under discussion.

Health Information

The authors define *health information* as content pertaining to health conditions (physical and mental), behaviors affecting health, public health, population health, health care, health policy, or biomedical science.

Source

For the purposes of this paper, *a source* is an entity that offers health information through one or more social media channels branded to that entity. A channel is a proprietary forum where a source can share content (text, visual, video, or audio) and interact with social media users who choose to "follow" or "subscribe" to that channel, as well as users who discover the content through search engines or SMPs' "recommended content" algorithms.

Credible Source of Health Information

Building on the definitions and discussion previously mentioned, the authors define *credible source of health information* as "a source that is likely to offer high-quality information and employ processes to reduce conflict

Box 4 | The Relationship Between Trust and Credibility

Trusted is not synonymous with *credible*. Sources considered credible by the authors' definition may not be trusted by all individuals and groups, while sources that are widely trusted may not be credible. However, trust affects the *perception* of credibility, and by extension, the influence of credible sources of health information. For example, according to a survey by the RAND Corporation, trust in the Centers for Disease Control and Prevention (CDC) declined by about 10 percent during the COVID-19 pandemic. The authors of the survey suggest that "public trust in federal government agencies has never been as important as it has been during the COVID-19 pandemic, yet public suspicions of scientific experts and levels of distrust of government institutions are increasing" [a]. Because the CDC plays an essential role in disseminating scientific information and public health guidance to the nation, its trust deficit is a significant problem that could have bearing on health outcomes.

Therefore, no matter how credible public health organizations might be, building trust should be a primary focus of their approach to information sharing and relationship building (through social media as well as other means). In a 2021 rapid expert consultation on promoting trust around the COVID-19 vaccine, the National Academies of Sciences, Engineering, and Medicine offered strategies for engaging communities to combat mistrust, including forming partnerships with community organizations; "engaging trusted messengers who have roots in the community"; and communicating across multiple, accessible channels [b].

Just as building trust should be a priority for credible sources of health information, ensuring the credibility of highly trusted and influential sources should be of primary concern for SMPs and other stakeholders concerned with public health and health communication.

NOTES: [a] https://www.rand.org/pubs/research_reports/RRA308-12.html
[b] National Academies of Sciences, Engineering, and Medicine. 2021. *Strategies for Building Confidence in the COVID-19 Vaccines.* Washington, DC: The National Academies Press. Available at: https://doi.org/10.17226/26068.

of interest and promote transparency and accountability." The use of the word "likely" in this definition reinforces the notion that source credibility does not *necessarily* equate to information quality, yet is still a useful indicator for consumers.

Foundational Principles

On the basis of their information gathering and deliberation, the authors developed the following foundational principles to guide identification of credible sources of health information in social media.

Principle 1: Science-Based
Sources should provide information that is consistent with the best scientific evidence available at the time and meet standards for the creation, review, and presentation of scientific content.

This principle reflects the authors' conviction that scientific evidence is the only reliable predictor of health outcomes and therefore should be the foundation of health information provided to consumers. There are a number of attributes (e.g., use of citations) that help to indicate whether a source is sharing information that is consistent with the best scientific evidence available at the time, described in the following section.

Principle 2: Objective
Sources should take steps to reduce the influence of financial and other forms of conflict of interest or bias that might compromise or be perceived to compromise the quality of the information they provide.

This principle acknowledges that all sources have COIs or inherent biases. However, in order to be considered credible, sources should strive to separate the presentation of health information from profit motives and other biases (e.g., political). Sources should also disclose conflicts, as noted in the next principle.

Principle 3: Transparent and Accountable
Sources should disclose the limitations of the information they provide, as well as conflicts of interest, content errors, or procedural missteps.

The final principle acknowledges the fallibility of both organizations—which cannot eliminate COI and errors—and science itself. At the frontiers of understanding, scientific knowledge changes over time as more evidence becomes available and as existing evidence is analyzed in new ways. Scientific evidence, no matter how rigorous, can never guarantee a certain outcome for every individual or every context. Furthermore, Black, Indigenous, and People of Color (BIPOC) and other groups, such as LGBTQIA+ individuals and people with disabilities, are underrepresented within organizations traditionally considered authorities in science, meaning that the best available science might not fully reflect their experiences (discussed further in "Structural Bias").

To maintain credibility, sources must clearly acknowledge the limitations of the information they share so that consumers can reach fully informed conclusions. Fundamentally, this last principle reflects one of the key themes among the public comments the authors received—the importance of protecting the right of individuals to autonomy and independent evaluation of the information they consume and the sources they choose to trust. It also acknowledges sources' right to freedom of speech [f], but at the same time, requires sources to be fully transparent and provide all the context necessary for consumers to reach an informed judgment. However, protection of free speech and consumer autonomy must be balanced against the harms of misinformation and disinformation, as well as recent anti-science and "post-truth" trends in the media [16]. "Post-truth" refers to an environment in which scientific evidence is disregarded by some in favor of an alternative set of beliefs [17].

Credibility Attributes

Using the foundational principles as a scaffold, the authors identified a set of attributes that generally describe credible sources of health information (see *Table 1*). Not every source can display every attribute, but this should not preclude a general assessment of credibility. For example, a professional association may have a lobbying arm, which is counter to one of the attributes under the "objective" principle. However, the same organization might have a research arm that nearly or fully aligns with the attributes under the "science-based" principle. Furthermore, this organization may clearly disclose its lobbying activities to the public and maintain a strict firewall between political messages and health information for the public, thereby aligning with attributes under the "transparent and accountable" principle.

A credible source should demonstrate a preponderance of the attributes listed in *Table 1* but should not be required to meet a formal numerical threshold. Although one of the key themes among the public comments that informed this paper was the desire for a simple rating system, the authors believe that such a calculus would be inappropriate given that each at-

tribute is not necessarily of equal weight or importance. Instead, SMPs and consumers of health information could consider these principles and attributes as a framework to inform their own assessments of a source's credibility. Further, sources of health information could consider using *Table 1* as a roadmap to assess and potentially enhance their own credibility.

To avoid perfection paralysis, the authors believe that *general* alignment with the principles and attributes listed in *Table 1*, coupled with full disclosure of any deviations, could serve as a reliable initial signal of a source's credibility. As noted in the sections that follow, some types of sources are subject to pre-existing, standardized vetting mechanisms that signal such alignment. However, there remain credibility concerns with these source types as a whole. *All* sources should publicly disclose deviations from the principles and attributes and be subject to other strategies to ensure information quality (described later in this paper).

Identifying Credible Sources of Health Information

Categorization

A very wide range of U.S. nonprofit or government sources provide health information through social media, including professional societies; health care organizations; public health departments; universities; think tanks; philanthropies; medical journals; grassroots community organizations; state, local, tribal, and territorial government health agencies, and more. The scope and size of these sources varies dramatically. Evaluating the credibility of each one individually, while a worthy eventual goal, is infeasible as a first step. Therefore, just as the evaluation of source credibility (versus information quality) is offered as an entry point into a larger task, the assessment of source categories (versus individual sources) is an initial tactic to assess credibility at scale.

Leveraging Pre-Existing, Standardized Vetting Mechanisms

Several categories of sources are subject to pre-existing, standardized vetting mechanisms that indicate *general* alignment with the authors' foundational principles and attributes. Therefore, SMPs could consider sources in these categories as *likely* to be credible. However, these vetting mechanisms are not an exact match for the principles and attributes and reflect varying degrees of rigor. In addition, there are credibility concerns associated with each of these categories, as noted in the sections that follow. Therefore, sources in these categories should undergo additional vetting by SMPs (and also, perhaps, by independent third parties, as is discussed later), including some form of content review, as they refine their approaches to source evaluation.

Accredited Organizations

Accreditation is a voluntary process by which an organization earns a formal qualification as proof of its ability to meet quality and performance standards set by an accreditor. Although processes vary considerably by accreditor, accreditation is generally an intensive evaluation that involves extensive documentation and a site visit. Accreditation standards are set on the basis of research and evidence that demonstrates which qualities are associated with the highest degree of organizational effectiveness and the best possible outcomes for patients and other beneficiaries.

Because organizations must apply for reaccreditation on a regular basis (e.g., every few years), maintenance of accreditation indicates an ongoing commitment to transparency and accountability. Accreditors provide publicly accessible lists of organizations that have earned accreditation, as well as, in some cases, organizations that have failed to earn or maintain accreditation.

Accreditors themselves engage in continuous quality improvement and are held to a high standard of performance based on their recognition by federal authorities such as the Department of Education. In some cases, accreditors may be sponsored by relevant professional associations, which can suggest policy changes that ensure up-to-date accreditation criteria. For example, the Association of American Medical Colleges and the American Medical Association jointly sponsor the Liaison Committee on Medical Education, which accredits medical schools.

In another example, the Centers for Medicare & Medicaid Services (CMS) awards "deeming authority" to approved health care organization accreditors. Deeming authority means that accreditation can substitute for inspection by a state agency to determine whether a health care organization is eligible to receive payment from Medicare and Medicaid programs [18]. Similarly, the U.S. Department of Education provides a list of accreditors that are "recognized by the Secretary as reliable authorities concerning the quality of education or training offered by the institutions of higher education or higher education programs they accredit" [19].

TABLE 1 | Foundational Principles and Attributes of Credible Sources of Health Information

Foundational Principle	Attributes
Science-Based: Sources should provide information that is consistent with the best scientific evidence available at the time and meet standards for the creation, review, and presentation of scientific content.	• Acknowledges the limitations and evolution of knowledge (e.g., early or incomplete knowledge, as seen in the COVID-19 pandemic; small sample size; correlation versus causation, etc.) • Clearly labels information with the date it was last updated and strives to reassess and update content • Demonstrates subject-specific expertise (i.e., consistent and well-regarded contributions in a given field) • Links to and is linked to by other credible sources [a] • Provides citations for information shared and evidence to justify claims • Synthesizes information from multiple sources, rather than a single source • Uses a consensus process to develop the information shared [b] • Uses peer review or another form of content review to vet information before sharing [c]
Objective: Sources should take steps to reduce the influence of financial and other forms of conflict of interest (COI) or bias that might compromise or be perceived to compromise the quality of the information they provide.	• Keeps health information separate from financial, political, or ideological messages • Maintains independence from funders [d] • Separates lobbying activities from health information (or does not engage in lobbying) • Does not include advertisements with relevant health information (or does not host advertisements at all) [e]
Transparent and Accountable: Sources should disclose the limitations of the information they provide, as well as conflicts of interest, content errors, or procedural missteps.	• Discloses financial and nonfinancial conflicts • Discloses relevant policy positions and lobbying activities • Follows FACA regulations or similar transparency policies [f] • Posts public corrections or retractions • Prioritizes accessibility and equitable access to information • Provides a mechanism for public feedback • Shares data, methods, or draft recommendations

[a] For example, an organization could seek public comments on an interim set of health guidelines before finalizing and sharing the information more broadly.
[b] A consensus process involves assembling a group of experts with diverse perspectives who assess a body of evidence and deliberate in order to arrive at an opinion or guidance that reflects the consensus of the group.
[c] A peer review process involves sharing the draft of a publication or other product with reviewers who have expertise or experience in the given topic and can provide feedback as to the product's accuracy, balance, and appropriateness.
[d] For example, an academic journal could maintain editorial independence (i.e. sole authority over published content) from the organization that funds it.
[e] For example, an organization might host an advertisement for a cancer drug but keep this advertisement separate from the information it shares about cancer.
[f] FACA stands for the Federal Advisory Committee Act, which established requirements for committees that advise the federal government. These requirements include public access to meetings and meeting notes, as well as summaries of expenditures (https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management/advice-and-guidance/the-federal-advisory-committee-act-faca-brochure)

Together, accredited organizations, accreditors, and collaborator organizations function as a network that supports consistent and high performance standards, continuous evaluation and improvement, and public transparency and accountability—although these characteristics are not specific to the context of sharing health information through social media.

Categories of accredited organizations that serve as sources of health information for the public include educational institutions (universities and health professions schools), health care organizations, health plans, and public health departments (see *Box 5* for a summary and *Appendix Table B-1* for a list of accreditors and what accreditation signifies for organizations in each category).

Credibility Concerns

As noted above, the accreditation mechanisms discussed in this section do not evaluate an organization's credibility as a source of health information in social media. Rather, they affirm the *general* credibility of an organization in its role as a provider of a specific service, such as education or health care. Accredited organizations may not always adhere to the authors' credibility principles and criteria (nonprofit health plans and ambulatory care centers, for example, may be subject to strong profit motives). Furthermore, accreditation may not be an option for all sources of high-quality health information. Therefore, accreditation is an imperfect proxy for the evaluation of an organization's credibility as a source of health information and should be viewed as a preliminary indicator.

Further, there is tremendous variation in rigor and scope across accreditation programs, so accreditation does not convey adherence to a common standard for credibility. It should also be noted that some accreditation programs offer accreditation to organizations that do not share high-quality health information as defined by the authors. For these reasons, accreditation cannot serve as a comprehensive evaluation of credibility as a source of health information and should be supplemented by other forms of vetting.

Box 5 | Types of Nonprofit, Accredited Organizations That Serve as Sources of Health Information in the United States

Health Professions Schools and Other Educational Institutions

- Schools of medicine
- Schools of nursing
- Schools of public health
- Schools of dentistry
- Schools of pharmacy
- Universities (e.g., departments or schools of biomedical science, health policy, social science, etc.)

Nonprofit Health Plans

Public Health Departments

- State
- Tribal
- Territorial
- Local
- U.S. military installation

Health Care Organizations

- Ambulatory care providers (e.g., behavioral health centers, birthing centers, dental offices, dialysis centers, medical offices, occupational health centers, outpatient surgical centers, pain management centers, podiatry centers, radiation oncology practices, student health clinics, urgent care practices, women's health clinics, etc.)
- Home-based health care providers
- Hospitals (e.g., academic medical centers, acute care and long-term care hospitals, critical access hospitals, and rehabilitation facilities. There are also a wide variety of specialty hospitals, including cancer, stroke, and cardiac centers; children's hospitals; psychiatric hospitals; women's hospitals, etc.)

NOTES: For-profit health plans are not considered in this paper. Public health departments are also government organizations, which are subject to additional transparency and accountability rules. Public health department accreditation is a relatively new field, and accreditation is issued by a single body, the Public Health Accreditation Board.

Academic Health and Medical Journals

Academic journals are scholarly periodicals that publish research or reports specific to a profession or field of study. Many journals promote their publications through social media; in addition, journalists summarize journal articles and share their topline findings through social media. Academic journals are generally affiliated with educational institutions or professional associations. Although they exercise editorial independence, many are owned by for-profit publishing corporations, such as Elsevier.

Academic journals generally adhere to rigorous processes to ensure scientific excellence and integrity, such as peer review. For example, health and medical journals indexed by the U.S. National Library of Medicine (NLM) through MEDLINE must meet clear standards for "scope and coverage, editorial policies and processes", scientific and methodological rigor, production and administration, and impact (see Box 3) [20]. A list of all MEDLINE-indexed journals is available from the NLM website [21].

Many journals also follow the *Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals* produced by the International Committee of Medical Journal Editors (ICMJE), an independent working group of medical journal editors [g]. Broadly, the recommendations establish standards for authorship, disclosure of financial and nonfinancial COI [h], editorial freedom, protection of research participants, corrections and retractions, and handling of scientific misconduct, among other guidance [22]. ICMJE publishes a list of journals that state that they follow the ICMJE recommendations on its website (ICMJE.org) but cautions that it cannot verify the accuracy or completeness of its list. However, echoing this paper's position that the pursuit of perfection should not hamper incremental progress, ICMJE further notes that "maintenance of such a list may help to promote improvements in the quality of medical science and its reporting by indicating the standards many editors indicate they work to uphold" [23].

Credibility Concerns

Despite rigorous editorial and scientific review processes, journals sometimes allow the publication of articles that contain errors or misinformation, some of which may be retracted later. A social media user who consumes information from such articles may never learn of their retraction. Furthermore, errors or oversimplifications may be inadvertently introduced by entities who communicate about research published by a journal or other source—an issue that is of particular concern in social media, given the brief and ephemeral nature of social media content.

Second, as noted earlier in this paper, the state of science is always evolving. Many academic journals publish the results of unique experiments that have not been—and in some cases cannot be—reproduced by other scientists. This phenomenon is referred to as a lack of "reproducibility" (defined as consistent results using the same data and processes) or "replicability" (defined as consistent answers to the same scientific question, using different data and processes) [24]. However, the scientific community does not always view challenges in reproducibility or replicability as a problem. Rather, early hypotheses and approaches are built on by other scientists and become part of the evolution of knowledge. However, these nuances are not likely to be clear to the average consumer of health information, who may interpret the results of a single experiment as conclusive. Regardless of reproducibility and replicability, entities that consume and communicate about research may place too much weight on a single study that may prove to be an outlier in meta-analyses or literature reviews.

Finally, there are a growing number of journals that misleadingly claim to be high-quality health and medical journals and do not conform with publishing best practices, including those outlined in the previous section. These journals publish almost every submission they receive, charge authors for the publication of their articles, and do not use scientific peer review processes. Further, some are deliberately deceptive by using titles that are similar to established, reputable journals [25]. Prospective authors can perform their own research to determine whether a journal they are considering for publication of their articles is reputable. However, this step is not likely to be taken by someone who encounters information from a journal that *seems* reputable in social media. Furthermore, for the reasons outlined in this section, the simple inclusion of an article in MEDLINE does not guarantee the absence of errors or misinformation.

Together, these credibility concerns call for an aggressive and sustained effort to educate consumers of health information about the nature of scientific experimentation, quality assurance processes upheld by academic journals, and, generally, the factors by which they can judge source credibility and information quality. The need for such an effort is discussed further in the following section.

Government Organizations

Federal, state, and local government organizations operate under a number of provisions that support their credibility as sources of health information—primarily in the areas of transparency and accountability. As part of the system of checks and balances built into the U.S. government, the Constitution gives the legislative and judiciary branches oversight over the executive branch, where many federal organizations that serve as sources of health information reside (see *Box 7*). For example, Congress could compel the disclosure of documents or require the sworn testimony of representatives from the CDC to evaluate the agency's response to COVID-19. Many federal agencies produce information at the request of Congress, with internal and external review to increase the quality of that information. For example, the U.S. Government Accountability Office produces nonpartisan fact-based information at

Box 6 | The Rise of "Preprint" Scientific Articles During the COVID-19 Pandemic

"Preprint" refers to an article that has not yet been accepted for publication by an academic journal or undergone peer review. Authors upload preprints to servers designed for that purpose, where they can be accessed by fellow researchers and members of the public. This allows research to be shared, commented on, and refined more quickly than the traditional journal publication process. Some preprints are submitted for publication by a journal at the same time as their upload to a preprint server, and the majority of preprints go on to be formally published by journals [a]. The major preprint server for biomedical research is called medRxiv and was founded by Cold Spring Harbor Laboratory, BMJ, and Yale University. Disclaimer language on the server specifies that, "Preprints are preliminary reports of work that have not been certified by peer review. They should not be relied on to guide clinical practice or health-related behavior and should not be reported in news media as established information" [b].

The scientific community heavily utilized the preprint mechanism to quickly share research and information during the COVID-19 pandemic. Of more than 125,000 scientific articles on COVID-19 during the first 10 months of the crisis, more than 30,000—or about 25 percent of the research—were hosted on preprint servers. According to a study of medRxiv and bioRxiv (a related server for preprint biology research), 85 percent of authors who submitted articles on COVID-19 used a preprint server for the first time during the pandemic. COVID-19 preprints were also widely cited compared with articles on other subjects (almost 60 percent were cited at least once) and shared, including through social media (the most popular preprint was mentioned nearly 27,000 times on Twitter). Despite the servers' admonition that preprints should not be relied on by the media, nearly 29 percent of COVID-19 preprints were featured in at least a single news article [a].

The increase in usage and popularity of preprints during the COVID-19 pandemic adds a layer of complexity to the discussion of academic journals as credible sources of health information, given the ease with which preprint research may be confused with articles that have undergone formal peer review and editorial oversight. However, preprint servers such as medRxiv (and, by extension, articles that carry a preprint citation) do not follow all of the authors' principles and criteria for credible sources of health information outlined in this paper.

[a] Fraser, N., L. Brierley, G. Dey, J. K. Polka, M. Pálfy, F. Nanni, and J. A. Coates. 2021. The Evolving Role of Preprints in the Dissemination of COVID-19 Research and Their Impact on the Science Communication Landscape. PLoS Biology 19(4):e3000959. https://doi.org/10.1371/journal.pbio.3000959
[b] medRXiv. About medRXiv. Available at: https://www.medrxiv.org/content/about-medrxiv (accessed June 19, 2021).

the request of congressional committees and subcommittees and operates a hotline for the public to report on government fraud, waste, or abuse.

Public transparency laws reinforce this accountability. For example, the Freedom of Information Act requires disclosure, upon requests from the public, of documents controlled by the federal government (with specified exceptions), which allows for independent scrutiny and critique of government information. The Federal Funding Accountability and Transparency Act requires the disclosure of information about any organization that receives federal funds, while the Digital Accountability and Transparency Act sets standards for availability of this information on the federal website USASpending.gov. The Federal Advisory Committee Act requires that advisory committees to the federal government operate in an open and transparent manner so that the public can access and review the information these groups generate. Government agencies that receive a certain level of research funding (internal or external) must make the results of the research (such as in journal articles) available to the public for free. In addition, many external groups monitor information released by the government.

Similar provisions enhance the credibility of state and local governments as sources of health information, although such provisions may be less strict and may vary from one jurisdiction to another. Furthermore, state lawmakers can support highly divergent public health policies, as demonstrated by variations

Box 7 | Major Federal Government Organizations That Serve as Sources of Health Information

- U.S. Department of Health and Human Services
  - Administration for Children and Families
  - Administration for Community Living
  - Agency for Healthcare Research and Quality
  - Agency for Toxic Substances and Disease Registry
  - Centers for Disease Control and Prevention
  - Centers for Medicare & Medicaid Services
  - Food and Drug Administration
  - Health Resources and Services Administration
  - Indian Health Service
  - National Institutes of Health
  - Office of the Assistant Secretary for Planning and Evaluation
  - Office of the Assistant Secretary for Preparedness and Response
  - Office of the National Coordinator for Health Information Technology
  - Office of the Surgeon General
  - Substance Abuse and Mental Health Services Administration
- U.S. Department of Veterans Affairs
  - Veterans Health Administration
- U.S. Department of Defense
  - Military Health System
- U.S. Department of Homeland Security
  - Federal Emergency Management Agency
- U.S. Department of Agriculture
- White House
  - Office of Science and Technology Policy
- Social Security Administration
- U.S. Agency for International Development
- U.S. Environmental Protection Agency
- U.S. Geological Survey
- U.S. Department of Commerce
  - National Oceanic and Atmospheric Administration

in mask-wearing guidance during the COVID-19 pandemic [26].

Credibility Concerns

Trust in the federal government is low among some groups, compromising its influence as a credible source of health information. According to a survey from the Pew Research Center, only 24 percent of Americans trust the federal government "to do what is right just about always or most of the time" [27] (this statistic refers to the federal government in general, not as a source of health information). Trends in trust of the government vary among political party affiliation as well as race and ethnicity, suggesting that perception of government credibility may vary across population groups [28].

Furthermore, provisions for transparency and accountability are important attributes of credible sources but are not a guarantee of high-quality information. Recent events have raised further concern, as in the example of the CDC's removal of scientific guidance after allegations of undue political pressure on the agency's staff [29]. Clearly, the degree of transparency and accountability upheld by the government at all levels is influenced by the leaders currently in office. Politicization can bias or limit the information that government organizations release. Government organizations may also withhold complete information because of privacy or security concerns, which may result in fragmented or distorted perceptions of issues. Therefore, although the authors believe that government organizations can generally be treated as credible sources, the principles and attributes identified in this paper should apply to them as well, and gaps in credibility should be further examined.

Nonprofit Organizations Not Subject to Standardized Vetting Mechanisms

Many categories of nonprofit organizations that are not subject to standardized vetting mechanisms serve as sources of health information. Some adhere to rigorous standards that align with the principles and attributes outlined in this paper, and some do not. There is no pre-existing, standardized mechanism for evaluating the credibility of sources in this category (although individual mechanisms exist). Therefore, SMPs that wish to assess the credibility of such sources should develop a standardized process for assessing alignment with the principles and attributes identified in this paper.

Table 2 lists types of organizations that share health information (excluding health care organizations, health plans, government organizations, and public health departments), along with the authors' general observations about the credibility of organizations in each category, drawing from the principles and attributes.

Credibility Assessment Steps

To assess the credibility of sources not subject to pre-existing, standardized vetting mechanisms that align with the authors' principles and attributes, SMPs would need to collect and evaluate a standardized set of data. The means of data collection could be either primary or secondary (i.e., SMPs could undertake their own discovery process or rely on information provided by a source). For example, primary data collection might mean using technology to "crawl" a source's website for evidence of citations, peer review processes, COI disclosures, etc. Secondary data collection might take the form of a credibility attributes and disclosures section that a source could provide to an SMP and post publicly on the homepage of its social media channel(s). This latter approach would require sources to self-regulate and comply with an informal "honor system" or "code of ethics." For example, a source would have to decide whether the content of an advertisement posted alongside health information constitutes a conflict of interest that could compromise the quality of that information.

On the other hand, as previously mentioned, sources that *are* subject to such standardized vetting mechanisms can be afforded a preliminary assumption of credibility, as well as government organizations by virtue of their strict accountability practices. However, even sources in these groups should strive to display a preponderance of the authors' credibility attributes and publicly disclose any deviations (as well as be subject to parallel content evaluation, as described in the following).

For any source type, SMPs' approach to credibility assessment should include a human-led quality assurance (QA) program. Algorithms and other automated technologies are likely not capable of evaluating every nuance of the credibility attributes. The QA system should verify alignment with source credibility attributes as well *as the quality of the information shared.* To ensure that consumers are accessing high-quality health information, some form of content assessment is essential as a supplement to source assessment.

TABLE 2 | Other Nonprofit Entities That Share Health Information (Excluding Health Care Organizations, Health Plans, Government Organizations, and Public Health Departments)

Organization Type	Definition	Credibility Observations [a]
Independent organizations or advisory panels that create evidence-based guidance (e.g., "blue ribbon" panels	Entities in this category produce evidence-based conclusions or recommendations at the request of the government or other entities to inform the development of public or organizational policy and practice. An example of an organization in this category is the U.S. Preventive Services Task Force.	These entities generally synthesize information from multiple sources and incorporate consensus processes, peer review, and measures to address bias and conflict of interest. These organizations typically do not engage in lobbying or advertising and maintain strict independence from funding organizations.
Professional associations or societies [b]	Organizations in this category exist to advance the interests of a given field through development of professional standards, supportive policies, and research, among other functions. Most have paying members. An example of an organization in this category is the American Public Health Association.	Many professional associations and societies engage in research or analysis that generally meets the standards for the creation, review, and presentation of scientific content. These organizations also tend to follow rigorous process to maintain transparency and accountability to their members and others in their field. However, many engage in advocacy or lobbying activities on behalf of member interests or mission-specific issues. Credibility assessments should ensure these activities are disclosed and kept separate from the presentation of relevant health information.
Advisory organizations or think tanks	Organizations in this category employ experts and researchers in order to comprehensively monitor and provide opinions and guidance on a given subject or group of subjects. Opinions and guidance are given in the form of media interviews, speeches, news articles, journal articles, books and reports, and beyond. Some may use consensus or peer review processes. An example of an organization in this category is the RAND Corporation.	Many of these organizations engage in research or analysis that generally meets the standards for the creation, review, and presentation of scientific content. However, many think tanks have political biases. Further, many employ scholars or experts who share personal opinions without content oversight from the organization. Credibility assessments should ensure these activities are disclosed and strive to separate ideological messages from relevant health information, as well as examine the knowledge generation processes of these organizations.

Health industry groups	Organizations in this category exist to advance the interest of a given health industry through development of standards, supportive policies, and research, among other functions. Most have paying members. An example of an organization in this category is the American Hospital Association.	Many health industry groups engage in research or analysis that generally meets the standards for the creation, review, and presentation of scientific content. However, many engage in advocacy or lobbying activities on behalf of member interests or mission-specific issues. Although health industry groups may be nonprofit, they represent for-profit interests. Credibility assessments should ensure these activities are disclosed and that profit motives are kept separate from the presentation of relevant health information.
Nongovernmental organizations (NGOs)	NGOs are mission-driven organizations that seek to advance social, political, or humanitarian goals domestically and globally. Many rely on donations. An example of an organization in this category is Partners in Health.	Some NGOs engage in advocacy or lobbying on behalf of mission-specific goals. Some seek to advance political or religious ideologies. Credibility assessments should ensure these activities are disclosed and kept separate from the presentation of relevant health information.
Foundations	Organizations in this category provide funding (through grants or gifts) and other forms of support for nonprofit organizations to advance common goals within the foundation's area of interest. An example of an organization in this category is the Robert Wood Johnson Foundation.	Foundations may fund and share research and analysis that generally meet the standards for the creation, review, and presentation of scientific content. These organizations usually require rigorous planning and evaluation of the projects they choose to support and generally provide some degree of public transparency in their investments. Foundations may incorporate ideological messages, which should be kept separate from the presentation of relevant health information.
Patient or disease advocacy groups	Organizations in this category exist to advance the interests of patients and their loved ones, generally or in relation to a specific disease or condition. They do so through raising awareness, investing in research, and providing direct support to patients and families, among other functions. Many rely on donations. An example of an organization in this category is the Cystic Fibrosis Foundation.	These organizations may fund and share research and analysis that generally meet the standards for the creation, review, and presentation of scientific content. However, many patient or disease groups engage in advocacy or lobbying activities. Credibility assessments should ensure these activities are disclosed and kept separate from the presentation of relevant health information.

Community health organizations	Organizations in this category exist to advance the health of a given community by raising awareness, fostering engagement, and connecting community members with resources, among other functions. In many cases, these groups focus on culturally competent communication and involve community members in planning and decision making. An example of an organization in this category is DC Health Matters.	Community health organizations may command a high degree of trust among their constituents and therefore serve as important sources of health information. However, there is tremendous variation among these organizations, requiring a high degree of granularity in credibility assessments.
News organizations	Nonprofit news organizations [c] include independent newspapers, magazines, websites, radio or audio networks, and more. An example of an organization in this category is National Public Radio.	News organizations generally use citations and date labels, post corrections and allow for public comment opportunities, exercise editorial independence from funders, and more. However, credibility assessments should keep in mind that many news organizations have political biases and may prioritize attention-grabbing stories over the objective presentation of science-based information.

[a] Observations in this column consider the authors' principles and credibility attributes in light of the general practices and characteristics of selected organization types.
[b] Note that some political advocacy groups have names similar to those of professional associations, such as the Association of American Physicians and Surgeons.
[c] Nonprofit news organizations are specified in accordance with the scope of this paper, described in section "Scope". However, for-profit news organizations (and other for-profit entities) are also influential sources of health information and can be difficult to distinguish from nonprofit sources. The credibility attributes and observations laid out in this paper may also be useful in assessing the credibility of for-profit news organizations, as well as other for-profit sources.

Although this paper does not provide guidance on principles or mechanisms for content assessment, the authors urge SMPs to invest in research and analysis to quickly build capacity in this area. Priority should be given to high-volume, highly influential sources of health information.

A particularly promising possibility for consideration by SMPs would be to outsource QA functions to an independent third party, either pre-existing or created for this purpose. This approach would bolster the objectivity and integrity of the process by reducing the role of SMPs, which are unavoidably conflicted by their financial and political stake in the performance of the system. To maximize independence and objectivity, this third party organization should not be solely funded by a single SMP.

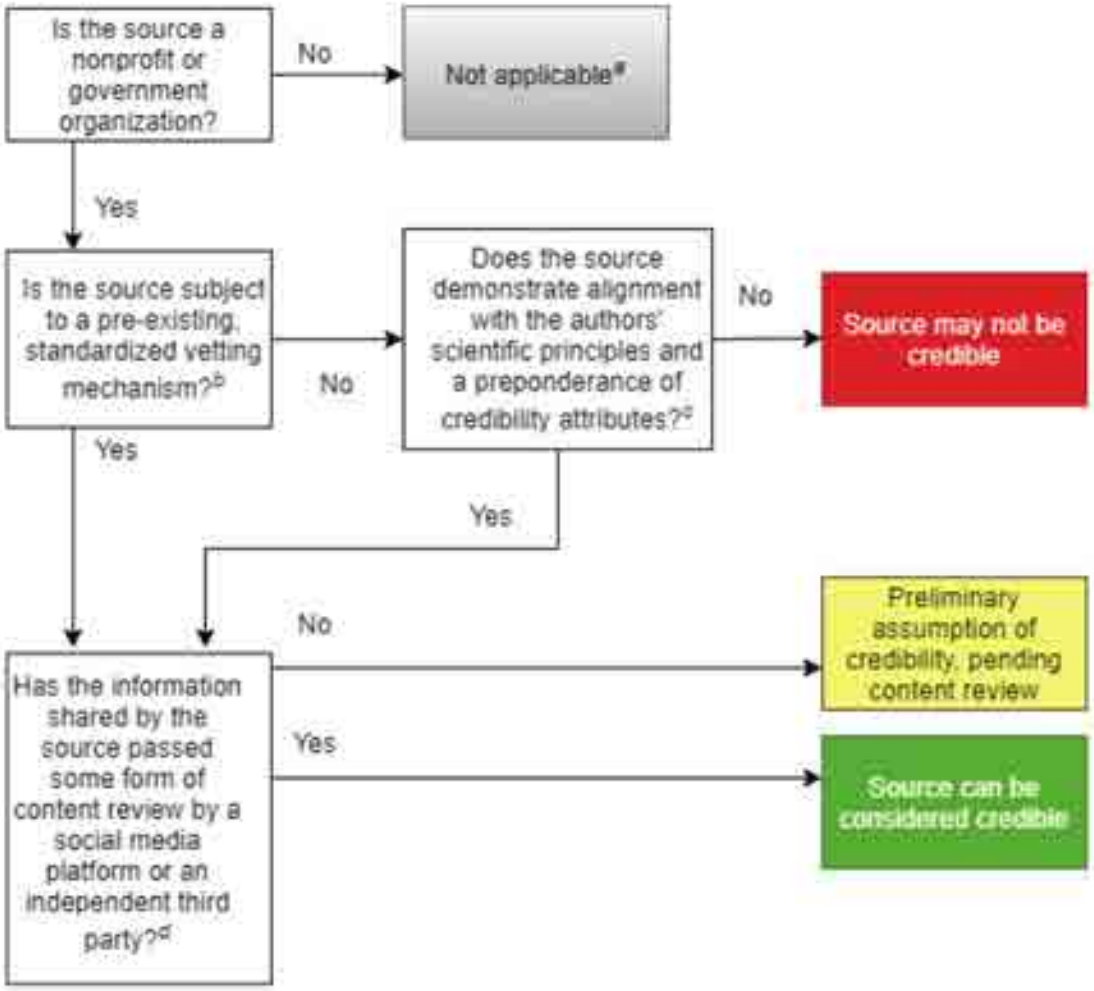
Identifying Credible Sources for Consumers

Given the preliminary nature of the approach described in this paper and lack of insight into the policies and capabilities of SMPs, the authors do not offer an opinion as to whether or how SMPs should "elevate" credible sources of health information (e.g., via an algorithm). However, when it comes to options for *identifying* such sources for consumers, the authors suggest that SMPs do not at this time affix a formal label such as "credible" or "non-credible." Instead, SMPs should provide contextual information that may serve as a "credibility cue" but stop short of a formal designation of credibility. For example, a platform could identify a source as an "Accredited Health Care Organization" and provide a link to a definition of that organization type, including general credibility observations such as those in *Table 1*. Of note, Twitter has taken a similar approach to identify

government- and state-affiliated accounts on its platform [30]. This method would also align with calls to preserve the right of individuals to make independent judgments about the information they are consuming (although it should be acknowledged that consumers' judgments are impacted by their degree of health and digital literacy, as described in the following).

Regardless of the specific approach to source identification, SMPs should be transparent with consumers about their policies as well as the principles and criteria that underlie them. Data collection and assessment, whether primary or secondary, as well as QA activities, should be performed at regular intervals (e.g., semi-annually) to ensure sources' ongoing alignment with the principles and attributes. Potentially, QA activities

FIGURE 1 | Assessment Flowchart for Credibility of Sources of Health Information in Social Media



[a] This chart is developed for credibility assessment of nonprofit and government organizations only. For-profit companies and individuals that serve as sources of health information should also undergo separate credibility assessment processes.
[b] Pre-existing, standardized vetting mechanisms that align with the authors' principles and attributes include accreditation, academic journal indexing, and government accountability rules. Even sources subject to one of these mechanisms should strive to meet the authors' stated credibility principles and attributes.
[c] See *Table 1* for a list of principles and credibility attributes.
[d] Ideally, a quality assurance system that includes content assessment should supplement assessment of source credibility.

could also incorporate consumer feedback. Sources that do not demonstrate ongoing adherence should lose any public signal of credibility, and that loss should be made visible to consumers. SMPs may have or could develop lists of sources that are known proponents of harmful information, and these should be made public for the benefit of consumers.

SMPs should also monitor the policies of peer social media companies, both to be aware of how their own content may be repackaged on other platforms (i.e., perhaps stripped of important contextual information) and to learn, share, and reach alignment on approaches to common challenges.

Parallel Strategies to Supplement Source Assessment

SMPs' approaches to source assessment should continue to be refined and improved, and, importantly, should be supplemented by other strategies (as called for in public comments; see *Box 2*).

Content Assessment

Once again, although a reasonable starting point, evaluation of source credibility alone is not an adequate tool to ensure social media users' access to high-quality health information. SMPs must supplement source assessment strategies with an equally robust system for content evaluation. In the interim, SMPs should clearly explain the limitations of source credibility to consumers (i.e., a source deemed credible is *likely* to share high-quality information, but not guaranteed). Ultimately, source credibility and information quality should be integrated under a single, streamlined assessment system to maximize clarity and usability for both sources and consumers.

Management of Misinformation

The elevation of credible sources of health information, while an important contribution, is not enough on its own to counteract the harms of misinformation and disinformation. SMPs should maintain parallel strategies to address such false and inaccurate information, as well as sources that deliberately promulgate such information. Admittedly, management of misinformation is a highly complex challenge, both politically and legally, making the elevation of credible sources and high-quality information a potentially more feasible priority.

As noted previously, the state of science and knowledge is always evolving, and information that was once consistent with the best available evidence at the time can quickly become outdated. Credible sources can avoid the perception of misinformation by using clear date labels and striving to update content regularly.

Health Literacy, Culturally Competent Communication, and Community Relationships

Regardless of the eventual system for elevating credible sources and high-quality information, consumers will still make their own judgments about which sources and information to trust. In fact, one of the major themes from the public comment period, summarized in *Box 2*, was that SMPs must protect freedom of speech and the autonomy of users in accessing the information that they choose.

Users seeking health information may not be satisfied with an SMP's assessment of source credibility or information quality. As explained by Lisa Fitzpatrick, founder and CEO of the Washington, DC-based community organization Grapevine Health, people are resourceful and often consult many sources, both online and offline, before reaching a conclusion [31]. Resourcefulness is an asset if people are empowered and provided with ready access to high-quality health information. Although many people have a high degree of health literacy, a large-scale effort is needed to ensure that resources are in place to support and educate *all* people to become savvy, informed, and science-literate users of social media. This concept is an important aspect of information equity [i] (across literacy levels, preferred languages, location/locality, etc.)—and, by extension, health equity.

Therefore, SMPs should invest in evidence-based health literacy and consumer education strategies to support the success of their in-house approaches to elevating credible sources and high-quality information. Such strategies could be designed and executed by the platforms themselves, but a better approach may be to delegate to independent third parties.

Consumers' evaluation of the credibility of online information goes beyond source and content characteristics to considerations of design, or the way information is presented [3]. A source's credibility is of little relevance if it fails to connect with its audience. As an illustration, Fitzpatrick shared a quote from a community member: "I don't understand what doctors are saying, and if I don't understand you, I can't trust you" [31]. Several of the public comments the authors received echoed this point, noting that credible sources may not always present information in a manner that is appealing, engaging, or culturally competent.

"Cultural competence" refers to the ability to interact effectively with diverse audiences by recognizing and responding to variations in social, cultural, and linguis-

tic needs [32]. Diversity should be considered across multiple dimensions, including but not limited to, race/ethnicity, education level, socioeconomic status, age, and political affiliation. Political affiliation may be particularly relevant to this discussion, as there is a 22 percent difference between Republicans who express a great deal of confidence in medical scientists (31 percent) and Democrats (53 percent) [33]. Republicans are also less approving of SMPs' efforts with regard to content moderation, making it important to engage with bipartisan opinions in the design of policies such as those discussed in this paper [34].

Organizations that strive to be credible sources of health information should invest in strategies to improve their communication skills by using language and images that are informed by cultural contexts as well as understandable and engaging (at the same time, however, they must share complete and precise information and avoid oversimplification) [j]. They should also seek to build authentic, collaborative relationships at the community level. These efforts may help to foster consumers' trust— which is all the more important as communication challenges during the COVID-19 pandemic may have impacted the perceived credibility of public health authorities in the United States [35].

As with efforts to advance health literacy and consumer education, SMPs should consider financial support for such endeavors to promote competent communication by credible sources on their platforms. Social scientists in the fields of science, risk, and health communication would make productive partners for SMPs in this work.

Source Self-Regulation and Consumer Evaluation

Rather than waiting for evaluation by SMPs, sources of health information that wish to be considered credible should take proactive steps to apply science-based, objective, and transparent and accountable principles to their institutional practices and presentation of information. The principles and attributes set forth in this paper may provide a useful starting point, as well as other resources (including those described in *Box 3* and *Appendix A*). By making these efforts transparent and highly visible to the public and their peers, organizations can begin to build a self-sustaining, cultural "norm" for credibility that may ultimately increase the quantity of high-quality information in social media and have a cascading effect on the quality of information both online and offline.

A transparent set of principles used by sources to assert their own credibility would also support consumers' independent judgments, as called for in the public comments that informed this paper. Consumer evaluation can supplement the efforts of SMPs to identify and elevate credible sources and high-quality information, as well as ensure accountability when sources fail to adhere to standards they set for themselves. However, there are several major limitations to the application of consumer evaluation in this context.

First, as noted previously, consumers have differing levels of health and digital literacy, which impacts their ability to assess the credibility of a source or the quality of a piece of information. This is why SMPs whose goal is to increase access to high-quality information should support efforts to advance health literacy. Second, consumer opinion is often captured through measurements of source or content popularity, comments, and recommendations, among other means [3]. Such elements can be easily "hijacked" by entities whose goal is to spread misinformation or disinformation, as has been seen in anti-vaccination disinformation campaigners' use of "bots" and "trolls" to amplify their reach and engagement on Twitter [37]. Finally, as noted in *Box 4*, the interplay between consumer trust and credibility is complex and may be difficult to parse in consumer feedback. Nevertheless, consumer feedback is an important consideration, including in the design of source and content evaluation policies.

Ethical and Public Health Considerations

In an effort to ensure that the guidance in this paper increases access to high-quality health information, thereby promoting health, and minimizes harm, the authors have also outlined ethical and public health considerations for the approach described herein.

Ethical Considerations

Control of Information

Control of information emerged as a key concern during the public comment period. SMPs' efforts to increase access to high-quality information (by elevating credible sources) may be perceived as censorship or an attempt to limit the autonomy of information consumers (see *Box 2*). Platforms should strive to engage consumers in the design and evaluation of such strategies and maintain public transparency around policies and actions taken. Policies should balance the need to minimize the harm that could occur through propagation of health misinformation (as seen during the COVID-19 pandemic [7]) with the right of the consumer to undertake a personal evaluation and judgment.

Structural Bias

BIPOC have historically been underrepresented in many institutions that enjoy a reputation for credibility today. For example, racial segregation persisted in U.S. universities until the latter half of the 20th century, and more insidious forms of prejudice endure to this day [37]. BIPOC researchers and their research insights are underrepresented in clinical and biomedical fields and are less likely to receive federal funding than their White counterparts [38]. According to 2020 data from the U.S. Office of Personnel Management, Black and other people of color made up 38 percent of the federal workforce but only 22 percent of Senior Executive Service positions [39]. This historic and ongoing underrepresentation of BIPOC and others in positions of influence in academia, science, health care, and government means information shared by these institutions may not always reflect the experiences of or resonate with these groups— thereby perpetuating underrepresentation and information inequity.

To counter this bias and increase equity and representation, SMPs should make a concerted effort to identify and promote sources that are not only credible but also trusted and utilized by diverse audiences, including BIPOC and other groups, such as new immigrants, LGBTQIA+ individuals, religious minorities, and people with disabilities. SMPs should assess consumer data to identify sources that are heavily utilized by marginalized groups and prioritize them for credibility evaluation and potential elevation. Partnerships with groups that represent the rights and health of such groups will be essential to the success of this effort.

Financial Conflict

A system that elevates credible sources of health information may create a new "credibility brand" that is profitable for both sources and SMPs themselves. As set forth in the authors' principles and criteria, credible sources should take steps to ensure that financial and ideological interests do not compromise the presentation of science-based health information. However, financial gain and enhanced influence may be unavoidable collateral effects of designation as a credible source in social media channels.

SMPs should support research to understand the impact of credibility designations on the quality of information shared by sources, on sources' level of influence both inside and outside social media, and on sources' financial status. Advertisements should not be attached to high-quality health information shared through SMPs, both to minimize financial conflicts of interest and to avoid compromising the quality and accessibility of the information (e.g., with distracting and potentially misleading ads).

To uphold their integrity, SMPs should separate their own profit motives as much as possible from efforts to elevate credible sources of health information. One way to achieve this would be for platforms to work with independent third parties to design and implement source and content evaluation and moderation strategies.

Feasibility and Appropriateness of SMPs' Role

This paper has made significant asks of SMPs beyond the initial task of identifying and elevating credible sources of health information. In addition to a quality assurance system for source evaluation, these include parallel strategies for content assessment and misinformation management, as well as collaborative efforts to promote equity and support public health research. Such activities will require a considerable investment of time and resources, and SMPs do not necessarily have a financial incentive to make this investment [41]. Some argue that platforms are actually disincentivized from interventions that could dampen profits driven by advertising and high rates of engagement with misinformation [42]. However, SMPs' engagement in highly visible social responsibility efforts, as well as an enhanced corpus of credible sources that are trusted and relied on by consumers, may prove financially and politically beneficial.

The complexity of SMPs' interests merits careful consideration of their role as moderators of health and other crucial public information. Although the authors believe that SMPs should take a proactive role across several dimensions, as outlined in this paper, government regulation and delegation to independent third parties should also be considered as potential supplementary approaches.

Public Health Considerations

Health Equity

A system to elevate credible sources—and thereby increase access to high-quality health information—must be designed to support health equity, as well as information equity, and not cement existing inequities. Diversity and inclusion are important components of a system that promotes health equity. As noted previously in the "Structural Bias" section, efforts to eliminate racial bias and foster diverse representation among credible sources of health information are important to avoid perpetuating health inequities.

Older people, adolescents, people with lower education and income levels, and racial and ethnic minority groups are more likely to face challenges related to limited health literacy [43]. Therefore, efforts to foster health literacy, engage in culturally competent communication, and build and sustain community relationships and trusted networks—as called for by the authors as a supplemental strategy to elevating credible sources—are supportive of health equity. SMPs should be sure to use accessible language when defining and explaining policies related to credible sources of information. SMPs should also consider digital literacy and strategies to address equity in access to high-quality digital information—a challenge referred to as the "digital divide."

The digital divide is defined as "disparities in technology access and use [that have] compounding effects on existing inequities along income, educational, racial, and geographic dimensions" [44]. Although approximately three-quarters of Americans have access to high-speed broadband internet at home, rates vary significantly by education level and income. In 2019, only 46 percent of people with less than a high school education had broadband, compared with 93 percent of college graduates. In 2021, the rates were 57 percent for people making less than $30,000 annually and 92 percent for people making more than $75,000. Disparities by race and ethnicity are less dramatic but still significant: 80, 71, and 65 percent for white, Black, and Hispanic people, respectively, in 2021 [44]. Despite this, Black and Hispanic people are more deeply engaged in social media than whites across some dimensions [45].

The digital divide is an important consideration for SMPs as well as other platforms that facilitate the sharing of health information. If efforts to increase access to high-quality health information disproportionately benefit highly educated, wealthy, and white people, then they are cementing health and information inequities.

Contribution to Public Health Research

SMPs can be important partners in improving public health, but only if they agree to share data (e.g. back-end data, algorithms and use engagement metrics, content moderation processes) with researchers. This paper provides guidance that is intended to increase access to high-quality health information and thereby promote individual and population health. However, SMPs alone have access to data that could form the basis of important health and behavioral research about how policies such as those discussed herein would actually affect the consumption of high-quality health information, as well as whether enhanced access to such information would favorably impact offline outcomes.

In addition to sharing such data as outlined previously, SMPs should be transparent about the methods they use to promote consumption of high-quality health information (e.g., through algorithmic recommendations), as well as the full scope of their policies and processes with regard to health information of any quality. As noted earlier, health misinformation and disinformation spread through social media can negatively impact health outcomes, and SMPs should take responsibility for and develop solutions to mitigate elements of their systems that enable such information to flourish.

SMPs' reluctance or failure to share such data and moderation methods would prevent fully productive collaborations with the public health and behavioral science communities. To be considered credible themselves, platforms should make a public and highly visible commitment to transparency and accountability, especially with regard to data, policies and methods that could impact public health.

Conclusion

Increasing access to high-quality health information in social media is a complex challenge that requires navigating tremendous volume and variation among sources and information; the continuous evolution of science and knowledge; and significant ethical quandaries—chief among them, the need to protect free speech and consumers' right to autonomy while minimizing the risk of harm from misinformation. To date, attempts at social media content moderation have been met with controversy and calls for federal regulation from both sides of the aisle [47]. Nevertheless, the potential influence of health information shared through social media on health outcomes, at both an individual and population level, compels action, even with the knowledge that such action will be incomplete at first.

This paper has presented guidance that could be leveraged by SMPs in identifying credible sources of health information—an incremental step toward the goal of enhancing access to high-quality health information. Although the scope of this discussion has been limited to U.S.-based nonprofit or government sources only, it is likely that many of the principles, attributes, and considerations can be applied to for-profit sources or individuals, as well as sources outside the United States. Efforts to fully assess the credibility of these

sources, many of which are highly influential, should be an urgent priority for SMPs.

However, source evaluation is not a comprehensive solution. Several parallel strategies are required to ensure information quality and combat the risks of health misinformation, as detailed earlier. Foremost among these is a strategy to assess information quality and develop content moderation plans in response. The authors acknowledge the infeasibility of evaluating the accuracy and balance of every piece of health information on social media. However, a system of "spot checks" for quality and integrity, supported by machine learning technology but supplemented by expert human evaluation, is within reach. SMPs should invest in developing principles, guidelines, and applications for content assessment alongside strategies for source evaluation. Ultimately, the two approaches should be consolidated in a single system for the identification and elevation of high-quality health information. As previously noted, SMPs' efforts in these areas should be supplemented by government regulation or delegation to independent third parties.

SMPs cannot, and should not, tackle this challenge alone. As those ultimately impacted by social media source or content curation strategies, consumers must be engaged in developing such strategies. Public engagement is also essential to promote transparency, foster trust, and minimize perceptions of censorship or paternalism. Organizations that use social media to share information have an important role as well, and should hold themselves publicly accountable to a set of principles that supports the quality of the information they share, as well as their own institutional credibility. Together, the actions taken by consumers, organizations, and SMPs can move toward greater availability and accessibility of high-quality health information.

Finally, consumers and organizations that utilize social media deserve to understand the mechanics and the outcomes of policies that affect the information they receive and share. Therefore, SMPs should make their source and content moderation practices (e.g., algorithms) and relevant data accessible to independent behavioral and public health researchers to analyze the effects on information consumption as well as offline behaviors. Without such information, consumers and organizations that collaborate with SMPs will have no way of knowing whether policies are justified or effective. To be effective partners in improving health, SMPs must make a firm commitment to transparency and accountability.

Notes

a] Social media platforms are for-profit companies that allow people and organizations to create profiles, interact with other users, share information, form groups or networks, and promote businesses or causes through various means.

[b] Facebook owns Instagram and Whatsapp (see https://about.facebook.com/company-info). YouTube is owned by Alphabet Inc., the parent company of Google (see https://abc.xyz).

[c] For an overview of the NAM project, see https://nam.edu/programs/principles-for-defining-and-verifying-the-authority-of-online-providers-of-health-information. YouTube provided funding totaling $100,000 to offset the NAM's operational expenses in facilitating the project. Karen DeSalvo, Chief Health Officer, Google Health, is an NAM member and serves on the NAM's governing Council (YouTube is owned by Alphabet Inc., the parent company for Google). Garth Graham, Director and Global Head of Healthcare and Public Health Partnerships, is an NAM member (see https://blog.youtube/news-and-events/new-health-content-coming-youtube).

[d] The NAM has a presence on Facebook, Instagram, Linkedin, Twitter, and YouTube.

[e] McCabe Message Partners, Washington, DC.

[f] It should be noted that freedom of speech has some limitations, including what is known as the "true threat" doctrine, which prohibits speech that constitutes a "clear and present danger," such as the famous example of "shouting fire in a theater." See https://fas.org/sgp/crs/misc/95-815.pdf.

[g] See http://www.icmje.org/about-icmje. The current members of the ICMJE are Annals of Internal Medicine, British Medical Journal, Bulletin of the World Health Organization, Deutsches Ärzteblatt (German Medical Journal), Ethiopian Journal of Health Sciences, JAMA (Journal of the American Medical Association), Journal of Korean Medical Science, New England Journal of Medicine, New Zealand Medical Journal, The Lancet, Revista Médica de Chile (Medical Journal of Chile), Ugeskrift for Laeger (Danish Medical Journal), the U.S. National Library of Medicine, and the World Association of Medical Editors.

[h] Proper disclosure of conflicts of interest relies on the integrity of authors and cannot be fully enforced by journals.

[i] Information equity refers to equity of people's access to information (e.g., through internet access) as well as the ability to understand and use that information to their benefit.

[j] For principles for making health information "understandable, useful, and navigable," see https://nam.edu/perspectives-2014-health-literacy-principles-guidance-for-making-information-understandable-useful-and-navigable.

APPENDIX A
Models for Assessment of Source Credibility

National Library of Medicine

The National Library of Medicine (NLM) has developed at least three major source evaluation systems that provide useful examples for the task at hand: MEDLINE indexing, MedlinePlus indexing, and the Disaster Lit database.

MEDLINE Journal Selection

The National Library of Medicine (NLM), the world's largest medical library, uses stringent criteria to determine whether a journal should be included in MEDLINE, NLM's premier bibliographic database. MEDLINE is the primary component of PubMed, a freely accessible online literature database developed and maintained by the NLM National Center for Biotechnology Information (NCBI), with new citations added daily.

In considering whether a journal merits inclusion in MEDLINE, NLM considers "the scientific and editorial character and quality of a journal". Several factors are used in making this decision, including the scientific policy set by the NLM Board of Regents [1], the suitability of the journal for the NLM Collection, and the recommendations of an NIH Federal Advisory Committee, the Literature Selection Technical Review Committee (LSTRC) [2].

The LSTRC evaluates journals for MEDLINE based on 5 critical elements, including scope and coverage, editorial processes, scientific rigor/methodological rigor, production and administration, and impact (more detail on all characteristics can be found at https://www.nlm.nih.gov/medline/medline_journal_selection.html [3]).

By using such clear and detailed guidelines for their journal selection process, NLM's goal with MEDLINE is to demonstrate a high level of scientific rigor while reflecting sufficient geographic heterogeneity.

MEDLINEPlus

MedlinePlus is another resource created and curated by the NLM. Unlike MEDLINE, which is primarily used by researchers and professionals, MedlinePlus is a health information website for patients, their families and friends, and the general public. MedlinePlus aggregates health information from a variety of sources. "Some pages, like the medical encyclopedia and drug information, are licensed from outside sources. Other pages, like health topic pages, medical tests, and genetic pages, are created specifically for MedlinePlus" [4].

Information on MedlinePlus is reviewed and updated according to guidelines developed for each type of page. Health topics are "updated as new information becomes available, and broken links are checked and fixed daily" [4]. Medical tests are reviewed at least every 3 years, although content is also updated as needed between review cycles. Genetics pages are reviewed by experts in the field before being posted to MedlinePlus and with each substantial revision thereafter, and patient support and advocacy groups provide feedback on select content. MedlinePlus also adds new and updated articles and illustrations to the A.D.A.M. Medical Encyclopedia each month, and an A.D.A.M. Editorial Policy ensures that included content presents evidence-based health information.

In determining whether to link to a nongovernment website, MedlinePlus staff considers a range of criteria related to the website's content, advertising, availability and maintenance, and user privacy. In examining a resource's content, these criteria include:

- The website offers a description of the organization, including a mission statement that aligns with MedlinePlus's aim to provide accurate health information to patients and their families and friends.
- "The organization provides accurate, science-based information that complements or enhances the health information found on MedlinePlus.
- The source of the content is trustworthy and transparent.
- The primary purpose of the website is educational, and the information is unbiased.
- The information provided is easy to understand, easy to navigate, and well organized.
- The website has original content.
- The website links only to reliable sources that meet MedlinePlus guidelines for links or other clearly stated guidelines established by the website" [5].

In addition to such content considerations, MedlinePlus gives preference to pages with no advertising. If the website has advertising, it must display an advertising policy that clearly separates educational content from advertising or sponsorship. MedlinePlus will not link to web resources that present content suggesting that Medline Plus endorses certain commercial products or services. For a resource to be linked on MedlinePlus, the website must also be consistently available, include contact information for customer support, and provide current information. Furthermore, websites must not require users to register, become a member of the organization, or pay a fee to view health information. Finally, MedlinePlus criteria specify that if a website collects personal information, it must clearly display "a privacy policy that explains how information collected from users remains private and confidential. If a website displays advertising, it should prevent advertisers and sponsors from collecting any personally identifiable information from users" [5].

In addition to these criteria for resources linked to MedlinePlus, for all the pages on MedlinePlus, a "page last reviewed" date is available near the bottom of the page to indicate "when the entire topic was reviewed and updated while a "page last updated" date indicates when any information was added to or removed from the health topic page" [5]. These additional indicators allow users to verify the currency of the content they are consuming.

The CRAP Test

Molly Beestrum, education and curriculum coordinator at Northwestern University's Galter Health Sciences Library & Learning Center, developed a system known as the CRAP Test that can be used in deciding whether a website is a credible, valid source. The CRAP Test considers four major website attributes: currency, reliability, authority, and purpose. To apply Beestrum's test, Colorado Community Colleges Online suggests asking the following questions:

"Currency

- How recent is the information?
- How recently has the website been updated?
- Is it current enough for your topic?

Reliability

- What kind of information is included in the resource?
- Is content of the resource primarily opinion? Is it balanced?
- Does the creator provide references or sources for data or quotations?

Authority

- Who is the creator or author?
- What are the credentials? Can you find any information about the author's background?
- Who is the publisher or sponsor?
- Are they reputable?
- What is the publisher's interest (if any) in this information?
- Are there advertisements on the website? If so, are they clearly marked?

Purpose

- Is this fact or opinion? Does the author list sources or cite references?
- Is it biased? Does the author seem to be trying to push an agenda or particular side?
- Is the creator/author trying to sell you something? If so, is it clearly stated?" [6]

Clinical Practice Guidelines We Can Trust

The 2011 Institute of Medicine (IOM) study *Clinical Practice Guidelines We Can Trust* is another resource that may provide useful insights into the determination process for high-quality health information in social media [7]. Clinical practice guidelines (CPGs) help to reduce the level of uncertainty in clinical practice by establishing standards of care backed by strong scientific evidence. These standards "are informed by a systematic review of

evidence and assessment of the benefits and costs of alternative care options" [7]. However, many different sets of CPGs have been developed and employed, to varying degrees of success. With nearly 27,000 guidelines in the National Guideline Clearinghouse (NGC) and numerous additional commercial guidelines, it can be challenging to "identify guidelines based on high-quality development methods. Although the NGC provides a standardized summary of each CPG posting, describing its development methodology and evidence base and providing a link to the full guideline, the NGC makes no quality judgment" [7]. As a result, it can be difficult for stakeholders to be confident of CPG quality.

To combat this issue, *Clinical Practice Guidelines We Can Trust* proposed eight standards for developing trustworthy CPG and called for the development of a mechanism to identify guidelines that meet these standards. These standards include: "emphasizing transparency; management of conflict of interest; systematic review—guideline development intersection; establishing evidence foundations for and rating strength of guideline recommendations; articulation of recommendations; external review; and updating" [7]. The report identifies three options in determining whether a CPG meets these standards: "1) identifying each guideline to see if it meets the specified standards; 2) certifying organizations producing guidelines that comply with quality standards; or 3) acknowledging standards compliance for each guideline production process prior to development of the guideline" [7].

Due to the large number of CPGs, the report suggests certification of organizations with trustworthy CPG development procedures rather than identification of individual trustworthy CPGs or identification of the development process for each CPG. This type of evaluation would entail "reviewing the procedures that applicant organizations use to produce various types of guidance, providing an identifiable mark to be placed on future CPGs of those organizations meeting accreditation requirements, and agreeing to maintain the approved processes during a 3-year accreditation period" [7]. This certification process "would not endorse particular drugs or treatment options for medical conditions or make clinical decisions about the guidelines it reviews" [7]. Instead, it would merely certify the organization's guideline development process and identify the resulting CPGs as trustworthy.

Health on the Net Foundation Certification

The Health on the Net Foundation (HON) is an international nonprofit organization based in Switzerland. The HON Code of Conduct (HONcode) was created to help standardize the reliability of medical and health information available online by defining a set of rules to hold website developers accountable to basic ethical standards in the presentation of information. This voluntary certification system is based on an "active seal" concept that helps users identify sources of reliable information.

To be certified by HON, a website must formally apply for registration. If accepted, the site must comply with all eight principles enumerated in the HONcode:

1. "Authoritative: Any medical or health advice provided and hosted on this site will only be given by medically trained and qualified professionals unless a clear statement is made that a piece of advice offered is from a non-medically qualified individual or organization.
2. Complementarity: The information provided on this site is designed to support, not replace, the relationship that exists between a patient/site visitor and his/her existing physician.
3. Privacy: Confidentiality of data relating to individual patients and visitors to a medical/health Website, including their identity, is respected by this Website. The Website owners undertake to honor or exceed the legal requirements of medical/health information privacy that apply in the country and state where the Website and mirror sites are located.
4. Attribution: Where appropriate, information contained on this site will be supported by clear references to source data and, where possible, have specific HTML links to those data. The date when a clinical page was last modified will be clearly displayed (e.g., at the bottom of the page).
5. Justifiability: Any claims relating to the benefits/performance of a specific treatment, commercial product, or service will be supported by appropriate, balanced evidence in the manner outlined previously in Principle 4.
6. Transparency: The designers of this Website will seek to provide information in the clearest possible manner and provide contact addresses for visitors that seek further information or support. The webmaster will display his/her E-mail address clearly throughout the Website.

7. Financial disclosure: Support for this Website will be clearly identified, including the identities of commercial and non-commercial organizations that have contributed funding, services, or material for the site.
8. Advertising policy: If advertising is a source of funding, it will be clearly stated. A brief description of the advertising policy adopted by the Website owners will be displayed on the site. Advertising and other promotional material will be presented to viewers in a manner and context that facilitates differentiation between it and the original material created by the institution operating the site" [8].

To determine whether a site adheres to these standards, sites requesting certification complete an interactive, online questionnaire that tells them what they must add or modify to conform to the HONcode principles. Then an HON team member inspects the site to verify compliance. Once a site has been verified, it identifies itself with the blue and red HONcode hyperlink (or "active") seal displayed in a prominent location, usually at the bottom of the homepage. Subscribing sites are subject to unannounced checks by HON to ensure continued compliance, and HON also relies on user reports to maintain website reliability.

URAC Health Content Provider and Health Website Certification

URAC provides health care organizations with evidence-based accreditation programs, including health content provider and health website certification. URAC accreditation involves a five-phase, voluntary process that requires reaccreditation every 3 years and is designed to facilitate continuous quality improvement. In the first phase, applicants provide URAC with standard information about their organization as well as specific information related to the type of certification being sought. In the second phase, a lead reviewer evaluates the submitted documents to determine whether they comply with URAC's standards. During this step, the lead reviewer may provide recommendations to the applicant on how to revise an application to conform to URAC's policies. The third phase involves an on-site validation review to ensure that the organization is following the standards in practice. In the fourth step, the URAC review team presents an anonymous report to a voluntary accreditation committee. This team of health experts is familiar with URAC standards and determines whether an organization receives full or partial accreditation. The final phase of the accreditation process includes ongoing monitoring such as random surveillance and required reporting of quality measures.

In all certification programs, URAC employs these five phases to focus on risk management, operations infrastructure, performance monitoring and improvement, and consumer protection and empowerment. Certification-specific standards are then designed to further support these goals. For instance, the" Health Content Provider accreditation process examines key areas such as disclosures, health content and service delivery, quality oversight committee, policies and procedures, health content and personal health management, and accountability" [9]. In contrast, considerations that factor into earning a Health Website Accreditation include privacy and security, health content editorial processes, disclosure of financial relationships, website linking policies, and consumer complaint processes.

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APPENDIX B

TABLE B-1: Types, Definitions, and Accreditors of Nonprofit Accredited Organizations That May Serve as Sources of Health Information in the United States and What Accreditation Signifies

Organization Type	Definition	Accreditors
EDUCATIONAL INSTITUTIONS		
What Accreditation Signifies for Organizations in This Category: Educational institutions that earn accreditation have chosen to participate in a voluntary, rigorous process to demonstrate their performance against standards for integrity and continuous improvement; academic excellence; a high level of leadership and employee performance; the well-being of students and patients (as applicable); and appropriate conduct of research.		
Schools of medicine	A medical school is a postgraduate educational institution, generally attached to a larger university system, that awards professional degrees to physicians.	• Accreditation Council for Continuing Medical Education • Accreditation Council for Graduate Medical Education • Commission on Osteopathic College Accreditation • Council on Podiatric Medical Education • Liaison Committee on Medical Education
Schools of nursing	Schools of nursing are undergraduate and postgraduate educational institutions, generally connected to a larger university system, that confer a range of professional or academic nursing degrees—including BSN, MSN, PhD, DNP, and others—as well as continuing education for practicing nurses.	• Accreditation Commission for Education in Nursing, Inc. • Accreditation Commission for Midwifery Education • Commission on Collegiate Nursing Education • Council on Accreditation of Nurse Anesthesia Educational Programs • National League for Nursing Commission for Nursing Education Accreditation
Schools of public health	Schools of public health are undergraduate and postgraduate educational institutions, generally connected to a larger university system, that confer bachelors, masters-, or doctoral-level academic degrees in public health.	• Council on Education for Public Health
Schools of dentistry	Schools of dentistry are postgraduate educational institutions that award degrees to dental professionals.	• Commission on Dental Accreditation
Schools of pharmacy	Schools of pharmacy are postgraduate educational institutions that award degrees to pharmacy professionals.	• Accreditation Council for Pharmacy Education

Universities	Universities are undergraduate and postgraduate educational institutions that confer academic degrees. Departments or schools of biomedical science, health policy, social science, and others may serve as sources of health information.	• Association for the Accreditation of Human Research Protection Programs • Higher Learning Commission • Middle States Commission on Higher Education • New England Association of Schools and Colleges Commission on Institutions of Higher Education • Northwest Commission on Colleges and Universities • Southern Association of Colleges and Schools Commission on Colleges • WASC Senior College and University Commission
HEALTH CARE ORGANIZATIONS		
What Accreditation Signifies for Organizations in This Category: Health care organizations that earn accreditation have chosen to participate in a voluntary, rigorous process to demonstrate their performance against standards for patient safety, high-quality care, and continuous improvement processes.		
Ambulatory care providers	Ambulatory care is care provided in outpatient settings. Types of ambulatory care organizations include behavioral health centers, birthing centers, dental offices, dialysis centers, medical offices, occupational health centers, outpatient surgical centers, pain management centers, podiatry centers, radiation oncology practices, student health clinics, urgent care practices, women's health clinics, and more. Ambulatory care covers Federally Qualified Health Centers (which include Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing) [b]. This category also includes Indian Health Service (HIS) and U.S. military and veterans ambulatory health care organizations.	• Accreditation Association for Ambulatory Health Care (AAAHC) [a] • Accreditation Commission for Health Care (ACHC) [a] • The Compliance Team [a] • Commission for the Accreditation of Birth Centers • Community Health Accreditation Partner (CHAP) [a] • Health Facilities Accreditation Program (HFAP) [a] • The Joint Commission (TJC) [a] • National Dialysis Accreditation Commission [a]

Hospitals	A hospital is a health care institution that provides primarily inpatient services including medical, surgical, or psychiatric treatment [c]. Types of hospitals include academic medical centers, acute care and long-term care hospitals, critical access hospitals, and rehabilitation facilities. There are also a wide variety of specialty hospitals, including cancer, stroke, and cardiac centers; children's hospitals; psychiatric hospitals; women's hospitals; and more. This category also includes Indian Health Service (HIS) and U.S. military and veterans hospitals.	• Center for Improvement in Healthcare Quality [a] • Commission on Accreditation of Rehabilitation Facilities [a] • DNV GL Healthcare [a] • HFAP • TJC
Home-based health care providers	A home-based health care provider offers services for illness or injury in a patient's home, including wound care, medication administration and management, nutrition counseling, and more. Home-based health care also includes hospice [c] and palliative care.	• ACHC • CHAP • Joint Commission
NONPROFIT HEALTH PLANS		
What Accreditation Signifies for Organizations in This Category: Health plans that earn accreditation have chosen to participate in a voluntary, rigorous process to demonstrate their performance against standards for quality improvement, management, credentialing, and member services and communication, among others.		
Nonprofit health plans	Nonprofit health plans provide coverage (insurance) for health and medical expenses and often provide preventive health services.	• National Committee for Quality Assurance • URAC
PUBLIC HEALTH DEPARTMENTS [e]		
What Accreditation Signifies for Organizations in This Category: Public health departments that earn accreditation have chosen to participate in a voluntary, rigorous process to demonstrate their performance against standards for ability to carry out the 10 Essential Public Health Services[f], effective department management, and effective communication with the governing entity (e.g., the state).		
Public health departments (state, tribal, local, territorial, and Army installation)	Public health departments provide services including disease and injury prevention, infectious disease response, and public education and health promotion.	• Public Health Accreditation Board

NOTES: [a] CMS deeming authority

[b] See https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

[c] See https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf.

[d] Hospice care can also be provided in inpatient settings

[e] Federal health plans and public health departments are also government organizations, which are subject to additional transparency and accountability rules

[f] See https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

APPENDIX C

Questionnaire Used to Collect Public Comments on the "Preliminary Discussion Document" for the National Academy of Medicine Project on "Principles for Defining & Verifying the Authority of Online Providers of Health Information"

Background

In order to enhance the accessibility of trustworthy health information on its platform, YouTube asked the National Academy of Medicine (NAM) to identify preliminary definitions of "authoritative" sources of health information and the criteria by which these sources derive and maintain their authority. The NAM project will also outline ethical and public health considerations for large-scale content curation strategies.

An expert advisory group will gather information and deliberate in order to author a peer-reviewed discussion paper for publication in *NAM Perspectives* in summer 2021. Papers published in NAM Perspectives are individually authored and do not reflect consensus positions of the NAM, the National Academies, or the authors' organizations. See project webpage >>

YouTube has informed the NAM that outcomes from this project will help to inform YouTube's identification and raising of "authoritative" sources of health information, but will not disadvantage sources that do not meet the requirements of specific authoritative source categories. Further, the NAM understands that YouTube will identify and characterize such "authoritative" sources in order to provide context for users but will not confer a formal designation of authority or trustworthiness at the source level. The project will also generate principles that may be of use to online platforms other than YouTube.

Public Discussion Document

To inform the project, the NAM is seeking feedback on a public discussion document containing preliminary principles and questions. The public comment period will last from 12 pm ET on April 5, 2021, until 11:59 pm ET on April 9, 2021.

An anonymized synthesis of feedback received through this process will be posted on the project webpage after the comment period closes. The NAM reserves the right to disregard feedback it considers to be off topic or inappropriate.

Download the discussion document here >>

To leave a comment, please complete the form below.

First and last name of commenter:*

Email address of commenter:*

If you are commenting on behalf of an organization, please enter the organization name here:

One-sentence summary of your comments:*

Complete comments:*

Would you like to receive email updates about this project?*

[ ] Yes
[ ] No

* = *Question is required*

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None to disclose.

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HAVE A NEWS TIP OR COMMENT?

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From: CyberScoop <news@cyberscoop.com>

To: Murthy, Vivek (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=79d446b2c25f4539a0c04237a1c1967c-Murthy, Viv <Vivek.Murthy@hhs.gov>

Subject: Inside a ransomware gang's operations and negotiations

Date: 2021/07/22 11:49:10

Priority: Normal

Type: Note

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CYBERSCO

CyberScoop

There's more sunlight into the opaque structure of ransomware gangs. Congress wants cyberattack co
Trade Commission. And France is fending off alleged Chinese government hackers. This is CyberSco

feature image

How Egregor leaned on its victims

A more than 100-page tranche of chat room negotiations betwee
Egregor ransomware gang and its victims offers a rare window in
how such criminal enterprises are structured and how they get wh
they want. Egregor, estimated to cause $80 million in global losse
before disappearing in February, showed little mercy for their victi
even when the negotiator on the other side pleaded poverty or
begged for their jobs. But the Egregor chat room negotiators also
gave a snapshot into some of its internal operations, referencing

finance department, a "decryption tools master-maker" and more documents obtained by IBM Security X-Force and Cylera. **Tim St has the scoop.**

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Pressure for the FTC to take on ransomware heats u

Florida Rep. Gus Bilirakis, the top Republican on the House Ener and Commerce Consumer Protection Subcommittee, filed legislat Tuesday that would require the Federal Trade Commission to rep the number of ransomware and cyberattack-related complaints it receives, and how it cooperated with international law enforceme respond to those issues. Until now, its international cooperation h largely focused on consumer protection efforts against call fraud a online scams. The new legislation could tilt those resources more heavily towards ransomware. **Tonya Riley has more.**

'Zut alors,' France says of Chinese espionage campa

Chinese government hackers known as APT31 are waging a "larg cyber reconnaissance campaign against organizations in France, according to the French National Agency for the Security of Information Systems. Also known as ANSSI, the agency said the hackers were making use of compromised routers. Among the m

prominent past alleged APT31 targets is the 2020 presidential campaign of then-contender Joe Biden. **Tim has this one, too.**

Managed Security Services: Better Protection, Lower Costs
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A new one to watch for

Officials in Geneva, Ohio, revealed that the small city was the vic of a breach involving a new and little-known form of ransomware. disclosure came after files taken from the city's servers appeared leak site operated by a ransomware outfit known as AvosLocker, which began publishing data stolen from its targets in early June. Allan Liska, an analyst at Recorded Future, said AvosLocker is "r new and have mostly hit relatively small targets so far." **StateSco Benjamin Freed writes.**

Tweet of the Day

Image

It's also sorely lacking in misinformation and disinformation, coarsening the public discourse, etc.

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Sent Date:	2021/07/22 11:48:29
Delivered Date:	2021/07/22 11:49:10
Message Flags:	Unread

From:	Murthy, Vivek (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1957C-MURTHY, VIV>
SentVia:	Atkins, Melea (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0128346FCB6A4E43BD3FE9273424ED9F-ATKINS, MEL>
To:	Murthy, Vivek (HHS/OASH) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1957C-MURTHY, VIV <Vivek.Murthy@hhs.gov>; Campos, Rafael (OS/OASH) (CTR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f4e8264a4c7b4cf6aed5a3f0344cce54-Campos, Raf <Rafael.Campos@hhs.gov>; Bian, Serena (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=307e0e470b984aa4affdbeb4f973defe-Bian, Seren <Serena.Bian@hhs.gov>; Waldo, Eric (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=7ead25012182469b9fbca545d1eb2a0d-Waldo, Eric <Eric.Waldo@hhs.gov>
Subject:	INTERNAL: Public Health Communications Collaborative Pre-Tape Moderated Discussion
Date:	2021/08/10 08:18:48
Start Date:	2021/08/13 14:00:00
End Date:	2021/08/13 14:45:00
Priority:	Normal
Type:	Appointment

- 2pm: Public Health Communications Collaborative (Health Misinformation)

Airing Date: Wednesday, August 18, 2021
Virtual Platform: Zoom Meeting
Link: b(6)

Meeting ID: b(6)
Passcode: b(6)

Format: Moderated conversation
OSG Point of Contact: Rafael Campos (rafael.campos@hhs.gov; b(6)

Sender:	Murthy, Vivek (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=79D446B2C25F4539A0C04237A1C1957C-MURTHY, VIV>; Atkins, Melea (HHS/OASH) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=0128346FCB6A4E43BD3FE9273424ED9F-ATKINS, MEL>
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Sent Date:	2021/08/10 08:18:48

From:	Katherine Bliss <KBliss@csis.org>
To:	Murthy, Vivek (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=79d446b2c25f4539a0c04237a1c1967c-Murthy, Viv <Vivek.Murthy@hhs.gov>
CC:	Campos, Rafael (OS/OASH) (CTR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f4e8264a4c7b4cf6aed5a3f0344cce54-Campos, Raf <Rafael.Campos@hhs.gov>; Beckman, Adam (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=2a00f6fceac04289866d64b3d44f8187-Beckman, Ad <Adam.Beckman@hhs.gov>; Michaela Simoneau <MSimoneau@csis.org>
Subject:	Invitation to offer keynote address at CSIS event on vaccine confidence and misinformation
Date:	2021/07/23 10:42:49
Priority:	Normal
Type:	Note

Dear Surgeon General Murthy,

Congratulations on the release of your recent advisory, *Confronting Health Misinformation*. As the director of the CSIS-London School of Hygiene and Tropical Medicine (LSHTM) project on Vaccine Confidence and Misinformation, I am writing to invite you to offer a keynote speech about the important issues you raise in the publication at an event hosted by the CSIS-LSHTM High Level Panel, which in May released its final report, *Why Vaccine Confidence Matters to National Security*. The panel was co-chaired by Steve Morrison, SVP and director of the CSIS Global Health Policy Center and Heidi Larson, founder of the Vaccine Confidence Project at LSHTM and included 25 experts from the fields of public health, national security, digital media communications, and public opinion surveys and analysis.

We currently have an opportunity to host a one-hour in-person event on vaccine confidence, misinformation, and national security, to be held at CSIS (1616 Rhode Island Avenue, NW) on the following dates:

- • Wednesday, August 4th, after 3:30pm,
- • Thursday, August 5th, after 2:30pm

CSIS is a fully vaccinated facility with the capacity to host small, size- in-person events limited to 30 or so attendees. We would simultaneously livestream the discussion and reach an estimated 200-300 live viewers, with several hundred additional viewers likely to watch a recording posted to our website immediately after the event.

Following your 10-15 minute keynote address, Steve Morrison, Heidi Larson, and one or two additional members of the High Level Panel would join you for a moderated discussion on the challenges of health and vaccine information within the Covid-19 context. However, we could also explore the possibility of a virtual-only public discussion, which could open up more dates/times the week of the 2nd.

Would you please let me know if you may be able to join us for a public event on health misinformation in early August?

I look forward to hearing from you and would be happy to speak with a member of your staff to provide additional information about CSIS, the High-Level Panel, or our recent report and associated digital products. I have also submitted an online request with details about the event through the HHS portal.

Sincerely,
Katherine Bliss

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IOAC statement at the Seventy-fourth World Health Assembly, 25 May 2021

25 May 2021

Statement

1. Thank you, Mr Chairman. Honourable ministers, excellencies, heads of delegation, Director-General, and distinguished colleagues. On behalf of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme - IOAC, I thank you for inviting us to present our report to this 74th session of the World Health Assembly. In presenting the report, we wish to pay tribute to all those working tirelessly across the world to bring the ongoing pandemic under control, and to those who have lost loved ones to COVID-19.

2. Since the inception of the WHO Health Emergencies Programme (the "WHE Programme") in 2016, IOAC has provided oversight and advised the Director-General, under the terms of its mandate. For the purposes of this, its ninth report to the governing bodies, IOAC has aligned its oversight of the Organization's response to COVID-19, with the terms of resolution WHA73.1. The Committee concentrated its review on WHO's leadership in the global response to COVID-19, on the Secretariat's work to support country preparedness and response, and it also examined the WHE Programme's role and responsibilities as the major component of the Organization's response to COVID-19.

3. In keeping with the IOAC mandate to provide oversight on WHO's work in outbreaks and emergencies, the Committee also assessed annual progress in WHO health emergency management, the transformation agenda and WHE programmatic areas, measuring it against the key performance indicators in our monitoring framework. An updated list of IOAC recommendations, and a summary of progress from May 2016 through to the end of April 2021, has been published on the IOAC website. Overall, the IOAC is satisfied with the achievements made, and impressed by the Secretariat's continuous efforts to implement the IOAC recommendations. IOAC recognizes that Dr Tedros is committed to implementing our recommendations. Indeed, some of the recommendations issued in this report, are already being implemented as we speak.

4. With regards to WHO's ongoing response to the COVID-19 pandemic, IOAC notes that the crisis has exposed failings in pandemic preparedness and response, and a shortfall in health security and equality across the world. But at the same time, there have been numerous examples of global solidarity and collaboration, together with remarkable progress in research and development. Despite the challenges faced, the report concludes that WHO has maintained, and indeed strengthened, its leadership position in the global response throughout the pandemic.

5. IOAC considers the Access to COVID-19 Tools (ACT) Accelerator to be an example of an unprecedented level of global collaboration and coordination, but, also notes that its implementation has been hampered by insufficient political will and global solidarity, limited production capacity of vaccines, and inadequate funding. We reiterate that the political and financial commitment of Member States is fundamental to fully achieving the potential of the ACT-Accelerator. The Committee is also

concerned about the lack of a global plan to operationalize the tools provided by the Accelerator, so as to maximize their scope and impact. Hence, our key recommendations include that: WHO should support Member States in developing a global strategy to roll out the ACT-Accelerator for operationalizing tools and maximizing impact with a public health approach, and should seek to ensure fair and equitable access to COVID-19 vaccines; The WHO Secretariat should support Member States to fully implement all the public health measures, and strengthen surveillance, monitoring and testing efforts, in the light of the new variants of the virus; the international community should address supply chain constraints to ensure the equitable distribution of COVAX doses and should guarantee investment, with a view to reducing the socioeconomic impacts of the global pandemic.

6. The COVID-19 pandemic has revealed shortcomings in the International Health Regulations, 2005 and highlighted the primary role of Member States in preparing for, and responding to, outbreaks and emergencies. We had very useful meetings with the IHR Review Committee members before beginning our drafting, and our report endorses many of the IHR Review Committee's recommendations. For example, the establishment of a national legal framework to ensure implementation of the IHR and public health control measures; the introduction of a mechanism to foster accountability of the whole of government; strengthening risk assessment; monitoring and data reporting and information sharing; empowering the role of national focal points; improving transparency; communication of temporary recommendations before a public health emergency of international concern is declared; and enhancing the WHO Secretariat's ability to fulfil its role through sustainable financing.

7. However, the IOAC continues to be concerned that the broad binary nature of the PHEIC mechanism does not provide a sufficient or actionable indication to Member States of the nature or severity of epidemic or pandemic risks. Whether through the PHEIC or some other related process, it is crucial that WHO work with Member States, to improve and clarify risk assessments, corresponding alerts, and empower IHR national focal points to take informed action. The IOAC further emphasizes that temporary recommendations issued by Emergency Committees must be tied to a set of concrete actions and response measures. Moreover, Member States should be held accountable, through an appropriate mechanism, for implementing recommendations in health crisis preparedness, readiness and response.

8. We reiterate our previous recommendation, that the Secretariat should further streamline the reporting process and review the existing tools and framework for national and international preparedness, including joint external evaluations, and national action plans.

9. With regards to travel advice, IOAC recommends that the role and impacts of travel restrictions and other border measures, as well as the international coordination of such measures, should be reviewed in preparation for the next pandemic.

10. IOAC welcomes all efforts towards preparing for future pandemic threat, hence recognizes the call to establish a new international treaty for pandemic preparedness and response under the auspices of WHO. Noting that any decision regarding such a treaty is Member States' prerogative, the Committee suggests that the treaty should support Member States to comply with the IHR; build national, regional and global resilience for pandemic responses; mobilize financial resources collectively; and ensure universal access to diagnostics, treatments and vaccines for future pandemics, based on the principles of solidarity, equity, accountability and transparency.

11. WHO's leadership role for health emergencies within the United Nations system has been strengthened through the COVID-19 pandemic, at both the global and field levels. IOAC notes that the role of WHO country offices has become increasingly important and recommends empowering WHO representatives to lead the public health response to COVID-19 at country level, as a part of the United Nations system.

12. Findings from the IOAC survey with WHO representatives confirm that the establishment of the WHE Programme has resulted in increasing WHO country offices' ability to manage health emergencies, but the HR capacity remains weak. The IOAC observes that the human resources planning for the WHE

Programme has never been fully implemented, mainly due to insufficient funding. IOAC recommends that the WHE Programme country business model be revised and adjusted to country-specific requirements with priority on fragile states, in line with the regional human resources plan. IOAC reiterates the principle of the single human resources plan for the WHE Programme, which should be under the responsibility of the Programme's Executive Director.

13. The WHE Programme has suffered from chronic financial and staffing constraints since its establishment. In response to the global pandemic, under the leadership of the Director-General, the WHO Secretariat has managed to surge capacity, by leveraging the whole Organization. IOAC recognizes that the Organization-wide response to COVID-19 is coordinated through the WHE Programme's incident management team, which is overstretched. The Committee consequently recommends that WHO review the current structure of, and vision for, the Incident Management System to ensure it has adequate capacity, resilience and sustainability. The Committee observes that the core science and guidance related to COVID-19 is managed within the Incident Management Team by the WHE Programme technical teams, in close collaboration with partners. We therefore recommend that WHO further strengthen core technical expertise capacity, by ensuring adequate staffing within the WHE Programme at headquarters level, while further strengthening collaboration with expert groups and expanding partnerships.

14. WHO's external communications have significantly improved throughout the COVID-19 pandemic and important progress has been noted in risk communication. The WHO Secretariat is encouraged to build up momentum, accelerating the implementation of a corporate communication strategy, and making an increased and sustained investment in communications. While recognizing that WHO has become the most-followed United Nations agency on social media, IOAC is deeply concerned by the high level of toxicity and incivility on social media against WHO and its personnel. The Committee strongly condemns personal attacks against the Director-General and WHO staff members, and, recommends that WHO build capacity to deploy proactive countermeasures against misinformation and social media attacks, and further invests in risk communication as an essential component of epidemic management.

15. IOAC observes that expectations of WHO's role have increased hugely since 2016, as has the scope of the Organization's work in both acute outbreaks and humanitarian crises. The WHE Programme has been at the heart of WHO's response to COVID-19 whilst also leading front-line emergency operations in the Democratic Republic of the Congo and Guinea in response to the Ebola virus disease outbreaks, and concurrently managing 65 graded emergencies over the 2020–2021 period.

16. IOAC is pleased to see the important progress made over the past two years in updating the current version of the Emergency Response Framework (ERF). The ERF proposes a revised accountability for the grading process and Incident Management System, with clearer roles and responsibilities for the Director-General, the regional directors, the WHE Executive Director, the regional emergency directors, WHO representatives and incident managers in managing WHO graded emergencies.

We also welcome the proposed integration of checklists for security, prevention of sexual exploitation and abuse, vaccine-preventable diseases and Contingency Fund for Emergencies, and, a framework for protracted emergencies in the updated version of the ERF. We urge the Global Policy Group to institutionalize the implementation of the managerial authorities, accountabilities and processes that have already been agreed, and to adopt the updated version of the Emergency Response Framework.

17. While the WHE Programme is not a stand-alone entity, and its success depends on operational support systems and other programmes, the IOAC reiterates that the WHE Programme's managerial authority and autonomy must be protected. The Committee commends Dr Tedros for his commitment to ensuring the agility, flexibility and effectiveness of the WHE Programme by implementing the IOAC recommendation, to establish dedicated teams within the centralized functional divisions such as communications, HR, procurement, resource mobilization and security, to support emergencies, with a dual reporting line to the WHE Programme and respective division heads. The Committee is also pleased

to report that a number of specific recommendations related to WHO security management, issued in this report are already being implemented and will come into effect shortly.

18. As WHO's emergency operations have been increasing in remote field contexts, the inherent risks have significantly increased and diversified over the years. Regarding the disturbing allegations of sexual exploitation, connected to the Ebola response in the Democratic Republic of the Congo, the IOAC expresses its concern at the slow progress of the fact-finding process. We urge WHO to immediately implement preventive and response measures in areas that are potentially high-risk for sexual exploitation and abuse. The IOAC recommends that WHO conduct a cross-Organization review of the current tools, structures, processes and coordination mechanisms to prevent, mitigate and manage all potential risks linked to emergency operations for both staff and communities.

19. The COVID-19 pandemic has given rise to questions regarding the adequacy of the WHE Programme budget and WHO financing. The IOAC welcomes Member States' commitment to, and ongoing discussions on, WHO finance. IOAC commends Member States' leadership for establishing a working group on sustainable financing. IOAC recommends that the predictability and sustainability of funding for the WHE Programme be improved through an increase in assessed contributions, non-specified multiyear funding arrangements for core voluntary contributions, and a wider donor base.

20. In its previous reports, the IOAC has repeatedly recommended, that an increased proportion of WHO core flexible funding should be allocated to the WHE Programme. We emphasize once again that WHO corporate core flexible funding is fundamental to build the Programme's capacities, as such funding provides financial sustainability for staffing.

21. The COVID-19 pandemic has resulted in total or partial disruption of essential health services in fragile, conflict-affected and vulnerable settings. IOAC recommends increasing current investment in resilient health systems, and universal health coverage, as delivery of an essential package of health services with sustainable funding is a key priority.

22. In the longer term, the Committee believes that further discussions should take place among Member States, to review whether WHO has the strategic capacity to support country preparedness and response, and whether WHO's funding is adequate for the WHE Programme to lead multidimensional and large-scale emergencies like the COVID-19 pandemic, alongside the increasing number of graded emergencies that it routinely manages.

23. Honorable ministers, excellencies, heads of delegations, distinguished colleagues, in concluding, we assess that WHO has maintained and strengthened its leadership position in the global response to the COVID-19 pandemic considering the constraints derived from fundamental problems. Numerous evaluations, reviews and assessments have documented the gaps and weaknesses in pandemic preparedness and response. It is time to take the bold decisions required to strengthen WHO and build an overarching architecture for global health based on solidarity and equity. IOAC believes that WHO must be at the centre of that governance structure, linking together the network of its 194 Member States, who are each accountable for global health, and are able to implement recommendations collectively. The world looks to WHO for guidance but to serve that purpose, WHO must be equipped with the necessary authority and resources to coordinate pandemic prevention and response. IOAC will continue to hold WHO accountable but Member States and partners must play their part as well, to help the Organization fulfil its role in protecting the health of populations across the world. Global health is truly a shared responsibility.

Note from the Secretariat:

The IOAC statement was delivered on 25 May 2021 by Dr Felicity Harvey, Chair of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

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Research Letter
June 10, 2021

Attitudes and Factors Associated With COVID-19 Vaccine Hesitancy Among Patients With Breast Cancer

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The COVID-19 pandemic has had a substantial effect on cancer care.[1] The recent widespread availability of vaccines against SARS-CoV-2 is a promising strategy to prevent COVID-19–associated mortality. However, previous reports have shown a high hesitancy rate to receive a COVID-19 vaccine among oncologic patients.[2,3] Because breast cancer is the most commonly diagnosed malignant neoplasm,[4] it is imperative to evaluate the specific concerns regarding COVID-19 vaccination among patients with this disease.

Methods

From March 12 to March 26, 2021, any woman with breast cancer residing in Mexico who visited the social media channels of nongovernmental organizations dedicated to improving breast cancer care were invited to complete a web-based survey. To assess COVID-19 vaccine hesitancy rates, participants were dichotomized into a vaccine-acceptant group (ie, willing to be vaccinated immediately) and a vaccine-hesitant group (ie, prefer to wait, only if vaccine is mandatory, or refuse). Respondents who previously had been vaccinated against COVID-19 were excluded from the statistical analysis.

Data analyses were performed using SPSS, version 27 (IBM Inc). Significance was defined as 2-tailed $P < .05$. The Research Ethics Committee of the School of Medicine of the *Instituto Tecnologico y de Estudios Superiores de Monterrey* approved the study. Informed consent was waived because the research was deemed to be of minimal risk and no identifiable data were collected.

Results

In all, 619 women with breast cancer residing in Mexico who visited the social media channels dedicated to improving breast cancer care responded to the survey; of these, 79 (13%) were excluded for prior COVID-19 vaccination. The remaining 540 women (median [range], 49 [23-85] years) were included. Of these 540 participants, 357 (66%) were willing to be vaccinated immediately and 183 (34%) were hesitant to be vaccinated—142 (26%) would wait to see the vaccine's adverse effects in others, 23 (4%) would only be vaccinated if it became mandatory, and 18 (3%) would refuse to be vaccinated.

The most common reasons motivating vaccine-acceptant patients were: to prevent COVID-19 (n = 301; 84%), to take care of their relatives (n = 227; 64%), an autoperceived social responsibility (n = 227; 64%), a fear of getting seriously ill (n = 217; 61%), and/or a desire for "getting back to normal" (n = 186; 52%). The reasons motivating vaccine hesitancy and the factors that might influence hesitant patients to accept immunization are shown in the Table. Regarding misconceptions, participants believed that the COVID-19 vaccines may contain a virus capable of causing infection (n = 115; 21%), are contraindicated in patients with breast cancer (n = 29; 5%), are not effective (n = 19; 4%), carry a computer chip to surveil the population (n = 10; 2%), and/or could cause infertility (n = 6; 1%).

Univariate analyses showed that factors associated with vaccine hesitancy include mistrust in the health care system (odds ratio [OR], 8.79; 95% CI, 4.26-18.15), misconception that COVID-19 vaccination is contraindicated in patients with breast cancer (OR, 8.41; 95% CI, 3.36-21.05), not having a close acquaintance already vaccinated against COVID-19 (OR, 2.63; 95% CI, 1.81-3.83), noncompliance with prior influenza immunization (OR, 2.27; 95% CI, 1.57-3.29), age younger than 60 years (OR, 2.01; 95% CI, 1.15-3.51), low educational attainment (OR, 1.84; 95% CI, 1.17-2.89), and not having a close acquaintance deceased from COVID-19 (OR, 1.5; 95% CI, 1.05-2.15) (Figure). Significant variables were included in a multivariate model and remained independent predictors of vaccine hesitancy, except for being less than 60 years of age (OR, 1.74; 95% CI, 0.87-3.50; $P = .12$) and not having a close acquaintance who died of COVID-19 (OR, 1.42; 95% CI, 0.89-2.29; $P = .14$). In comparison with the vaccine-acceptant group, hesitant patients were more likely to state that having a close acquaintance who did not experience a vaccine-related adverse reaction (OR, 5.66; 95% CI, 3.47-9.22), having more information about vaccine effectiveness (OR, 3.82; 95% CI, 2.58-5.68) and safety (OR, 3.10; 95% CI, 2.09-4.60), mandatory vaccination (OR, 3.33; 95% CI, 1.48-7.48), and being recommended by their oncologist to be vaccinated (OR, 3.29; 95% CI, 2.27-4.77) were needed to motivate them to receive a COVID-19 vaccine.

Discussion

The suboptimal acceptance of a COVID-19 vaccine is a reason for concern,[2] especially among individuals with a higher risk of severe illness. Strategies that focus on building vaccine literacy and confidence in the health care system are urgently needed to enhance vaccine acceptance. To achieve this, clear and credible communication that addresses patient misinformation and specific concerns must be encouraged.[3] Moreover, the active participation of oncologists is essential to educate cancer patients on the benefits of COVID-19 immunization and to endorse vaccination.

Some limitations of this study include its cross-sectional nature, reliance on self-reported data, limited sample size, and lack of formal survey sampling. However, this study provides much needed data to elucidate the factors associated with vaccine hesitancy in patients with breast cancer.

Immunization remains the leading strategy for reducing the COVID-19 burden. Interventions directed toward raising awareness of the benefits of vaccination, especially among the most vulnerable, are a priority for increasing the uptake of COVID-19 vaccines.

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Viewpoint
COVID-19: Beyond Tomorrow
March 3, 2021

The Potential Future of the COVID-19 Pandemic -- Will SARS-CoV-2 Become a Recurrent Seasonal Infection?

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JAMA. Published online March 3, 2021. doi:10.1001/jama.2021.2828
COVID-19 Resource Center
author interview icon
Interviews

Conversations with Dr Bauchner (28:38)
Will COVID-19 Become a Recurrent Seasonal Disease?

Backward 15 Play Forward 15

There is growing optimism and hope that by virtue of ongoing immunization efforts, seasonality (declining infections through August), and naturally acquired immunity, by spring and early summer 2021 in the US there will be a substantial decline in the number of deaths and hospitalizations related to COVID-19. However, this optimism must be tempered by several important factors. The likelihood of achieving herd immunity against SARS-CoV-2 is low simply because not all individuals in the US are eligible to be vaccinated and a quarter of eligible individuals will likely decline to be immunized. Moreover, the vaccines do not provide full immunity against infection, and the currently available vaccines are less effective against variant B.1.351, and possibly other variants. Accordingly, the public and health systems need to plan for the possibility that COVID-19 will persist and become a recurrent seasonal disease.

Herd immunity is a theoretical construct from infectious disease modeling that posits that in a population in which every individual is equally likely to encounter every other individual, transmission will not be sustained when immunity through past infection, vaccination, or both reaches the level of $1 - (1/R)$, where R is the number of infections caused by a single infection in a population in which everyone is susceptible.[1] Reality diverges from this simple notion. First, because COVID-19 is clearly seasonal, like other coronaviruses, the herd immunity level will be lower in the summer and higher in the winter. Second, herd immunity depends on how much interaction individuals have with one another, which will vary by state or city after social distancing mandates are lifted. Third, nonrandom

mixing (individuals are not equally likely to interact with one another) can lead to modifications of the level of immunity required to stop transmission. Despite these factors, some public health officials suggest that achieving winter herd immunity in the presence of new more contagious variants will require more than 70% to 80% of individuals to be immune.

Three key considerations will make achieving herd immunity against COVID-19 challenging. First, vaccines will have a reduced effect on preventing infection from the B.1.351 variant. Moderna and Pfizer vaccines have an overall effectiveness against symptomatic disease of approximately 95% for wild-type variants, whereas adenovirus vector vaccines, such as the Janssen/Johnson &Johnson vaccine, have effectiveness closer to 70%. Evidence on vaccine efficacy for preventing infection, however, comes only from 1 group in the AstraZeneca trial that showed 55% protection against infection as measured through weekly nasal swabs vs 70% protection for symptomatic disease.[2] Furthermore, for the 3 vaccines tested against the B.1.351 variant, Janssen, Novavax, and AstraZeneca reported effectiveness estimates for symptomatic disease of 57%,[3] 49%,[4] and a statistically nonsignificant percentage, respectively. If the B.1.351 variant becomes dominant, a simple calculation suggests that the aggregate effectiveness of vaccines for preventing B.1.351 transmission in the US could be only 50% (ie, based on current effectiveness of 90% to prevent symptomatic disease × 20% reduction of efficacy for preventing infection compared with symptomatic disease and assuming an average reduction in efficacy for B.1.351 of 33% [excluding the statistically insignificant protection from the AstraZeneca vaccine]).

Second, not enough individuals will receive the vaccine. Because the vaccines are currently not authorized for use in children, only approximately 75% of US individuals are eligible to be immunized. Perhaps more important in the long run, not all individuals are willing be immunized. Data collected daily through Facebook's Data for Good initiative provide timely information on the proportion of individuals who respond yes or "yes, probably" to the question, Will you take the vaccine if offered it? These positive responses regarding likelihood of vaccine receipt increased in January 2021 and have reached 71%,[5] similar to the 72% response in a nationally representative sample.[6] Even with an effective approved vaccine for children, if B.1.351 or some other variant becomes dominant, the US can expect vaccine-derived immunity to reach only 37.5% (the estimated potential 50% aggregate efficacy for transmission × 75% of individuals receiving the vaccine) in 2021 if all supply and administration difficulties are overcome.

Third, there is concern about the extent to which previous infections from one variant protect individuals from reinfection with some new variants. Novavax reported that in a phase 2b clinical trial in South Africa, the COVID-19 incidence rate in the placebo group, predominantly from variant B.1.351, was 3.9% both among individuals with COVID-19 seropositivity and those who were COVID-19 seronegative.[7] The interpretation by Novavax of this finding has been that past infection provides no immunity against new variants. If that is true, herd immunity can be achieved only through vaccination. But if B.1.351 spreads widely, vaccine-derived immunity will likely be much lower than the levels required to reach herd immunity by the 2021-2022 northern hemisphere winter.

Various models suggest continuing COVID-19 surges are possible even without B.1.351 dominance.[8] A winter surge of infection with B.1.351 dominance may occur in 2021-2022. Hospitalization and death rates, however, may be expected to be lower, assuming vaccines remain more effective for preventing symptomatic disease and remain effective for preventing severe disease and death. For example, the Janssen vaccine was more than 85% effective against severe disease, even in South Africa, with no hospitalizations or deaths reported in the trial, albeit with a very wide CI for these outcomes.[3] If transmission remained similar to what occurred this winter, hospitalizations and deaths should be less in winter 2021-2022. But the magnitude of the winter surge also depends on behavior. Through mask wearing and social distancing, only an estimated 19% of US residents have been infected so far. In the next winter, it will be problematic to maintain social distancing mandates due to public fatigue and the potential lasting effect of the pandemic on the economy. Despite the protection from vaccination,

effective *R* in the absence of concerted social distancing and low levels of mask use could be higher next winter than this winter.

If new variants continue to appear, winter surges may become the norm. This prospect requires advance planning and consideration of a range of strategies to mitigate the consequences for communities and health systems. Five strategies should be considered and vigorously debated in the months ahead.

1. Intensify global vaccination efforts. New variants can appear anywhere and more transmission will increase the likelihood of their emergence. Intensified expansion of vaccination in low- and middle-income countries along with high-income countries could help reduce the harm of recurrent seasonal COVID-19 and could reduce the frequency of new variants.

2. Monitor the epidemic and the emergence of new variants and accelerate the modification of vaccines to enhance their efficacy for emerging high-risk variants if they are shown to significantly reduce vaccine protection. The US, European Union, and other high-income countries should invest in global surveillance, including with genome sequencing, to facilitate early detection of variants and track trends at the local level. Strategies of creating multivalent vaccines and adapting vaccines to new variants through boosters will need to be deployed rapidly to maintain overall vaccine efficacy. If variants continue to emerge, it is possible that annual vaccination will be needed, similar to that for seasonal influenza. However, Centers for Disease Control and Prevention data indicate that seasonal influenza vaccine uptake averaged 50% and estimated vaccine efficacy averaged 35% from 2014 to 2019.[9] For COVID-19, the identification of new variants and modification of vaccines to be efficacious for these variants would need to be more effective.

3. Manage and finance winter hospital surges. COVID-19 has burdened intensive care units (ICUs) in the US this winter. Social distancing measures have reduced COVID-19 transmission and substantially reduced influenza transmission. US hospitals have avoided the double pressure on bed availability from both influenza and COVID-19 infection. A shift to recurrent seasonal COVID-19 makes it unlikely governments would adopt social distancing mandates every winter, potentially leading to hospitalizations for influenza and COVID-19. ICU bed availability pressure could require halting elective procedures in peak months such as December and January. Hospitals may need to develop greater capacity to respond to surges with sufficient bed capacity and personnel, and anticipate associated financial implications. Financing mechanisms that address that currently hospital income is driven by elective procedures would need to be considered.

4. Reduce transmission in peak months through employer and educational institution action. Although it is unlikely that the federal government or state governments will use social distancing mandates every winter, employers and educational institutions could adopt certain measures. Actions could include establishing mandatory vaccination, requiring masks during peak transmission months, and avoiding superspreader events by moving meetings or classes with attendance above a certain number to digital platforms. Requiring vaccination where legally allowed could help increase vaccination rates. Requiring mask use in the winter months could contribute both to reduced transmission in those settings and cultural change toward accepting mask use as normal.

5. Modify behavior of at-risk individuals. Increased risk of death in a winter surge may be large enough to motivate at-risk individuals to change their behavior. Higher-risk individuals (eg, aged ≥65 years or with comorbidities) would need to consider winter behavioral modification such as mask wearing and avoiding congregate settings such as bars, indoor dining, concerts, and sports events, and any setting in which transmission risk is high.

It is not clear whether COVID-19 will become a chronic seasonal disease. There is too much uncertainty about the probability and frequency of emergence of new variants, the reduction in vaccine efficacy for each variant, the critical question of cross-variant immunity, and the consistency of safe human behavior. However, the prospect of persistent and seasonal COVID-19 is real. If immunity from infection for the same SARS-CoV-2 variant or vaccine-derived immunity wanes, the prospect would increase

further. There is much to learn in the coming months about variants, vaccines, and immunity. Recurrent seasonal COVID-19 could require both health system change and profound cultural adjustment for the life of high-risk individuals in the winter months. There is an urgent need to prepare for such a scenario by aligning surveillance, medical response, public health response, and socioeconomic programs.

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Article Information

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Rapid COVID-19 State of Vaccine Confidence Insights Report

April 13-15, 2021 | Recommendation to Pause Use of Johnson & Johnson's Janssen COVID-19 Vaccine

Centers for Disease Control & Prevention, COVID-19 Response, Vaccine Task Force
Vaccine Confidence Team, Insights Unit

In response to the joint CDC/FDA recommendation to pause the use of Johnson & Johnson's Janssen COVID-19 Vaccine, a rapid assessment based on the methods and inputs from the COVID-19 State of Vaccine Confidence Insights Report was conducted.

The Rapid COVID-19 State of Vaccine Confidence Insights Report seeks to better understand consumer, provider, and state and jurisdiction chief concerns about the recommendation to pause use of the J&J/Janssen vaccine. The report describes threats to COVID-19 vaccine confidence, content gaps and information voids, circulating mis- and disinformation, and action steps for federal agencies to take now.

The information in this report is a snapshot from April 13, 2021 through April 15, 2021.

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Perceptions, Concerns, and Threats to Vaccine Confidence

Following the joint Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA) announcement, consumers in the United States commented online that they perceived the decision to pause use of the J&J/Janssen COVID-19 Vaccine to be more beneficial or detrimental for the health and safety of the country. Some praised CDC and FDA for reacting quickly, noting that the decision demonstrates that vaccine safety is a priority.[1,2] However, more consumers expressed the belief that CDC and FDA may have misjudged the risk to the public.[3,4,5,6] Given the rarity of the severe blood clotting events,[7,8] pro-vaccine consumers were concerned that the decision to pause the vaccine would damage vaccine confidence broadly and undermine the safety of all three COVID-19 vaccines.[9,10,11] Consumers also expressed concern that the country's vaccine uptake would suffer,[12,13,14] despite White House attempts to assure the public that this pause would not have a significant impact on the rate of vaccinations or population vaccination goals.[15] Broader implications of the pause include concerns about whether rural vaccination will be jeopardized,[16] whether efforts to reach population immunity will be dempened,[17] or if it is an indication that we will learn about long-term or other adverse vaccine events in the future.[18,19,20] Polls indicate that such vaccine interruptions may shake consumers' confidence in the safety of a vaccine;[21] vaccine confidence fell significantly in Europe following the AstraZeneca pause, such that more than half of the people in Germany, France, and Spain believed the vaccine was unsafe.[21,22]

Early polling data in the United States suggest that the pause in the J&J/Janssen vaccine triggered a decline in consumer confidence in the safety of this vaccine. After the announcement, only 37% called the vaccine safe, a drop of 15% in two to three days.[23] A separate survey indicated that among consumers intending to get vaccinated against COVID-19, those willing to get the J&J/Janssen COVID-19 vaccine fell from 49% to 22% from April 12 to April 14.[24] Notably, the percentage of women willing to get this vaccine fell to 15% — a drop of 31 percentage points.[25] So far, this drop in vaccine confidence does not appear to extend to the Pfizer-BioNTech and Moderna COVID-19 vaccines.[27] Currently, 59% of consumers consider them to be safe and 19% feel that they are unsafe. These data remained steady over time,[28] indicating that concerns over the J&J/Janssen COVID-19 Vaccine may not have impacted confidence in the mRNA COVID-19 vaccines at this time.

Lastly, the pause in the J&J/Janssen vaccine might cause the "wait and see" group to wait even longer before getting vaccinated, thereby increasing their own risk of COVID-19 and affecting population immunity more broadly. About one-third of the movable middle—people who want to "wait and see" before getting vaccinated—indicate that vaccine effectiveness and vaccine safety data are most likely to influence their decision to get vaccinated.[a] In this same group, 57% were most concerned about vaccine side effects.[a] Additionally, a recent poll found that people wanting to "wait and see" before deciding to get vaccinated reported that if they decided to get vaccinated they would probably or definitely get any of the three available brands (Pfizer-BioNTech, Moderna, and J&J/Janssen),[29] but a slightly larger share indicates they would "definitely" get the one-dose J&J/Janssen vaccine (16%).[30]

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[a] Unpublished data. IPSOS and NORC Omnibus Surveys, March Wave 2 (Mar 19-29). For methods and previous Omnibus data, please see Nguyen KH, Srivastav A, Razzaghi H, et al. COVID-19 Vaccination Intent, Perceptions, and Reasons for Not Vaccinating Among Groups Prioritized for Early Vaccination — United States, September and December 2020. *MMWR Morb Mortal Wkly Rep* 2021;70:217–222. DOI: http://dx.doi.org/10.15585/mmwr.mm7006e3

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Content Gaps and Information Voids

Consumers gathered on social media, where mentions of the J&J/Janssen COVID-19 Vaccine peaked on April 13 and increased by 1018% from the previous day across all platforms. Mentions have since declined but remain elevated. Facebook interactions regarding side effects or adverse effects also peaked on April 13 and increased by 343% from the previous day and continue to remain elevated. Several content gaps and information voids emerged related to guidance for people who have recently received the J&J/Janssen COVID-19 Vaccine, vaccine safety, and this specific adverse event. These questions should be anticipated and addressed through expanded online content and talking points. Questions from consumers emerged on social media in response to news coverage and federal government social media channels, organically through social media and forum platforms, and through CDC-INFO.

Questions that emerged on April 13, 2021:

Potential Actions Needed for Those Recently or Soon-to-Be Vaccinated

- What next steps should consumers take who recently received the J&J/Janssen COVID-19 Vaccine?
    - What side effects are normal and what side effects should they look out for?
    - Are there some side effects that were previously considered normal, that are now potential signs of a severe blood clotting event?
    - If consumers feel that they are experiencing symptoms of severe blood clots, who should they contact and where should they go for help?
- What if consumers are already scheduled to receive the J&J/Janssen COVID-19 Vaccine?

Blood Clots, COVID-19 Vaccine Brands, and Personal Risk

- Why is there not a risk of this type of adverse event with mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna)?
    - What is the difference between mRNA vaccines and viral vector vaccines?
    - Are rare blood clots associated with the Pfizer-BioNTech and Moderna vaccines?
- What is the difference between cerebral venous sinus thrombosis (CVST) and other types of blood clots?
- Did those patients affected by CVST have any underlying medical issues or conditions that put them at increased risk?
    - Were birth control pills involved or related?
    - Was Factor V Leiden, a genetic change of one of the clotting factors in the blood that can increase chances for developing blood clots, related?
    - What were the demographics of those patients affected?
- Is this the same problem linked to the AstraZeneca vaccine in Europe?
- What is the relative risk of blood clots?
    - As compared to COVID-19 illness?
    - As compared to the rate of blood clots in the population?

Content gaps and information voids shifting in the following days. While many of the questions in the 'Potential Actions Needed for Those Recently or Soon-to-Be Vaccinated' have been answered, new

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questions and concerns emerged, and some remained following the ACIP meeting on April 14, 2021. Many of the questions above regarding 'Blood Clots, COVID-19 Vaccine Brands, and Personal Risk' continue to go unanswered, with additional contextual questions and questions regarding other COVID-19 vaccines surfacing. Questions from clinicians were also seen through CDC-INFO.

New questions that emerged from April 14, 2021 through April 15, 2021:

Potential Actions Needed for Consumers Recently or Soon-to-Be Vaccinated

- How do consumers report an adverse event after receiving J&J/Janssen COVID-19 Vaccine?
- How long should consumers who received J&J/Janssen COVID-19 Vaccine monitor their health for symptoms for CVST?
- What actions should consumers take after receiving J&J/Janssen COVID-19 Vaccine?
    - Is there anything consumers can do to decrease their risk of CVST or another blood clotting event, such as take aspirin or blood thinners?
    - Should consumers get their platelet counts checked?
    - Should consumers delay airplane travel?
    - Should consumers stop taking birth control pills?
- What about consumers who still want to get vaccinated with J&J/Janssen COVID-19 Vaccine?

Personal Risk Concerns

- Is there an increased risk for consumers who have a history of blood clotting, heart attack, high cholesterol, or high blood pressure?

Vaccine Pause

- Why couldn't interim recommendations be made?
    - If cases were only seen among women, why can't men continue to receive the J&J/Janssen COVID-19 Vaccine?
    - If cases were only seen in people under 50 years old, why can't people over 50 years old still receive the J&J/Janssen COVID-19 Vaccine?
- Why were Pfizer-BioNTech and Moderna COVID-19 vaccines not paused when CVST cases were identified after vaccination?

Vaccine Pause Implications

- Will this pause delay ACIP decisions to recommend new COVID-19 vaccines?
- Will this pause change ACIP future decisions about recommendations for COVID-19 vaccination for children?

Provider Inquiries

- Are providers prohibited from administering J&J/Janssen COVID-19 Vaccine during the pause?
- What actions need to be taken related to remaining supply of J&J/Janssen COVID-19 Vaccine?
- How can I effectively talk to patients who received J&J/Janssen COVID-19 Vaccine and are experiencing symptoms?

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Misinformation and Disinformation Themes

Vocal vaccine deniers were both validated and fueled by the April 13 announcement. Misinformation related to the pause in administration of J&J/Janssen COVID-19 Vaccine began to circulate rapidly including about the adverse events , broader conspiracy theories related to the J&J/Janssen vaccine, COVID-19 vaccines more generally, and the COVID-19 pandemic. Ranked in order of volume, the most central misinformation themes included:

1. **There are more cases of severe blood clots from the J&J/Janssen COVID-19 Vaccine than the government is reporting; this is not actually a rare adverse event.** Some allege that there are additional severe blood clot cases not being reported or that are underreported. Vaccine deniers claim that less than 10% of adverse events are reported to VAERS.[11,12,13] Some believe that the government waited this long to pause any vaccine because reaching President Biden's vaccine goal was of primary importance, rather than the safety and health of consumers.[14]
2. **Pfizer-BioNTech and Moderna's COVID-19 vaccines have the same rates of adverse events, but the government has incentive to keep these vaccines on the market.** There are claims that the mRNA COVID-19 vaccines are also resulting in hospitalizations and death due to severe blood clots, but these vaccines were not paused because government leaders have financial motivations for keeping those vaccines on the market.[35,36,37] Additionally, some believe the COVID-19 pandemic itself is a hoax formulated by the government as a means to work with pharmaceutical companies for financial gain.[38]
3. **The severe adverse events are actually related to the J&J/Janssen COVID-19 Vaccine production issues.** Deniers believe that victims received contaminated vaccine or vaccine mixed with the AstraZeneca vaccine, which has been linked to the same type of blood clots in Europe.[39,40,41]
4. **It is not possible for COVID-19 vaccines to be safe because they are not FDA approved and are "experimental."** Deniers stated that such adverse events should be expected because the COVID-19 vaccines have not been tested thoroughly and that an Emergency Use Authorization is merely an extension of the clinical trial period. Additionally, many claims also cited that vaccine companies not being liable for adverse events as an additional reason to not trust vaccines.[41,42]
5. **Tech companies have been censoring the truth about COVID-19 vaccines.** Some contend that the news out of federal agencies on April 13 aligns with the content they have been posting for months about the dangers of COVID-19 vaccines. They feel that previous removal of posts or account restrictions are a double standard as the government has been claiming these vaccines are "safe and effective."[44,45,46,47]
6. **The pandemic is about government control.** Claims that government agencies are working with technology companies to cover-up the truth about the COVID-19 pandemic and vaccinations were among the top shared posts on Facebook following the announcement to pause the J&J/Janssen COVID-19 Vaccine.[48,49,50]

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Ways for Federal Agencies to Take Action Now

Disseminate messages focused on the importance of vaccination as an important tool to end the pandemic.

- Disseminate messages on agency channels highlighting that vaccination will play a key role in ending the COVID-19 pandemic.
- Disseminate messages that the U.S. vaccination system will continue to offer safe and effective vaccines to all consumers and will continue to monitor vaccine safety through rigorous vaccine safety monitoring systems.
- Disseminate messages that the integrity and transparency of safety monitoring systems will be maintained. Increased reports of adverse events to safety monitoring systems are expected and will be appropriately investigated.
- Disseminate messages about how ACIP makes decisions and their role in safety monitoring and the U.S. vaccination system.
- Coordinate messages across all federal agencies to ensure alignment and credibility.
- Leverage #SleeveUp and #WeCanDoThis for consumers to highlight their continued confidence in COVID-19 vaccines and the vaccination system.
- Work with partners to identify trusted messengers and local influencers to amplify vaccination stories.

Fill content gaps and information voids.

- Expand web content to include additional frequently asked questions, expanded guidance for individuals who received the J&J/Janssen COVID-19 Vaccine, and clinical guidance for healthcare providers.
- Create clear, consistent messaging about vaccine developments and communicate often about what is known and unknown about the J&J/Janssen COVID-19 Vaccine.
- Develop content in a variety of styles, including easy to use graphics, videos, and social media content, to answer questions and fill information gaps.

Address mis- and disinformation.

- Develop and disseminate plain language talking points and suggested social media messages and unbranded assets for social media influencers and the COVID-19 Community Corps.
- Partner with technology companies and notify them of key messages to flag or remove. Ensure technology companies promote resources with credible, evidence-based information about COVID-19 vaccines beyond resources from federal agencies and health departments.
- Expand Myths and Facts web content to address new mis- and disinformation themes and update content regularly.
- Empower consumers to have effective, empathetic conversations about vaccines with family and friends online and offline.

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Work with healthcare providers, with additional focus on OB/GYNs and women-focused health organizations.

- Empower healthcare professionals to relay information about vaccine effectiveness and vaccine safety to patients; strengthen their capacity to have empathetic vaccine conversations.
- Offer healthcare providers and trusted advocates content prioritized for female patients concerned about vaccine safety and effectiveness.
- Provide guidance for how to communicate with consumers who recently received the J&J/Janssen COVID-19 Vaccine including what they should do, whom they should contact, and where they should go if they think they are experiencing an adverse event or side effect.

Support research efforts to better understand which communities are most affected by the pause of J&J/Janssen COVID-19 Vaccine.

- Expand current polling mechanisms to include questions about the pause of J&J/Janssen COVID-19 Vaccine and other safety concerns.
- Identify poll indicators that could be used to better understand how current safety concerns impact people's intent to get vaccinated.
- Determine which communities are impacted by vaccine access issues following the pause and which are impacted by restricted choice of 2-dose mRNA COVID-19 vaccines.
- Identify which communities' motivations to get vaccinated have been most affected.
- Identify which communities are most impacted due to barriers for distributing mRNA COVID-19 vaccines.
- Identify which communities are most impacted due to barriers to vaccine confidence that are specific to J&J/Janssen COVID-19 Vaccine (e.g., one dose vaccination, non-mRNA vaccine).

Work with states and jurisdictions to ensure continuity of COVID-19 vaccination.

- Clarify how the pause of J&J/Janssen COVID-19 Vaccine impacts COVID-19 immunization programs and what actions they need to take.
- Identify jurisdictions that had specific needs related to J&J/Janssen COVID-19 Vaccine and support the adjusting of tactics to administer 2-dose mRNA COVID-19 vaccines.
- Provide guidance for how to communicate with consumers who have J&J/Janssen COVID-19 Vaccine appointments about rescheduling and what next steps are (e.g., receiving a 2-dose mRNA COVID-19 vaccine at same appointment, re-registering for a 2-dose mRNA COVID-19 vaccine at a later date).
- Provide guidance for adjusting existing webpages and content that mention J&J/Janssen COVID-19 Vaccine.

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Appendix: Inputs and Sources

Input	Sources	Tactics for Utilization
Meltwater	• Facebook, Twitter, Instagram • Blogs • News media • Online forums	• Share of voice topic analysis • Emerging theme topics • Identify high reach/velocity topics
OADC Channel Comment Analysis	• Native platform searches	• Sentiment analysis • Identify message gaps/voids
CrowdTangle	• Facebook	• Top pages (voices), groups • General trends/sentiment analysis • News analysis through posts
FEMA Social Listening Report	• Hootsuite • Brandwatch • CrowdTangle • Meltwater	• Trends/sentiment analysis • National and global news analysis
CDC-INFO Metrics	• CDC-INFO inquiry line list • Prepared response (PR) usage report	• Cross-compare PR usage with inquiry theme analysis • Sentiment analysis • Identify information gaps/voids
Poll Review	• Harris Poll, PEW research, Gallup Poll, KFF • New data related to vaccine hesitancy	• Identify socio-behavior indicators related to motivation and intention to vaccinate

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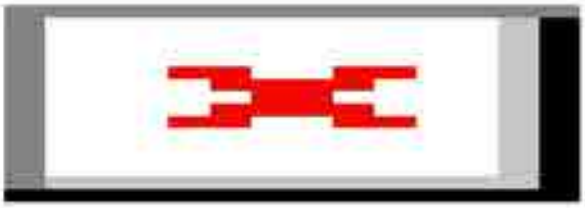

COVID-19 Vaccines: Why Are They Politicized?

Jul 16

Written By John P. Moore

America's COVID-19 vaccines are driving the nation's economic and social recovery from the worst of the pandemic. Their development during 2020 was a dramatic triumph for medical science. Programs initiated by the Trump administration and driven to fruition by the Biden team should be seen as bipartisan accomplishments by the public and private sectors working together in the national interest. And yet scarcely a day goes by without controversies, criticisms, and challenges about these life-saving solutions to the pandemic. Instead of celebrating what was achieved, politicians, pundits, and the public cavil and query the science behind the vaccines and how they are being utilized. Why all the angst? Why all the politics? There are no easy answers...

As of Thursday, approximately 48.2% of the country is fully vaccinated, according to the CDC. While the vaccination effort has curbed a nation-wide surge, the pandemic's trajectory will soon show very starkly how there are now "Two Americas." In the northeast and on the west coast, the rates of infection, hospitalization, and death will remain low and manageable. Although there will continue to be COVID-19 deaths in these parts of the country, life will continue to be a reasonable facsimile of what it was in early 2020.

In the south and some central states, however, the increasingly rapid spread of the highly contagious and more lethal Delta variant is already causing worrying new surges in hospitalizations and death. That trend is going to accelerate through the summer and will worsen even more in the fall.

Why the differential? It is because immunization rates are high in the north-east and west, but distressingly bad in states such as Missouri, Mississippi, Arkansas and Alabama. Although there are various reasons why vaccine uptake is low in the south, a continued refusal to take the pandemic seriously is one driver. Republican-run states have the most relaxed pandemic restrictions, and polling shows that Republican voters continue to refuse to be vaccinated and reject many basic safety measures such as mask-wearing and targeted restrictions. Ironically, those who are refusing the vaccines are delaying America's return to the fully normal, restriction-free life that they crave.

Many Republican politicians and their supporters choose to emphasize "personal freedom" and reject the role of the federal or state government in safeguarding its people. Sadly, the "live free or die" mantra all too often becomes "live free *and* die" - when a lethal virus spreads, every American is vulnerable. In a complex society, we generally accept various restrictions on our freedom to act as we might wish. Americans do not smoke in schools, restaurants, or hospitals. We wear seat belts in cars and some citizens live in states where you are not allowed to open carry a firearm in any place where alcohol is served. And yet, vaccines and masks are rejected for reasons that are generally so bizarre as to be laughable – except that death isn't funny.

Many baseless claims and conspiracy are being perpetuated by some politicians and media personalities. Allow me to myth-bust some of them: The COVID-19 vaccines do not turn people into human magnets; they do not cause people to transmit rays via 5G networks that mess up women's menstrual cycles or fertility; they do not modify people's DNA or contain tracking microchips that control our minds.

The misinformation about vaccines is as pernicious as "The Big Lie" about the 2020 election and is believed by the same sections of American society. Dubious statements by some politicians, Fox News "personalities," and on other right-wing online news channels are magnified by Facebook, Instagram and YouTube. This misinformation ecosystem is collectively responsible for why so many Republican voters distrust the COVID-19 vaccines.

Conversely, the "mainstream media" that is typically trusted by Democratic party voters has been a rich and valuable source of accurate information and insightful coverage. It is guided by medical and scientific professionals who understand these vaccines, how they work, and what benefits they confer. The difference is stark and tragic.

The polarization in political attitudes and information sources seems to worsen daily. It is shocking to hear Congresswoman Marjorie Taylor Greene describe door-to-door vaccine distributors as "brown shirts" (i.e., Nazis). Congressman Madison Cawthorne has attacked them as people who may "take way your guns and bibles." The federal government already has employees who visit most American homes daily without confiscating prized possessions – they work for the US Postal Service.

These congressional representatives are not just being foolish, their words are dangerous. In recent years, vaccine distributors in Pakistan, Afghanistan, and Nigeria have been executed for doing their jobs. Who is to say that cannot happen here in today's America?

While the COVID-19 vaccines are life-saving technologies, there are genuine questions that deserve discussion. Those of us who communicate about vaccines are routinely asked serious questions by friends, members of the public, and medical writers. The public interest in vaccines is substantial – and rightly so.

Legitimate concerns have arisen about rare but troubling vaccine side effects. The Johnson &Johnson and AstraZeneca (in Europe) adenovirus-based vaccines have triggered blood clotting disorders that can be fatal, particularly in younger women. The same vaccines were recently linked to rare and seemingly less serious neurological side effects, most often in men over the age of 50. The Pfizer and Moderna mRNA vaccines are associated with generally mild heart muscle inflammations in a small number of young men.

However, a sense of perspective needs to be applied when considering these troubling, real but sporadic outcomes. First and foremost, these adverse events occur in between 1 in 100,000 and 1 in a few million recipients. Secondly, no health intervention is perfectly safe when applied to hundreds of millions of people – each with their own unique genetic makeup and medical history. We have learned to accept some risks to incur the benefits. The COVID-19 vaccines are no different – harm caused to hundreds of people, however tragic, must be balanced against the many millions of lives they will save. In short, the risks of death and long-term severe illness are far greater after contracting COVID-19 than when taking the vaccines that protect us against those terrible outcomes.

Will the COVID-19 vaccines continue to be effective in the face of the rapidly spreading Delta variant? So far, the answer seems to be yes. The mRNA vaccines, in particular, raise such a high level of antibodies that there's enough "spare capacity" left over to deal with Delta and its kin. There may be more mild infections in vaccine recipients than we are used to seeing, but protection against severe disease and death is still preserved. Last month, even with Delta infections on the rise, over 99% of American COVID-19 deaths were in non-vaccinated people.

The latest question concerns the need for a booster shot. Public confidence in vaccine efficacy may have been harmed recently when Pfizer renewed its call for a third, booster shot of its mRNA vaccine. There was a rapid push-back from the CDC and FDA, preceded and then supported by public comments from many medical science professionals. The vaccines may indeed lose some potency over time, but immunity does not suddenly fall off a cliff.

While it is reasonable for Pfizer, and other companies, to plan for any future booster doses, the company's recent actions raised additional issues. The American political left does not trust Big Pharma, and what Pfizer did was seen in some circles as an attempt to boost profits more than immunity. There was also the perception that a company was treading into decision-taking areas that are the responsibility of federal agencies. The CDC, FDA and NIH monitor vaccine performance and will determine if and when a booster dose is needed. That process will surely involve close liaison with the vaccine companies that have worked with the government since the pandemic began.

At some point, a booster immunization may be needed, but that time is not now. The current priority in the USA is to maximize the number the number of people taking their first and second doses. And it's in America's best interests to help provide vaccine doses to the rest of world – as well as the moral issues involved, the global economy will remain depressed while the virus continues to circulate and generate new variants.

The national vaccine development and rollout program is something all Americans should take pride in. Its success has transformed the nation's health and financial welfare. Without the vaccines, our current death toll of 607,000 would easily be in the millions. But instead of a universal celebration of science's success, party politics promotes farcical myths that compromise confidence in the vaccines and slows our recovery from a horrible pandemic. To say this is tragic is an understatement.

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CEPI Gavi unicef World Health Organization

JOINT COVAX STATEMENT ON THE EQUAL RECOGNITION OF VACCINES

Geneva/New York/Oslo, 01 July 2021 - COVAX was built on the principle of equitable access to COVID-19 vaccines to protect the health of people all across the globe. That means protecting their lives and livelihoods, including their ability to travel and conduct trade. As travel and other possibilities begin to open up in some parts of the world, COVAX urges all regional, national and local government authorities to recognise as fully vaccinated all people who have received COVID-19 vaccines that have been deemed safe and effective by the World Health Organization and/or the 11 Stringent Regulatory Authorities (SRAs) approved for COVID-19 vaccines, when making decisions on who is able to travel or attend events.

Any measure that only allows people protected by a subset of WHO-approved vaccines to benefit from the re-opening of travel into and with that region would effectively create a two-tier system, further widening the global vaccine divide and exacerbating the inequities we have already seen in the distribution of COVID-19 vaccines. It would negatively impact the growth of economies that are already suffering the most.

Such moves are already undermining confidence in life-saving vaccines that have already been shown to be safe and effective, affecting uptake of vaccines and potentially putting billions of people at risk. At a time when the world is trying

to resume trade, commerce and travel, this is counter-effective, both in spirit and outcome.

COVAX commends countries that have already shown commitment to equity as well as safety by accepting travelers protected by all vaccines validated by WHO Emergency Use Listing (EUL) and/or the 11 Stringent Regulatory Authorities (SRAs) approved for COVID-19 vaccines. We call on other nations and regions to do the same.

Notes to editors

About COVAX

COVAX, the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator, is co-convened by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance Gavi) and the World Health Organization (WHO) - working in partnership with UNICEF as key implementing partner, developed and developing country vaccine manufacturers, the World Bank, and others. It is the only global initiative that is working with governments and manufacturers to ensure COVID-19 vaccines are available worldwide to both higher-income and lower-income countries.

CEPI's role in COVAX

CEPI is leading on the COVAX vaccine research and development portfolio, investing in R&D across a variety of promising candidates, with the goal to support development of three safe and effective vaccines which can be made available to countries participating in the COVAX Facility. As part of this work, CEPI has secured first right of refusal to potentially over one billion doses for the COVAX Facility to a number of candidates, and made strategic investments in vaccine manufacturing, which includes reserving capacity to manufacture doses of COVAX vaccines at a network of facilities, and securing glass vials to hold 2 billion doses of vaccine. CEPI is also investing in the 'next generation' of vaccine candidates, which will give the world additional options to control COVID-19 in the future.

Gavi's role in COVAX

Gavi leads on procurement and delivery at scale for COVAX: designing and managing the COVAX Facility and the Gavi COVAX AMC and working with its traditional Alliance partners UNICEF and WHO, along with governments, on country readiness and delivery. As part of this role, Gavi hosts the Office of the COVAX Facility to coordinate the operation and governance of the mechanism as a whole, holds financial and legal relationships with 193 Facility participants, and manages the COVAX Facility deals portfolio: negotiating advance purchase agreements with manufacturers of promising vaccine candidates to secure doses on behalf of all COVAX Facility participants. Gavi also coordinates design, operationalisation

and fundraising for the Gavi COVAX AMC, the mechanism that provides access to donor-funded doses of vaccine to 92 lower-income economies. As part of this work, Gavi provides funding and oversight for UNICEF procurement and delivery of vaccines to all AMC participants – operationalising the advance purchase agreements between Gavi and manufacturers – as well as support for partners' and governments work on readiness and delivery. This includes tailored support to governments, UNICEF, WHO and other partners for cold chain equipment, technical assistance, syringes, vehicles, and other aspects of the vastly complex logistical operation for delivery. Gavi also co-designed, raises funds for and supports the operationalisation of the AMC's no fault compensation mechanism as well as the COVAX Humanitarian Buffer.

WHO's role in COVAX

WHO has multiple roles within COVAX: It provides normative guidance on vaccine policy, regulation, safety, R&D, allocation, and country readiness and delivery. Its Strategic Advisory Group of Experts (SAGE) on Immunization develops evidence-based immunization policy recommendations. Its Emergency Use Listing (EUL) / prequalification programmes ensure harmonized review and authorization across member states. It provides global coordination and member state support on vaccine safety monitoring. It developed the target product profiles for COVID-19 vaccines and provides R&D technical coordination. WHO leads, together with UNICEF, the Country Readiness and Delivery workstream, which provides support to countries as they prepare to receive and administer vaccines. Along with Gavi and numerous other partners working at the global, regional, and country-level, the CRD workstream provides tools, guidance, monitoring, and on the ground technical assistance for the planning and roll-out of the vaccines. Along with COVAX partners, WHO has developed a no-fault compensation scheme as part of the time-limited indemnification and liability commitments

UNICEF's role in COVAX

UNICEF is leveraging its experience as the largest single vaccine buyer in the world and working with manufacturers and partners on the procurement of COVID-19 vaccine doses, as well as freight, logistics and storage. UNICEF already procures more than 2 billion doses of vaccines annually for routine immunisation and outbreak response on behalf of nearly 100 countries. In collaboration with the PAHO Revolving Fund, UNICEF is leading efforts to procure and supply doses of COVID-19 vaccines for COVAX. In addition, UNICEF, Gavi and WHO are working with governments around the clock to ensure that countries are ready to receive the vaccines, with appropriate cold chain equipment in place and health workers trained to dispense them. UNICEF is also playing a lead role in efforts to foster trust in vaccines, delivering vaccine confidence communications and tracking and addressing misinformation around the world.

About ACT-Accelerator

The Access to COVID-19 Tools ACT-Accelerator, is a new, ground-breaking global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. It was set up in response to a call from G20 leaders in March and launched by the WHO, European Commission, France and The Bill &Melinda Gates Foundation in April 2020.

The ACT-Accelerator is not a decision-making body or a new organisation, but works to speed up collaborative efforts among existing organisations to end the pandemic. It is a framework for collaboration that has been designed to bring key players around the table with the goal of ending the pandemic as quickly as possible through the accelerated development, equitable allocation, and scaled up delivery of tests, treatments and vaccines, thereby protecting health systems and restoring societies and economies in the near term. It draws on the experience of leading global health organisations which are tackling the world's toughest health challenges, and who, by working together, are able to unlock new and more ambitious results against COVID-19. Its members share a commitment to ensure all people have access to all the tools needed to defeat COVID-19 and to work with unprecedented levels of partnership to achieve it.

The ACT-Accelerator has four areas of work: diagnostics, therapeutics, vaccines and the health system connector. Cross-cutting all of these is the workstream on Access &Allocation.

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Surge Questions

Are you in a surge?

- Case rates are significantly below where they were when we took office.
- At the same time, we will likely continue to have an increase in COVID cases in the weeks ahead—
  - With these cases concentrated in communities with low vaccination rates and occurring primarily among unvaccinated individuals.
- We have highly effective vaccines.
  - It's free. It's safe. It's easy. And it's convenient. To get vaccinated.

How long will the surge last?

- We will likely continue to have an increase in COVID cases in the weeks ahead—
  - With these cases concentrated in communities with low vaccination rates and occurring primarily among unvaccinated individuals.
- These are tragic because they are preventable.
  - Everyone, no matter where they live, has vaccines readily available to them.
- So, if you are unvaccinated – please get vaccinated now.
  - It's free. It's safe. It's easy. And it's convenient.

Declaring Victory Too Soon

What happened to the summer of freedom?

- We've come a long way in six months.
    - Cases were at about 180,000 per day when we took office.
    - Deaths were at 3,000 per day.
    - And only 3 million people were fully vaccinated.
- Now, for the more than 160 million people who are fully vaccinated, they are living life more safely and more freely.
    - Because fully vaccinated people have a high degree of protection - including from variants in the country.
- But to be clear, if people are not vaccinated, they are at risk. They should go get vaccinated and continue to wear a mask and take other precautions until they are fully vaccinated.

Was Fourth of July a Mistake?

- We've come a long way in six months.
    - Cases were at about 180,000 per day when we took office.
    - Deaths were at 3,000 per day.
    - And only 3 million people were fully vaccinated.
- Now, for the more than 160 million people who are fully vaccinated, they are living life more safely and more freely.
- The Fourth of July was a moment for us to step back and celebrate that progress.
    - The American people should be proud of the work we've collectively done.
- But we never said this pandemic was over.
    - We are working hard to vaccinate millions of people across the summer months, and we encourage people to get vaccinated as soon as possible.
- Finally, I'll note that this event was done in the right way.
    - It was an outdoor event.
    - We had rigorous screening and testing protocols.
    - All unvaccinated individuals needed to mask and socially distance.
- We need to recognize how far we've come and acknowledge the work left ahead of us.

Schools, Businesses, Economy

Should kids be going back to school?

- CDC's school guidance will help every school open safely for in person learning next year.

- We know that with masking, distancing, and other mitigation strategies like testing, we can safely reopen all schools for full-time in-person instruction.

- We've provided funding for schools – more than $122 billion in ARP funding to help schools invest in mitigation strategies like PPE, additional space, hiring more teachers, or extending learning and enrichment programs.

- The best way to collectively go back to school this fall is for everyone age 12+ to get vaccinated.

Should businesses be bringing people back to work given the Delta surge?

- These are decisions that businesses will need to make based on the communities they are in and local vaccination and case rates.

- We've called on businesses to make it easy for their employees to get vaccinated by offering:

    - PTO

    - Incentives

    - On site vaccinations

- We know that vaccinations, masking, screening testing, ventilation, handwashing are important layers of prevention to keep people safe.

    - Employers should be implementing these strategies as they consider reopening.

Does this surge threaten to shut down the economy?

- Even as cases rise, we do not expect anticipate the virus having anything like the economic impact we saw last year.

- Now more than 160 million people are fully vaccinated and are living life more safely and more freely.

- The best thing people can do for their own health and the overall economy is to go get vaccinated.

Vaccination Mandates

Why not institute vaccine mandates?

France, Greece, and Italy all did or health care workers -- shouldn't the U.S. consider it?

- Some employers – hospitals and health systems, colleges and universities, and large and small employers – have chosen to take this step.
    - And we expect others will do this as well.
- What we are focused on is continuing to make sure people have information about the importance of getting vaccinated and making it easy for people to access a vaccine once they've made a decision.
- We're going community by community, person by person- and as we saw over the course of June, this strategy is working and we're continuing to make progress.
    - So we're going to keep at it.

Dr. Fauci says he supports more mandates.

- Dr. Fauci was conveying is that there will be decisions made by local leaders.
- Just like there will be decisions made by business leaders, by institutional leaders, and by health care leaders on how they can keep their communities safe.
- We support their right to make those decisions.

Military Mandates

- As the President has said, any decision would be made in consultation with the Secretary, and I have no news to make on this topic.

- Almost 70% of active duty troops are vaccinated.

- We encourage everyone to get vaccinated.

    - DoD has focused on making vaccines and information available at every level - from the Secretary to the health facilities at the local installations.

Mask Mandates and State Lockdowns

Mask Mandates/ LA County

- These are local decisions that communities should make based on their vaccination and case rates.

Will you reinstate federal mask mandates

- We continue to require masks on public transport.
- Community decisions should be made at the local level based on a community's vaccination and case rates.

Should states shut down to contain the delta variant?

- These are local decisions that communities should make based on their vaccination and case rates.

- We're working with states surge response teams to help states prevent, detect and respond to hotspots among the unvaccinated. These teams will:

    - Support expanded vaccination efforts like mobile units and increased education and outreach.

    - Surge testing into communities

    - Provide therapeutics like monoclonal antibodies to help treat those infected with COVID

    - Deploy federal personnel to augment local staff supporting vaccination, testing and therapeutics work

    - Leverage CDC's technical expertise in fields like epidemiology, data analysis, field investigations and public health communications

- But all of this is avoidable if people will just get vaccinated. Because the bottom line remains:

    - If you're vaccinated, you are well protected. And if you're unvaccinated, you are at risk.

Vaccine Program Slowing

Anything more you can do to increase vaccinations?

- In the past week, the five states with the highest case rates – Arkansas, Florida, Louisiana, Missouri, and Nevada – had a significantly higher rate of people getting newly vaccinated, compared to the national average.

- Our job is to keep reaching each Americans where they are.
    - To answer their questions.
    - To make it as easy for them to get a shot when they are ready.

- We will go community by community, neighborhood by neighborhood, person by person
    - We'll meet people where they are: in places of worship, with mobile clinics, at walk up pharmacy appointments, at their workplace, or in their school
    - We'll answer people's questions. Doctors and health care providers are essential. They are trusted messengers and more and more doctor's offices and clinics have vaccines.

- Every individual that we vaccinate is progress. Every shot matters.
    - It's another life protected.
    - Another community that is safer.
    - And another step toward putting this pandemic behind us.

- Across the summer months, that will result in millions more Americans getting vaccinated. It won't happen overnight. But every additional person is important progress.

Are you hitting a wall on vaccinations?

- We're making significant progress.

- In the past 10 days, millions of Americans have rolled up their sleeves to get vaccinated and we have gotten a total of 5 million shots in arms.

- Every individual that we vaccinate is progress. Every shot matters.

    - It's another life protected.
    - Another community that is safer.
    - And another step toward putting this pandemic behind us.

- We continue to vaccinate millions of people because we're executing on our plan:

    - Vaccine in 42,000 local **pharmacies** –most offering walk-in vaccinations from providers they know and trust.

    - A renewed emphasis on getting vaccines to more and more **family doctors and health care providers** so more Americans can get this shot at their doctor's office - where they are used to getting health care.

    - Intensify our efforts to bring vaccines to where people spend the most time during the week - at places of **work and schools**.

    - Sending out even **more mobile** clinics to meet people wherever they might be gathered, from summer festivals to sporting events to places of worship.

Boosters

Do people need boosters?

- Americans who have been fully vaccinated do not need a booster shot at this time.
- FDA and CDC are engaged in a rigorous scientific process to consider whether or when a booster might be necessary.
- I want to be clear: we are prepared for any and every scenario, including for boosters, if or when the science shows they are needed.
- We have secured enough vaccine supply—and if needed, we will ensure Americans who might need a booster shot are able to get it quickly and easily.
- The science will guide this, and as Dr Walensky and Dr Fauci are making clear, this is a question that they are continually evaluating.

Already talking about boosters in the US and we have people dying around the world?

- The President's first priority is to take care of the American people.
- We are a country that has suffered more than 600,000 deaths, more than any country in the world.
- And given the unpredictability of this virus, we must be prepared for a range of scenarios, including the possibility of boosters.
- On the global front, over the past few weeks alone, the President has committed to sharing 580 million doses of vaccine to the world, including –
    - Half-a-billion doses of Pfizer for 100 countries in need.
    - This is – by far – the largest-ever donation of COVID-19 vaccines by a single country.
    - We've already shared 80 million.
- This is American leadership, and we're committed to sharing tens of millions of *additional* doses across the summer months.

Will you have enough supply?

- We will be ready from a supply perspective to protect the American people.
- We've purchased booster shots from Moderna and we're almost complete with our Pfizer contract.
- Right now, our message to people is simple: now is the time to get vaccinated.
    - It's free. It's safe. It's easy. And it's convenient.

Surge Response Teams

- We are already helping many states to identify and address specific needs—across testing, therapeutics, technical assistance, and vaccine confidence.

- Just this week, at the request of the Nevada Governor Sisolak, we are deploying 100 people to the state to help enhance vaccine access and support vaccine outreach efforts.

- And we are providing CDC's technical expertise—including on genetic sequencing, data analysis and outbreak response—to Missouri to help support the state in its response.

- We stand ready to meet with our state partners to ensure they have the support they need to curb the spread of the virus and increase vaccinations in their state.

+++

- If more examples are needed:

    - In Colorado, we've lent technical expertise in epidemiology and data analysis to help the state respond to an outbreak.

States Increasing in Vaccinations Backup

- States with the highest case rates are seeing their vaccination rates go up.

- In the past week, the five states with the highest case rates – Arkansas, Florida, Louisiana, Missouri, and Nevada – had a significantly higher rate of people getting newly vaccinated, compared to the national average.

- The U.S. reported a national average increase of about 1%. The five states recorded an average increase of about 1.5%.

    - Arkansas: 1.8%
    - Missouri: 1.6%
    - Nevada: 1.6%

	7 day case rate per 100,000	weekly increase in reported 12+ newly vaccinated
Arkansas	237	1.81%
Florida	183	1.33%
Louisiana	151	1.30%
Missouri	203	1.56%
Nevada	154	1.55%
Average	**185.6**	**1.51%**
US	**55.5**	**1.04%**

POTUS

Protocols

- We have rigorous screening and testing protocols in place for individuals who meet with the President.

- Our protocols build upon CDC recommendations and the advice of other health and medical experts

- The health and medical team at the White House are in constant contact with doctors and medical experts, and we will update any protocols based on best practices.

Should POTUS get a booster?

- Americans who have been fully vaccinated do not need a booster shot at this time, and that remains true of the President.

- FDA and CDC are engaged in a rigorous scientific process to consider whether or when a booster might be necessary.

- I want to be clear: we are prepared for any and every scenario, including for boosters, if or when the science shows they are needed.

- We have secured enough vaccine supply—and if needed, we will ensure Americans who might need a booster shot are able to get it quickly and easily.

- The science will guide this, and as Dr Walensky and Dr Fauci are making clear, this is a question that they are continually evaluating.

International Travel

- We've made important progress on the pandemic, and we will continue to put public health first.

- Any decisions about reopening international travel will be guided by our public health and medical experts.

- As you heard the President say, we're planning to update him again soon.

- We must remain vigilant, particularly about the spread of variants, and we'll reopen when the health and medical experts believe it's safe to do so.

TRANSCRIPT

Q Very short one for each of you. Mr. President, my question -- my first question touches an issue that worries a lot of people in the U.S. and in Germany. Can you explain to us why there still is a travel ban for people coming from Germany or other states of the European Union, while people from Turkey, where the number of new cases are seven times as high, can come?

You all have repeatedly said that you're following scientific data. What is the main argument for not lifting that travel ban for the Schengen region?

PRESIDENT BIDEN: We brought in the head of our -- our COVID team because the Chancellor brought that subject up. It's in the process of (inaudible) how soon we can lift the ban -- it's in process now. And I'll be able to answer that question to you within the next several days -- what is likely to happen. I'm waiting to hear from our folks in our -- our COVID team as to when that should be done. And the Chancellor did raise it. (Laughs.)

CHANCELLOR MERKEL: (As interpreted.) I did raise the issue, yes, and got the same answer that the President gave you just now. The COVID team is evaluating the matter. We had an exchange on -- in both areas.

The Delta variant actually being on the increase, that is, again, a new challenge to both of us. And obviously, before such a decision, one has to reflect, and it has to be a sustainable decision. It is certainly not sensible to have to take it back after only a few days. So I'm -- have every confidence in the American COVID team.

Vaccine Verification

- There will be no federal vaccinations database and no federal mandate requiring vaccination credentials.

- The private sector and not for profit coalitions are already taking steps on this initiative, and we encourage that innovation.

- We've been clear with stakeholders about our position. Vaccine credential systems should meet key standards on:

    - Affordability

    - Digitally and on paper

    - Protecting people's privacy and security.

Mis/Disinformation

What is the White House doing to stop mis/disinformation?

- Let me be clear, any individuals or organizations feeding misinformation are doing a disservice to the country and to the doctors, faith leaders, community leaders and others who are working to get people vaccinated, save lives, and end this pandemic.

- We're asking technology companies to operate with greater transparency and accountability.
    - We want to see them reduce the spread of misinformation, most notably by changing their algorithms to promote quality information about vaccines.

- We also know that government can play an important role too.
    - We've increased mis/disinformation research and tracking within the Surgeon General's office, and we're flagging problematic posts for social platforms.
    - We're working with doctors and medical professionals to connect medical experts with popular to arm their audiences with accurate information and boost trusted content.
    - We created the COVID Community Corps to get factual information into the hands of local messengers.
    - We're investing the President, Vice President, and Dr. Fauci's time in meeting with influencers on Instagram, YouTube, Tik Tock and Snapchat to collaborate and get the facts out to people.

Recusal Language:

- I recused myself from any matters dealing with Facebook.
- I'll let Dr. Murthy take that question.

As a Facebook board member, do you, Jeff, feel any responsibility?

- To clarify, I resigned from the board in the Spring of 2020.
- Any individuals or organizations feeding misinformation are doing a disservice to the country and to the doctors, faith leaders, community leaders and others who are working to get people vaccinated, save lives, and end this pandemic.
- We're asking technology companies to operate with greater transparency and accountability.
    - We want to see them reduce the spread of misinformation, most notably by changing their algorithms to promote quality information about vaccines

What are your proposed changes to social media companies?

We've asked social media companies to take four key steps:

1. *Promote Quality Information in its Feed Algorithm.*

    - Content should not only be identified as misinformation, but should be down-ranked in newsfeeds below information from trusted sources. They should also provided clear, public, metrics of success for their promotion/reduction strategy.

2. *Create Robust Enforcement Mechanisms Across Platforms and Provide Transparency About the Rules (i.e. one standard for Facebook, Instagram, etc).*

    - Twelve people produce 65% of anti-vaccine misinformation on social media platforms.

    - We need all platforms to take action, not just some: we note that all 12 remain active on Facebook despite some being banned on other platforms.

3. *Take Faster Action Against Harmful Posts.*

    - Social media firms need to move quicker to remove harmful, violative posts. Posts that will be within their policies for removal often remain up for days – that's plenty of time for them to cause harm.

4. *Measure and publicly share the impact of misinformation on their platform.*

    - Social media companies should provide data on the reach of COVID vaccine misinformation -- not just engagement -- and the audiences that its reaching.

Describe the meetings between Facebook and the White House.

- I am not going to readout meetings, but you can rest assured that Facebook is aware of our concerns and we have requested changes.

- To date, posts that glorify vaccine rejection or spread mis/disinformation are allowed to gain millions of likes on Facebook.

    - It's important to remember that no major medical organization endorses the idea of remaining unvaccinated.

Next are the steps to combating misinformation?

Outside Government:

- We're asking technology companies to operate with greater transparency and accountability and to take more concrete steps to reduce the spread of misinformation on their platforms.

- We're asking health organizations to proactively address misinformation with their patients.

- We're asking educational institutions to help improve health information literacy.

- We're asking researchers and foundations to help us learn more about how health misinformation spreads and how to stop it.

- We're also asking media outlets to proactively address the public's questions without inadvertently amplifying health misinformation.

Within Government:

- However, we know that government can play an important role too – by investing in research, by bringing individuals and organizations to together to address misinformation, and by supporting health professionals.

Miscellaneous

Afghanistan/Kabul

- There is a third wave happening throughout the country, and the Embassy is implementing mitigation measures to ensure the safety, security, and health of staff.

- Given the fact that the embassy in Kabul has very limited medical facilities and difficulty treating patients on compound, they've taken the extra step of requiring contractors to deploy only vaccinated workers to Kabul.

Title 42

- Defer to Dr. Walensky

FLOTUS Olympics

- The Alliance between the United States and Japan is critical.
    - It's a cornerstone of peace and security in the region.
- This trip demonstrates our close cultural partnership.
- The first Lady is fully vaccinated and our protocols build upon CDC recommendations and the advice of other health and medical experts.

Tennessee

- Any actions that would limit an American's access to that information or outreach on these vaccines are a disservice to our public health and our country's recovery from this pandemic.

- I'm not going to comment on personnel issues, but I want to make something clear: the Delta variant poses a threat to Americans of all ages, and we continue to see young people hit by the virus, as we've vaccinated so many of our elderly and most vulnerable.

- We need everyone – from the media to government officials – to step up and tell the truth. The consequences of not doing so are lethal

- So let me be clear: science and health should drive these decisions, not politics, and we need to be listening to our public health professionals who have been on the front lines over the past 16 months fighting to save lives, provide accurate information to Americans, and leading the vaccination charge.

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Today's Funding Announcements

$100M Rural Funding

What is this money for?

- This funding from the American Rescue Plan will help get more rural Americans vaccinated.
- It will provide nearly 2,000 rural health clinics the resources they need to increase vaccine education and outreach efforts in rural communities.
- We know that trusted messengers within a community – often rural health clinics – are critical voices to answering people's questions and getting people vaccinated.
- That's why today's announcement is so important.

Why did it take so long to announce this funding?

- Rural health clinics had to submit applications for the grant funding, and HHS moved as expeditiously as possible to review them and make the awards.

$1.6B Congregate Settings

What does this money do?

- This funding from the American Rescue Plan will help bolster testing and mitigation measures in high-risk congregate settings such as:
    - Homeless shelters
    - Prison systems
    - Domestic violence shelters

Why did it take so long to announce this funding?

- Throughout the pandemic, there have been multiple waves of testing funding.
- This one is coming at a critical time, as Delta variant spreads and threatens these high-risk populations as we continue to work to vaccinate people.
- We're pleased to announce this funding today, and we continue to encourage people to follow CDC guidance and get tested if they're experiencing symptoms.

Non-public information for JZ: This funding was earmarked as $1.8T for testing in congregate settings including homeless shelters and prisons – but Congress appropriated the money to HHS (which runs no prisons.) So HHS had to work through a complex legal/budget processes to set up partnerships with DOJ, and separately with HUD before funding.

Surge

What are you doing about cases rising?

- We know that vaccination are our pathway out of this pandemic.
    - The good news is, hundreds of thousands of people are getting vaccinated each day, and we are working hard to vaccinate millions of people throughout the summer and fall.
- In areas where we are seeing increasing cases, we are deploying COVID-19 Surge Response teams that are helping states with additional testing, therapeutics, technical assistance, and vaccination efforts.
- For example, just last week, at the request of the Nevada Governor Sisolak, we deployed 100 people to the state to help enhance vaccine access and support vaccine outreach efforts.
    - And we're lending technical expertise to public health officials battling this in Colorado and Missouri.
- We are working hand in hand with states and communities to ensure they have the support they need to curb the spread of the virus and increase vaccinations.

It feels like things are getting worse.

- When President Biden took office, there were thousands of people dying every day.
    - Case rates were significantly higher.
    - Today, there are about 300 people dying a day – and those deaths are absolutely preventable and unnecessary.
- This is becoming a pandemic for the unvaccinated, and we will likely continue to have an increase in COVID cases in the weeks ahead.
    - With these cases concentrated in communities with low vaccination rates and occurring primarily among unvaccinated individuals.
- The good news is, because we have so many people fully vaccinated – 80% of our seniors who are most vulnerable – we will likely see smaller increases in hospitalizations than we experienced previously.
- If you still have questions about getting the shot, that's okay.
    - But please reach out to your doctor or someone else you trust to get those questions answered.
    - The sooner more people get vaccinated, the sooner we can put this pandemic behind us.
    - It's free. It's safe. It's easy. And it's convenient. To get vaccinated.

States Engaged by Surge Teams [As of July 20, 2021]

We've engaged about 10 states so far— to identify and address specific needs—across testing, therapeutics, technical assistance, and vaccine confidence.

- AL: Held initial call on Tues, 7/20
- FL: Will hold initial call on Thurs, 7/22
- IL: CDC deploying team (2 personnel on Mon, 7/19 and 1 on Tues, 7/20) to investigate church camp outbreak that resulted in 80+ infections
- LA: Held initial call on Mon, 7/19 – state asked for CDC deployment to support screening testing programs in colleges
- MS: Held initial call on Tues, 7/20
- MO: CDC has activated a 2-person team and is preparing to deploy another 4 epidemiological and technical experts early this week to support sequencing, hotspots tracking, and investigate positive tests among vaccinated residents in long-term care facilities; state has also requested 10 ambulances from FEMA
- NV: FEMA will have 100 people on the ground by early this week, and the group will be fully activated on Tues, 7/20 – Secretary Becerra will visit a pop-up clinic at a low-income unit on Thurs, 7/22
- NC: FEMA preparing to build out vaccination sites for a 90-day period starting on Thurs, 7/22, using 2 – 6 contract personnel to support logistics and operations
- TN: State asked CDC for assistance to support vaccination program on Mon, 7/12 – CDC preparing deployment
- WY: Setting up call for briefing with ASPR – state interested in receiving technical assistance for hospitals/monoclonals

Vaccine and Mask Mandates

Vaccine Mandates

- Some employers – hospitals and health systems, colleges and universities, and large and small employers – have chosen to take this step.
    - And we expect others will do this as well.
- What we are focused on is continuing to make sure people have information about the importance of getting vaccinated and making it easy for people to access a vaccine once they've made a decision.
- We're going community by community, person by person- and as we saw over the course of June, this strategy is working and we're continuing to make progress.
    - So we're going to keep at it.

Mandates [As of July 19, 2021]

- **~586** schools mandate vaccinations, reflecting **~10%** of institutions and **~25%** of undergraduate and graduate enrollment

Mask Mandates

Should individuals or communities go back to mask mandates?

- If you're vaccinated, you are well protected from the most severe consequences of COVID like death and hospitalization – including from the Delta variant.
- If you are not vaccinated, CDC recommends that you continue to wear a mask and take other precautions until you are fully vaccinated.
- There may be vaccinated people who still want to mask for an extra layer of protection, and that is okay.
- Communities may also decide to put masking back in place based on community vaccination and case rates.
- The bottom line is everyone should be doing what they can to protect themselves, getting the shot as soon as possible and masking up until they are fully vaccinated.

Is the White House Considering reinstituting masks mandates?

- We follow the guidance and advice of health and medical experts.
- Public health guidance is made by the CDC, and they continue to recommend that fully vaccinated individuals do not wear a mask.
- If you are not vaccinated, you should be wearing a mask.
- There may be vaccinated people who still want to mask for an extra layer of protection, and that is okay.
- The bottom line is everyone should be doing what they can to protect themselves, getting the shot as soon as possible and masking up until they are fully vaccinated.

Vaccinations Slowing

What can you do to convince more people to get vaccinated?

- In the past week, the five states with the highest case rates — Arkansas, Florida, Louisiana, Missouri, and Nevada — had a higher rate of people getting newly vaccinated compared to the national average.

- Our job is to keep reaching each Americans where they are.
    - To answer their questions.
    - To make it as easy for them to get a shot when they are ready.

- We will go community by community, neighborhood by neighborhood, person by person.
    - We'll meet people where they are: in places of worship, with mobile clinics, at walk up pharmacy appointments, at their workplace, or in their school
    - We'll answer people's questions. Doctors and health care providers are essential. They are trusted messengers and more and more doctor's offices and clinics have vaccines.

- Every individual that we vaccinate is progress. Every shot matters.
    - It's another life protected.
    - Another community that is safer.
    - And another step toward putting this pandemic behind us.

- Across the summer months, that will result in millions more Americans getting vaccinated.
    - It won't happen overnight.
    - But every additional person is important progress.

Why not engage Trump?

Why won't the White House ask Donald Trump to help persuade people to get the vaccine?

- The previous President got vaccinated, Mitch McConnell and numerous anchors on Fox News have gotten vaccinated.
- We know that actually the people who are most influential are a person's friends and family.
- People trust people in their own community most when it comes to questions about the vaccine.

Schools, Businesses, Economy

Should kids be going back to school?

- CDC's school guidance will help every school open safely for in person learning next year.

- We know that with masking, distancing, and other mitigation strategies like testing, we can safely reopen all schools for full-time in-person instruction.

- We've provided funding for schools – more than $122 billion in ARP funding to help schools invest in mitigation strategies like PPE, additional space, hiring more teachers, or extending learning and enrichment programs.

- The best way to collectively go back to school this fall is for everyone age 12+ to get vaccinated.

Should businesses be bringing people back to work given the Delta surge?

- These are decisions that businesses will need to make based on the communities they are in and local vaccination and case rates.

- We've called on businesses to make it easy for their employees to get vaccinated by offering:

    - PTO

    - Incentives

    - On site vaccinations

- We know that vaccinations, masking, screening testing, ventilation, handwashing are important layers of prevention to keep people safe.

    - Employers should be implementing these strategies as they consider reopening.

Does this surge threaten to shut down the economy?

- Since President Biden took office, the economy has created over 3 million job – more jobs created faster than any other president's first four months in history.

- Even as cases rise, we do not expect anticipate the virus having anything like the economic impact we saw last year.

- Now, more than 160 million people are fully vaccinated and are living life more safely and more freely.

    - Our most vulnerable populations are protected at even higher rates.

    - The vaccines work – including against the variants – protecting against severe cases, deaths and hospitalizations.

    - As a result, our experts don't expect to see hospitalizations or deaths at the same level as we did before.

- The best thing people can do for their own health and the overall economy is to go get vaccinated.

- Our country and our economy are in a much stronger place than we were in January 2021.

- Simply put – America is not going to turn back the clock to March 2020.

White House COVID Protocols

Should you strengthen protocols around the President?

- We have rigorous screening and testing protocols in place for individuals who meet with the President.

- Our protocols build upon CDC recommendations and the advice of other health and medical experts

- The health and medical team at the White House are in constant contact with doctors and medical experts, and we will update any protocols based on best practices.

There's been a breakthrough case at the White House. Are you changing your rules on campus?

- Our guidance is based on the advice of health and medical experts.
- Any consideration or change of guidance would be made in consultation with the CDC.
- Those decisions would be made by the White House Medical Unit and our campus operations team.

Misinformation

What is the White House doing to stop mis/disinformation?

- Let me be clear, any individuals or organizations feeding misinformation are doing a disservice to the country and to the doctors, faith leaders, community leaders and others who are working to get people vaccinated, save lives, and end this pandemic.

- We're asking technology companies to operate with greater transparency and accountability.

    - We want to see them reduce the spread of misinformation, most notably by changing their algorithms to promote quality information about vaccines.

- We also know that government can play an important role too.

    - We've increased mis/disinformation research and tracking within the Surgeon General's office, and we're flagging problematic posts for social platforms.

    - We're working with doctors and medical professionals to connect medical experts with popular to arm their audiences with accurate information and boost trusted content.

    - We created the COVID Community Corps to get factual information into the hands of local messengers.

    - We're investing the President, Vice President, and Dr. Fauci's time in meeting with influencers on Instagram, YouTube, Tik Tock and Snapchat to collaborate and get the facts out to people.

Has the WH talked to Fox to get them to encourage vaccinations?

- The White House understands the importance of reaching Fox's audience about the COVID-19 vaccines and their benefits.
    - Our press team is in regular contact about stories, coverage, and ensuring our top principles are on Fox shows.
- The White House has also engaged more broadly with the network on their coverage of COVID-19 and vaccine confidence, as we have with other media outlets.
- We're heartened to see additional accurate coverage of the COVID-19 vaccines on Fox.
- As with any misinformation, we don't shy away from calling it out and pushing the media platform to provide the right information to their viewers on public health issues.

Facebook Recusal

- I recused myself from any matters dealing with Facebook.
- I'll let Dr. Murthy take that question.

As a Facebook board member, do you, Jeff, feel any responsibility?

- To clarify, I resigned from the board in the Spring of 2020.
- Any individuals or organizations feeding misinformation are doing a disservice to the country and to the doctors, faith leaders, community leaders and others who are working to get people vaccinated, save lives, and end this pandemic.
- We're asking technology companies to operate with greater transparency and accountability.
    - We want to see them reduce the spread of misinformation, most notably by changing their algorithms to promote quality information about vaccines

Travel

- Let me be clear: this is not an easy decision. The interagency team is aligned around the common goals of: following the science and the trajectory of the virus, which is evolving in real time and ensuring we sustainably reopen.

- Our top focus is making sure that we are keeping the American people safe and the virus at bay. We don't take this responsibility lightly.

- The team is planning to update the President again soon.

- We must remain vigilant, particularly about the spread of variants, and we'll reopen when the health and medical experts believe it's safe to do so.

Why is the FDA taking so long to approval the drug?

- The FDA is the gold standard for vaccine review and approval.
- They will run an independent and rigorous scientific processes.
- When that process is complete, the American people can rest assured that the FDA maintained its world-class standards for review.

When will kids be eligible?

When will my 6-year-old be able to get the vaccine?

- Dr. Fauci thinks sometime in the fall.

Global

Toplines

- On the global front, over the past few weeks alone, the President has committed to sharing 580 million doses of vaccine to the world, including –
    - Half-a-billion doses of Pfizer for 100 countries in need.
    - This is – by far – the largest-ever donation of COVID-19 vaccines by a single country.
    - We've already shared 80 million.
- This is American leadership, and we're committed to sharing tens of millions of *additional* doses across the summer months.
- This builds on:
    - Our commitment to COVAX – U.S. is the largest contributor.
    - Our Quad partnership that is on track to help produce at least 1 billion doses of COVID vaccines in India for the Asia region by the end of 2022.
    - The U.S. is working with G7 development finance institutions to support vaccine manufacturing in Africa – for Africa.
        - The US and partners have made a groundbreaking commitment to bolster Africa's vaccine manufacturing capacity by providing financing to a South African business to bolster manufacturing capacity to produce more than 500 million doses of the Johnson & Johnson vaccine by 2022.
- Our actions are serving as a catalyst for other countries to contribute doses and funding for the rest of the world.

Is USAID underfunding COVAX?

Awaiting clearance from USAID as of 9:30 pm on July 21.

- We've already given $2 billion to COVAX to support global vaccinations – the largest contribution in the world.

- We've delivered one of the single most important commodities a country fighting this pandemic could as for – 500M doses of a highly effective mRNA vaccine.

- The resources needed to defeat a global pandemic will come from countries around the world. But right now, the United States is the single largest contributor to COVAX in terms of monetary funding and vaccines donated.

- We are serving as a catalyst for other nations.

Breakthrough Cases

- The vaccines are highly effective at preventing the most severe consequences of COVID like death and hospitalization – including from the variants.

- As we manage this virus moving forward, some people who have been vaccinated may experience asymptomatic infection or a mild COVID case.

- But importantly, when those do occur, people are highly protected from severe COVID, hospitalization, or death.

- We've come a long way in six months.

    - Because we have so many people fully vaccinated, we will likely see smaller increases in hospitalizations, similar to the Israel and UK experience.

- Our message remains the same: the best way to protect yourself against severe disease from is to get vaccinated.

Boosters

- Americans who have been fully vaccinated do not need a booster shot at this time.

- FDA and CDC are engaged in a rigorous scientific process to consider whether or when a booster might be necessary.

- I want to be clear: we are prepared for any and every scenario, including for boosters, if or when the science shows they are needed.

- We have secured enough vaccine supply—and if needed, we will ensure Americans who might need a booster shot are able to get it quickly and easily.

- The science will guide this, and as Dr. Walensky and Dr. Fauci are making clear, this is a question that they are continually evaluating.

J&J Booster

- The doctors say there currently is no science backing up getting another shot if you received J&J.
- J&J is a safe and effective vaccine – including against the variants.
- If you are vaccinated, you are highly protected from the Delta variant.
- What we are seeing right now is a pandemic of the unvaccinated.

A new study shows J&J is less effective.

- Our public health officials and experts continue to monitor available data and studies examining effectiveness.
    - This process takes into account laboratory data, clinical trial data, and cohort data - which can include data from specific pharmaceutical companies, but does not rely on those data exclusively.
- There have been several studies of J&J done but no conclusive determination yet.
- We continue to review any new data as it becomes available and will keep the public informed.
    - We are prepared should boosters be needed in the future, and we will update the public as necessary with the latest information they need.
- At this time, experts continue to recommend that the general public does not need a booster shot.
- We still have a large portion of the population that is unvaccinated, and right now we need more people to continue getting vaccinated to increase their protection and help curb the pandemic.

Miscellaneous

Vaccine Verification

- There will be no federal vaccinations database and no federal mandate requiring vaccination credentials.

- The private sector and not for profit coalitions are already taking steps on this initiative, and we encourage that innovation.

- We've been clear with stakeholders about our position. Vaccine credential systems should meet key standards on:

    - Affordability

    - Digitally and on paper

    - Protecting people's privacy and security.

COVID Origins

- The U.S. Intelligence Community has coalesced around two likely scenarios for the origin of COVID:
    - It emerged from human contact with an infected animal
    - It emerged from a laboratory accident
- The President has asked the Intelligence Community to take 90 days to bring us closer to a definitive conclusion about the origin.
    - We are in the middle of that process.
- For months, we have conveyed our serious questions about the pandemic, including its origins within China.
- We look forward to the conclusion of this report.

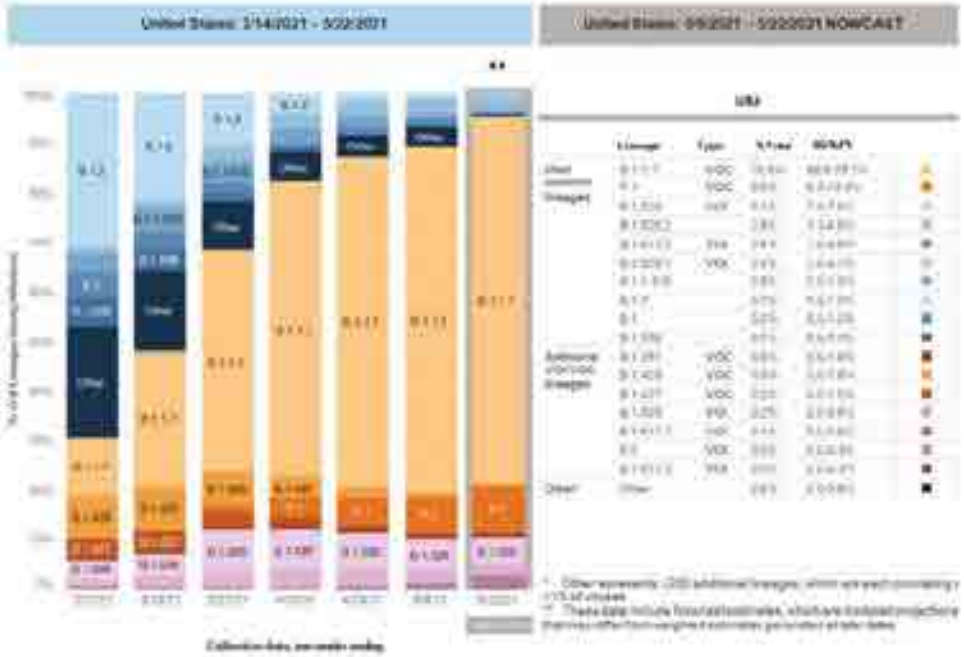
SARS-CoV-2 Interagency Group

SITREP – Genomic Surveillance, Emerging Variants, and Variant Characterization
Updates from last SITREP in BLUE

Date: 28 May 2021
Report Period: 26 May 2021 – 28 May 2021
Next SITREP: 1 June 2021

KEY UPDATES and VARIANTS CIRCULATING IN THE UNITED STATES

- CDC genomic surveillance efforts support ongoing efforts to characterize SARS-CoV-2 variants and the SARS-CoV2 Interagency Group is focused on the rapid characterization of emerging variants to understand their potential impact on critical SARS-CoV-2 medical countermessures, including vaccines, therapeutics, and diagnostics.
- For the two-week period ending May 22, 2021, the national prevalence of B.1.1.7 is projected to remain steady at 73.8% and is projected to be greater than 60% in HHS Regions two through ten. The combined national prevalence of B.1.427 and B.1.429 is projected to decrease to 0.7%. The national prevalence of P.1 is projected to increase to 9.6%, and B.1.351 is projected to decrease slightly to 0.6%.
- Of the 22,457 B.1.1.7 sequences in GISAID with collection dates over the last four weeks, there are 78 B.1.1.7 sequences with the E484K substitution and 228 B.1.1.7 sequences with the S494P substitution.
- B.1.1.7 has been detected in 155 countries; B.1.351 has been detected in 111 countries; P.1 has been detected in 62 countries; B.1.427 has been detected in 25 countries; and B.1.429 has been detected in 33 countries.
- Variants of Interest include B.1.526.1, B.1.526, B.1.525, P.2, B.1.617, B.1.617.1, B.1.617.2, and B.1.617.3 lineages. The estimated national prevalence of the B.1.617.2 lineage is predicted to increase to 2.6% for the two-week period ending May 22, 2021. B.1.617.1 and B.1.617.3 are predicted to remain less than 1%.
- Publication describing methodology for weighting variance prevalence estimates and nowcasting submitted to MMWR
- Household transmission studies evaluating transmission of 1) B.1.1.7 compared to non-B.1.1.7 and 2) B.1.526 compared to other lineages are in the analytic phase; *findings anticipated soon*
- CDC is using multiple surveillance approaches to identify cases of vaccine breakthrough and identify significant signals associated with variants
- CDC is Performing sequencing of SARS-CoV-2 cases in multiple enhanced study platforms and on-going cohort studies, including COVID-Net, SUPERNOVA, Overcoming COVID, and New Vaccine Surveillance Network (NVSN) to determine if there are differences in clinical and epidemiologic characteristics of specific variants
- Collaborating with multiple states to conduct cohort studies investigating the severity of B.1.1.7 and other SARS-CoV-2 variants of concern and interest using genomic and case surveillance data
- Update in clearance for the Science Brief for Recommendations Fully Vaccinated People, including updating evidence on variants
- Special Topics: SARS-CoV-2 Variants and Sequencing in India (see Global Variant Section).



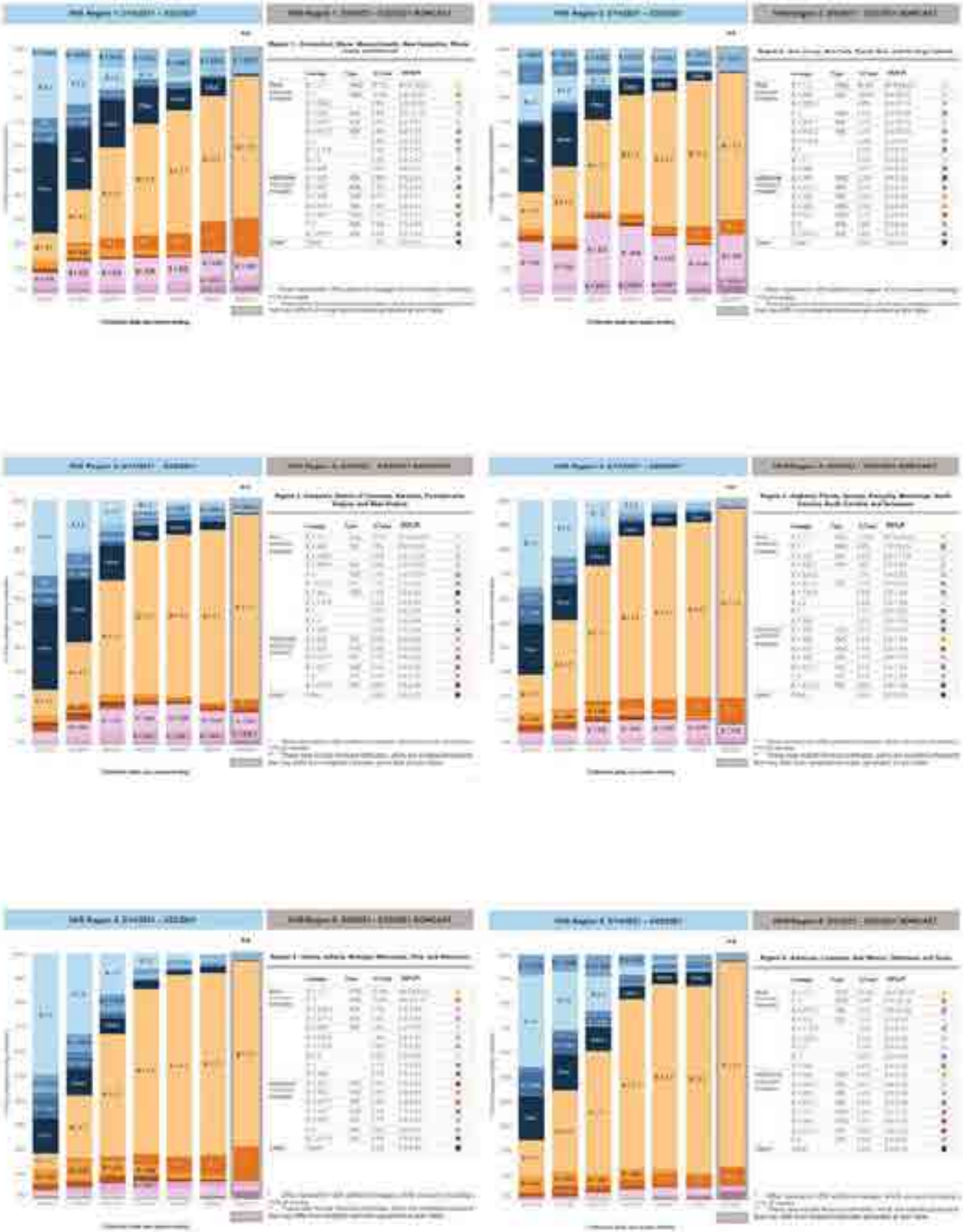
Left: The data in the bar chart show the weighted proportions (prevalence) of SARS-CoV-2 circulating in the US using Pango lineages, based on CDC national genomic surveillance over a 12-week period, grouped in two-week intervals according to **sample collection date**. The far-right bar shows NOWCAST proportions, which are based on a multinomial regression model of weighted sequencing data to estimate variant proportions and prediction intervals. NOWCAST proportions provide timely estimates while accounting for limited sequence data availability, as samples from that interval are still being processed. Nowcast estimates are projections and may differ from weighted estimates generated at later dates.

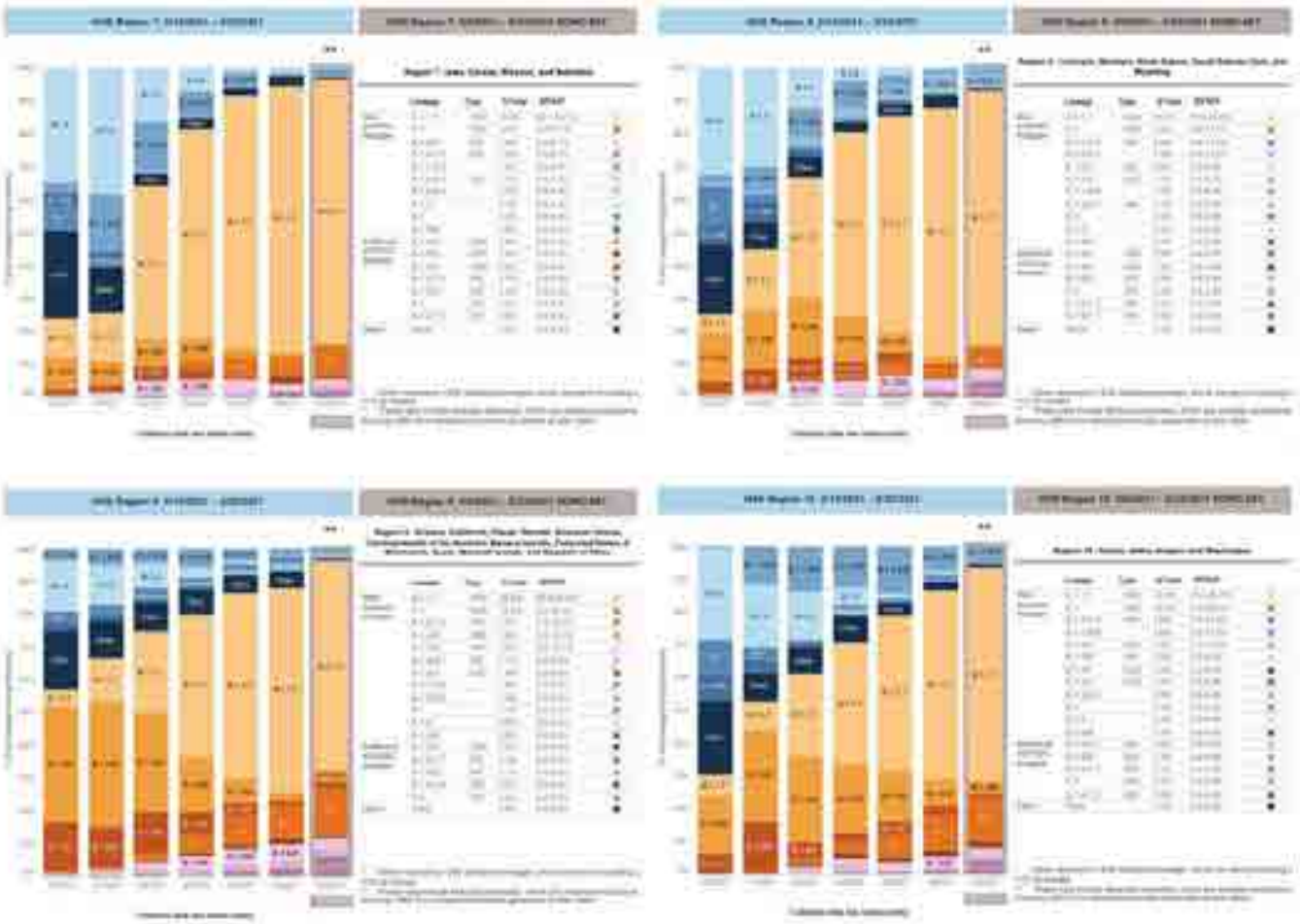
REGIONAL SUMMARY

For the two-week period ending May 22, 2021

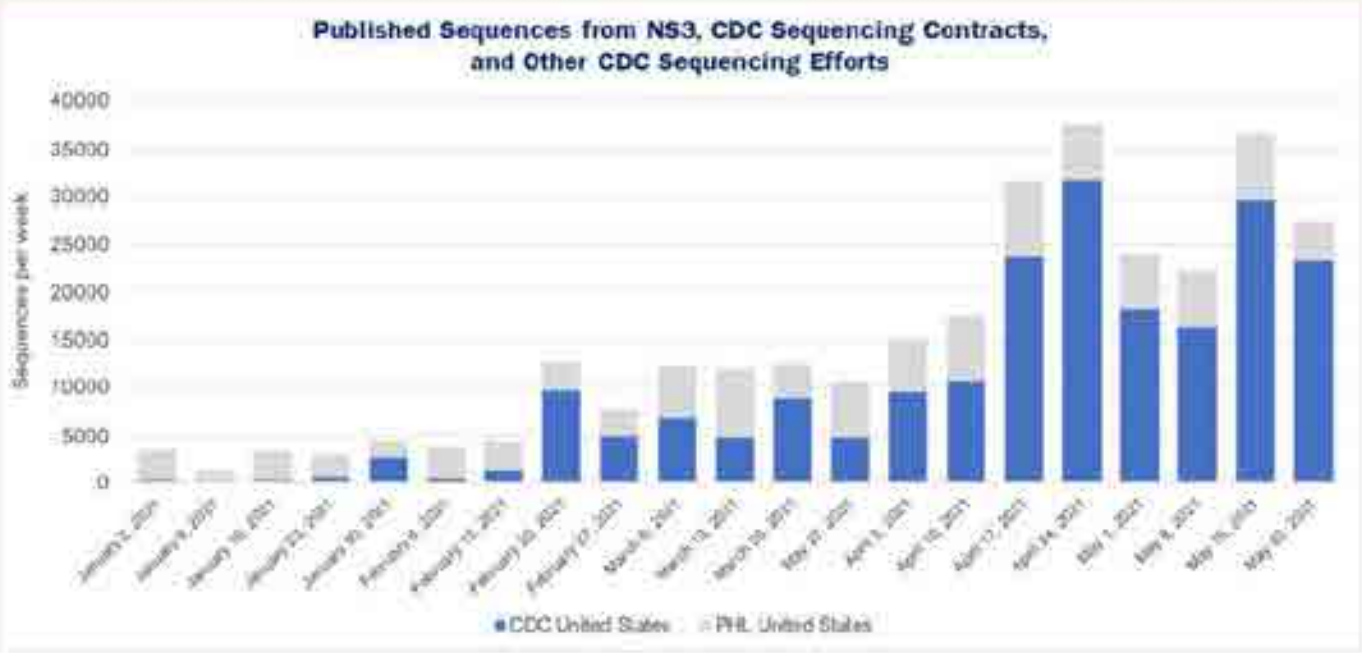
- The regional proportions of **B.1.1.7** are predicted to be **greater than 60%** in **all HHS Regions except Region 1** (57.7%).
- The combined regional proportions of **B.1.427** and **B.1.429** are predicted to decrease and be highest in **HHS Regions 9 (5.4%) and 10 (4.9%).**
- The proportion of **P.1** is **greater than 10%** in **HHS Regions 1, 5, 9, and 10.**
- The regional proportion of **B.1.351** is predicted to be **greater than 1%** in **HHS Regions 3 and 10.**
- The proportion of **B.1.526** continues to be **highest** in **HHS Region 2** at 16.6%.
- The proportion of **B.1.526.1** is predicted to be **higher than 2.5%** in **HHS Regions 1-3 and 5.**
- The proportion of **B.1.617.2** is predicted to be **higher than 2.5%** in **HHS Regions 2, 6, and 8-10**

Regional Prevalence of SARS-CoV-2 Variants. The US map divided into the ten HHS Regions and the pie charts represent the predicted proportions (prevalence) of Pango lineages for the two-week period ending May 22, 2021





Genomic Surveillance



Sequences in Public Databases		
Genetic Sequence Data in Public Databases	**GISAID**	**GenBank**
Global SARS-CoV-2 Sequences	1,718,652	517,105
United States SARS-CoV-2 Sequences	497,557	293,503
Collection dates within the last 14 days	2,244	1,547
Collection dates within the last 28 days	34,286	28,949

- DoD-GEIS partner laboratories have received more than 8,000 SARS-CoV-2 samples for sequencing that include samples from Active Duty Service Members (ADSMs), Military Health System (MHS) beneficiaries, foreign nationals, and external US civilian populations. They've sequenced 6,556 samples; approximately 96% are from ADSMs and MHS beneficiaries. Of those, 981 are from participants in the IDCRP-EPICC study. Approximately 450 samples have been sequenced by OCONUS laboratory partners.
- As of May 27th, GEIS partners have detected the following variants of concern among MHS samples. Samples were collected from January to May of 2021. Most recent week of reporting is indicated with (+n):

Variant	Total Cases of Each VOC reported by GEIS Partners*	Vaccine breakthroughs by VOC**
B.1.1.7 (20I/501Y.V1)	1,036 (+225)	7
B.1.351 (20H/501Y.V2)	118 (+25)	6
P.1 (20J/501Y.V3)	46 (+20)	3
B.1.427 (20C/S:452R)	54 (+1)	-
B.1.429 (20C/S:452R)	224 (+21)	-
Total	1,475 (+292)	16

GEIS NGSBC reporting laboratories: NHRC, NMRC, TAMC, USAFSAM, USAMRIID, WRAIR
*Data from recent weeks is still being processed/under investigation and therefore numbers are subject to change. Includes some VOC cases within DoD reported to GEIS from outside commercial or state and local public health laboratories.
**VOC vaccine breakthrough cases are also included in the totals in column 2.
Changes since last weekly report in blue and increase in counts in (+).

- As of May 27th, GEIS Partner Network Sequencing Submissions and Results for SARS-CoV-2 **Vaccine Breakthrough Cases** (n=37); this does not include IDCRP-EPICC samples:

Sample Collection Month*	AFRICOM (n=11)	EUCOM (n=1)	INDOPACOM (n=3)	NORTHCOM (n=22)
February 2021 (n=1)	-	-	-	B.1.260 (1)
March 2021 (n=12)	**B.1.1.7** (2), **B.1.351** (1)	-	-	B.1.1.318 (1), **B.1.1.7** (2), B.1.2 (2), **B.1.351** (1), **B.1.526** (1), NA (2)
April 2021 (n=16)	B.1 (2), B.1.1.97 (1), **B.1.351** (4), **B.1.612** (1)	NA (1)	**P.1** (3)	**B.1.1.7** (2), **B.1.526.1** (1), NA (1)
May 2021 (n=1)	-	-	-	**B.1.617.2** (1)
Unknown (n=7)	-	-	-	**B.1.1.7** (1), TBD (6)

*Data on vaccine breakthrough cases collected and submitted for sequencing is incomplete; updates are made as data is received on a monthly basis.
NA = Not applicable or PANGO lineage assignment was not able to be made from sequence data; TBD = final PANGO lineage assignment is not yet reported
BOLD **indicates a lineage designated a** Variant of Concern (VOC) **or** Variant of Interest (VOI) **as designated by CDC**

Variant Studies

- NIAID/VRC – Comprehensive assessment of the impact of variants B.1.1.7, B.1.351, P.1, B.1.429, and B.1.526 on binding, neutralizing, and ACE2-blocking antibodies elicited by the mRNA-1273 vaccine over seven months. At peak response to second dose, all subjects had robust responses to all variants, and binding and functional antibodies against variants persisted over six months. Across all assays, B.1.351 had the greatest impact on antibody recognition and B.1.1.7 the least. Pre-print

B.1.1.7 Variant

- Neutralizing activity of convalescent serum and post-vaccination serum against B.1.1.7.
  - NIAID/VRC – Lentiviral PsVN assay testing Moderna sera through Day 209 and convalescent sera
- Other activities
  - NIAID/RML
    - Comparative environmental stability: planned

B.1.351 Variant

- General Updates
  - NIAID/VRC – Results from Moderna's VSV pseudovirus neutralization assay, the VRC's lentiviral pseudovirus neutralization assay, and Emory's FRNT assay are forthcoming.
- Other activities
  - NIAID/VRC – Cell-surface-spike binding assays (point and full B.1.351): on-going
  - NIAID/IRF – In vitro Ab screens
    - Neutralization capacity for several tested products was markedly reduced and neutralization capacity for two products was lost completely.
    - Stock provided by BEI has a titer too low to be useful in our assay. We are exploring options.
  - NIAID/RML
    - Comparative environmental stability: planned
    - Transmission studies: planned

P.1 Variant

- Neutralizing activity of convalescent serum and post-vaccination serum against P.1
  - David Ho (Columbia): P.1 is refractory to multiple neutralizing mAbs and is relatively resistant to neutralization by convalescent plasma and vaccinee sera. Cryo-EM structure of P.1 spike trimer reveals exclusively one-RBD-up conformation. Article
- Other activities
  - NIAID/IRF – Live virus assay testing of a panel of therapeutic monoclonal antibodies will be repeated the week of 5/31.
  - NIAID/RML – Planned (once in possession of P.1 variant):
    - Comparative environmental stability
    - Vaccine efficacy with the AZD1222
    - Transmission studies

B.1.429 Variant

- Other activities
  - NIAID/IRF – Virus stocks have been expanded and sequencing complete. Sequence is consistent with the reported sequence. Testing against therapeutic Ab panel is pending.
  - NIAID/RML – Variant transmission studies with CAL.20C variant (B.1.429): planned

B.1.526 Variant

- Neutralizing activity of convalescent serum and post-vaccination serum against B.1.526
  - Florian Krammer (MSSM) and Mehul Suthar (Emory): testing the direct comparison of B.1.526 (E484K) vs. B.1.526 (S477N) in live virus assays.
- NIAID/VRC – ACE2 inhibition assay: testing ongoing

Additional Studies, Reagent, and Tools

- NIAID/VRC – MSD plates displaying the B.1.351 variant (MSD RSA 351: L18F/D80A/D215G/del242-244/R246I/K417N/E484K/N501Y/614G/701V).
  - The objective is to screen current vaccine sera and prepare for future trials including the B.1.351 strain. The plates can also be used for ACE2 inhibition studies (see table). Plates will be qualified and ultimately validated for use in ph1-3 clinical trials.
  - NIAID/VRC is setting up a multiplex assay to screen immune responses to several variants of concern. This will be extremely useful to test sera from volunteers in current SARS-CoV-2 clinical trials measuring durability of immune responses from EUA approved vaccines, as well as immune responses in volunteers vaccinated with new variant versions of the coronavirus vaccine (SARS-CoV-2 Vaccine V2). The multiplex assay will evaluate 4 paired variants spike and RBD, plus N protein and negative control. It is also currently being used for NHP studies and screening convalescent sera from individuals infected with B.1.351.
- NIAID/VRC continues to work with MSD, DMID, and BARDA on securing SARS-CoV-2 variant protein in sufficient quantities to react to the demand for reliable serological analyses. VRC has received MSD 384 Ver #2 "351" plates for QC analyses.

MSD 384 well 4 plex format				
Version	CoV-2 Antigens			
#1	1273 S-2P	1273-RBD	N	BSA
#2	1273 S-2P	B.1.351 RBD	N	B.1.351 S-2P

- NIAID Structural Genomics Centers:
  - Protein production has been completed for full-length recombinant Spike from B.1.351 (~32 mg), P.1 (~45 mg), and B.1.1.7 (35 mg) variants by Noah Sather's group at Seattle Children's Research Institute.
    - QC analyses on all three proteins include verification by SARS-CoV-2 specific RBD mAb and polyclonal serum for identity and antigenicity and have been evaluated by analytical SEC.
    - Aliquots of all three proteins have been shipped to NIAID/VRC (Adrian McDermott), Florian Krammer, and Patrick Wilson.
    - 800 vials of 25ug at 0.25ug/ml and 50 vials of 100 ug at 1mg/ml of B.1.351, P.1 and B.1.1.7 full-length spike protein have been shipped to BEI and scheduled to arrive by 4/8/21.
  - Protein production for B.1.526 (NY strain) has been purified and undergone QC. Aliquots of the protein have been shipped to NIAID/VRC (Adrian McDermott), Florian Krammer, and Patrick Wilson.
    - 800 vials of 25ug at 0.25ug/ml and 18 vials of 100 ug at 1mg/ml of B.1.526 have been shipped to BEI on 4/20/21.
  - DNA constructs for cloning of expression plasmids of the B.1.617, B.1.1.1, and A.23.1 spike variants have been ordered. B.1.617 will be prioritized for protein production.
  - B.1.617 has been cloned and pending sequence confirmation. DNA production and transfection are scheduled for next week.
  - Cryo EM structure determination for the following Spike protein variants has been initiated:
    - B.1.351 (501Y.V2) and B.1.1.7: structure determination is ongoing.
    - P.1: spike did not fold properly.
    - B.1.427.
    - B.1.429: clones have been ordered from Genscript for structure determination.

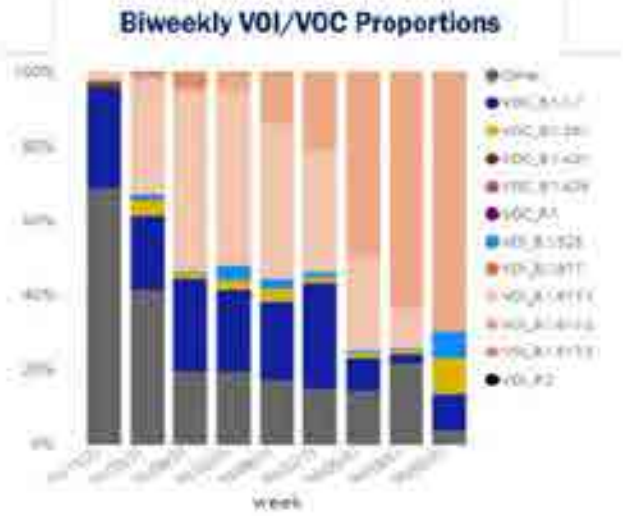
One Health

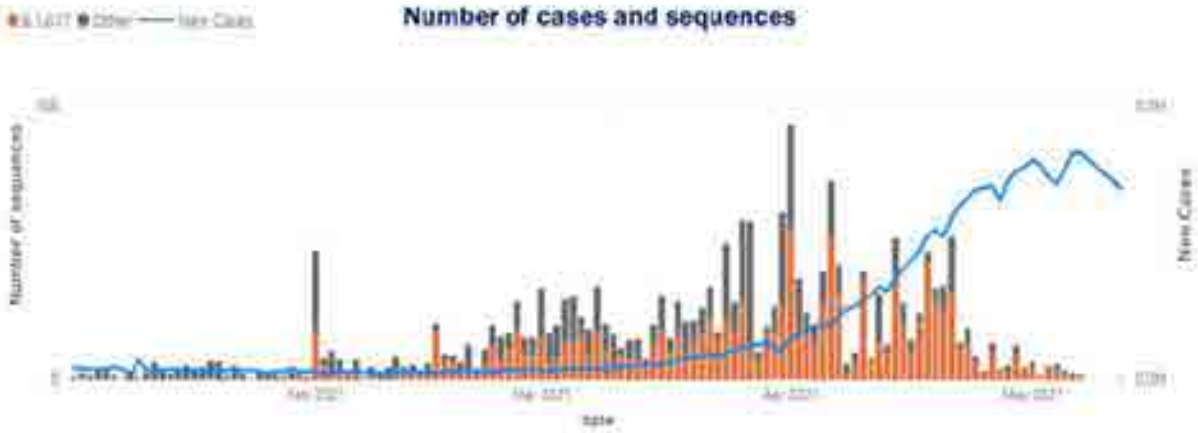
Variants Detected in Animals in the United States				
Variant	Collection Date	Location	Animal Species	Clinical Signs
B.1.526	1/26/2021	Florida	Dog (1)	Mild respiratory
B.1.429	1/20/2021	Arizona	Cat (1)	Mild respiratory
B.1.429	1/30/2021	California	Cat (1)	Mild respiratory
B.1.1.7	02/12/2021	Texas	Cat (1), Dog (1)	Asymptomatic at initial sample; respiratory signs >1 month later
B.1.526	03/06/2021	Connecticut	Dog (1)	Deceased
B.1.526	03/06/2021	New Jersey	Cat (1)	Deceased
B.1.525	03/16/2021	Arizona	Cat (1), Dog (1)	Asymptomatic
B.1.1.7	04/04/2021	Pennsylvania	Lions (2)	Mild respiratory
B.1.1.7	04/09 & 12/2021	Virginia	Tigers (3)	Mild respiratory
B.1.1.7	04/15/2021	Georgia	Otters (7)	Mild respiratory
B.1.1.7	04/15/2021	Texas	Cat (1)	Mild respiratory
B.1.1.7	04/15/2021	Texas	Cat (1)	Asymptomatic

Rows highlighted in mint indicate animals discovered through active surveillance (e.g., household transmission studies). Two animals that died or were euthanized were detected to be infected with a variant post-mortem. In one animal (CT dog), no further information on the contribution of SARS-CoV-2 to the animal's death is available. In the other (NJ cat), SARS-CoV-2 was determined to be incidental to the primary reason for euthanasia. Of note, all animals with SARS-CoV-2 infection reported recently have been infected with the B.1.1.7 variant of concern.

Global SARS-CoV-2 sequencing capacity

Special Topic: SARS-CoV-2 Variants and Sequencing in India



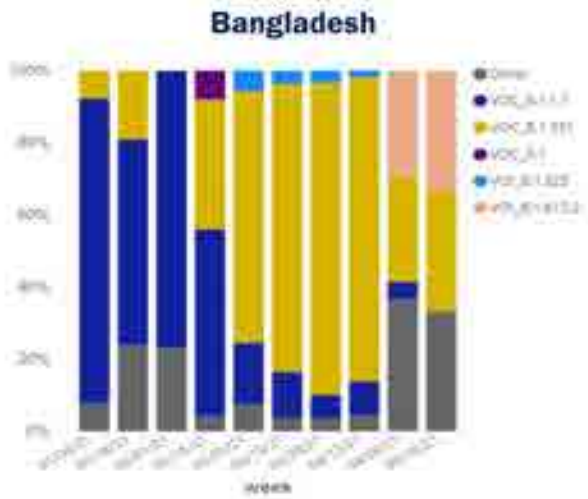


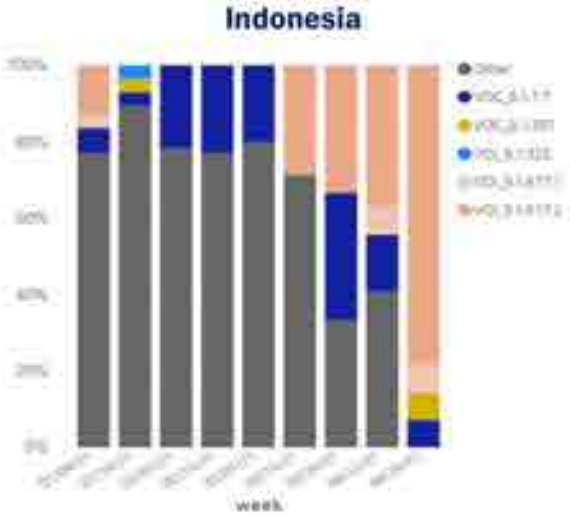
- As of May 27, more than 16,000 sequences from cases reported in India were submitted to the GISAID database from 80 laboratories in India.
- There continues to be increased detection of B.1.617 sub-lineages that were first identified in the country during October 2020.
- While several Variants of Concern, including B.1.1.7 and B.1.351, have also been detected in India, B.1.617 become the predominant lineage reported in India as of mid-March 2021. Although B.1.1.7 continues to be detected in high proportions in northern states of India, the B.1.617.2 sub-lineage has become the predominate lineage detected in the country.
- The rise in cases in India is likely multifactorial, but B.1.617 and its sub-lineages possess spike protein substitutions predicted to increase infectivity and transmissibility and impact virus neutralization by antibodies from previously infected individuals and vaccine recipients.
- Heterogeneity exists in spike protein substitutions among the B.1.617 sub-lineages. Additional phenotypic characterization is needed to assess the impact of this heterogeneity.
- To date, 54 countries including some neighboring India have reported detection of B.1.617.2, and this variant has been detected in travelers returning from India to other countries. In India and neighboring countries, low percentages of COVID 19 cases with sequence data reported underscores the need for expansion of genomic sequencing capacity in these countries.
- Neighboring countries and other SEARO region countries, including Bangladesh, Sri Lanka, and Indonesia, have identified B.1.617.2 sub-lineage viruses with increasing proportions in recent weeks.

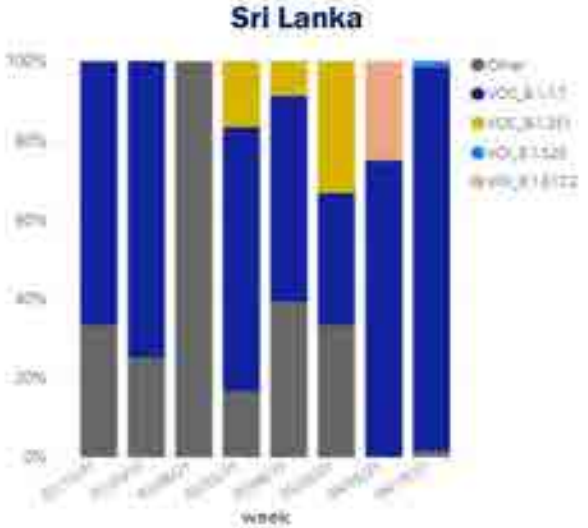
- CDC is supporting the Government of India by helping to enhance sequencing capacity among laboratories within national laboratory networks.

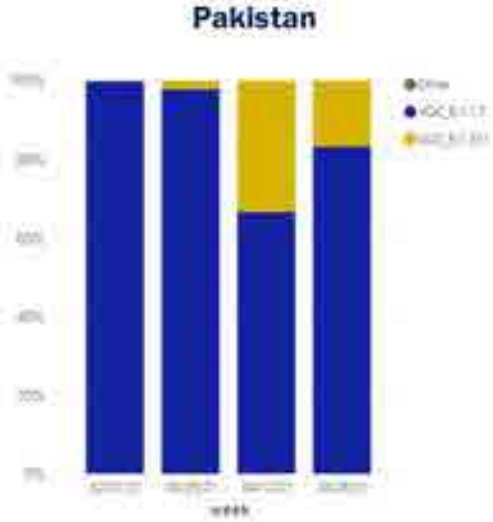
Sequence data submitted by India and neighboring countries			
SEARO Country	Sequences	Reported cases	% of cases with sequence data
Bangladesh	1,603	792,196	0.2
Bhutan	0	1,423	0
Democratic People's Republic of Korea	0	0	0
India	16,067	27,157,795	0.06
Indonesia	1,792	1,786,187	0.10
Maldives	0	58,345	0
Myanmar	41	143,296	0.03
Nepal	50	528,848	0.01
Sri Lanka	383	169,900	0.23
Thailand	1,055	137,894	0.77
Timor-Leste	19	6,014	0.32
Other Neighboring Countries	Sequences	Reported Cases	% of cases with sequence data
Afghanistan	16	67,743	0.02
Pakistan	300	905,852	0.03

Biweekly proportions of Variants of Concern and Variants of Interest detected in select SEARO countries and countries neighboring India









Countries Reporting SARS-CoV-2 Variants of Concern as of May 18, 2021

Countries reporting B.1.1.7 variant

Countries reporting B.1.351 variant

Countries reporting P.1 variant

Countries reporting B.1.617.2 variant

Countries reporting B.1.617.1 variant

Countries reporting B.1.617.3 variant

Resources and Publications

- **CDC Web Resources:** Variants of the Virus that Causes COVID-19, Variant Proportions in the U.S., Genomic Surveillance for SARS-CoV-2 Variants, SARS-CoV-2 Variants, National Genomic Surveillance Dashboard, New COVID-19 Variants, How CDC is responding to SARS-CoV-2 variants globally
- **Public Health England:** New SARS-CoV-2 Variant
  - SARS-CoV-2 variants of concern and variants under investigation in England – Technical Briefing 10
  - SARS-CoV-2 variants of concern and variants under investigation in England – Technical Briefing 11
  - SARS-CoV-2 variants of concern and variants under investigation in England – Technical Briefing 12
  - SARS-CoV-2 variants of concern and variants under investigation in England – Technical Briefing 13
- **Rambaut Lab, University of Edinburgh:** Global Report tracking New SARS-CoV-2 variant

- **Nextstrain:** SARS-CoV-2 Resources
- **Scripps Research Institute:** SARS-CoV-2 (hCoV-19) Mutation Situation Reports
- **University of California-Riverside:** Coronavirus 3D Website
- **University of Chicago:** NIAID Bioinformatics Resource Center (BRC)
- **Scripps Research institute** (outbreak.info)
- **Bloom Lab:** Sites in SARS-CoV-2 RBD where mutations reduce binding by antibodies / sera
- **NCATS** OpenData Portal – curated summary of variant data
- **bioRxiv:** Infection and vaccine-induced neutralizing antibody responses to the SARS-CoV-2 B.1.617.1 variant
- **bioRxiv:** Reduced sensitivity of infectious SARS-CoV-2 variant B.1.617.2 to monoclonal antibodies and sera from convalescent and vaccinated individuals.

Media Surveillance

28 May 2021

- **ABC News (Australia):** Indian variant of COVID-19 spreads as quickly as misinformation about 'most infectious' virus
- **Time Magazine:** Why 'Breakthrough' Infections Even After COVID-19 Vaccinations Shouldn't Be Surprising
- **CNN:** 'Get vaccinated, hit the beach'
- **The Hill:** ACLU calls for COVID-19 vaccines for those in ICE detention
- **Washington Post:** India's covid surge has killed more than 500 doctors and sickened hundreds of others since March, stretching staffs thin
- **BBC:** Indian variant: Covid cases low but creeping up

27 May 2021

- **CNBC:** FDA official says heart issue possibly linked to Covid vaccines is rare, would inoculate own kids
- **Reuters:** UK cases of Indian variant double to nearly 7,000 in a week
- **Washington Post:** Yes, we'll probably need coronavirus booster shots. But which one?
- **Wall Street Journal:** Russia Rolls Out Covid-19 Vaccine for Animals
- **CNN:** Vaccine tourists are coming to America
- **Reuters:** Post vaccination infection rare but possibly contagious: study refutes another anti-vax pregnancy claim
- **BBC:** Covid-19: Up to 75% of new UK cases could be Indian variant - Matt Hancock
- **Reuter:** Coronavirus variant could push back England's reopening, PM Johnson warns
- **Reuter:** Tokyo Games could lead to Olympic coronavirus variant - Japanese doctor

26 May 2021

- **New York Times:** Immunity to the Coronavirus May Persist for Years, Scientists Find
- **New York Times:** Influencers Say They Were Urged to Criticize Pfizer Vaccine
- **CNN:** Here's why schools are on alert over new coronavirus variants
- **Reuters:** Australia's Victoria state to enter COVID-19 lockdown after 'highly-infectious' outbreak

25 May 2021 (Late Breakers)

- **New York Times:** Moderna Vaccine Highly Effective in Adolescents, Company Says

Summary – Variants of Concern

Pango lineage	B.1.1.7	B.1.351	P.1	B.1.427/B.1.429
Nextstrain clade	20I/501Y.V1	20H/501Y.V2	20J/501Y.V3	20C/S:452R
First detected/emerged	United Kingdom - 20 September 2020	South Africa - August 2020	Brazil / Japan – December 2020	California – September 2020 (B.1.427) and June 2020 (B.1.429
Spike Protein Substitutions	Δ69/70, Δ144Y, (**E484K***), (**S494P***), **N501Y**, A570D, D614G, P681H, T716I, S982A, D1118H	(L18F*), D80A, D215G, ΔL242-L244, (R246I*), **K417N**, **E484K**, **N501Y**, D614G, A701V	L18F, T20N, P26S, D138Y, R190S, **K417T**, **E484K**, **N501Y**, D614G, H655Y, T1027I, V1176F	B.1.427: **L452R**, D614G B.1.429: S13I, W152C, **L452R**, D614G
Transmissibility	56% increased primary transmission (est. 50%-74%), increased secondary attack rate (est. 10% to 55%) link	50% increased primary transmission (range 20%-113%) link	Suggested to be increased based on similar spike protein substitutions in B.1.351	~20% increased transmissibility g, h
Severity	Likely increased severity link	No impact reported to date	No impact reported to date	Potential increased severity

* Substitutions in parenthesis with an asterisk are detected in some sequences but not all

Serum neutralization[¥]

Natural infection (prior circulating variants)	1.1-3.8-fold reduction in neutralizing activity (1, 2, 3, 5)	2.1-33-fold reduction in neutralizing activity (1)[£]	6.5-fold reduction in neutralizing activity (11)	4-6.7-fold reduction in neutralizing activity (13)
Vaccine – Pfizer BioNTech link	Up to 2-fold reduction in neutralizing activity (1, 5) **B.1.1.7+E484K**: 3.1-5.3-fold reduction in neutralizing activity[£]; 85% against B.1.1.7 in UK, Israel, and Qatar & 100% for severe disease	3-14-fold reduction in neutralizing activity (1, 8, 14, 15); 75% efficacy against B.1.351 in Qatar	2.2-15.1-fold reduction in neutralization activity (11, 14)	2-4-fold reduction in neutralization activity (13)[£]
Vaccine – Moderna link	1.2-2.1-fold reduction in neutralizing activity (1, 2, 3, 4) **B.1.1.7+E484K**: 6.7-9.6-fold reduction in neutralizing activity[£]	3.8-8.6-fold reduction in neutralizing activity (1, 4)[£]	2.8-fold reduction in neutralization activity (11)	2-3.4-fold reduction in neutralization activity (13)[£]
Vaccine – AstraZeneca	2.3-9-fold reduction in neutralizing activity; preliminary data indicate 75% efficacy in UK (6)[£]	2.5-31.5-fold reduction in neutralizing activity[£]; preliminary data indicate 10% efficacy (9, 15)	1-4-fold reduction in neutralizing activity[£]	
Vaccine – Novavax	2.1-8.9-fold reduction in neutralizing activity; preliminary data indicate 86% efficacy (2, 7)[£]	9-18-fold reduction in neutralizing activity[£]; Preliminary data indicate 55% efficacy in HIV(-) subjects; 49% in South Africa (7)		2-2.5-fold reduction in neutralizing activity[£]
Vaccine – Janssen/ J&J link	3.3-fold reduction in neutralizing activity[£]; 86% efficacy against B.1.1.7 in the UK; 74% efficacy in the US	6-40-fold reduction in neutralizing activity[£]; 52% efficacy in South Africa; 74% efficacy in the US (10)	66% efficacy in Brazil; 74% efficacy in the US	74% efficacy in the US

¥ Titer is compared to the reference (WT) strain and varies by assay (e.g., Wuhan strain, D614G); most data referenced is preliminary
£ Unpublished data

Impact on therapeutics[i]

Bamlanivimab + Etesevimab (Eli Lilly)	No change link	>45-fold reduction link	>511-fold reduction (11, 12) link	7.4-fold reduction link
Casirivimab + Imdevimab (Regeneron)	No change link	No change link	No change link	No change link
Remdesivir (Gilead)	None reported or predicted	None reported or predicted	None reported or predicted	None reported or predicted

[i] The impact shown for each therapeutic is largely based on neutralization studies using pseudoviruses

Impacts on diagnostics	Currently, low risk of overall impact. Impact on Ag tests expected to be low, pending evaluation	Currently low risk of overall impact. Impact on Ag tests expected to be low, pending evaluation	Currently low risk of overall impact. Impact on Ag tests expected to be low, pending evaluation	Currently low risk of overall impact. Impact on Ag tests expected to be low, pending evaluation
Countries reporting cases	155	111	62	33 (B.1.429) 25 (B.1.427)

Summary – Variants of Interest

Pango Lineage	Nextstrain	Spike Protein Substitutions	First Detected	Attributes
B.1.526	20C/S:484K	**Spike:** (L5F), T95I, D253G, (S477N), (E484K), D614G, (A701V)	United States (New York) November 2020	• Reduced susceptibility to the combination of bamlanivimab and etesevimab monoclonal antibody treatment; however, the clinical implications of this are not known. Alternative monoclonal antibody treatments are available. link • Reduced neutralization by convalescent and post-vaccination sera. *Convalescent sera:* 4.1 to 11.3-fold reduced neutralization. *Moderna vaccinee sera:* 3.3 to 3.6-fold reduced neutralization. *Pfizer vaccinee sera:* 3.6-fold reduced neutralization
B.1.526.1	20C	**Spike:** D80G, Δ144, F157S, L452R, D614G, (T791I), (T859N), D950H	United States (New York) October 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by convalescent and post-vaccination sera
B.1.525	20A/S:484K	**Spike:** A67V, Δ69/70, Δ144, E484K, D614G, Q677H, F888L	United Kingdom/Nigeria December 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by convalescent and post-vaccination sera
P.2	20J	**Spike:** E484K, (F565L), D614G, V1176F	Brazil April 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Reduced neutralization by post-vaccination sera. Pfizer vaccinee sera: 13.4-fold reduced neutralization
B.1.617	20A	**Spike:** L452R, E484Q, D614G	India February 2021	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Slightly reduced neutralization by post-vaccination sera link
B.1.617.1	20A/S:154K	**Spike:** (T95I), G142D, E154K, L452R, E484Q, D614G, P681R, Q1071H	India December 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Reduced neutralization by sera from convalescent and Moderna and Pfizer vaccinees link
B.1.617.2	20A/S:478K	**Spike:** T19R, (G142D), Δ156, Δ157, R158G, L452R, T478K, D614G, P681R, D950N	India December 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by post-vaccination sera
B.1.617.3	20A	**Spike:** T19R, G142D, L452R, E484Q, D614G, P681R, D950N	India - October 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by post-vaccination sera

Substitutions in parentheses are found in some, but not all, sequences

Access

Objective	Initiative	Status
Establish on-site clinics	Community colleges / retail pharmacy partnership	Announced; matchmaking underway
	CBOs and FBOs (e.g., YMCA) / VA partnership	Preparing to offer VA intervention to states
	Call to action for employers & unions to offer clinics	Holding ongoing employer conversations
	Barbershop/Beauty Salon in-shop vaccination efforts	In conversation with partners including Black Coalition Against COVID and Maryland's Center for Health Equity
	Toolkit for other organizations seeking on-site clinics	In progress
Use federal and state channels to close gaps	Rural Health Clinic direct vaccine delivery	Underway; need to enroll more
	VA partnership with states requesting mobile support	West Virginia selecting pilot sites for VA mobile vaccinations
	USDA-VA partnership for clinics in rural areas	Signing MOU; USDA selecting sites using CDC analysis
	Vaccination at national parks, with free admission	Discussing potential initiative with DOI
	Partner with American Hospital Association (AHA) to expand state vaccine distribution to hospitals	Michigan ready to kick off pilot. LA and NJ expressed interest
Remove other access barriers	Free rideshare to/from vaccination, through July 4	Completed; Uber/Lyft offering free rides starting May 24
	Free public transit to/from vaccination	DOT identifying localities without free mass-/para-transit; discussing non-emergency medical transportation with CMS
	Compensation & PTO for employee vaccination	Ongoing conservations
	Free childcare during vaccination	Finalizing commitments to offer drop-in childcare
	Minimization of ID barriers at vaccination sites	HRSA working to minimize PRF ID requirements

Incentives

Objective	Initiative	Status
Mobilize consumers incentives	Month of business incentives	Ongoing conversations
	CEO-to-CEO letter publication, calling for incentives	Calls in progress
	Vaccination clinic days with consumer incentives (e.g., MLB game day vaccination + ticket giveaway)	Developing events with NASCAR, MLB
	Private and Medicaid managed plan insurance incentives, including dependent coverage	Working with AHIP, ACHP, CMS
Mobilize college/ university incentives	"Vaccine Champion Campus" challenge for college/university vaccination commitments	In progress -- preparing for announcement
	Student/campus leader action competition	Ready for announcement
	College sports partnerships / campus competitions	In progress

Awareness

Objective	Initiative	Status
Maximize direct federal marketing	Pharmacy partner push	Complete
	Call to action for physicians	Developed provider communication resources
	Targeted federal agency equity outreach	Building data with HHS and key stakeholders to better target confidence efforts for priority groups
	Government-wide website banner with VaccineFinder and text number	Beginning discussion; preparing to make ask of agencies
	Ask agencies to post signage and push out consumer resources through their networks, in addition to vaccine.gov widget	Beginning discussion; preparing to make ask of agencies
Launch community canvassing	Call to action for mayors to lead door-to-door effort	Ask made at U.S. Conference of Mayors (5/14), with best practice sharing from Mayor Bowser
	National Month of Action for canvassing & vaccination	June 4-July 4, kicking off a social call to action day on Friday, May 21
Engage media and platforms	Vaccination information on social media platforms	Ongoing
	Principals events with influencers	Raised at Principals Committee meeting last week; POTUS & Dr. Fauci YouTube events with influencers this week
Combat mis-information	SG's bulletin on the health threats of misinformation	Developing bulletin
	Countermeasures for sources of pervasive misinformation (e.g., mythbusters)	Launching research into primary sources of misinfo

THE WHITE HOUSE
WASHINGTON

COVID-19 Update

July 6, 2021

DRAFT / PRE-DECISIONAL

Agenda

- State of the Pandemic
- COVID Response: Areas of Focus
  - Surge Response Teams
  - Vaccine Confidence
  - Vaccination Equity
- Global Vaccine Distribution

State of the Pandemic (as of 7/3/2021)

Key Metrics

	Total to date	Most recent day	7-day daily average	Week-on-week change
Cases	33,530,880	15,555	13,242	+10.6%
Confirmed COVID Hospital Admissions	2,289,396	1,739	1,898	+4.2%
Deaths	603,018	287	216	-9.6%
Test Positivity	7.6%	N/A	2.5%	+0.6% (absolute change)

Community Transmission Levels

Level of Risk	Low	Moderate	Substantial	High
% of Counties (6/27-7/3, 2021)	32%	45%	12%	12%

*Based on new cases per 100,000 persons and % positive tests during the last 7 days

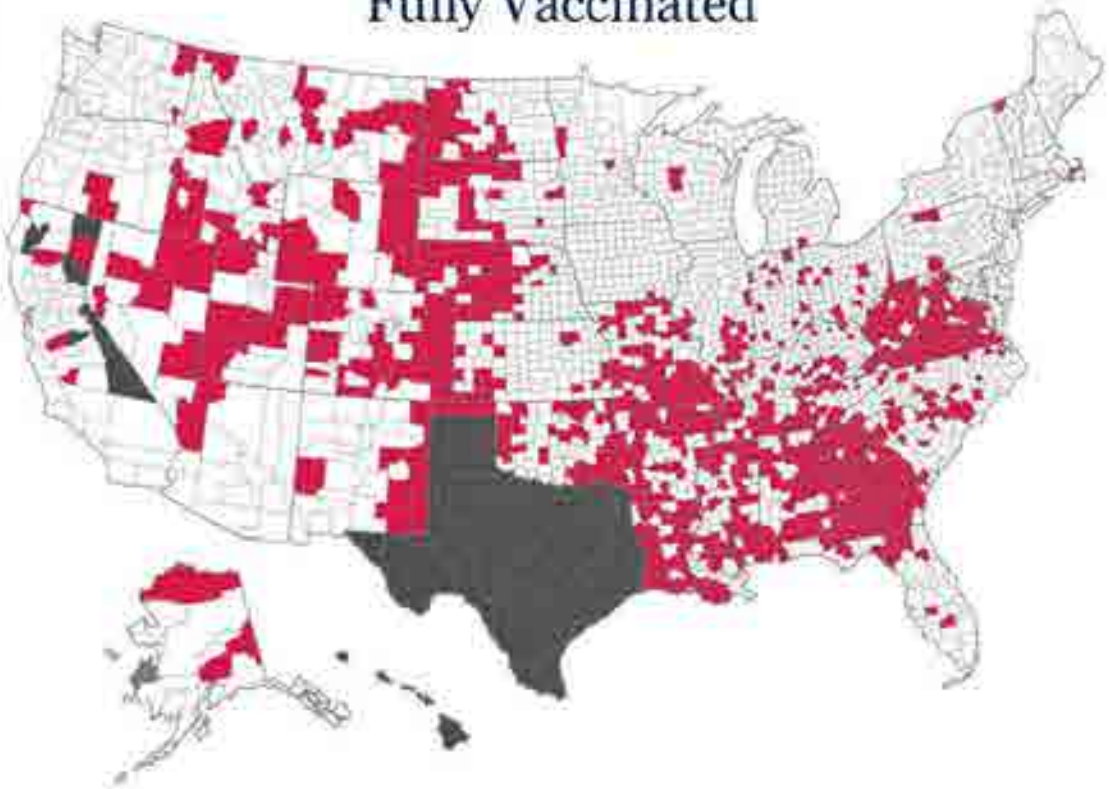
Delta Variant

- US Prevalence: ~26.1% for the 2-wk period ending June 19th
  - Lowest: HHS Region 4 (7.4%)
  - Highest: HHS Region 7 (57.5%)

Low Vaccination Rates Linked to Cases and Deaths

- 1079/3219 counties (34%) in the U.S have <30% of the population fully vaccinated
- Majority (59%) of counties with case rates ≥100/100,000 have <30% of the population fully vaccinated
- Preliminary data from a collection of states over the last 6 months suggest 99.5% of deaths from COVID-19 have occurred in unvaccinated people
- From May through November 2021, projected cumulative mortality rate is higher for states with lower vaccination coverage

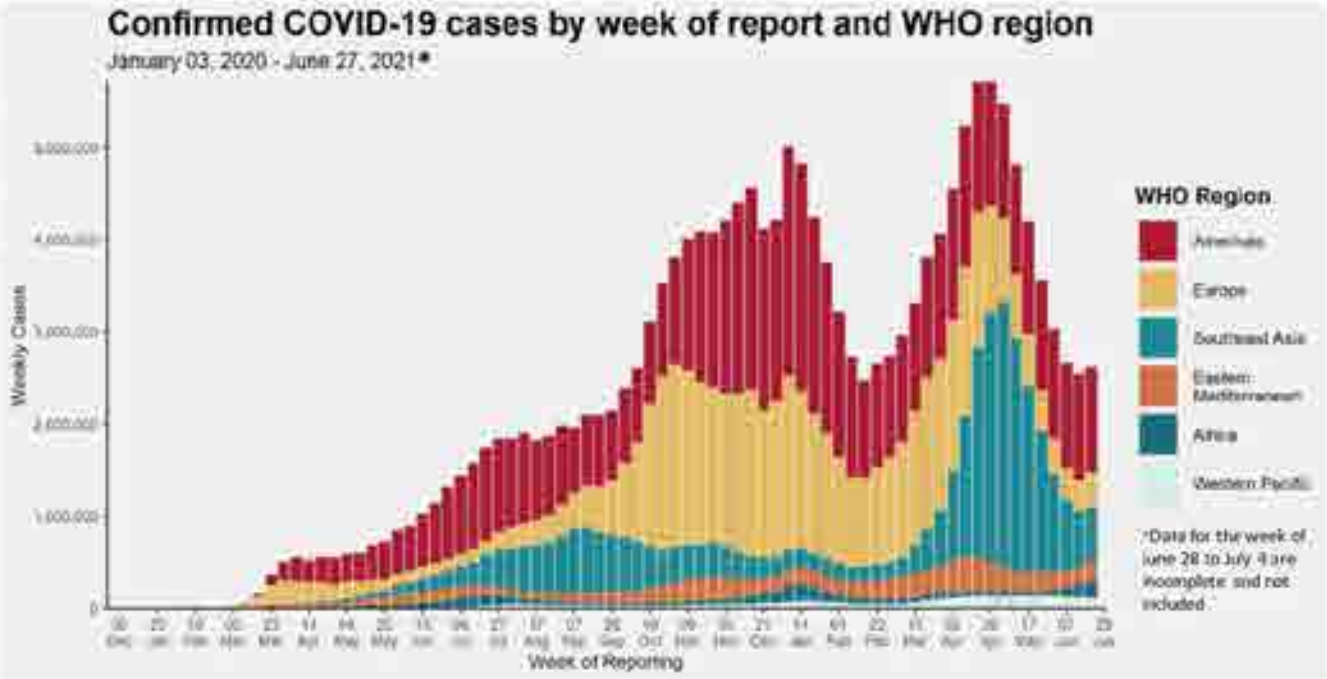
Counties with <30% of the Population Fully Vaccinated



Data Source: COVID Data Tracker and HHS Protect. Time Period: Fri Jun 25, 2021. Time Period: Fri Jun 25, 2021. Hawaii and Texas are excluded as county-level vaccination information is unavailable. California counties with <20k population also are excluded. Excluded counties and counties with missing data are shaded in gray.

Global Epidemiology (as of 7/2/2021)

- **Cases** are:
  - Increasing in Africa and Eastern Mediterranean
  - Starting to plateau in Southeast Asia and Europe after previous declines
  - Continuing to plateau in the Americas and Western Pacific
- Global **deaths** decreased by 10.2% last week to this week*
- Countries reporting the **highest case counts**† in the last week: Brazil & India
  - Greatest percent increase in cases in the last week were in Guinea, Nigeria, and Mozambique



182,319,261
Total Confirmed Cases

2.8%
Change in Weekly Cases*

2,651,010
New Cases in Last 7 Days

3,954,324
Total Deaths

*Percent changes are based on comparison of complete weeks (a complete week runs Monday to Sunday)
†Countries with population size less than 10 million are excluded for this analysis

COVID-19 Vaccines Protect Against the SARS-CoV-2 Delta Variant

- Infection
- Symptomatic Disease
- Hospitalization

THE LANCET
published online June 14, 2021

SARS-CoV-2 Delta VOC in Scotland: Demographics, Risk of Hospital Admission, and Vaccine Effectiveness

A Sheikh et al. on behalf of Public Health Scotland and the EAVE II Collaborators

- At least 14 days after the second dose, Pfizer-BioNTech vaccine 79% effective against PCR-confirmed infection with SARS-CoV-2 Delta variant
- 2 doses of Oxford-AstraZeneca vaccine 60% effective

medRχiv

THE PREPRINT SERVER FOR HEALTH SCIENCES

Posted May 24, 2021

Effectiveness of COVID-19 Vaccines against the B.1.617.2 Variant

JL Bernal, M Ramsay et al.

- 2 weeks after 2nd dose, Pfizer-BioNTech vaccine 88% effective against symptomatic disease from SARS-CoV-2 Delta variant
- 2 doses of Oxford-AstraZeneca vaccine 60% effective against Delta
- 3 weeks after one dose, both vaccines only 33% effective against symptomatic disease from Delta

Public Health England

Press Release

June 14, 2021

Vaccines Highly Effective Against Hospitalization From Delta Variant

- Pfizer-BioNTech vaccine 96% effective against hospitalization from Delta variant after 2 doses
- Oxford-AstraZeneca vaccine 92% effective against hospitalization from Delta variant after 2 doses

Johnson & Johnson Vaccine-Induced Antibodies Neutralize Delta Variant in Laboratory Tests

July 1, 2021

Cold Spring Harbor Laboratory

bioRχiv

THE PREPRINT SERVER FOR BIOLOGY

Ad26.COV2.S Elicited Neutralizing Activity Against Delta and Other SARS-CoV-2 Variants of Concern

M Jongeneelen, B Brandenburg et al.

- Tests of blood of people vaccinated with single dose of the J&J vaccine show that the Delta variant and other variants are effectively neutralized
- Neutralization at a higher level than with Beta variant in South Africa where high J&J vaccine efficacy against severe/critical disease was demonstrated

COVID Surge Response Teams: Localized Approach

Data analytics

Identify where **unvaccinated pockets** are and where hotspots are/may emerge, by reviewing COVID-19 case, death, hospitalization and vaccination rates and trends

Targeted support

Engage state and local leaders through **Federal Response Teams** ready to surge federal **resources and support**, including:

- Additional testing capacity
- Deploying therapeutics
- Further enhancing vaccination efforts with strategies such as mobile
- CDC technical expertise and consultation
- CDC experts on-the-ground to support field investigations
- Federal personnel to provide support for vaccinations, testing and therapeutics as needed
- Support on vaccine confidence strategies and outreach

Applies localized approach to **state-by-state** vaccination support process in Spring

Surge resources already deployed to **Colorado**, with additional resources in process for **Missouri**

COVID Response: Areas of Focus

Surge response

Launch surge teams to monitor where hotspots emerge and marshal resources for localized support on testing, therapeutics, supplies, and vaccination

Vaccine confidence

Continue to build vaccine confidence at a hyper-local level, with efforts in target markets to identify local hesitancy drivers and address misinformation

Localized vaccination

Expand localized vaccination efforts while preparing for potential boosters, including launching a back-to-school/ back-to-work campaign and building on the more than 10,000 doctors offices offering vaccine

School reopening

Launch a "Return to School Roadmap" and launch public campaign to help schools and districts reengage students and families in in-person learning

Supply chain & testing

Begin ARP investments to expand the U.S. industrial base and implement testing stockpiling plan. Make tests more accessible and strengthen public messaging on testing

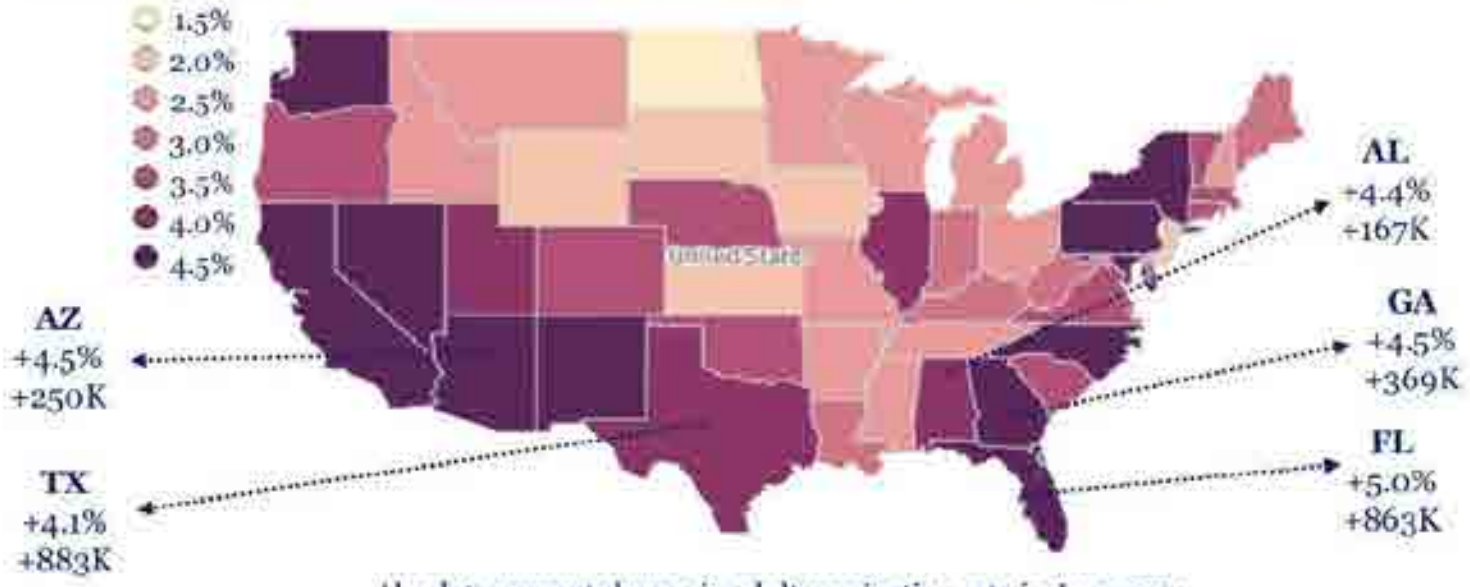
Ensuring equity will continue to be a central part of all COVID Response work, with a focus on:

- Removing structural barriers to accessing information and resources
- Strengthening the data environment to inform equity interventions
- Building partnerships to transition COVID-19 health equity efforts into impactful long-term health equity policies

Vaccine Confidence and Motivation

- **Willingness to get vaccinated has plateaued:** 69.7% of adults were vaccinated or plan to get vaccinated, as of mid-June; 12.7% say they probably will get vaccinated or are unsure; 17.7% are reluctant[1]
- **Health misinformation is a critical barrier:** 67% of unvaccinated adults think common COVID-19 vaccine myths are or might be true[2]
- **Pandemic progress has reduced motivation:** 50% of unvaccinated adults say cases are so low there is no need for more vaccinations[2]
- **Long COVID messaging may help:** 40% of unvaccinated are more likely to consider vaccination after hearing Long COVID testimonials[3]

Month of Action *drove significant uptake in low vaccination regions*



Absolute percent change in adult vaccination rate in June 2021

The path forward

Building trust & mobilizing the public

- Local trusted messengers, including the vaccinated
- Pediatrician & family medicine partnerships
- Parent outreach
- Targeted traditional & digital media
- Long COVID & variants messaging
- Technology company engagement
- Surgeon General's Advisory on health misinformation

Sources: (1) CDC National Immunization Survey, June 13-19 2021; (2) KFF Poll, April & June 2021 (3) Resolve to Save Lives, unpublished data, May 21-June 10 2021.

Ensuring Equitable Vaccination

- Estimated percentage of Hispanic and Black individuals with at least one shot (this excludes 8% that identify as multiple/other):
  - **~64%** of Hispanic individuals age 18+ have received first doses (vs. 64% for White)
  - **~51%** of Black individuals age 18+ have received first doses
  - For age 65+, nearly 90% of both White and non-white groups have received first doses

- The gap is closing, with people of color accounting for a **greater** proportion of all vaccinations:
  - Hispanic individuals account for **31%** of first doses in past month (vs. 14% from December to June)
  - Black individuals account for **12%** of first doses in past month (vs. 9% from December to June)
  - For age 65+, non-white individuals now account for over half of all individuals with first doses

- Continuing the push to increase vaccination equity, including:
  - Engaging SBA to promote **paid time off** for vaccination in small, minority-owned businesses
  - Extending drop-in **child care** services
  - Launching a challenge to encourage and facilitate local public-private-philanthropic **partnerships**
  - Increasing **on-site vaccination clinics** at CBOs, FBOs, and barbershops and salons and dovetailing with back-to-work/back-to-school efforts

Global Donation of 580 Million+ Doses

Donating excess U.S. vaccine supply

- We have shared **80 million** doses of U.S. vaccine supply with **46 countries**, the African Union, and CARICOM through bilateral sharing and COVAX
- **Over 40 million** of these have already been shipped out—including to the Republic of Korea, Mexico, Canada, Brazil, Taiwan, Honduras, Colombia, Pakistan, Peru, Ecuador, Malaysia, Bangladesh, and El Salvador
- Additionally, we anticipate donating **tens of millions** more doses of excess U.S. supply in July and August

Making dedicated purchases to donate to the world

- Remain on schedule to deliver the first **200 million doses** of the 500 million Pfizer vaccine to 100 of the lowest income countries
- Conducting early stage negotiations with **Moderna** and **Johnson & Johnson** on potential agreements for the world
- Exploring efforts to **transfer** mRNA drug substance technology to countries outside the U.S.

U.S. Leadership in Global Donations

"Pakistan receives 2.5M doses of Moderna COVID vaccine from the U.S."

> Bringing one of the most impressive global cooperative programs to fruition.
>
> – *Canada*

> About 99.8% of the Janssen vaccines has been successfully administered as of today, 25th of June. I could also personally feel the status of ROK-U.S. alliance further elevated through the success of vaccine transportation.
>
> – *Republic of Korea*

> America's donation of three million vaccine doses to Brazil is a lasting tribute to the almost 200-year friendship that unites our countries. Brazil and the U.S. are working together to overcome this pandemic and build an ever stronger partnership for the benefit of our peoples.
>
> – *Brazil*

Thank you message on Taipei 101, Taiwan

THE WHITE HOUSE
WASHINGTON

Dr. Murthy's slides

April 19, 2021

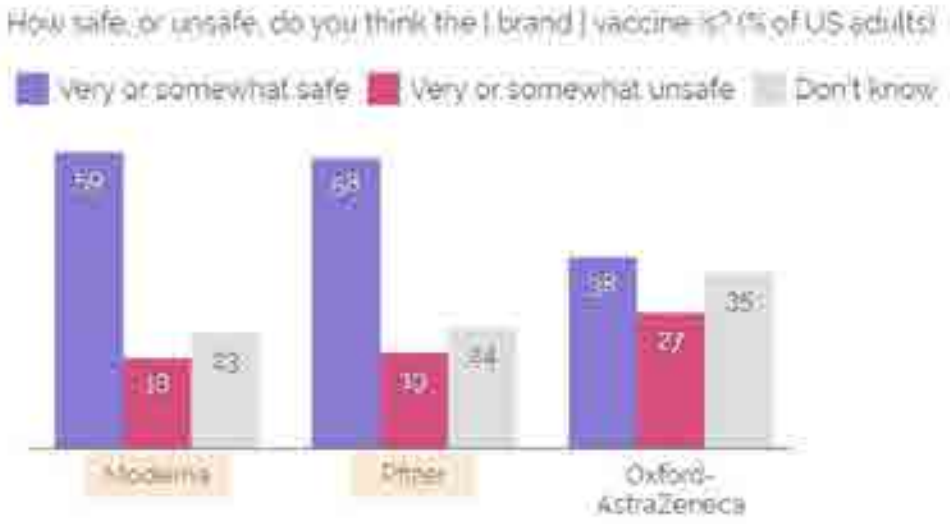
DRAFT / PRE-DECISIONAL

Before the J&J pause, **vaccine confidence** was increasing, yet key gaps existed

Trend	Detail
✓ Willingness to get vaccinated has been rising among Americans	• **67%** of adults were vaccinated or very likely to get vaccinated as of early April (vs. **49%** in January)[1]
✓ Racial & ethnic disparities in vaccine confidence have been narrowing	• **55%** of Black adults were vaccinated or very likely to get vaccinated as of late March (vs. **20%** in December)[2] • **61%** of Latinx adults (vs. **26%**)[2] • **64%** of White adults (vs. **40%**)[2]
▧ However, a stable proportion of adults still has not planned to receive a vaccine	• **14%** of adults were very unlikely to get vaccinated as of early April (vs. **17%** in January)[1]
▧ Differences by political, rural, and age have remained wide	Vaccine confidence as of late March was lower among: • Republican (**46%** vaccine confident vs. **79%** of Democrats)[2] • Rural (**54%** vaccine confident vs. **66%** urban)[2] • Young adults (**25%** aged 18-29 want to "wait & see" vs. **17%** aged 50-64, though less eligible at the time)[2]

Sources: (1) HHS CET national poll, April. (2) Kaiser Family Foundation Poll, March 15-22.

Early data suggest the **J&J pause** reduced confidence, but effects are not yet clear



- In one poll, confidence in **J&J** vaccine safety fell **15** percentage points in 2-3 days
- In the same poll, confidence in safety of **Pfizer** and **Moderna** vaccines remain unchanged from February levels, but additional data is needed
- One-third of people previously uncertain about getting a vaccine had indicated safety data would influence their decision; J&J may **lengthen** this **"wait and see"** period
- **Misinformation** rapidly circulated after the J&J pause

COVID-19 Response is leading a **campaign** to build confidence

Efforts are underway across HHS

- COVID-19 Community Corps is engaging **trusted messengers** (when deciding whether to get a vaccine, 3 in 4 adults would turn to a health provider; more than half would turn to family or friends)
- Paid media and advertisement campaign is underway in XX states across YY venues
- $ZZZ funding have been made available to agencies and organizations for vaccine confidence work

J&J pause presents an **opportunity** to deliver our mandate of building trust

- What you are seeing right now is your safety system working for you. A signal came up, so FDA and CDC jumped on it.
- These are very rare events. If you received the J&J vaccine, it is extremely likely you will be fine, like millions of others.
- We continue to have great faith in the effectiveness and safety of the Pfizer and Moderna vaccines.
- What I am most concerned about are rising case numbers. The virus has cost us more than 500,000 friends and family members; we all want to turn this pandemic around and protect our loved ones.

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Appendix
Vaccine confidence

For Vivek to delete/swap

Note: The following 3 slides include excerpts from the HHS Current Events Tracker latest data (Apr 16 – still BEFORE J&J) that we can include potentially.

These are all screenshot slides, but if we were to include, we'd of course ensure format is appropriate and polished.

CET WAVE 11 RESULTS

Vaccine Ready

Age
More likely to be older (ages 65 or older)

Education
More likely to have college or higher education

Income
More likely to make $100K annually or more

Political Ideology
More likely to be liberal

Region
More likely to live in a metro area and in the Northeast

Marital Status
More likely to be married

Wait and See

Age
More likely to be younger

Education
More likely to have less than a high school education

Income
More likely to make less than $50K annually

Political Ideology
More likely to be conservative

Region
More likely to live in a non-metro area

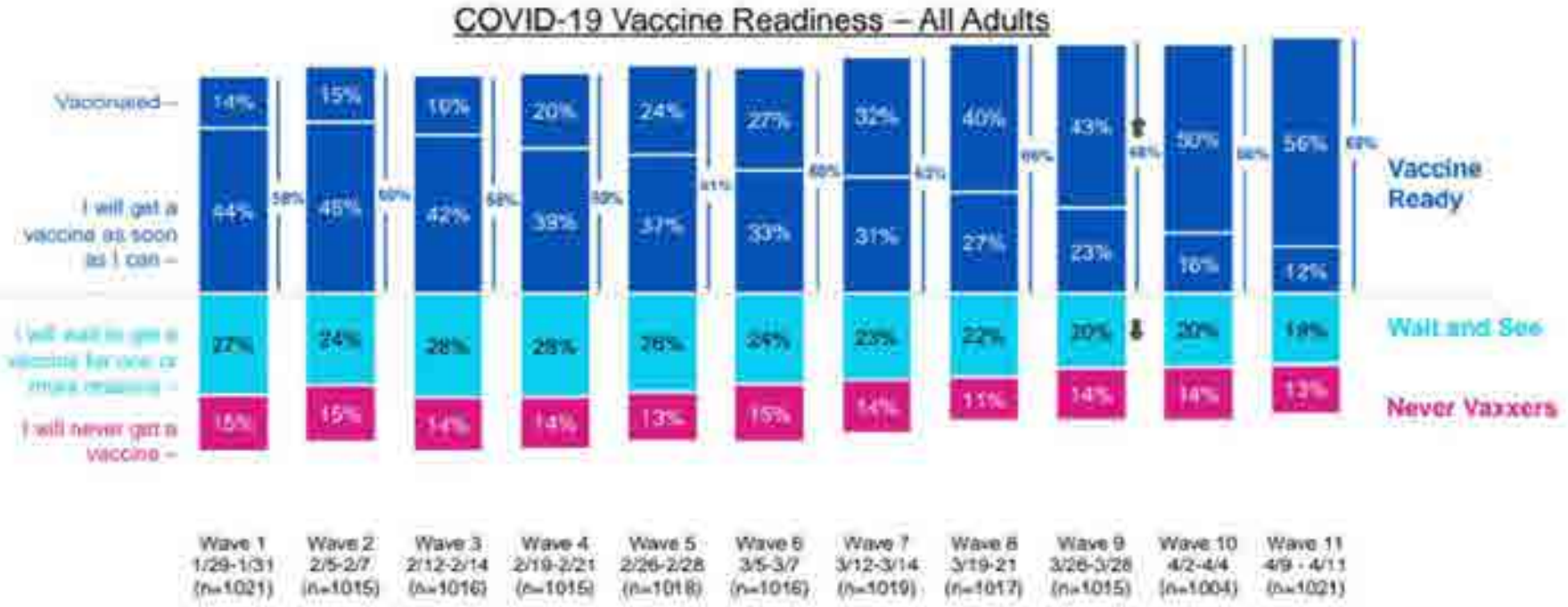
Marital Status
More likely to not be married

Note: Findings reported here have fluctuated between waves but have been observed as significant, recurring trends for the Vaccine Ready and Wait and See subgroups

BERT, CET: Food and Drug Administration (FDA) authorized vaccines to prevent COVID-19 are now available to everyone. Have you received a COVID-19 vaccine? BERTA, CET: Food and Drug Administration (FDA) authorized vaccines to prevent COVID-19 are now available to everyone. How safe will you get vaccinated? For any questions, please ask an expert, research, or talk to someone who wants a vaccine can get it.

UNCLASSIFIED // PRE-DECISIONAL // FOUO

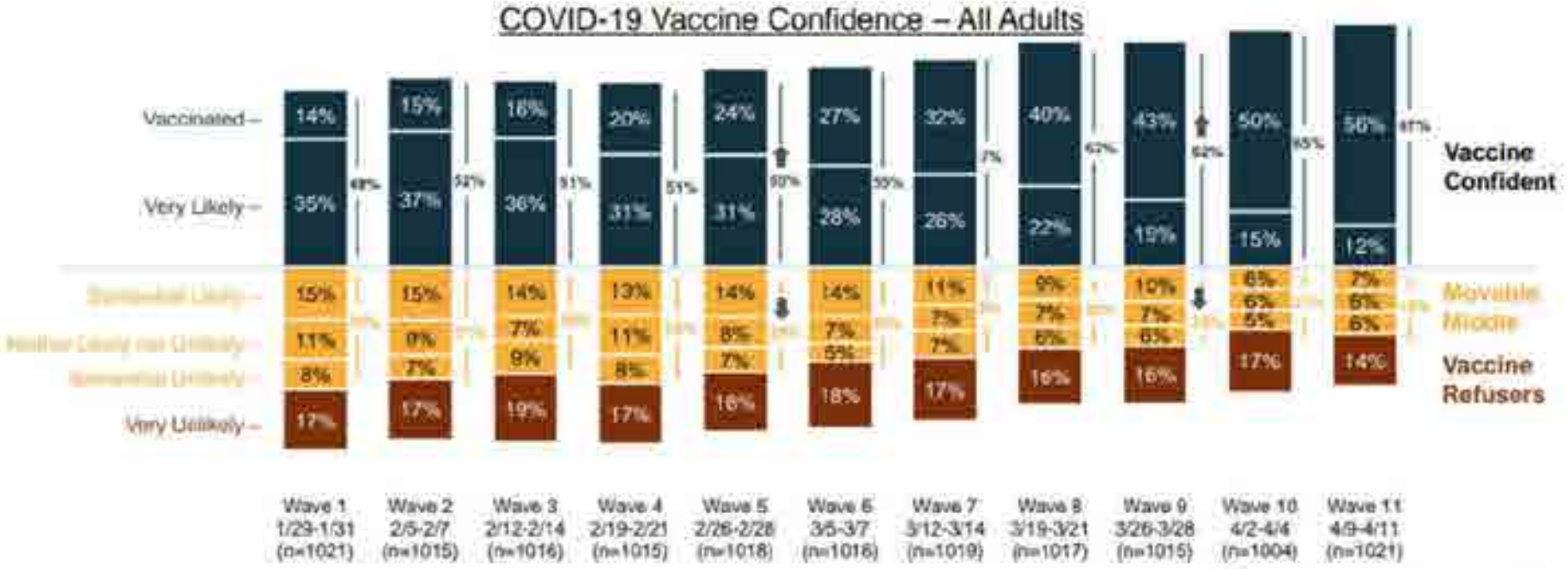
In Wave 11, 68% of Americans were vaccinated or will get vaccinated as soon as they can.



HHS COVID-19 Public Education Campaign 11

UNCLASSIFIED / PRE-DECISIONAL / FOUO

Sixty-seven percent of adults were either vaccinated or very likely to get vaccinated.



UNCLASSIFIED // PRE-DECISIONAL // FOUO

COVID-19 Community Corps is engaging trusted messengers to build vaccine confidence

- Launched with **275** founding members last week with Vice President Harris; now **4,500+** members
- **Arming trusted messengers** with scientific information & tools
- **Founding members** of the Corps include American Farm Bureau, NASCAR, WWE, Black Coalition Against COVID, Minority Business Roundtable, American Medical Association, Center for Native American Youth
- Reaching **underserved & minority communities** by empowering subject matter experts, hosting listening sessions, & crossing language barriers

Friends

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THE WHITE HOUSE
WASHINGTON

Dr. Murthy's slides

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Before J&J pause, **willingness to get vaccinated** was increasing, yet gaps existed

Trend	Detail
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Sources: (1) HHS CET national poll, April. (2) Kaiser Family Foundation Poll, March 15-22.

Preliminary data: Confidence in **J&J safety** is lower but stable for **Pfizer & Moderna**

Initial findings

- Confidence in J&J safety fell 15 points, but mRNA vaccines held
- 88% of people aware of the pause view it as a responsible decision
- Majority of voters report pause did not decrease likelihood of getting vaccinated

How safe, or unsafe, do you think the [brand] vaccine is? (% of US adults)

Public Education Campaign

Building trust & educating the public with:

- Trusted messenger program
- Adolescent campaign
- Private partnerships
- Earned media
- Social media
- Support for states
- Conservative campaign
- "We Can Do This" paid media

Sources: (1) The Economist / YouGov, April 10 - 13, 2021.

COVID-19 Response is leading a **campaign** to build confidence

Efforts are underway across HHS

- COVID-19 Community Corps is engaging **trusted messengers** (when deciding whether to get a vaccine, 3 in 4 adults would turn to a healthcare provider; more than half would turn to family or friends)
- Paid media and advertisement campaign is underway in XX states across YY venues
- $ZZZ funding have been made available to agencies and organizations for vaccine confidence work

J&J pause presents an **opportunity** to further build trust

- The safety system seems to be working for you. FDA and CDC acted on critical information.
- These are very rare events. If you received the J&J vaccine, it is extremely likely you will be fine, like millions of others.
- We continue to have great faith in the effectiveness and safety of the Pfizer and Moderna vaccines.
- What I am most concerned about are rising case numbers. The virus has cost us more than 500,000 friends and family members; we all want to turn this pandemic around and protect our loved ones.

TBD
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Public Education Campaign Core Strategy

Today, we have enough vaccine supply to where **vaccine demand** will be the decisive factor in whether we defeat COVID-19. To increase demand, we are prioritizing:

Four target audiences » **Five engagement channels** » **Key Factors**

- Black communities
- Hispanic communities
- Conservatives
- Young people

- Earned media
- Digital engagement
- Paid media
- Private sector engagement
- ***Most importantly:*** Prioritizing trusted messengers

- Understanding the risk of COVID
- Trust in the safety and effectiveness of the vaccines and the government
- Convenience and accessibility of the vaccines.

Priority Projects

Trusted Messenger Program

- *COVID-19 Community Corps* (calls, trainings, social media assets)
- *We Can Do This Live* (matching celebrities with experts)

Adolescent Campaign

- Paid media (parents)
- Social media (adolescents)
- Coordination with parent groups & youth associations
- Pitching to women's magazines & outlets

Private Partnerships

- Employers (getting staff and customers vaccinated)
- Entertainment (consumer marketing)
- Talent agencies (celebs)

Earned Media

- Networks and shows (messaging)
- Targeted regional pitching leveraging Corps partners (e.g., AMA, regional CBOs)

Social Media

- Focused campaigns (e.g., Mother's Day, graduation)
- Video production and design work for creative assets

Support for States

- Strike team and resources for states
- Targeted outreach to community organizations in critical states and localities

Conservative Campaign

- Trusted messengers and spokespeople
- Targeted pitching
- AMA / NAB program

"We Can Do This" Paid Media Campaign

- May 5: Targeting 18+ on eligibility & vaccines.gov
- May 17: Targeting health navs & targeted geographies
- Early June: Targeting remaining "Moveable Middle" by subpopulation

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Appendix
Vaccine confidence

For Vivek to delete/swap

Confidence in safety of COVID-19 vaccines before and after J&J pause

Highlight	Detail
Two-thirds of adults already have gotten or plan to get a vaccine	• Republicans (45%), young adults (36%) people in rural areas (35%) and people in the Midwest(35%) are more likely to report NOT planning to get vaccinated, compared to 27% overall. [1]
Confidence in the safety of the J&J vaccine declined after pause announcement; Confidence in mRNA vaccines held steady	• Confidence in J&J vaccine declined from 52% to 37% immediately after the pause announcement. • Confidence in Moderna and Pfizer vaccines held steady at 59% and 58% [2]
Social media abuzz with misinformation	• The Most Popular J&J Vaccine Story On Facebook? A Conspiracy Theorist Posted It The most popular link on Facebook about the Johnson & Johnson news was shared by a conspiracy theorist and self-described "news analyst & hip-hop artist" named AnOmaly who thinks the pandemic is a cover for government control. [3]
Most people consider federal health official reliable sources of information	• 63% of adults say they trust federal health officials to provide reliable information on COVID-19 • Trust is lower (48%) among those with a "wait and see" approach to vaccination[4]

Sources: (1) Quinnipiac University Poll, April 14, 2021. (2) Economist/YouGov poll, April 14, 2021. (3) NPR, April 15, 2021. (4) CET Wave 11 Results, April 9-11, 2021

Americans' plans to get a COVID-19 vaccine before the pause

- 68% of American adults plan to get vaccinated or already have gotten vaccinated.
- Some groups are more likely to plan NOT to get vaccinated.
  - 45% of Republicans
  - 36% of 18-34 year olds
  - 35% of people in the Midwest
  - 35% of 35-49 year olds
  - 34% of people in rural areas
- Poll completed prior to pause announcement.

34. Which comes closest to your situation: you are not planning to receive a COVID-19 vaccine, or you are planning to receive or have already received a COVID-19 vaccine?

	ADULTS						WHITE 4 YR COLL DEG	
	Tot	Rep	Dem	Ind	Men	Wom	Yes	No
Don't plan to	27%	45%	7%	29%	30%	23%	13%	30%
Plan to/Already	68	50	91	66	63	73	86	64
DK/NA	5	5	3	5	6	4	1	5

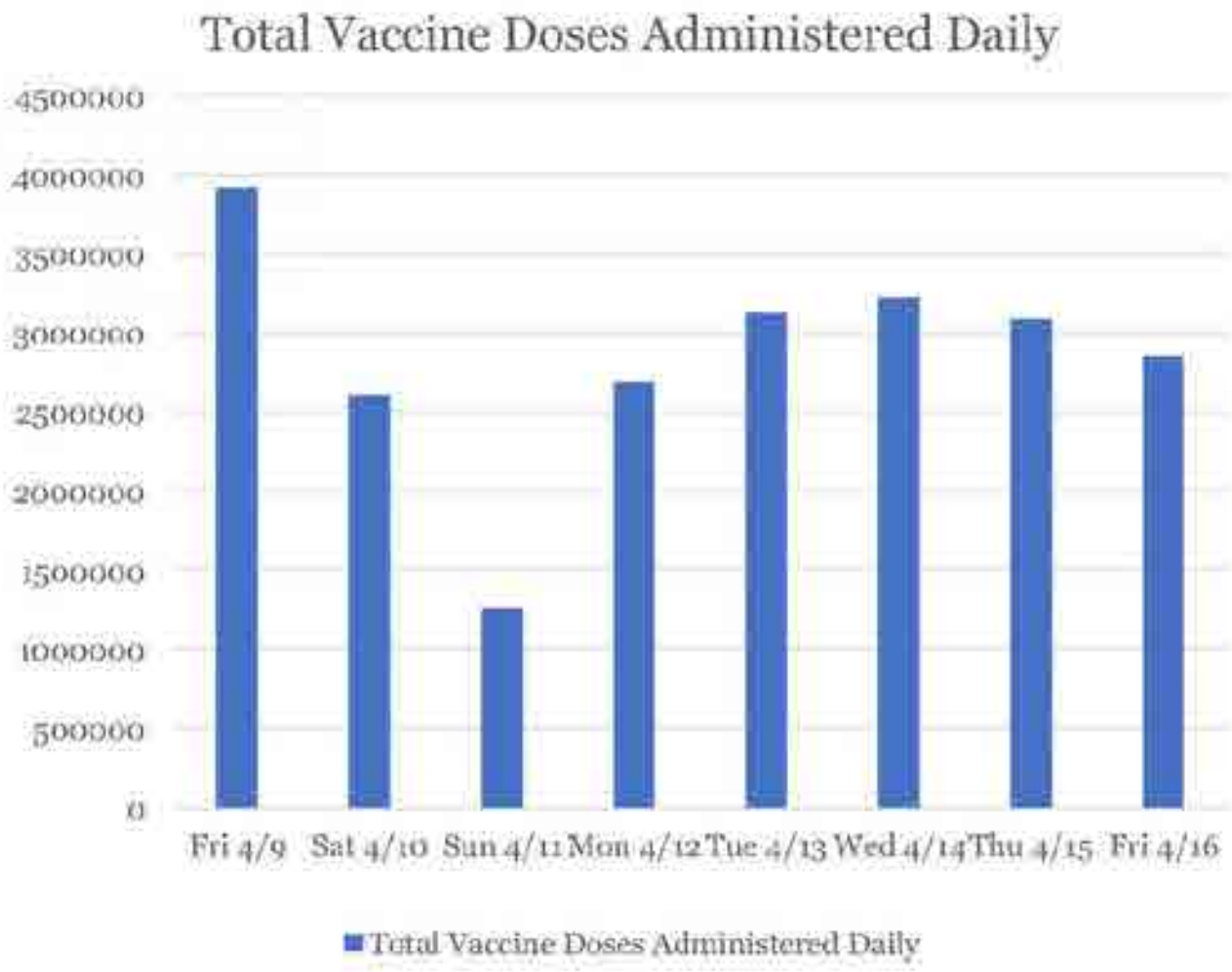
	AGE IN YRS				WHITE				
	18-34	35-49	50-64	65+	Men	Wom	Wht	Blk	Hsp
Don't plan to	36%	35%	22%	10%	29%	20%	24%	19%	30%
Plan to/Already	59	60	73	89	67	76	72	78	62
DK/NA	6	5	4	1	5	3	4	3	8

	REGION				DENSITY		
	NEast	MWest	South	West	City	Suburb	Rural
Don't plan to	19%	35%	25%	26%	25%	20%	34%
Plan to/Already	77	60	68	70	71	75	61
DK/NA	3	5	7	4	5	5	6

Sources: (1) Quinnipiac University Poll, April 14, 2021, https://poll.qu.edu/images/polling/us/us04142021_uscd43.pdf

Trends in administration of COVID-19 vaccines before and after pause

- Immediate trends based on incomplete data suggest potential decline in number of vaccines administered daily.
- More data need to determine the longer-term impact of the pause announcement on population willingness to be vaccinated.



Sources: (1) CDC Vaccine Tracker, 2021 https://covid.cdc.gov/covid-data-tracker/#vaccination-trends. (2) CDC, 2018 (3) (4)

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More likely to live in a metro area and in the Northeast

Marital Status
More likely to be married

Wait and See

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HHS COVID-19 Public Education Campaign 10

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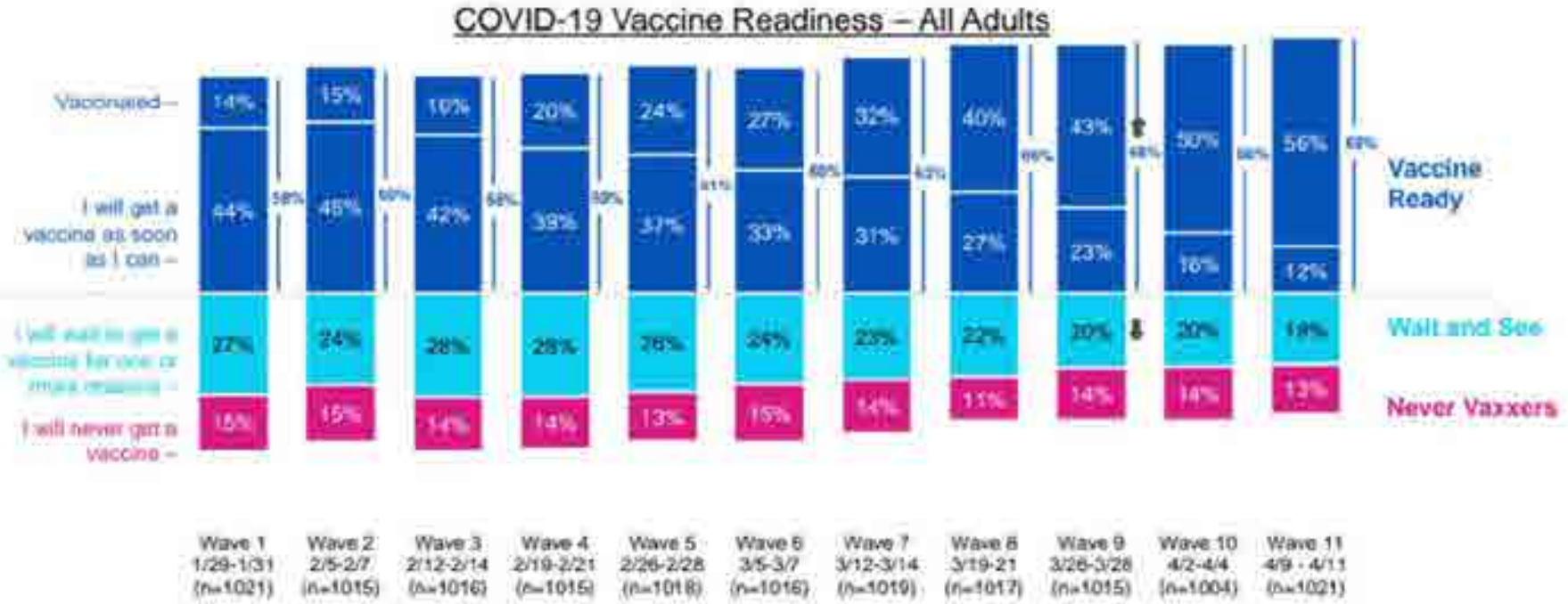
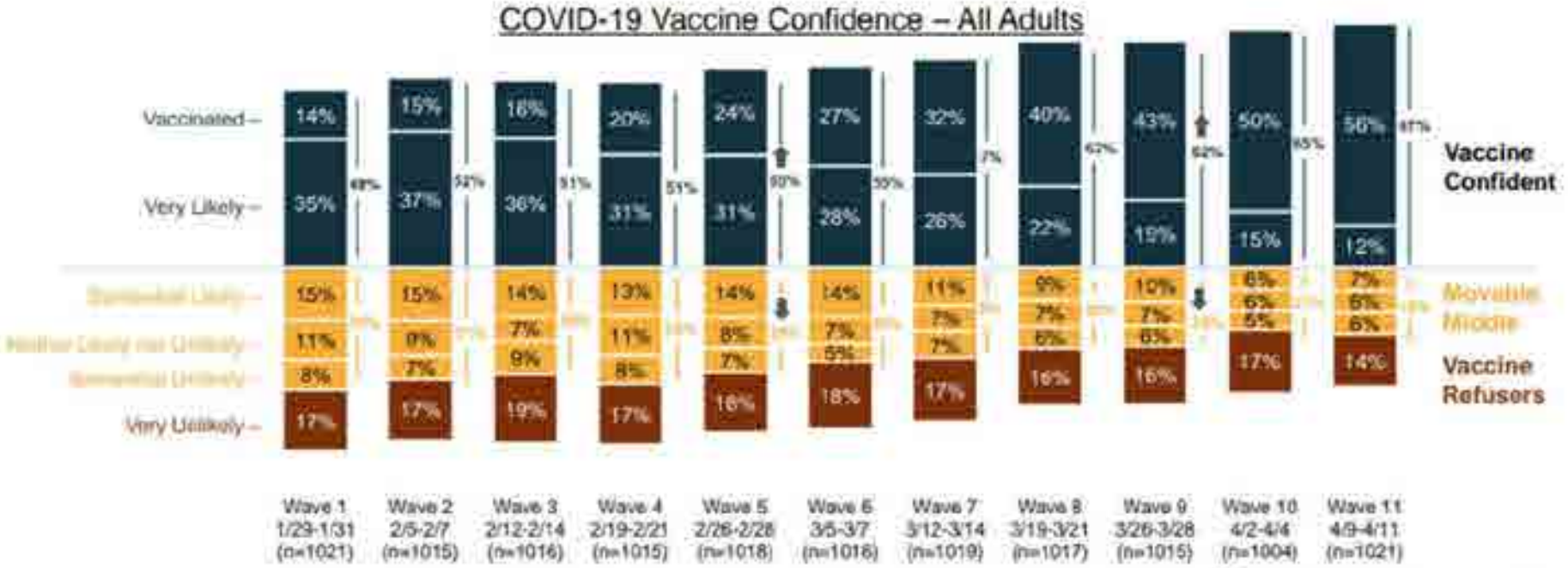
UNCLASSIFIED // PRE-DECISIONAL // FOUO

In Wave 11, 68% of Americans were vaccinated or will get vaccinated as soon as they can.



HHS COVID-19 Public Education Campaign 11

Sixty-seven percent of adults were either vaccinated or very likely to get vaccinated.



HHS COVID-19 Public Education Campaign 12

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- **Founding members** of the Corps include American Farm Bureau, NASCAR, WWE, Black Coalition Against COVID, Minority Business Roundtable, American Medical Association, Center for Native American Youth
- Reaching **underserved & minority communities** by empowering subject matter experts, hosting listening sessions, & crossing language barriers

Friends

Pharmacists

WE CAN DO THIS

Nurses

Faith Community

Toll of the COVID-19 pandemic

- An estimated nearly 40,000 children in America lost a parent to COVID-19, according to a new model (1)
- About 1 in 3 people with COVID-19 were diagnosed with a psychiatric or neurological condition in the following six months (2)
- Percentage of adults reporting recent symptoms of an anxiety or depressive disorder is rising (41% in February 2021 vs. 36% in August 2020) (3)

Sources: (1) JAMA Pediatrics (2) Lancet Psychiatry (3) CDC MMWR

Vaccines are our way out of the pandemic

- By April 19, XX% of adults will be eligible for a vaccine
- We have enough supplies for XX people
- Vaccine confidence is also rising, with 61% of people vaccinated or wanting to receive a vaccine "as soon as possible" as of late March (vs. 34% in December)

Sources: (1) Kaiser?

Trusted messengers are essential for health education & empowerment

- More than 3 in 4 adults in the United States have said they would likely turn to a doctor, nurse or other health care provider when deciding whether to get a vaccination (1)
- More than half said they'd likely turn to family or friends about whether to get a vaccination (1)
- **Covid-19 Community Corps** is growing (275 members last week to 4,500+ members today)

Sources: (1) KFF January

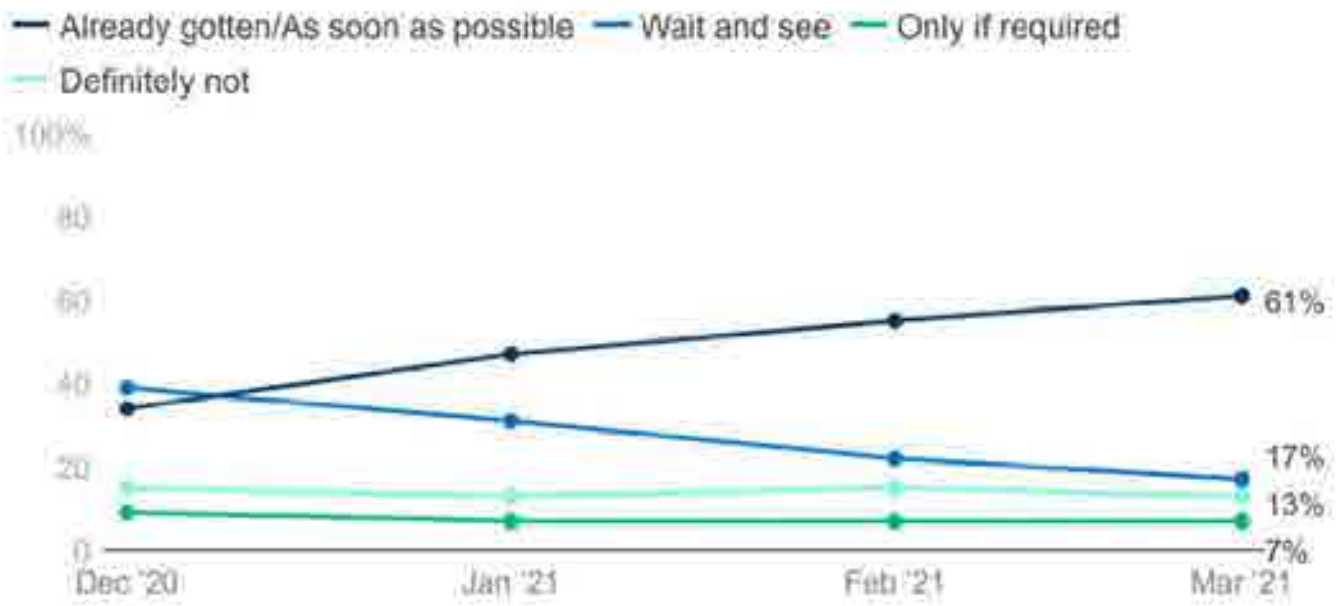
Vaccine confidence

Internal, pre-decisional, notes ONLY not for presentation

Confidence in COVID-19 vaccines is rising

As important as supply is empowering people to receive a vaccine

Vaccine confidence is rising, with 61% of people vaccinated or wanting to receive a vaccine "as soon as possible" as of late March (vs. 34% in December 2020)



Source: KFF Vaccine Monitor, March 2021.

Vaccine confidence is increasing, yet key gaps remain

Trend	Detail
√ Willingness to get vaccinated is rising among Americans	• **61%** of adults will or have gotten a vaccine (vs. **35%** in Dec.)[2]
√ Racial & ethnic disparities in vaccine confidence are narrowing	• **55%** of Black adults will or have gotten a vaccine (vs. **20%** in Dec.) • **61%** of Latinx adults (vs. **26%**) • **64%** of White adults (vs. **40%**)[2]
▧ However, a stable proportion of adults still do not plan to receive a vaccine	• **16%** of adults say they are "very unlikely" to get vaccinated (vs. **17%** in Jan.)[1]
▧ Differences by political, rural, and age remain wide	Vaccine confidence is lower among: • Republican (**46%** say they will get a vaccine vs. **79%** of Democrats)[2] • Rural (**49%** say they will get a vaccine vs. **66%** urban)[2] • Young adults (**25%** want to "wait & see," though less eligible currently)[2]

Sources: (2) Kaiser Family Foundation Poll, March 15-22.

Trusted messengers are essential for health education & empowerment

- More than 3 in 4 adults in the U.S. have said they would likely turn to a doctor, nurse or other health care provider when deciding whether to get a vaccination[1]
- More than half said they would likely turn to family or friends about whether to get a vaccination[1]
- **Covid-19 Community Corps** is growing – 275 members last week to 4,500+ members today
- We all have a role to play in driving empowerment, education & access – join us at WeCanDoThis.hhs.gov

Source: KFF Vaccine Monitor, January 2021.

COVID-19 Community Corps is engaging trusted messengers to build vaccine confidence

- Launched with **275** founding members last week with Vice President Harris; now **4,500+** members
- **Arming trusted messengers** with scientific information & tools
- **Founding members** of the Corps include American Farm Bureau, NASCAR, WWE, Black Coalition Against COVID, Minority Business Roundtable, American Medical Association, Center for Native American Youth
- Reaching **underserved & minority communities** by empowering subject matter experts, hosting listening sessions, & crossing language barriers

Friends

Pharmacists

WE CAN DO THIS

Nurses

Faith Community

Community Corps is one of multiple strategies on vaccine confidence

- Providing $3 billion through CDC to support local efforts to strengthen vaccine confidence.
- Providing $332 million to jurisdictions for community health worker services to support COVID-19 prevention and control, as well as for training, technical assistance, and evaluation
- Providing $250M in local grants through the HHS Office of Minority Health to improve vaccine confidence
- Providing $100M in funding to help community organizations assist at-risk seniors and people living with disabilities access vaccines

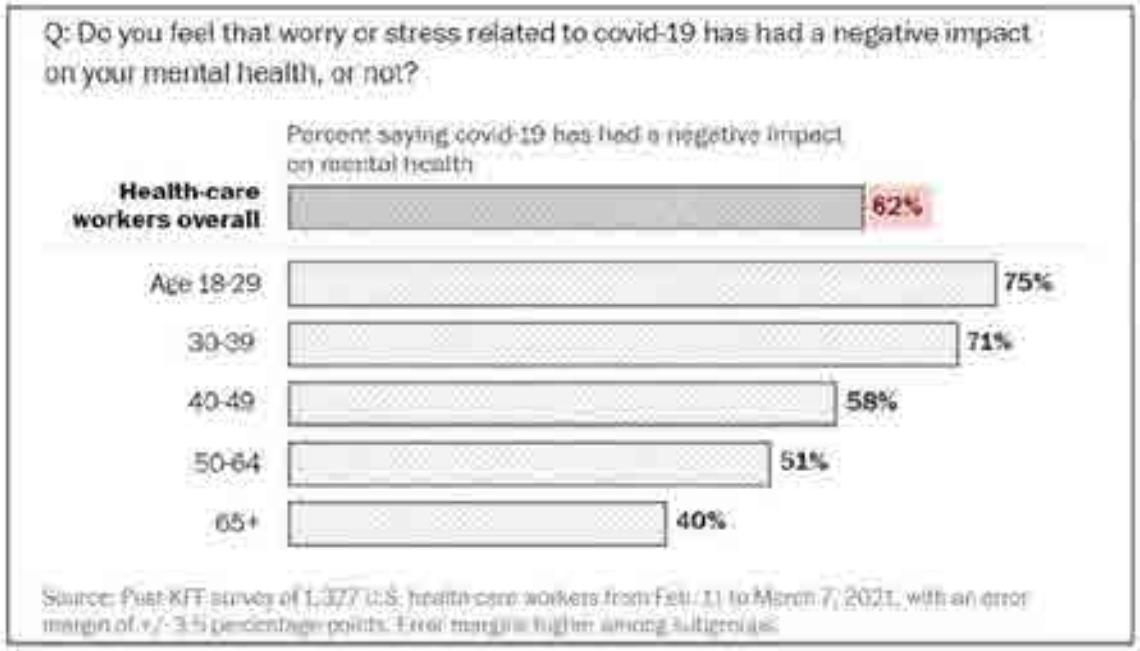
Mental health

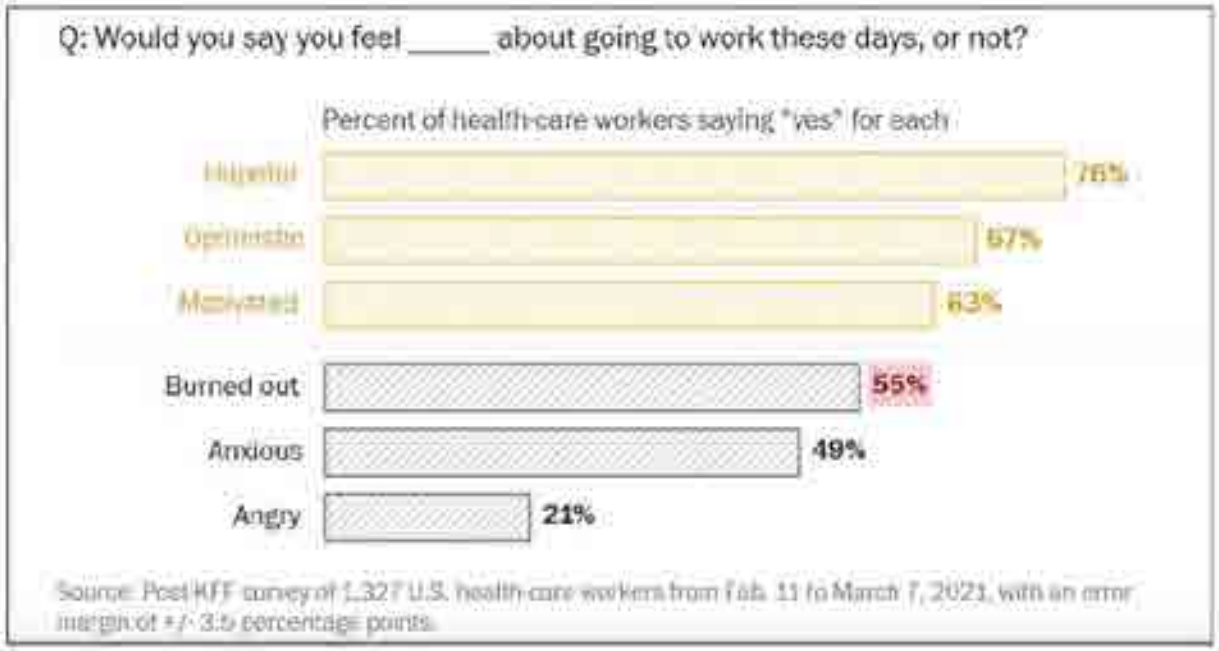
Internal, pre-decisional, notes ONLY not for presentation

We continue to learn about the pandemic's **toll**

- An estimated nearly 40,000 children in America lost a parent to COVID-19, according to a new model[1]
- About 1 in 3 people with COVID-19 were diagnosed with a psychiatric or neurological condition in the following 6 months – anxiety & depression were among the most common[2]
- 35% of adults reported recent symptoms of an anxiety or depression in March 2021, up from 11% in 2019 – 50% of young adults reported these symptoms (18-29 years)[3]

Sources: (1) Kidman R et al JAMA Pediatrics, Apr 2021. (2) Taquet et al, Lancet Psychiatry, Apr 2021. (3) CDC NCHS, March 2021.





Frontline health professionals are experiencing staggering rates of burnout and trauma

- **62%** of health-care workers say worry or stress related to COVID-19 has had a negative effect on their mental health
- **55%** of health-care workers feel "burned out" going to work

As vaccinations progress, we need a **bold agenda for the pandemic's mental health toll**

First 100 Days momentum is promising

- $4 billion to enable SAMHSA and HRSA to expand access to prevention & treatment services for mental health & substance use disorders (ARP)
- Greater access to insurance with ACA premium assistance & increased Medicaid funding (ARP)

Major opportunities remain to address COVID-19's mental health crisis

- Invest in evidence-based strategies to promote mental health among **our children**
- Support all **essential workers** with "anywhere, anytime" crisis support
- Grow mental **health workforce** capacity to address shortages
- Build a national plan to strengthen **community resilience** & address loneliness
- Achieve mental health payment **parity** & expand access to **telemental** health services
- Pave a comprehensive approach to addressing **veteran suicide**

        - https://www.statnews.com/2021/05/19/how-the-covid-pandemic-ends-scientists-look-to-the-past-to-see-the-future/?utm_source=STAT+Newsletters&utm_campaign=13566a0efe-MR_COPY_02&utm_medium=email&utm_term=0_8cab1d7961-13566a0efe-153408610
    - **23 Epidemiologists on When and How the U.S. Can Fully Return to Normal**
        - Government mandates are lifting, but these experts say the pandemic won't really end nationally until more people, including children, are vaccinated.
        - https://www.nytimes.com/2021/05/15/upshot/epidemiologists-covid-return-normal.html
- **Other headlines**
    - **Federally funded community health centers have now administered more than 10 million COVID-19 vaccines, the Biden administration is set to announce this morning.**
        - More than 60% of them went to racial and ethnic minorities.
    - **The U.S. Preventative Services Task Force recommended Americans begin getting colorectal cancer screenings at age 45, rather than 50, Axios' Jacob Knutson reports.**
    - **An estimated 40 percent of doctors in India have gotten Covid, and more than 250 have died since early April.**
    - **Many New York businesses are allowed to fully reopen today. Parts of Europe are also lifting restrictions.**
    - **E.U. approves plan to reopen borders to vaccinated Americans and others after more than a year of restrictions**
        - The change would allow travelers who have received doses of vaccines approved for use in the European Union to enter E.U. borders for tourism and other nonessential travel, easing strict restrictions imposed early in the pandemic. A formal final approval is still necessary, but its passage is not in doubt.

Note: Media headline and content may be direct excerpts from news articles and are intended for informational updates, not as original writing.

SURGEON GENERAL IN THE NEWS

- N/A

COVID TEAM UPDATES
(9:30 AM EST DEPUTIES)

Note: To be completed in the SharePoint during the 9:30 AM call.

- Natalie
    - Moving likely to M/W/F
    - Agenda more in advance
- Courtney
    - Walensky testfiying on the hill

- Otherwise no news
- CDC
  - Deaths are lagging – continuing to investigate, it's just slow
  - Hospitalizations continuing to come down, which is encouraging

Sonya Sackner-Bernstein:

DRAFT / DELIBERATIVE / PRE-DECISIONAL

Access

Objective	Initiative	Status
Establish on-site clinics	Community colleges / retail pharmacy partnership	Announced: matchmaking underway
	CBOs and FBOs (e.g., YMCA) / VA partnership	Preparing to offer VA intervention to states
	Call to action for employers & license to offer clinics	Holding ongoing employer conversations
	Barbershop/Beauty Salon & shop vaccination efforts	In conversation with partners including Black Coalition Against COVID and Maryland's Center for Health Equity
	Toolkit for other organizations seeking on-site clinics	In progress
Use federal and state channels to close gaps	Rural Health Clinic direct vaccine delivery	Underway: result to enroll more
	VA partnership with states requesting mobile support	West Virginia selecting pilot sites for VA mobile vaccination
	USDA-VA partnership for clinics in rural areas	Signing MOU. USDA selecting sites using CDC analysis
	Vaccination at national parks, with free admission	Discussing potential initiative with DOI
	Partner with American Hospital Association (AHA) to expand state vaccine distribution to hospitals	Michigan ready to kick off pilot. LA and NJ expressed interest
Remove other access barriers	Free rideshare to/from vaccination, through July 4	Completed. Uber/Lyft offering free rides starting May 24
	Free public transit to/from vaccination	UUI identifying travelers without free mass transit access, including non-emergency medical transportation with CMS
	Compensation & PTO for employee vaccination	Ongoing conversations
	Free childcare during vaccination	Finalizing commitments to offer drop-in childcare
	Minimization of ID barriers at vaccination sites	HRSA working to minimize PRF ID requirements

- Access is critical
  - Including where people get hair done
  - Working with employers to offer compensation and PTO for getting vaccinations
  - More than 1/3 of adults are concerned they'd need to provide SSN or other ID to get a vaccine – working with HHS for provider relief fund to reduce barriers for uninsured folks

DRAFT / DELIBERATIVE / PRE-DECISIONAL

Incentives

Objective	Initiative	Status
Mobilize consumers incentives	Month of business incentives	Ongoing conversations
	CEO-to-CEO letter publication, calling for incentives	Calls in progress
	Vaccination clinic days with consumer incentives (e.g. MLB game day vaccination + ticket giveaway)	Developing events with NASCAR, MLB
	Private and Medicaid managed care insurance incentives, including dependent coverage	Working with AHIP, ACHP, CMS
Mobilize college/ university incentives	"Vaccine Champion Campus" challenge for college/university vaccination commitments	In progress – preparing for announcement
	Student/campus leader action competition	Ready for announcement
	College sports partnerships / campus competitions	In progress

- Mobilizing incentives to help motivate people
- Particularly focused on young adults – higher ed
  - Young adults are least likely to say they're vaccinated or intend to do so
  - We know peer influences can have a big impact on vaccination decisions

DRAFT / DELIBERATIVE / PRE-DECISIONAL

Awareness

Objective	Initiative	Status
Maximize direct federal marketing	Pharmacy partner audit	Complete
	Call to action for physicians	Developed provider communication resources
	Targeted federal agency equity outreach	Building data with HHS and key stakeholders to better target confidence efforts for priority groups
	Government-wide website banner with Vaccine Finder and text number	Beginning discussion; preparing to make ask of agencies
	Ask agencies to post signage and push out consumer resources through their networks, in addition to vaccine.gov widget	Beginning discussion; preparing to make ask of agencies
Launch community canvassing	Call to action for mayors to lead door-to-door effort	Ask made at U.S. Conference of Mayors (5/14), with best practice sharing from Steve Bowser
	National Month of Action for canvassing & vaccination	June 1–July 4, kicking off a social call to action day on Friday, May 21
Engage media and platforms	Vaccination information on social media platforms	Ongoing
	Principals events with influencers	Raised at Principals Committee meeting last week; POTUS & Dr. Fauci YouTube events with influencers this week
Combat mis-information	SG's bulletin on the health threats of misinformation	Developing bulletin
	Countermeasures for spread of pervasive misinformation (e.g. myth busters)	Launching research into primary sources of misinfo

- 20% of adults don't have information on where and when they can get a vaccine
  - Trusted professionals
  - Mobilize community providers through national door to door effort

DRAFT – PREDECISIONAL

THE WHITE HOUSE
WASHINGTON

White House Conversation
Primary Care Providers, Health Systems, and the Next Phase of the Vaccination Rollout

The White House is proposing an event for the nation's primary care providers and health systems on their critical role in this next phase of the vaccination effort. The event will be an opportunity to express gratitude to primary care providers and health systems for their service to their patients, state, and country throughout the COVID-19 response and vaccine rollout. It will focus on the importance of primary care providers and health systems in further expanding efforts to administer vaccination programs and educate their patients on the vaccine, as well as the tools the federal government is providing to support them.

The event will feature five conversations with primary care providers and health system leaders on innovative approaches they are taking to patient outreach and implementing their own vaccination programs. Each conversation will be chaired by a different public health leader from the Biden Administration – Dr. Fauci, Dr. Walensky, Dr. Murthy, Dr. Nunez-Smith, and Dr. Choucair – and the following topics will be covered:

- Primary care providers, vaccine education, and countering misinformation
- Health systems, vaccine outreach, and confidence
- Primary care provider offices as vaccination sites
- Adolescent vaccine confidence and access
- Primary providers, health systems, and equity

Proposed participants:
Government participants

- Dr. Bechara Choucair; White House Vaccinations Coordinator
- VADM Vivek H. Murthy; United States Surgeon General
- Dr. Anthony Fauci; Director of the U.S. National Institute of Allergy and Infectious Diseases; Chief Medical Advisor to the President
- Dr. Rochelle Walensky; Director of the Centers for Disease Control and Prevention
- Dr. Marcella Nunez-Smith; Chair of the COVID-19 Equity Task Force

Healthcare system participants

- Members from each of the ~12 large provider associations listed below
- Presidents of Centene, Kaiser Permanente
- State Health Officers from Maryland, Ohio

Proposed Invitees:

- Provider Associations Membership: American Medical Association (AMA), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Hospital Association (AHA), American Medical Group Association (AMGA),

DRAFT – PREDECISIONAL

American Association of Nurse Practitioners (AANP), Primary Care Collaborative (PCC), American College of Obstetricians and Gynecologists (ACOG), American College of Emergency Physician (ACEP), National Hispanic Medical Association (NHMA), American Nurses Association (ANA), Children's Hospital Association (CHA)

- Health Department Membership: Association of State and Territorial Health Officials (ASTHO), National Association of County Health Officials (NACCHO), Big Cities Health Coalition (BCHC), National Council for Urban Indian Health (NCUIH)

Commented [SJPE1]: @Eduardo, who are we missing here?

Proposed Format and Timing:

- Timing: Friday June 11, or Monday June, 14
- Duration: 1 hour
- Location: South Court Auditorium; Dr. Choucair, Dr. Murthy, Dr. Fauci in person; All others remote
- Format: Similar to Community Corps Kick-off (Link here)
- Chairs: Dr. Choucair and Dr. Murthy

Proposed Agenda:

HIGHLY PRELIMINARY: TO WORK WITH EACH PRINCIPAL'S TEAM ON TOPICS THEY WANT TO COVER AND HOW BEST TO STRUCTURE THEIR SEGMENT

- Dr. Murthy and Dr. Choucair: Kick-off (5 min). Thank folks for joining, discuss agenda, objectives for the event. Preview announcements (e.g., AMGA commitment; Centene and Kaiser robocalls; AHA hospital best practices effort).
- Dr. Fauci: Primary care providers, vaccine education, and countering misinformation (10 mins): Opens session on why PCPs are so important to the vaccine outreach effort (most trusted messengers by their patients and communities). Has conversations with 3-4 PCPs on how they're conducting patient outreach and countering misinformation.
- Dr. Murthy: Health systems, vaccine outreach, and confidence (10 mins): Opens session on the critical role of health systems and health plans in vaccine outreach. Interviews Centene and Kaiser Presidents on this topic and on their robocalls effort. Interviews American Hospital Association on their call to action and 1-2 members about best practices they've implemented (e.g., ED discharge vaccinations). *HIGHLY PRELIMINARY – DR. MURTHY'S TEAM TO REVIEW AND SHARE INPUT OF WHAT HE'D LIKE TO COVER*
- Dr. Choucair: Primary care provider offices as vaccination sites (10 mins). Opens session on what the Biden Administration is doing to help increase vaccinations at PCP offices. Interviews Maryland and Ohio SHOs on their best practices for activating PCPs. Interviews 1 PCP in each state as well on best practices for vaccinating at their office.
- Dr. Walensky: Adolescent vaccine confidence and access (10 mins). Opening remarks on improving confidence and access in adolescents. Announces AAP parent/adolescent outreach effort. Interviews 3 pediatricians (from AAP, AAFP, and CMA) on best practices for increasing confidence in this community.
- Dr. Nunez-Smith: Primary providers, health systems, and equity (10 mins). Opens on how PCPs can help promote equitable access to the vaccine. Interviews 3-4 PCPs on best practices. Potentially include a PCP from a rural health clinic to promote rural efforts as well.
- Dr. Murthy and Dr. Choucair: Closing (5 min). Thank folks for joining and the participants. Re-iterate asks: reach out to your patients and communities about getting vaccinated and sign up to vaccinate in your offices.

THE WHITE HOUSE
WASHINGTON

White House Conversation
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The event will feature five conversations with primary care providers, health system leaders, and state health officers on innovative approaches they are taking to patient outreach and implementing vaccination program at primary care provider offices. Each conversation will be chaired by a different public health leader from the Biden Administration – Dr. Fauci, Dr. Walensky, Dr. Murthy, Dr. Nunez-Smith, and Dr. Choucair – and the following topics will be covered:

- Primary care providers: Vaccine education and countering misinformation
- Health systems: Improving vaccine access and outreach
- Pediatricians, Health systems: Increasing adolescent vaccine uptake
- Primary care providers, Health systems: Improving vaccine equity
- Health departments: Activating primary care provider offices as vaccination sites

Participants:
Government participants

- VADM Vivek H. Murthy; United States Surgeon General
- Dr. Rochelle Walensky; Director of the Centers for Disease Control and Prevention
- Dr. Anthony Fauci; Director of the U.S. National Institute of Allergy and Infectious Diseases; Chief Medical Advisor to the President
- Dr. Marcella Nunez-Smith; Chair of the COVID-19 Equity Task Force
- Dr. Bechara Choucair; White House Vaccinations Coordinator

Healthcare system participants – Exact participants still being confirmed, but will be sourced from the following

- Select members from the ~12 large provider associations listed below
- State Health Officers from Maryland, Ohio

Invitees:

- Provider Associations Membership: American Medical Association (AMA), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians

(ACP), American Hospital Association (AHA), American Medical Group Association (AMGA), American Association of Nurse Practitioners (AANP), Primary Care Collaborative (PCC), American College of Obstetricians and Gynecologists (ACOG), American College of Emergency Physician (ACEP), National Hispanic Medical Association (NHMA), American Nurses Association (ANA), Children's Hospital Association (CHA), American College of Emergency Physicians (ACEP)

- Health Department Membership: Association of State and Territorial Health Officials (ASTHO), National Association of County Health Officials (NACCHO), Big Cities Health Coalition (BCHC), National Council for Urban Indian Health (NCUIH)

Proposed Format and Timing:

- Timing: Friday June 11, 3-4 PM ET
- Duration: 1 hour
- Location: South Court Auditorium; Dr. Choucair, Dr. Murthy in person. Dr. Fauci TBD. Dr. Walenksy, Dr. Nunez-Smith remote.
- Format: Similar to Community Corps Kick-off (Link here). Each principal will lead a 10 min discussion on a different topic. Each will start by offering 2-3 min of opening remarks, and then start a conversation with 2-4 PCPs, health system leaders, and/or state health officers (depending on the topic), to raise questions and highlight best practices on that topic.
- Chairs: Dr. Choucair and Dr. Murthy

Proposed Agenda: *DETAILS UNDER EACH HEADING HIGHLY PRELIMINARY*

- **Dr. Murthy and Dr. Choucair: Kick-off (7 min).**
  Thanks folks for joining, discusses agenda, objectives for the event. Previews major provider associations / health systems commitments (e.g., AMGA commitment; Kaiser robocalls initiative; AHA hospital best practices effort). *More info on potential announcements below.*
- **Dr. Murthy: Primary care providers: Vaccine education and countering mis-info. (10 mins):**
  Opens session on why PCPs are so important to the vaccine outreach effort (most trusted messengers by their patients and communities). Has conversations with 3-4 PCPs on how they're conducting patient outreach and countering misinformation.
- **Dr. Walensky: Health systems: Improving vaccine access and outreach (10 mins):**
  Opens session on the critical role of health systems and health plans in vaccine outreach. Interviews the Kaiser Permanente President on their robocalls effort / patient outreach effort. Interviews hospital executive from the American Hospital Association on their call to action effort (e.g., how they're promoting ED discharge vaccinations). Interviews member of the American Medical Group Association on their commitment to patient outreach. *See further details on these efforts below.*
- **Dr. Fauci: Pediatricians, Health systems: Increasing adolescent vaccine uptake (10 mins).**
  Opening remarks on improving confidence and access in adolescents. Discusses AAP/AAFP/CMA parent and adolescent outreach effort. Interviews 2 pediatricians from these on best practices for increasing confidence for adolescents and their parents.
- **Dr. Nunez-Smith: Primary care providers, Health systems: Improving vaccine equity (10 mins).**
  Opens on how PCPs can help promote equitable access to the vaccine. Interviews 2-3 PCPs on best practices. Potentially include a PCP from a rural health clinic to promote rural efforts as well.
- **Dr. Choucair: Health depts: Activating PCP offices as vaccination sites (10 mins).**

Opens session on what the Biden Administration is doing to help increase vaccinations at PCP offices. Interviews Maryland and Ohio SHOs on their best practices for activating PCPs. Interviews 1 PCP in each state as well on best practices for vaccinating at their office.

- **Dr. Murthy: Closing (3 min).** Thank folks for joining and the participants. Re-iterate asks: reach out to your patients and communities about getting vaccinated and sign up to vaccinate in your offices.

Potential commitments - Major provider associations and health systems:

1. **Medical Groups Commitment to Action (AMGA):** The members of the American Medical Group Association (AMGA), the nation's largest association of medical groups, health systems, and other organized systems of care, are committing to proactively educate and reach out to their patients about the vaccine; to work with community-based organizations on expanding vaccine access in vulnerable communities; to serve as trusted community ambassadors for the vaccine, including on traditional and social media; and to encourage their healthcare employee colleagues to get the vaccine. The AMGA represents 175,000 physicians, across all 50 states. They provide care to 120 million patients. A call to action letter from the White House will be sent out to their members on Monday or Tuesday.
2. **Hospitals Commitment to Action (AHA):** The American Hospital Association is committed to doing a call to action to their member hospitals encouraging them to adopt best practices to expedite shots in arms. These include: Vaccinations upon discharge from hospitals, vaccinations at emergency departments; distributing shots to hospital affiliated primary care providers; encouraging hospitals to ramp-up pop-up clinics; committing to redouble efforts on hospital staff vaccine uptake. So far, 340 hospitals are on board for the ED vaccination effort. We'd like to get the remaining hospitals to adopt the effort. The AHA is also launching a new program to connect employers who want to host onsite vaccination programs with local hospitals that have vaccine.
3. **National Association of Broadcasters (NAB):** NAB, representing more than 7,000 TV and radio stations across the country, will have local station members participate in the National Month of Action. NAB members will be airing vaccine education segments in their programming featuring trusted voices from the community, as well as medical professionals from leading medical associations across the country, including the American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Hospital Association, American Association of Nurse Practitioners, and Primary Care Collaborative. Medical experts will have the opportunity to share information on benefits of vaccination, address questions and concerns, and publicize where individuals in the community can get vaccinated. And, the Administration will continue deploying medical experts, public health leaders, and Cabinet officials through a whole-of-government approach to communicate directly with Americans, including by working with social media platforms and engaging celebrities and influencers to reach people where they are. This effort was announced last week during the month of action kickoff.
4. **Health Systems Outbound Calling Commitment:** To share more info by Tuesday.
5. **American College of Emergency Physicians (ACEP):** Working on a potential emergency department focused commitment with ACEP. To share more info by Tuesday.

THE WHITE HOUSE
WASHINGTON

White House Town Hall
Primary Care Providers, Health Systems, and the Next Phase of the Vaccination Rollout

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The event will feature five conversations with primary care providers, health system leaders, and state health officials on innovative approaches they are taking to patient outreach and implementing vaccination program at primary care provider offices. Each conversation will be chaired by a different public health leader from the Biden Administration – Dr. Murthy, Dr. Walensky, Dr. Fauci,, Dr. Nunez-Smith, and Dr. Choucair – and the following topics will be covered:

- Primary care providers: Vaccine education and countering misinformation
- Health systems: Improving vaccine access and outreach
- Pediatricians: Increasing adolescent vaccine uptake
- Primary care providers: Improving vaccine equity
- Health departments: Activating primary care provider offices as vaccination sites

Participants:
Government participants

- VADM Vivek H. Murthy; United States Surgeon General
- Dr. Rochelle Walensky; Director of the Centers for Disease Control and Prevention
- Dr. Anthony Fauci; Director of the U.S. National Institute of Allergy and Infectious Diseases; Chief Medical Advisor to the President
- Dr. Marcella Nunez-Smith; Chair of the COVID-19 Equity Task Force
- Dr. Bechara Choucair; White House Vaccinations Coordinator

Invitees (There are many more, this is non-exhaustive):

- Provider Associations Membership: American Medical Association (AMA), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Hospital Association (AHA), American Medical Group Association (AMGA), American Association of Nurse Practitioners (AANP), Primary Care Collaborative (PCC), American College of Obstetricians and Gynecologists (ACOG), American College of Emergency Physician

(ACEP), National Hispanic Medical Association (NHMA), American Nurses Association (ANA), Children's Hospital Association (CHA), American College of Emergency Physicians (ACEP)

- Health Department Membership: Association of State and Territorial Health Officials (ASTHO), National Association of County Health Officials (NACCHO), Big Cities Health Coalition (BCHC), National Council for Urban Indian Health (NCUIH)

Format and Timing:

- Timing: Friday June 11, 3-4 PM ET. **PLEASE ARRIVE AT LEAST 15 MINUTES EARLY (i.e., 2:45 PM)**
- Link: b(6)
- Duration: 1 hour
- Location: South Court Auditorium; Dr. Choucair, Dr. Murthy in person. Dr. Walenksy, Dr. Nunez-Smith, Dr. Fauci remote.
- Format: Similar to Community Corps Kick-off (Link here). Each principal will lead a 10 min discussion on a different topic. Each will start by offering 2-3 min of opening remarks, and then start a conversation with 2-4 PCPs, health system leaders, and/or state health officers (depending on the topic), to raise questions and highlight best practices on that topic.
- Chairs: Dr. Choucair and Dr. Murthy
- **Note: Please pass it off to the next discussion leader after you have spoken.**

Schedule

Time	Topic	In Person Discussion Leaders	Remote Discussion Leader	Remote Panelists
3:00 - 3:05	Intro	1. Dr. Choucair 2. Dr. Murthy	*Will not be speaking, will be on camera* Dr. Walensky; Dr. Fauci; Dr. Nunez Smith	N/A
3:05 - 3:18	Primary care providers: Vaccine education and countering misinformation	Dr. Murthy	N/A	Dr. Kohar Jones Dr. Basim Khan One more
3:18 - 3:28	Health systems: Improving vaccine access and outreach	N/A	Dr. Walensky	Dr. Mark S. Rosenberg; Dr. Andrew Bindman
3:28 - 3:38	Pediatricians: Increasing adolescent vaccine uptake	N/A	Dr. Fauci	Dr. Lee Beers
3:38 - 3:48	Primary care providers: Improving vaccine equity	N/A	Dr. Nunez-Smith	Dr. Kanini Rodney
3:48 - 3:58	Health departments: Activating PCP offices as vaccination sites	Dr. Choucair	N/A	Dr. Angela Marshall Dr. Bruce Vanderhoff
3:58 - 4:00	Conclusion	Dr. Murthy; Dr. Choucair	*Will not be speaking, will be on camera* Dr. Walensky; Dr. Fauci; Dr. Nunez Smith	N/A

Agenda

- **Dr. Choucair, Dr. Murthy: Kick-off (3:00 – 3:05, 5 min).**
  Dr. Choucair welcome and agenda (1-2 mins). Dr. Murthy thanks the provider community, previews major provider associations / health systems commitments (2-3 mins).

- **Dr. Murthy: Primary care providers: Vaccine education and countering misinformation. (3:05 – 3:18, 13 mins):**
  Opens session on why PCPs are so important to the vaccine outreach effort (most trusted messengers by their patients and communities). Starts panel with 3 PCPs:
  Panelists:
  - *Dr. Basim Khan*, VA, Primary care physician, Executive Director at Neighborhood Health, a Federally Qualified Health Center. Will discuss low tech ways to reach out to patients, community engagement work with faith groups.

- *Dr. Kohar Jones,* Chicago, Primary care physician for the homeless. Will discuss how the local pediatrician at school talked with the kids parents about COVID and was very effective
- On more panelist, TBD.

- **Dr. Walensky: Health systems: Improving vaccine access and outreach (3:18 – 3:28, 10 mins):** Opens session on the critical role of health systems and hospitals in vaccine outreach and uptake. Interviews two health system leaders:
  Panelists:
  - *Dr. Mark Rosenberg* – President of ACEP; Chair of emergency medicine at St. Joseph's Health in Patterson, New Jersey. Will discuss best practices for operating a vaccination upon ED hospital discharge program.
  - *Dr. Andrew Bindman* – Chief Medical Officer, Kaiser Permanente. Will discuss Kaiser's Month of Action efforts to improve patient vaccine access and uptake, and lessons learned for other health systems.

- **Dr. Fauci: Pediatricians: Increasing adolescent vaccine uptake (3:28 – 3:38, 10 mins):** Opening remarks on improving confidence and access in adolescents. Discussion with 1 pediatrician on increasing confidence for adolescents and their parents:
  Panelists:
  - *Dr. Lee Beers, M.D.* – President of AAP; Professor of Pediatrics and the medical director for Community Health and Advocacy at Children's National Hospital.

- **Dr. Nunez-Smith: Primary care providers: Improving vaccine equity (3:38 – 3:48, 10 mins):** Opens on how PCPs can help promote equitable access to the vaccine. Interviews 1 PCP on best practices.
  Panelists:
  - *Dr. Kanini Rodney, MD* – Internist Birmingham, Alabama. Affiliated with Birmingham Veterans Affairs Medical Center.

- **Dr. Choucair: Health depts: Activating PCP offices as vaccination sites (3:48 – 3:58, 10 mins):** Opens session on why PCP office vaccinations are so important. Interviews 1 Maryland PCP and 1 member of Ohio state health department on their best practices for activating PCPs as vaccinators.
  Panelists:
  - *Dr. Angela Marshall, MD* – Internal Medicine Specialist in Silver Spring, MD. Will discuss her practice's participation in the Maryland Primary Care Vaccination Program, and best practices for other PCPs.
  - *Dr. Bruce Vanderhoff, MD, MBA* – Chief Medical Officer of the state of Ohio. Will discuss Ohio's efforts to activate PCPs in their vaccination rollout.

- **Dr. Murthy: Closing (3:58 – 4:00, 2 min).**
  Thanks viewers and participants for joining and thanks the participants. Re-iterate asks: reach out to your patients and communities about getting vaccinated and sign up to vaccinate in your offices.

Bios

Basim Khan, MD, MPA is a primary care physician and Executive Director at Neighborhood Health, a Federally Qualified Health Center that serves approximately 40,000 mostly low-income patients in Northern Virginia. He attended the University of California Los Angeles for medical school and completed his internal medicine residency at the University of California San Francisco in a primary care track for the underserved at San Francisco General Hospital. He received his Bachelor's Degree from Brown University and a Master's in Public Administration from Harvard University's Kennedy School of Government as a Zuckerman Fellow. Dr. Khan served as a Presidential Leadership Scholar in 2017 and was selected as a Washington Business Journal's nonprofit CEO/Executive Director of the Year in 2018. He has served on the Board of Directors of the National Physicians Alliance and the Culmore Clinic as well as the Virginia Governor's Council of the American College of Physicians. Dr. Khan's primary interest is advancing health equity and increasing access to health care in Northern Virginia. He also has an interest in health policy, health care delivery reform, and economic development. He speaks Urdu/Hindi, Pashto, and Spanish and is Board Certified in Internal Medicine and a Fellow of the American College of Physicians.

Mark S. Rosenberg, DO, MBA, FACEP was chosen president-elect during ACEP19 in Denver, Colorado. ACEP's Council votes on the president-elect, who will serve a one-year term and will assume the presidency at ACEP20.

Dr. Rosenberg is chair of emergency medicine at St. Joseph's Health in Patterson, New Jersey. He also serves as the hospital's chief innovation officer and led the development of the nation's first Alternative to Opioids program.

Dr. Rosenberg was first elected to the ACEP Board in 2015. He also serves on the board of directors of the Emergency Medicine Foundation and on the national Pain Management Task Force of the U.S. Dept. of Health and Human Services.

Dr. Rosenberg earned his medical degree from the Philadelphia College of Osteopathic Medicine and is certified by the American Osteopathic Board of Emergency Medicine (AOBEM) and the American Board of Emergency Medicine (ABEM) in emergency medicine and hospice and palliative care.

Andrew Bindman, MD, is executive vice president and chief medical officer for Kaiser Foundation Health Plan, Inc. and Hospitals.

Dr. Bindman previously spent more than 30 years at the University of California, San Francisco where he practiced and taught clinical medicine while conducting research in health access and outcomes that resulted in more than 180 published scientific articles. A noted policy advocate, he has held advisory and leadership roles for the U.S. House Energy and Commerce Committee, the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality, the California Medicaid Research Institute, and the Healthy California for All Commission, among other agencies.

Dr. Bindman is a graduate of Harvard College and the Mount Sinai School of Medicine. A board-certified general internist, he completed his residency in internal medicine at UCSF and was a Robert Wood Johnson Foundation Clinical Scholar at Stanford University. He was elected to the National Academy of Medicine in 2015, where he currently serves on the organization's board for health care services and chairs the workshops on diagnostic excellence. In 2021, he was elected to the Association of American Physicians in recognition for his notable contributions to advancing scientific and practical medicine.

Lee Ann Savio Beers, M.D., is a professor of Pediatrics and the medical director for Community Health and Advocacy at Children's National Hospital. She is the 2021 president of the American Academy of Pediatrics. She oversees the Child Health Advocacy Institute's Community Mental Health CORE, which includes initiatives such as the DC Mental Health Access in Pediatrics Program and the Early Childhood Innovation Network, and serves as a catalyst to elevate the standard of mental health care for every young person in Washington D.C.
She earned her medical degree from Emory University School of Medicine and completed a pediatric residency at the Naval Medical Center in Portsmouth VA. Prior to joining Children's National, she was a general pediatrician at the Naval Hospital in Guantanamo Bay, Cuba and the National Naval Medical Center in Bethesda, MD.
Her clinical and research interests include adolescent pregnancy and parenting, the integration of mental health and pediatric primary care, the impact of adversity and stress on child well-being and advocacy education. She lives in Washington D.C. with her husband Nathaniel and two children.

Dr. Kanini Z. Rodney Bio

For over 15 years, Dr. Kanini Z. Rodney, MPH, MBA, MD, FACP has been a noteworthy physician and leader within the Veterans Administration. Dr. Rodney currently holds the role of Deputy Associate Chief of Staff, Community and Primary Care Based Medicine (2019) as well as the Women's Health Medical Director (2012) at the Birmingham VA Health Care System (BVAHCS). She is the clinical lead of the two Women's Health Clinic and practices as a board-certified internal medicine physician and designated women's health provider.

Dr. Rodney is also the National Subject Matter Expert for the Breast Cancer Registry (BCR)/System for Mammography Resolution Tacking (SMART); the Southeast Region (VISN 7) Women's Health Clinical Consultant; Co-Chair of the Health Committee of AlaVetNet, an initiative of the Alabama Governor; Co-Chair of the Women's Veterans Health Committee; and lead of the Community Care Breast Imaging Improvement Process. In 2018, she spearheaded the implementation of the 1st Annual Women Veterans Health Expo in the state of Alabama. The Expo has provided training for over 650 individuals in the last 3 years.

In the past few months, Dr. Rodney has led the highly successful COVID-19 Vaccine Initiative at the Birmingham VA Healthcare System with responsibility for operations and outreach. During this time, she led Women's Health COVID-19 Chit Chat for Maternity Veterans; implementation of the Emergency Department COVID-19 Home Monitoring/Care Strategies for low and moderate risk patients; and the COVID-19 Symptom Tracker Review.

Dr. Rodney is engaged in governance and decision-making through her work on various committees at the national, VISN and local level. Among her many roles at the BVAHCS, Dr. Rodney also serves as Co-Chair for the Primary Care, Integrated Clinical Communities Committee; Chair of the Tri-facility LGBT Experience & Environment of Care Improvement Initiative; Co-Chair for the Telehealth Committee; and Chair for Pharmacy & Therapeutics Committee. She has formerly served as the Acting Chief of Mental Health and Interim Associate Chief of Staff Primary Care at the BVAHCS; and Acting Chief of Staff and Acting Associate Chief of Staff, Medicine and Specialty Care at the Tuscaloosa VA Medical Center.

Dr. Kanini Z. Rodney is a graduate of the VA's Executive Potential Program, the South-East Network Executive Health Care Institute Program, and the Physician Leadership Program. She received her medical education and was inducted into the Alpha Omega Alpha Medical Honor Society at Morehouse School of Medicine in Atlanta GA. She later completed her Internal Medicine residency training at Brigham and Women's Hospital/ Harvard Medical School, Boston MA. Before completing her medical education, Dr. Rodney received her Master's in both Public Health and Business Administration from Emory University's Rollins School of Public Health and Goizueta Business School, respectively, and her Bachelor of Science degree from the University of the West Indies, Mona Campus.

Dr. Angela Marshall, MD is a Internal Medicine Specialist in Silver Spring, MD and has over 22 years of experience in the medical field. She graduated from Indiana Univ medical school in 1999. Comprehensive Women's Health was one of the first 17 practices to join the Maryland primary care vaccine program. Comprehensive Womens Health is a Level 3 NCQA recognized practice and vibrant leader in the Washington metropolitan area.

CWH delivers the highest quality care to individual patients so they feel good inside and out. CWH values providing stellar and comprehensive patient experiences, strives to stay ahead of the curve in medical technologies and practices, focuses on the individual while building a supportive community for women's health, and works as a team with a 'can-do' attitude. Amidst all their patient work, they also work to give back to the Washington metropolitan area. They have administered at least over 800 doses of COVID vaccine to date (outdated stat). Comprehensive Women's Health serves a primarily African American population. They have an additional site in Glenn Dale, which has joined the vaccine program more recently. CWH has been part of Netrin Health Accountable Care Organization since 2017 and works with Netrin as a Care Transformation Organization.

Bruce Vanderhoff, MD, MBA, was appointed chief medical officer of the state of Ohio in November of 2020. Previously, served as senior vice president and chief medical officer at OhioHealth since December 2008.

Dr. Vanderhoff earned his bachelor's degree and medical degree from the University of Pennsylvania in Philadelphia and a master's degree in Business Administration from Franklin University in Columbus, Ohio. He completed his residency in family medicine at York Hospital in York, Pennsylvania where he was chief resident.

A diplomat of the American Board of Family Medicine and a fellow in the American Academy of Family Physicians, Dr. Vanderhoff's many professional affiliations include the Healthcare Institute, the Health Management Academy, the American Academy of Family Physicians, the Ohio State Medical Association and the Columbus Medical Association. Dr. Vanderhoff is a clinical professor of Family Medicine at Ohio University and an adjunct associate professor of Family Medicine at The Ohio State University. He is on the board of Rev1 Ventures (formerly TechColumbus), a member of the Ohio Hospital Association's Clinical Advisory Committee, as well as Franklin University's Healthcare Management Advisory Board. Dr. Vanderhoff served as a delegate to the Ohio State Medical Association and as a member of the Governor's Advisory Council on Health Care Payment Innovation. He has authored numerous journal articles and book chapters over the span of his career and is a distinguished teacher and lecturer.

Internal only, draft, initial notes

White House COVID-19 Press Conference Notes

March 24, 2021

Highlights:

Today is National Safe School Reopening Summit with Department of Education

1 in 3 adults has received 1 vaccine dose

NEJM HCW vaccine studies released

Mr. Andy Slavitt

Milestones:

- We're a long way from where we were 7 weeks ago
- No country has vaccinated more people than US
- In 62 days since taking Office we've more than tripled vaccine output

US Epidemiological Data:

- 1 in 3 adults has received 1 dose (84 million)
- More than 1 in 6 adults has received 2 doses (45 million)
- Today we cross a milestone of 70% of those 65+ having received at least one dose

New Updates:

- Yesterday in weekly call w/ Governors we announced we will have **27 million doses** allocated across all distribution channels
- 2/3 will go to states/jurisdictions, 1/3 to pharmacy programs
- Today is **National Safe School Reopening Summit with Department of Education**
- $81 billion will be made available to states, DC, PR to support efforts to reopen schools and meet needs of students- this gets us closer to goal of reopening schools within 100 days
- We are continuing 3 pronged strategy of increasing supply, vaccinators and vaccine sites- partnerships with vaccine manufacturers, vaccinators and HHS
- We have more to work to do until all Americans are vaccinated

Dr. Rochelle Walensky

US Epidemiological Data:

- **Cases have increased slightly** (7 day average)
- Deaths and hospitalizations remain stable
- We've seen **significant decline in ER visits for those ages 65+**

- **We're seeing a stall in the pandemic- I'm very concerned**

Vaccine Progress:

- **Extraordinary progress** in last few weeks; impressed with vaccine pace
- **Many Americans have embraced vaccines; encouraged others** to get vaccinated
- 16-20 million people vaccinated/week
- Several studies in NEJM show real world protection among vaccinated HCWs
- We're closer to resuming activities with loved ones

Mental & Physical Wellbeing:

- We've experienced so much loss
- Our daily lives changed- juggling childcare, virtual learning, work
- **Stress, uncertainty, isolation has had profound effect on mental wellbeing**
- **We need to maintain wellness and resilience-** take care of yourself, get back to things that make you feel connected and good
- Connect with a friend, take a walk, check in on your neighbor, eat healthy, get sleep, exercise- these things can make such a difference in how we feel
- Hearing about the pandemic all day can be upsetting- **beneficial to disconnect from screens for a while**
- See CDC site for tips

Schools:

- **Schools are now able to move forward w/ broader reopening due to released guidance on physical distancing**
- **Pharmacy program** is vaccinating teachers and childcare staff- 1.3 million have been vaccinated
- We want **school and childcare staff to be vaccinated by end of March**
- I am joining POTUS, FLOTUS, VP, Secretary of Education at Summit this afternoon to hear from staff and students about how they've gotten back to in-person learning

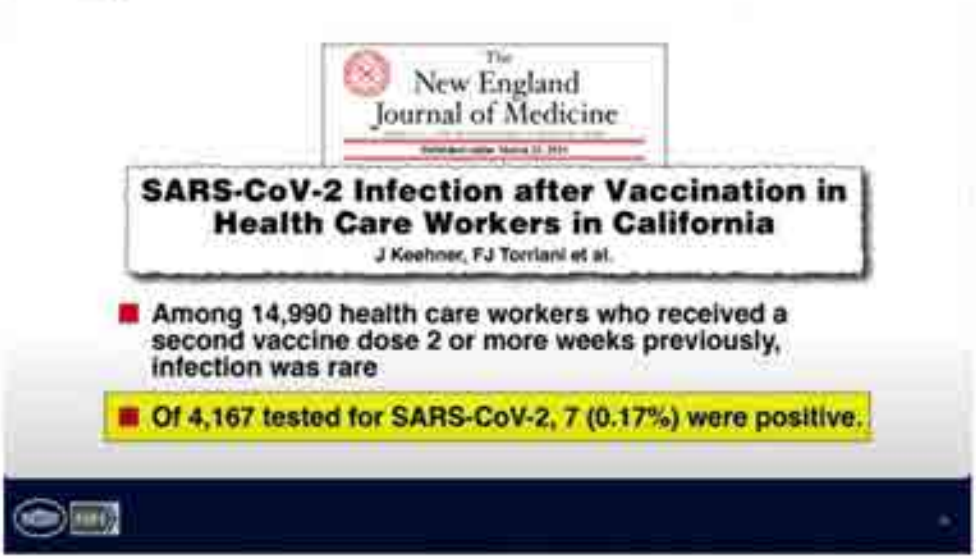
Dr. Anthony Fauci

Real-World Vaccine Data:

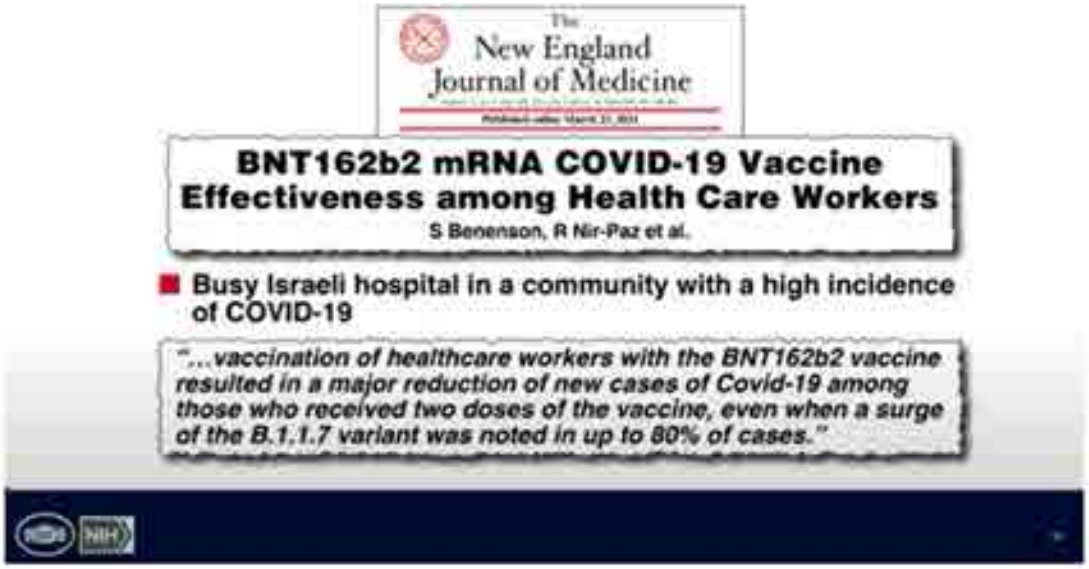
- New **data on HCWs that was released yesterday in NEJM**

- **University of Texas Southwestern Medical Center** study- those fully vaccinated had extremely low infection rate

- **California** study



- **Israel** study- 117 variant in 80% of cases



- At the end of the day effective **vaccines are what will end the pandemic**

Questions:

1. **Question: Meg Tyrell, CNBC:** Can you address what happened yesterday regarding **AstraZeneca and communication with DSMB?** The Washington Post and NYT reported that the **efficacy is not that different from the statement that AstraZeneca released?** Also, **how does the CDC view variant 526 as NYC officials said that they believe it's more transmissible**? Is it a **variant of concern vs. a variant of interest**? Is the government considering **increasing vaccinations in areas with higher rates of variants?**

    - **Dr. Anthony Fauci:** AstraZeneca worked with the DSMB and briefed BARDA and the NIH. The DSMB said that the data in the press release was not accurate regarding efficacy. We put out a statement saying that AstraZeneca should get back to the DSMB to ensure that the data that is made public is reflective of the actual data. **AstraZeneca is getting back to the DSMB and will release a modified statement.**

    - **Dr. Rochelle Walensky:** We are following 526 carefully in the Northeast, New York and New Jersey. Early data suggests increased transmissibility but it does not appear to be as transmissible as 117. There are interagency discussions as to whether 526 should be a variant of concern.

2. **Question: Jeff Mason, Reuters:** Dr. Fauci, are you concerned about **hesitancy once the AstraZeneca vaccine becomes available in the US**? What do you expect the **pace of vaccination to be in April**?

- **Dr. Anthony Fauci: We're always concerned when there's a miscommunication** that would add to vaccine hesitancy- we **want to make sure we're complete transparent regarding vaccine messaging.** This will likely turn out to be a good vaccine but the final analysis will be done by the FDA and VRPAC.

- **Mr. Andy Slavitt:** Last week President Biden said that this week we'd make a commitment as to what our goal is for the upcoming period of time- we will let the President do so.

3. **Question: Ricardo, AP:** It is hard to miss sense of excitement in your voices regarding statistical changes as Dr. Walensky is normally guarded. **Are we finally turning the corner of the pandemic?**

- **Dr. Rochelle Walensky:** Yes, I am normally guarded but I am enthusiastic about the early data regarding infection rates, ER hospitalization rates, and vaccination rates. I am concerned regarding the footage of Spring Break and those who do not continue to implement strategies. We need to have more than 13% of the population fully vaccinated to have protection. We are watching what's happening where people are vacationing right now.

- **Dr. Anthony Fauci: We are at the corner; whether we are turning it remains to be seen. When you have high levels of daily infection you cannot declare victory. The slide that showed 0.05% infection, that's where we want to be.**

4. **Question:** The **WHO warned there is a gap between vaccines in rich countries and COVAX and there is a false sense of security in rich countries**. Could **vaccine hoarding make the pandemic last longer?** Also, **Dr. Fauci you are meeting with officials from Brazil this week. Should AstraZeneca go to countries that are most in need** and to avoid spillover to other places?

- **Mr. Andy Slavitt:** The **President's #1 priority is to vaccinate this country. We've had more deaths than anywhere in the world**. We need to make this country safe again. We've made it a **priority to return to global leadership. As you've said until we work on COVID across the globe we cannot conquer it.** We are giving vaccines to Mexico and Canada and we are working with the Quad to improve manufacturing capacity. We have given a large amount of money to COVAX. We are in **close communication/daily communication with officials in Brazil.**

- **Dr. Anthony Fauci: In the future we will have surplus vaccines** and we are considering making vaccines available to all countries that need it.

5. **Question: Chris Seamus, Detroit Free Press:** In **Michigan we are seeing big outbreaks in K-12 schools since reopening this month-** while the staff are vaccinated, kids are unvaccinated and **schools have shutdown**. What is the **benefit of reopening schools if they shutdown later**? Is **the 3 foot spacing rule still a good idea with the emergence of variants**?

- **Dr. Rochelle Walensky:** We don't want schools to reopen and close- we have layered mitigation strategies.

Internal only, draft, initial notes

White House COVID-19 Press Conference Notes

March 22, 2021

Highlights: XX

- **Mr. Jeff Zients**
  - For the first time the US vaccinated more than 3 million people on consecutive days this week
  - 44 million fully vaccinated
  - 69% of seniors received first vaccine, 42% fully vaccinated
- **Dr. Rochelle Walensky**
  - COVID-19 data overview
    - Slight increase in cases from previous 7 day period- very concerning
    - Hospital admissions stable over past two weeks, deaths declining
    - Northeast and upper Midwest starting to see continuing rise in cases
    - These statistics should be a warning sign to the American people
    - Continued relaxation measures while variants spread are a serious threat to progress we've made as a nation
    - 427 429 estimated to account for 52% of cases in California
    - 117 estimated to be responsible for 9% cases in NJ, 8% in FL
  - Behavioral messaging
    - I get it- we all want to return to spend time with family
    - We need to hang in there just a bit longer
    - As a country we must decide what path we will take
    - I'm concerned we will see another surge as we saw in Europe
    - Nearly 25% of American population received 1 vaccine dose
    - 13% of population fully vaccinated
    - More vaccine supply on the way
    - More people ages 26-45 in ER than those 65+
    - I'm calling Americans to action to recommit to doing the right thing re: healthy behaviors

- **Dr. Anthony Fauci:**
    - Good news today in field of vaccines
    - Results announced yesterday regarding Phase 3 trial for chimp adno vector used by AstraZeneca
    - Trial involved more than 32,000 people 18+, 88 sites mostly in US, some in Chile and Peru- 2:1 vaccine to placebo- 60% had comorbidities associated with severe covid-19
    - 78.9% efficacy at preventing symptomatic disease
    - Comparable efficacy across ethnicity and age
    - No specific safety concerns found by DSMB
    - No evidence of thrombosis or events related to thrombosis
    - US played important role in this study- BARDA, NIH
    - NIAID monitored the trial- coauthored pre preclinical studies
    - Vaccine can be held at refrigerated temperatures for 6 months
    - Emergency use in more than 70 countries across 6 continents, WHO

Questions:

Q: Dan Merganno, Buzzfeed: As more people get vaccinated will we see lower death rates with higher case numbers?

A: Walensky: The death rate of those under age 65 will be consistent with the number of overall cases

Q: Tom Howell, Washington Times: With the news around AstraZeneca and Novvax, what are you thinking in terms of supplies? Such as what to do with surplus, how do you maintain interest at home in getting vaccinated?

A: Jeff: It's too early for us to say we have a surplus- highest priority is to vaccinate the US public as fast as possible. The more we increase confidence and supply the more flexibility we have regarding vaccinating adolescents, sharing supply with other countries. Having more supply is great for the world.

Fauci: Many countries in Europe and the world authorized the AstraZeneca vaccine. The US study confirmed the safety which helps support global public health

Jeff: FDA has a strong rigorous process for evaluating products- once the EUA is done we will feel even more comfortable

Q: Jeremy Diamond, CNN: We've been between 54-58000 cases over past two weeks. What more are you doing to have states re-impose COVID restrictions? Do u still expect J&J to release 20 million doses by the end of the month?

A: Walensky: We are reaching out to individual states, having weekly governor calls. We encourage them to look at case data, what's happening with variants. We're doing as much outreach as we can to slow relaxation

Zients: The President, Fauci, Walensky said they believe it's a mistake to get rid of mask mandates- individuals, employees, employers have authority

In terms of J&J we will have more supply this week- the first week of April we can say more

Q: Rachel Rubin, Politico: How many J&J will be released next week

Jeff: We cannot give a number but we won't be far away from the desired number

Q: Nancy Corris, PBS: How do you intend to handle hesitancy regarding the AstraZeneca vaccine? What's your guidance for vacationing? TSA said Sunday was their busiest air travel day this year.

A: Zients: We do briefings in the first place to address hesitancy

Fauci: There has been no indication of thromboembolic events in this study- when you give the vaccine to millions of people you need to look at the prevalence of adverse events in general in society

FDA going to carefully go over the data- there will be application for EUA

Zients: People ask why FDA takes so much time, why is there such an emphasis on FDA's independence and transparency- American public needs great confidence about the scientific products

Walensky: CDC is working on updated guidance regarding behaviors including travel

Much of the travel has been related to spring break

If we look at Europe, we don't want to see rapid uptick in cases- now is not the time to travel

From:	Sanchez-Velasco, Marissa EOP/WHO (b)(6)
To:	Sanchez-Velasco, Marissa EOP/WHO
Subject:	COVID TPs on SG Health Misinformation Advisory
Date:	2021/07/16 18:24:22
Priority:	Normal
Type:	Note

Hello! Attached are talking points on the Surgeon General's health misinformation advisory that went out yesterday. Thanks and have a good weekend!

Sender:	Sanchez-Velasco, Marissa EOP/WHO (b)(6)
Recipient:	Sanchez-Velasco, Marissa EOP/WHO
Sent Date:	2021/07/16 18:23:58
Delivered Date:	2021/07/16 18:24:22

7.16.21 Talking Points on the Surgeon General's Health Misinformation Advisory

- Yesterday, United States Surgeon General Dr. Vivek Murthy issued an advisory on the dangers of health misinformation.
- Too often across the country, the voices of doctors, nurses, scientists, and public health experts are drowned out by false, inaccurate, or misleading information about health.
- During the COVID-19 pandemic, health misinformation has led people to resist wearing masks in high risk settings, to turn down proven treatments, and to choose not to get vaccinated. All this has led to avoidable illness and death.
- **Simply put, health misinformation has cost us lives.**
- Technology companies have enabled misinformation to multiply through their design, their powerful algorithms, and their consistent refusal to accept responsibility for their influence.
- Journalists and media companies have a responsibility when covering health information to provide clear, accurate evidence-based reporting because the cost of amplifying bad health information costs lives.
    - News outlets, including local news, have a critical role to play in promoting accurate information, and also, at times, in correcting false information.
- If we want to fight health misinformation, we need all of society to do their part. The advisory has issued the following recommendations:
    - Individuals and families should raise their bar for sharing health information by checking sources before they share information to ensure it is backed by credible, scientific sources. And if you're not sure, don't share.
    - We expect more from technology companies and are asking them to operate with greater transparency, to modify their algorithms to avoid amplifying misinformation, and to consistently take action against misinformation super-spreaders on their platforms.
    - The advisory also asks organizations to do their part in every sector: from health to education, research to journalism, and philanthropy to government.
- We need to turn the tide against health misinformation, and must act now. Every one of us has the power and the responsibility to make a difference in this fight.
- You can read the full advisory at surgeongeneral.gov/healthmisinformation

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