

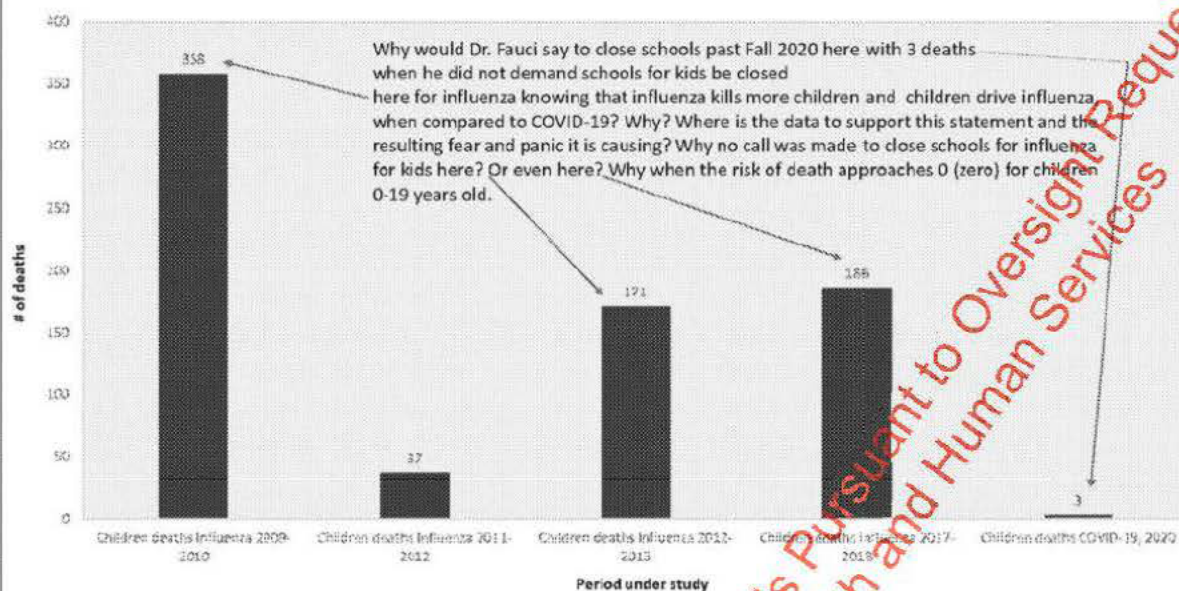
Message

From: Alexander, Paul (HHS/ASPA) (VOL) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 5/13/2020 1:54:12 PM
To: S R [REDACTED]@gmail.com]
Subject: FW: Influenza and COVID-19 deaths children 2009-2020
Attachments: Influenza vs COVID-19 deaths Children USA 2009-2020.ppt

To print confidential.

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Comparative deaths from Influenza and COVID-19 in children, USA, 2009-2020



Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) (VOL) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 5/17/2020 11:21:49 PM
To: Paul Elias Alexander [REDACTED]@yahoo.com]
Subject: Facts for President
Attachments: Facts for President May 16.doc

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Paul Elias Alexander <[REDACTED]@yahoo.com>
Sent: Sunday, May 17, 2020 6:14 PM
To: S R [REDACTED]@gmail.com>; Alexander, Paul (HHS/ASPA) (VOL) [REDACTED]
Subject: Re: COVID Lockdown - Impacts; unemployment and suicide rates

Best,

Paul E. Alexander, PhD
Health Research Methodologist, Department of Health Research
Methods, Evidence and Impact,
McMaster University
Assistant Professor
<http://hei.mcmaster.ca/>
GUIDE Research Methods Group

<https://protect2.fireeye.com/url?k=f51cc874-a949c1a4-f51cf94b-0cc47a6a52de-069784bff404bc3f8&u=http://guidecanada.org/>

On Sunday, May 17, 2020, 03:25:08 p.m. EDT, S R <[REDACTED]@gmail.com> wrote:

Researchers warn the COVID-19 lockdown will take its own toll on health:

<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>

https://protect2.fireeye.com/url?k=21573c75-7d0235a5-21570d4a-0cc47a6a52de-a6ff85176f49c7d9&u=https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

References:

Phillips, Julie A., and Colleen N. Nugent. 2014. "Suicide and the Great Recession of 2007-2009: The Role of Economic Factors in the 50 U.S. States." *Social Science & Medicine* (1982) 116 (September): 22-31.

Luo, Feijun, Curtis S. Florence, Myriam Quispe-Agnoli, Lijing Ouyang, and Alexander E. Crosby. 2011. "Impact of Business Cycles on US Suicide Rates, 1928-2007." *American Journal of Public Health* 101 (6): 1139-46.

We are modelling deaths of despair as a consequence of COVID-19 and based on drugs, alcohol, and suicidal causes

- Modelling is based on 1% increase in unemployment yields 1.6 % deaths of despair/suicide (Phillips and Nugent, 2014); note WBT models based on this assumption of 1%:1.6%

- We are modelling due to COVID-19

- We are modelling due to the effects of lockdown and isolation/uncertainty and the resulting uptick in deaths of despair

- Based on that and accepting a "medium" recovery rate of economy (this is based on the exceptional impact the President's policies had pre- COVID-19 lockdown getting the economy to 3.5% unemployment; note that we could have modeled as due to a 'slow' recovery' or 'fast' but we handicapped and chose the middle group.

- We will use a US 2018 population of 327,167,434, and so rounded to 330,000,000

- Therefore, for 2020, for a medium rate of recovery, there are 15, 000 deaths projected per 1.6 % increase in deaths of despair (WBT based model)

- Therefore, assuming the employment rate was 4% when lockdown started (but it was 3.5 %), then as of May 17, 2020, the unemployment rate hovers at around 15%

- Therefore, this means an 11% point increase

- Some suggest it will get to 20%, some to 32%

- We will split the difference of 15% - 32% = 17 % = 8.5 %

- 11% + 8.5 % = approx 20%

- Thus with a 20 point increase, and based on a 1.6 % increase or 15K deaths per point increase

- Therefore 20 x 15 = 300,000 additional deaths for 2020 based on the lockdown and deaths of despair due to COVID-19

- 1) [HYPERLINK "<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>"]

The YWCA of Northern New Jersey, in another example, told Reuters its domestic violence calls have risen up to 24% since lock down started

- 2) [HYPERLINK "<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>"]

If the jobless rate rises to 20%, this could translate into 48 million years of lost human life.

- 3) [HYPERLINK "<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>"]
[HYPERLINK "<https://www.psychologytoday.com/us/blog/acquainted-the-night/202003/will-covid-19-make-the-suicide-crisis-worse>"]

[HYPERLINK "<https://www.ncbi.nlm.nih.gov/pubmed/24925987>"] for every one percentage point increase in unemployment, according to research published by lead author Aaron Reeves from Oxford University. One of the silent drivers of our current suicide crisis is the high percentage of [HYPERLINK "<https://www.psychologytoday.com/us/blog/acquainted-the-night/201903/thoughts-the-suicide-epidemic>"].

[HYPERLINK "https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf"]

Some modelling argues that the risk of 'deaths of despair' due to unemployment is even higher, in that a one-point increase in unemployment rates increases suicide rates by 1.3%; another research group estimates that in the Great Recession a one point increase in unemployment increased suicides by 1.6%

- 4) American cancer society

[HYPERLINK "<https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2019.html>"]

1,762,450 new cases per year which means approx.150,000 new cancer cases per month diagnosed in US.

If 86% drop in detection of new cases per mth, that means 130,000 135,000 per month not detected. Assume March to April and we will include May as it is half done, this means 135 K x 2.5 = 337 K or roughly 350 K of new cancer that have escaped treatment.

- 5) CDC Childhood vaccine ordering program (Vaccine tracking system)

[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm?s_cid=mm6919e2_w" \l "F1" down"]

There has been a 60% decline (March 2020) in childhood vaccines being ordered, with a dramatic drop seen from the first case in Jan 20th 2020 (around 1st case) to mid April e.g. for non-influenza

doses, there was a cumulative change (decline) of 3 million less doses ordered and for measles, there were 410,000 less doses ordered across the same period. This translates into millions of US infants and children not being adequately vaccinated and thus at risk for severe outbreaks of measles, mumps, rubella, whooping cough, diphtheria, tetanus etc. This is a catastrophic situation for many of these can result in severe illness and death to children.

- 6) [HYPERLINK "<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>"]

[HYPERLINK "<https://www.rwjf.org/en/library/research/2016/09/the-relationship-between-school-attendance-and-health.html>"]

High school students who miss 3 days school per month are 7 times more likely to drop out before graduating. live nine years less than their peers

- 7) [HYPERLINK "<https://nationalpost.com/health/sacrificed-in-the-name-of-covid-patients-tens-of-thousands-affected-by-surgery-cancellations>"]

Almost 200,000 surgeries and other procedures, cancer screening tests and clinical trials of experimental medicines were shelved indefinitely as hospitals braced for a possible flood of COVID-19 patients. A deluge that never quite materialized.

Modelling in Ontario [HYPERLINK

"https://drive.google.com/drive/folders/1T5I2VKuYFD0FmFGItcH_ZX1XioH4vYU"] of elective heart surgeries would result in more than 30 deaths by early May.

For other patients, there was at least the anxiety of having to wait longer to have a tumour removed, clogged artery cleared or painful joint replaced. In Ontario, only about 20 to 40 per cent of the usual volume of elective cancer surgeries has taken place during the lockdown

- 8) [HYPERLINK "https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf"]

A recent study found that a 1-point increase in unemployment increased drug-related deaths by 3.3% (and 3.9% for opioid related deaths)

- 9) [HYPERLINK "<https://www.npr.org/sections/coronavirus-live-updates/2020/05/14/855894146/some-of-the-greatest-causes-of-misery-u-n-warns-of-pandemic-s-mental-health-cost>"]

One report found that in the U.S. alone, the effects of the virus likely mean that as many as 75,000 more people will die from drug or alcohol misuse

Facts for the President

Cancer:

[HYPERLINK "<https://www.forbes.com/sites/miriamknoll/2020/05/11/delaying-your-mammogram-during-coronavirus-yay-or-nay/>" \l "5b93379517a9"]

Approximately 1.8 million new cancer cases across the US each year, which means 150,000 new cases per month. A recent [HYPERLINK "<https://ehrn.org/wp-content/uploads/Preventive-Cancer-Screenings-during-COVID-19-Pandemic.pdf>" \o "<https://ehrn.org/wp-content/uploads/Preventive-Cancer-Screenings-during-COVID-19-Pandemic.pdf>" \t "_blank"] found that cancer screening appointments across the U.S. dropped between 86%-94% in March 2020, as compared to March 2019. This means 135,000 cancer cases per month going undiagnosed and untreated. In addition, existing cancer treatments are being rescheduled and this may impact morbidity and mortality. If the trend continues and centers are not able to resume testing, cancer cases could go undiagnosed for prolonged periods of time which may lead to tumor detection at a later stage. Late stage tumor detection will likely lead to increased mortality risk. Over [HYPERLINK

"https://seer.cancer.gov/csr/1975_2017/browse_csr.php?sectionSEL=1&pageSEL=sect_01_table_01.html" \o

"https://seer.cancer.gov/csr/1975_2017/browse_csr.php?sectionSEL=1&pageSEL=sect_01_table_01.html" \t "_blank"] people are estimated to die from cancer in the U.S. in 2020. This means approximately 50,000 per month die from cancer (all inclusive) per month.

What does this mean?

Britain:

[HYPERLINK "<https://www.theguardian.com/society/2020/apr/29/extra-18000-cancer-patients-in-england-could-die-in-next-year-study>"]

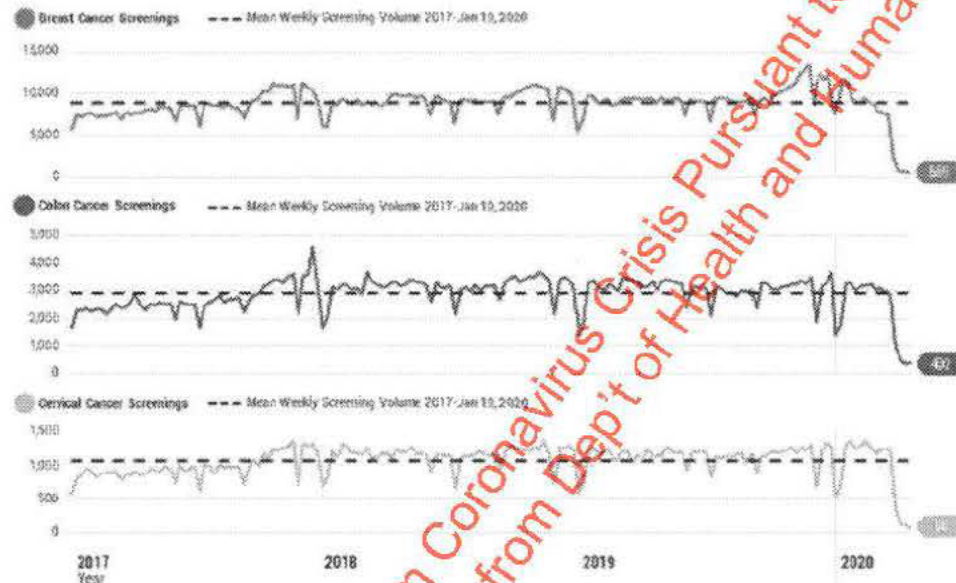
Almost 18,000 more people with cancer in England could die after the coronavirus pandemic led hospitals to suspend treatment and deterred patients from seeking NHS care, research has found. [HYPERLINK "<https://www.theguardian.com/society/cancer>"] experts claim that an extra 6,270 people in England who have been newly diagnosed with the disease could die from it over the next 12 months as a direct result of the disruption caused by coronavirus, and the additional toll taking into account all those living with cancer could be 17,915.

USA:

Excess Cancer Deaths Predicted as Care Disrupted by COVID-19 - MEDSCAPE – May 01, 2020.

Researchers project 34,000 excess deaths among cancer patients in the United States in the next 12 months; note, in the United States, the estimated excess number of deaths applies only to patients older than 40 years of age

Cancer Screenings in the U.S.



Mean weekly cancer screenings in the U.S. (courtesy of EPIC Health Research Network)

EPIC HEALTH RESEARCH NETWORK 5/4/2020

Suicide:

Researchers warn the COVID-19 lockdown will take its own toll on health:

[HYPERLINK "<https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/>" \t "_blank"]

[HYPERLINK "https://protect2.fireeye.com/url?k=3d9b8610-61ce8fc0-3d9bb72f-0cc47a6a52de-f81b705d1d68a20&a=https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf" \t "_blank"]

References:

Phillips, Julie A., and Colleen N. Nugent. 2014. "Suicide and the Great Recession of 2007-2009: The Role of Economic Factors in the 50 U.S. States." *Social Science & Medicine* (1982) 116 (September): 22-31.

Luo, Feijun, Curtis S. Florence, Myriam Quispe-Agnoli, Lijing Ouyang, and Alexander E. Crosby. 2011. "Impact of Business Cycles on US Suicide Rates, 1928-2007." *American Journal of Public Health* 101 (6): 1139-46.

We are modelling deaths of despair as a consequence of COVID-19 and based on drugs, alcohol, and suicidal causes

- Modelling is based on 1% increase in unemployment yields 1.6 % deaths of despair/suicide (Phillips and Nugent, 2014); note WBT models based on this assumption of 1%:1.6%

- We are modelling due to COVID-19

- We are modelling due to the effects of lockdown and isolation/uncertainty and the resulting uptick in deaths of despair

- Based on that and accepting a "medium" recovery rate of economy (this is based on the exceptional impact the President's policies had pre- COVID-19 lockdown getting the economy to 3.5% unemployment; note that we could have modeled as due to a 'slow' recovery' or 'fast' but we handicapped and chose the middle group.

- We will use a US 2018 population of 327,167,454, and so rounded to 330,000,000

- Therefore, for 2020, for a medium rate of recovery, there are 15, 000 deaths projected per 1.6 % increase in deaths of despair (WBT based model)

- Therefore, assuming the employment rate was 4% when lockdown started (but it was 3.5 %), then as of May 17, 2020, the unemployment rate hovers at around 15%

- Therefore, this means an 11% point increase

- Some suggest it will get to 20%, some to 32%

- We will split the difference of 15% - 32% = 17 % = 8.5 %

15% + 8.5 % = approx 20%

- Thus with a 20 point increase, and based on a 1.6 % increase or 15K deaths per point increase

- Therefore $20 \times 15 = 300,000$ additional deaths for 2020 based on the lockdown and deaths of despair due to COVID-19

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Backup in case sites delete:

[[HYPERLINK "https://www.theguardian.com/society/2020/apr/29/extra-18000-cancer-patients-in-england-could-die-in-next-year-study"](https://www.theguardian.com/society/2020/apr/29/extra-18000-cancer-patients-in-england-could-die-in-next-year-study)]

Coronavirus crisis could lead to 18,000 more cancer deaths, experts warn

Analysis models impact over next year of delays in getting diagnosis and treatment

- [[HYPERLINK "https://www.theguardian.com/society/2020/apr/29/cancer-patients-like-me-are-just-getting-forgotten-about"](https://www.theguardian.com/society/2020/apr/29/cancer-patients-like-me-are-just-getting-forgotten-about)]

[[HYPERLINK "https://www.theguardian.com/profile/deniscampbell"](https://www.theguardian.com/profile/deniscampbell)] and [[HYPERLINK "https://www.theguardian.com/profile/caroline-bannock"](https://www.theguardian.com/profile/caroline-bannock)]

Tue 28 Apr 2020 19.01 EDT Last modified on Wed 29 Apr 2020 06.29 EDT

-
-
-

Shares
1516

[HYPERLINK "<https://www.theguardian.com/society/2020/apr/29/extra-18000-cancer-patients-in-england-could-die-in-next-year-study>" \l "img-1"] While some of the projected additional deaths will be among people with cancer who contract Covid-19, others will occur because diagnosis was late or treatment such as chemotherapy was delayed. Photograph: Christopher Thomond/The Guardian

Almost 18,000 more people with cancer in England could die after the coronavirus pandemic led hospitals to suspend treatment and deterred patients from seeking NHS care, research has found.

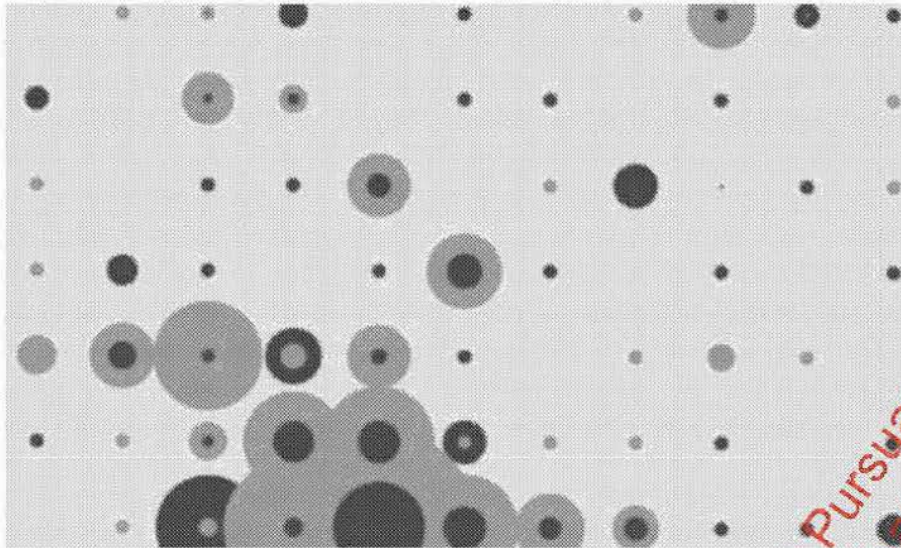
[HYPERLINK "<https://www.theguardian.com/society/cancer>"] experts claim that an extra 6,270 people in England who have been newly diagnosed with the disease could die from it over the next 12 months as a direct result of the disruption caused by coronavirus, and the additional toll taking into account all those living with cancer could be 17,915.

That is an increase of 20% on the 89,576 deaths among cancer patients recorded annually in England, according to the latest available statistics.

The UK hospital death toll from coronavirus stands at 21,678, and more than 4,300 people have died in care homes in the past fortnight, bringing the total to more than 26,000 Covid-19 deaths since the pandemic took hold in Britain.

The [HYPERLINK "https://www.researchgate.net/publication/340984562_Estimating_excess_mortality_in_people_with_cancer_and_multimorbidity_in_the_COVID-19_emergency"] sheds light on some of the wider health impacts of the pandemic. Macmillan Cancer Support described the findings as extremely worrying and said cancer should not become "the forgotten C" during the coronavirus crisis.

NHS England has launched a [HYPERLINK "<https://www.theguardian.com/world/2020/apr/25/england-campaign-targets-seriously-ill-patients-avoiding-hospitals>"] urging people with symptoms of any potentially serious illness to seek help in the normal way by visiting A&E, a GP or dialling 999.



Coronavirus: the week explained - sign up for our email newsletter

Read more

Urgent referrals by GPs for cancer tests have fallen by 76% and appointments for chemotherapy by 60% since the pandemic arrived in February despite NHS England [[HYPERLINK "https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf"](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf)] cancer treatment “should continue unaffected” The health service hopes to resume cancer operations this week but faces a large backlog.

The new research, from University College London (UCL) and [[HYPERLINK "https://www.data-can.org.uk/"](https://www.data-can.org.uk/)], a health data research hub for cancer diagnosis and treatment in the UK, is the first to quantify the potential impact of the NHS delaying many forms of cancer treatment, including diagnostic tests and operations, and people not wanting to risk going into hospital in case they become infected. It is based on data from the health records of more than 3.5 million patients in England.

Advertisement

While some of the projected additional deaths will be among people with cancer who contract Covid-19, others will occur because diagnosis was late or treatment such as chemotherapy was delayed, the researchers conclude.

“Our findings demonstrate the serious potential for unintended consequences of the response to the Covid-19 pandemic, which may negatively impact on patients with cancer and other underlying health conditions,” said Dr Alvina Lai, a lead author of the study and a lecturer in health data analytics at UCL’s institute of health informatics.

The NHS should recognise patients affected as being particularly vulnerable and manage their care to reduce the risk to their health, Lai added.

Prof Peter Johnson, NHS England's top cancer doctor, said on Wednesday that people with possible signs of cancer who delay seeking care could face serious consequences. He said they should have symptoms such as a lump or new mole checked out as soon as possible.

Patients can have cancer surgery at one of the NHS's "Covid-free cancer hubs" already operating in 19 areas of England, he added.

Almost eight in 10 of the extra fatalities will be people recently diagnosed with cancer who also have at least one other long-term illness, such as heart problems, high blood pressure, obesity or diabetes, the NHS-funded study concluded.

Prof Mark Lawler, of Queen's University Belfast and Data Can's scientific lead, said: "The results are concerning. We believe countries need to rapidly understand how the emergency is affecting cancer outcomes, otherwise we risk adding cancer and other underlying health conditions to the escalating death toll of the Covid-19 pandemic."

Prof Harry Hemingway, a senior author and the director of UCL's institute of health informatics, said: "The overall impact of the Covid-19 emergency on deaths in cancer patients could be substantial. There are many factors operating here including rapid changes to diagnosis and treatment protocols, social distancing measures, changes in people's behaviour in seeking medical attention and [the] economic impact of Covid-19, as well as deaths due to Covid-19 infection."

One patient with bowel cancer told The Guardian that he had had a CT scan but his planned colonoscopy – a diagnostic procedure – at a hospital in south-west England had been postponed for an unspecified period because the hospital's endoscopy department had closed until the Covid-19 crisis eases.

"I am totally gutted to think I've been chunked on the pile in favour of coronavirus victims. For all I know they are giving me a death sentence [by] not looking at my case," he said.

Another person said their mother's surgery to remove a 3cm bladder tumour had been delayed for up to eight weeks because her hospital's urology department had been shut as part of its preparations for Covid-19 cases. "This is worse than any nightmare I might ever have imagined in my darkest hour," the relative said.

Excess Cancer Deaths Predicted as Care Disrupted by COVID-19

Pam Harrison

May 01, 2020

6 ADD TO EMAIL ALERTS

Editor's note: Find the latest COVID-19 news and guidance in Medscape's Coronavirus Resource Center.

The majority of patients who have cancer or are suspected of having cancer are not accessing healthcare services in the United Kingdom or the United States because of the COVID-19 pandemic, the first report of its kind estimates.

As a result, there will be an excess of deaths among patients who have cancer and multiple comorbidities in both countries during the current coronavirus emergency, the report warns.

The authors calculate that there will be 6270 excess deaths among cancer patients 1 year from now in England and 33,890 excess deaths among cancer patients in the United States. (In the United States, the estimated excess number of deaths applies only to patients older than 40 years, they note.)

"The recorded underlying cause of these excess deaths may be cancer, COVID-19 or comorbidity (such as myocardial infarction)," Alvina Lai, PhD, University College London, United Kingdom, and colleagues observe.

"Our data have highlighted how cancer patients with multimorbidity are a particularly at-risk group during the current pandemic," they emphasize.

The study was published on ResearchGate as a preprint and has not undergone peer review.

Commenting on the study on the UK Science Media Center, several experts emphasized the lack of peer review, noting that interpretation of these data needs to be further refined on the basis of that input. One expert suggested that there are "substantial uncertainties that this paper does not adequately communicate." But others argued that this topic was important enough to warrant early release of the data.

Chris Bunce, PhD, University of Birmingham, United Kingdom, said this study represents "a highly valuable contribution."

"It is universally accepted that early diagnosis and treatment and adherence to treatment regimens saves lives," he pointed out.

"Therefore, these COVID-19-related impacts will cost lives," Bunce said.

"And if this information is to influence cancer care and guide policy during the COVID-19 crisis, then it is important that the findings are disseminated and discussed immediately, warranting their release ahead of peer view," he added.

In a Medscape UK commentary, oncologist Karol Sikora, MD, PhD, argues that "restarting cancer

services can't come soon enough."

"Reasonably Argued Numerical Estimate"

"It's well known that there have been considerable changes in the provision of health care for many conditions, including cancers, as a result of all the measures to deal with the COVID-19 crisis," said Kevin McConway, PhD, professor emeritus of applied statistics, the Open University, Milton Keynes, United Kingdom.

"It seems inevitable that there will be increased deaths in cancer patients if they are infected with the virus or because of changes in the health services available to them, and quite possibly also from socio-economic effects of the responses to the crisis," he continued.

"This study is the first that I have seen that produces a reasonably argued numerical estimate of the number of excess deaths of people with cancer arising from these factors in the UK and the USA," he added.

Declines in Urgent Referrals and Chemo Attendance

For the study, the team used DATA-CAN, the UK National Health Data Research Hub for Cancer, to assess weekly returns for urgent cancer referrals for early diagnosis and also chemotherapy attendances for hospitals in Leeds, London, and Northern Ireland going back to 2018.

The data revealed that there have been major declines in chemotherapy attendances. There has been on average a 60% decrease from prepandemic levels in eight hospitals in the three regions that were assessed.

Urgent cancer referrals have dropped by an average of 76% compared to prepandemic levels in the three regions.

On the conservative assumption that the COVID-19 pandemic will only affect patients with newly diagnosed cancer (incident cases), the researchers estimate that the proportion of the population affected by the emergency (PAE) is 40% and that the relative impact of the emergency (RIE) is 1.5.

PAE is a summary measure of exposure to the adverse health consequences of the emergency; RIE is a summary measure of the combined impact on mortality of infection, health service change, physical distancing, and economic downturn, the authors explain.

Comorbidities Common

"Comorbidities were common in people with cancer," the study authors note. For example, more than one quarter of the study population had at least one comorbidity; more than 14% had two.

For incident cancers, the number of excess deaths steadily increased in conjunction with an increase in the number of comorbidities, such that more than 80% of deaths occurred in

patients with one or more comorbidities.

"When considering both prevalent and incident cancers together with a COVID-19 PAE of 40%, we estimated 17,991 excess deaths at a RIE of 1.5; 78.1% of these deaths occur in patients with ≥ 1 comorbidities," the authors report.

"The excess risk of death in people living with cancer during the COVID-19 emergency may be due not only to COVID-19 infection, but also to the unintended health consequences of changes in health service provision, the physical or psychological effects of social distancing, and economic upheaval," they state.

"This is the first study demonstrating profound recent changes in cancer care delivery in multiple centers," the authors observe.

Lai has disclosed no relevant financial relationships. Several coauthors have various relationships with industry, as listed in their article. The commentators have disclosed no relevant financial relationships.

The study is available for download from the ResearchGate website.

Follow Medscape Oncology on Twitter for more cancer news: @MedscapeOnc.

6 Read Comments

Medscape Medical News © 2020

Cite this: Excess Cancer Deaths Predicted as Care Disrupted by COVID-19 - Medscape - May 01, 2020.

Comments (6)

What to Read Next on Medscape

Special Coverage: COVID-19

Recommendations

Message

From: Alexander, Paul (HHS/ASPA) (VOL) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 5/17/2020 1:21:58 AM
To: Paul Elias Alexander [REDACTED]@yahoo.com]; S R [REDACTED]@gmail.com]
Subject: data to research urgently on private laptop

From: Michael Caputo [REDACTED]@gmail.com>
Sent: Saturday, May 16, 2020 9:20 PM
To: Alexander, Paul (HHS/ASPA) (VOL) [REDACTED]
Subject: Re: Hello-follow up

You need to take ownership of these numbers. This is singularly important to what you and I want to achieve.

Michael Caputo
[REDACTED]

On May 16, 2020, at 8:18 PM, Alexander, Paul (HHS/ASPA) (VOL) [REDACTED] wrote:

Once there is data we will find it.

Problem is with it being so new, not much of this type of information has accumulated. If it is there in any manner then do not worry we will tease it out.

Yes, please connect me with whomever.

Sent from my iPhone

On May 16, 2020, at 2:52 PM, Michael Caputo [REDACTED]@gmail.com> wrote:

An oped? Speech?

I know the President wants us to enumerate the economic cost of not reopening.
We need solid estimates to be able to say something like:

50,000 more cancer deaths!
40,000 more heart attacks!
25,000 more suicides!
155,000 more trauma deaths!
240,000 hospitals will close!
400,000 health care workers jobless!
170,000 more high school dropouts!

Etc

Dr Redfield told me he has someone at CDC researching similar topics. Let me connect you.

Michael Caputo
[REDACTED]

On May 16, 2020, at 1:52 PM, Alexander, Paul (HHS/ASPA) (VOL) [REDACTED] wrote:

We are doing work behind the scenes this weekend on this. See below.

From: Alexander, Paul (HHS/ASPA) (VOL)
Sent: Saturday, May 16, 2020 1:49 PM
To: Brennan, Patrick (OS/ASPA) [REDACTED]
Subject: RE: Hello-follow up

My man, sounds like a great plan. I looked at the preliminary and talked a little as to what is the key issue...the key issue people will have is this:

- Why are you (governments, public health officials) saying now that it is safe for me to go out and slowly resume normal life activities?
- Message should include: We know you are scared for this virus that emerged from China has presented us with many unknowns and death to our most precious citizens. The omission by China and the World Health Organization (WHO) initially of key information such as human-to-human spread had a tremendous impact on global nations' ability and capacity to respond. However, over the last 3 months, evidence has accumulated and now we have more data about this virus and know that not everyone in the population is at equal risk. The elderly are at high risk, not younger healthy adults or children. The risk to our children approaches zero and is vanishingly small. While we open the country, we have to remain vigilant with social distancing, hand washing, heightened sanitation...so that we do not put the elderly at risk for getting this virus. It is them we sought initially and still seek now, to protect. We have taken measures to beef up our healthcare systems so as to handle surges at hospital emergency rooms. We have to continue to protect our frail and elderly population as they are the most hard hit from this virus. The rest of the population has to jointly play a role in this by reducing the spread to the elderly while going about your daily life activities. If you are younger and healthy, then your risk of severe illness or death is vanishingly small and thus we have to go on with living lives as we develop a vaccine (s) and effective therapeutics. The consequences of failing to do so will have far greater consequences on lives e.g. deaths of despair will accumulate, lack of vaccinations for traditional vaccine preventable illnesses for children due to fear of doctor office and institutional

settings, depression, alcohol abuse, drug abuse, small and medium sized business failure, loss of jobs, loss of homes etc. and the consequences of these emotionally and psychologically to people, than COVID-19 on its own. We must get on with our lives now.

Something like this. We have to now 'unscare' people while as we re-open, we will see blips and spikes in cases and deaths. We must school them that we will respond to the spikes and hotspots as needed.

From: Brennan, Patrick (OS/ASPA) [REDACTED]
Sent: Saturday, May 16, 2020 9:22 AM
To: Alexander, Paul (HHS/ASPA) (VOL) [REDACTED]
Subject: Re: Hello-follow up

I think we may have what we need now — I just fwded you some great data that was pulled from databases HHS subscribes to (IQVIA stuff, you're probably familiar) which covers the slipper healthcare item very well. I am going to draft it today and see how it writes; I will send you a draft as soon as I've got it and we can see where, if anywhere, we need anymore data. Sound good?

Sent from my iPhone

On May 16, 2020, at 5:16 AM, Alexander, Paul (HHS/ASPA) (VOL) [REDACTED] wrote:

Hi Patrick, so what do you think is the best model to approach this with? Do we wait for folk to come back with data points? Or do we generate some now beyond the ones we have? What types of data do you seek or do you think is optimal for this? In reality, this is not studied like the effects of the virus on health. What we seek are more socio economic data effects, psychological data etc. that will be more 'soft' narrative data.

But I am very keen on helping you and Paul etc. optimally so any heads up form you will be good.

Regards

From: Brennan, Patrick (OS/ASPA) [REDACTED]
Sent: Friday, May 15, 2020 3:21 PM
To: Pollard, Ashton (OS/IOS) [REDACTED]
Cc: Alexander, Paul (HHS/ASPA) (VOL)

[REDACTED]
Subject: Re: Hello-follow up

Thank, Ashton.

Paul, I'm the guy with the office next to you haha, but haven't been in this week.

My understanding is that we should circle up with Paul to understand the ETA on data calls from parts of HHS.

I suspect that data won't be ready soon enough though — so what we should do is pull outside, existing data (although in some cases CDC and SAMHSA may have existing studies on health and employment etc.) I will build a draft of the op ed from that.

Paul, you have an existing document with some research pulled on this question, right? Can you send me that?

On May 15, 2020 at 3:13 PM,
Pollard, Ashton (OS/IOS)

[REDACTED] wrote:

Great! Yes — that's what I thought we were discussing, but I needed a little additional context. I am adding Patrick Brennan here as a start and we can circle back with Paul. Patrick is the Secretary's speechwriter, so he will be the primary architect of those talking points. Hope this is helpful and let me know if you need anything else!

From: Alexander, Paul (HHS/ASPA)
(VOL) [REDACTED]
Sent: Friday, May 15, 2020 3:11 PM
To: Pollard, Ashton (OS/IOS)
[REDACTED]
Subject: RE: Hello-follow up

Hi Ashton, thanks much and I sure am excited by this work for the President

too. Very tough time but full of much hope. And being strong.

Anyway, yes, I think its Paul Mango etc. Not sure but yes, Patrick too as they are trying to put some talking point together to go out as per Judy. Has to do with the Health vs Health to focus on the impact of COVID outside of the infection and the short and long term effects of COVID that go beyond COVID.

Judy said she wanted something by Wed. Thus if they wanted my eye balls on the stuff, then I just wanted some link. I do not know any of these people.

From: Pollard, Ashton (OS/IOS)

Sent: Friday, May 15, 2020 3:06 PM

To: Alexander, Paul (HHS/ASPA) (VOL)

Subject: RE: Hello-follow up

Paul,

Nice to meet you as well! Welcome to HHS.

Regarding linking you up with folks, since I came in a little late, are we referring to Paul Mango and Patrick Brennan? They were on the phone.

Let me know exactly who you mean and I'm happy to make the connection!

Thanks,
Ashton

From: Alexander, Paul (HHS/ASPA) (VOL)

Sent: Friday, May 15, 2020 3:02 PM

To: Pollard, Ashton (OS/IOS)

Subject: Hello-follow up

Hi Ashton, so good meeting you today
and thank you for willingness to help
me this morning as the badge is taking
long and so it's a drama each morning.

Anyway, based on what Judy was asking
just now, please help if they want my
role with Paul and the others...can you
help link me up to the folk Judy was
saying to get something in writing ready
by Wednesday.

And please you all call me Paul. Not Dr.
Alexander.

Grateful!

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public
Affairs (ASPA)
US Department of Health and Human
Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

[REDACTED]

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 7/27/2020 6:57:26 PM
To: Alexander, Paul (HHS/ASPA) (VOL) [REDACTED]
Subject: FW: Refuting MMWR CDC

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC

Tel: [REDACTED] (Office)

Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Paul Elias Alexander [REDACTED]@yahoo.com
Sent: Monday, July 27, 2020 2:02 PM
To: Alexander, Paul (HHS/ASPA) [REDACTED]
Subject: Fw: Refuting MMWR CDC

Best,

Paul E. Alexander, PhD
Health Research Methodologist, Department of Health Research
Methods, Evidence and Impact,
McMaster University
Assistant Professor
<http://hei.mcmaster.ca/>
GUIDE Research Methods Group
<https://project2freeeye.com/url?k=1b619a01-473493d1-1b61ab3e-0cc47a6a52de-4f1bc1312e9c5e29&u=http://guidecanada.org/>
WHO/PAHO Emergency consultant (COVID-19)
Washington, DC.

----- Forwarded Message -----

From: S R [REDACTED]@gmail.com>

To: Pea [REDACTED]@yahoo.com>

Sent: Monday, July 27, 2020, 12:53:52 p.m. EDT

Subject: Refuting...

Title: Safe re-opening of schools across America - Cases in point: YMCA of America, New York City's Department of Education, and Brown University

In the era of COVID-19, parents across the USA, and globally, are quite rightly concerned about their children's safe return to school. Government leaders, policy makers, school administrators, parents, and even children are spending vast amounts of time considering how a safe re-opening of schools could take place in September 2020 (or thereabouts). This on the heels of accumulating evidence that it is imperative that schools re-open for children given the negative impact of school closure on the social, psychological, emotional, and safety components of a child's life. When a child attends in-person full-day school (or part-day as the case may be), many needs, including nutrition, are met. There has to be an in-person component to accrue the benefits of schooling. In this regard, some have made their case for only in-person schooling for children and have highlighted the potential limitations of remote type learning, arguing that the child's brain grows more rapidly when there is in-person relationships with active, hands-on exploration. No doubt, the preferred format of the re-open for particular schools and settings will be dictated by the nature of the COVID-19 spread at that time. There will be variation in the epidemiology of COVID-19 by location/setting across the USA and this must be considered by relevant decision-makers. As the USA, at all levels of society, works to reduce transmission of COVID-19 and thus the risk to high-risk persons, any re-open decisions must consider the local circumstances for the extent of transmission. In moving to get schools re-opened safely, this has been the clarion call by the administration and President Trump's Coronavirus Task Force experts, who have been in line with recent Centers for Disease Control and Prevention (CDC) guidance on the re-opening of schools.

There will no doubt be areas where the guardrails that indicate greater spread such as positivity rate will be more elevated and as indicated, these would need decisions on a case-by-case basis. For example, if a location in the USA is experiencing a positivity rate of 5% or more (using 5% as a threshold for increased spread) and indications are of ongoing spread, then such a location would need to consider other school re-opening options other than the in-person full-day model e.g. remote learning, a hybrid model etc. Thus they would only re-open safely when the spread is brought under control. It makes sense that a carte blanche 'uniform' approach to re-opening of schools is not the way to go. This is justifiable when the safety of children remains paramount and particularly to the US government's administration experts tasked with this.

We do have evidence from global nations, especially across Europe that have re-opened schools, that have shown that it can be done safely with little, if any, impact on children, especially in terms of the risk of COVID-19 transmission to them. There are indications that there is almost zero evidence of spread of infection from child to child or child to adult. Children seem to not be the key drivers of COVID in schools or the larger communities seasonal influenza whereby children are the drivers of influenza. It is also being reported that not one nation in the entire world has thus far reported child care centers or elementary/primary schools as significant sources of COVID-19 transmission.

In this regard, we draw your attention to the very promising results that emerged in the USA in many YMCA centers that remained open during the last months. We think this will help shed light onto the prospect of school re-opening safely once risk reducing guidance such as CDC's guidance for safe school re-opening is followed. This adherence to the safety guidance must be maintained by all involved parties within the system e.g. teachers/guidance counsellors/administrators/kids etc.

Specifically, very informative and encouraging data has emerged from the YMCA of the USA and New York City's Department of Education whereby the two organizations reportedly followed safety guidance that closely mirrors guidance recently put out by the CDC. Similarly, Brown University's survey analysis of child care centers have also yielded very important data on the risk of COVID-19 spread among children in the USA. For example,and insert some of the data here and close off

<https://www.npr.org/2020/06/24/882316641/what-parents-can-learn-from-child-care-centers-that-stayed-open-during-lockdowns>

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 8/9/2020 7:18:03 PM
To: [REDACTED]@YAHOO.COM
Subject: FW: Follow up on CDC report on COVID-19 in children hospitalized; see link below

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Saturday, August 8, 2020 11:45 PM
To: Kent, Charlotte (CDC/DDPHSS/CSELS/OD) [REDACTED] Caputo, Michael (HHS/ASPA)
[REDACTED] Murphy, Ryan (OS/ASPA) [REDACTED]; Witkofsky, Nina (CDC/OD/OCS)
[REDACTED] Redfield, Robert R. (CDC/OD) [REDACTED] Casey, Christine G. (CDC/DDPHSS/CSELS/OD)
[REDACTED]
Subject: RE: Follow up on CDC report on COVID-19 in children hospitalized; see link below

Dr. Casey, see below to Dr. Kent but she is on leave and I am informed you are taking her role for now.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)

Sent: Saturday, August 8, 2020 11:42 PM

To: Kent, Charlotte (CDC/DDPHSS/CSELS/OD) [REDACTED]; Caputo, Michael (HHS/ASPA)

[REDACTED] Murphy, Ryan (OS/ASPA)

[REDACTED] Witkowsky, Nina (CDC/OD/OCS)

[REDACTED] Redfield, Robert R. (CDC/OD)

Subject: Follow up on CDC report on COVID-19 in children hospitalized; see link below

<https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s>

Good night Michael, I have given this thought and felt I would write making this request formal.

Michael, I am asking that you put an **immediate stop** on all CDC MMWR reports due to the incompleteness of reporting that is done in a manner to mislead the public. Importantly, CDC sends us shortly before putting out, a summary paragraph and I repeatedly write them about the summary as it leaves one unable to assess the full report and we go back and forth...how could we be clearing things without the full report??? CDC to me appears to be writing hit pieces on the administration and meant at this time to impact school re-openings and they then send it to the media knowing it is deceiving. I ask it be stopped now! Give us the full word document, NOT the summary!!!!

Dr. Redfield, my deepest respect to you, I am a huge admirer of all the great things you have done for this world...and I request Sir that you work with us at ASPA to ensure all is stopped now so that the reporting is accurate please. I am sure you are not aware of these reports as you can read and see the summary is not reflective of the content.

This immediate stop will ensure that reports are only cleared if I get ahead of time, the:

- 1) actual 'full' MS Word version and NOT the summary, we must clear the full report, with the relevant tables, in final form that they at CDC decided will be the posted report. FINAL, not scratched up. Their final. I must read it, refer back to the CDC writers, and get agreement on 1-2 lines before it is posted. The reports must be read by someone outside of CDC like myself, and we cannot allow the reporting to go on as it has been, for it is outrageous. Its lunacy. They may say 'it's the data'; I agree on one level, but they are constantly reporting incompletely and writing in a manner to make the nation run and dig a hole and climb inside with their children for 10 years. It makes no sense. It is meant to deceive and this recent report will show it clearly, and I will get to it.
- 2) If I see the final report, and we agree on my 2 lines, only then can it be posted. If this is not done, then cannot be reported and cleared by ASPA. Period. CDC cannot police itself, they have shown this in the reporting. There is something more beside the report afoot and this mail is not the place to get into it. The result is the administration and public is not being served. All the nation seeks is unbiased reporting of the facts, not a spin and report meant to tell a specific narrative for CDC's goals. I am not sure of what it is but it stinks. I cannot read a report and get pull hair out of my head.
- 3) Nothing to go out unless I read and agree with the findings how they CDC, wrote it and I tweak it to ensure it is fair and balanced and 'complete'. And not misleading.
- 4) Please put a stop on all immediately Michael.

- 5) Again, I request as part of this, 2 reports be adjusted online (the Georgia camp and this one on hospitalized COVID children).

I will use the above embedded CDC report as a clear example (see url). I will also refer to the recently published report MMWR on the Georgia camp. These 2 are highly instructive but the one on hospitalized COVID children is most recent and important to discuss.

I am asking that CDC immediately go back to the 2 reports and adjust the summary and if this is not done, then the stoppage be immediate. Any administration or President served by CDC with this type of reporting will be badly served.

Georgia camp MMWR

For the Georgia camp report, it was concerning to read for it of course was a hit piece on the administration's push to open schools. We can see it. But CDC could have at the least stated in their summary or conclusion (to pretend some balance or objectivity) that it is likely that the spread was due to

- 1) those in the camp (campers and teachers/camp leads) not adhering to CDC guidelines on mitigating spread
- 2) the children or campers not mandated to use masks or social distance... then of course there will be rampant spread
- 3) what was the extent of the teachers etc. using masks and importantly
- 4) how could the people hosting the camp not consider that cramming 25 kids into a cabin (many camps slept like this) not contributing to prolific spread...

so I request that CDC go back to that report and insert this else Michael, pull it down and stop all reports immediately. CDC tried to report as if once kids get together, there will be spread and this will impact school re-opening...that was the aim and that's how it reads and is disingenuous. Very misleading by CDC and shame on them. Their aim is clear. This hurts any President or administration. This is designed to hurt this President for their reasons which I am not interested in. I am interested in this or any President being served fairly and that tax payers money not be used for political reasons. They CDC work for him. The public wants honesty and fair reporting so that they can be informed, not to be deceived.

Hospitalized COVID children MMWR

Now, for this present report on COVID in hospitalized children url:
<https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s>

I have copied this full report for record keeping.

Now this report on COVID in hospitalized children concluded in its summary (blue):

Box 1: Existing summary

What is already known about this topic?

Most reported SARS-CoV-2 infections in children aged <18 years are asymptomatic or mild. Less is known about severe COVID-19 in children requiring hospitalization.

What is added by this report?

Analysis of pediatric COVID-19 hospitalization data from 14 states found that although the cumulative rate of COVID-19-associated hospitalization among children (8.0 per 100,000 population) is low compared with that in adults (164.5), one in three hospitalized children was admitted to an intensive care unit.

What are the implications for public health practice?

Children are at risk for severe COVID-19. Public health authorities and clinicians should continue to track pediatric SARS-CoV-2 infections. Reinforcement of prevention efforts is essential in congregate settings that serve children, including childcare centers and schools.

How could CDC start off stating that most cases are asymptomatic and mild, yet conclude that children are at risk for severe COVID-19....based on what? What evidence??? Where in that report is that data?

I request CDC go back and take this down, or immediately fix the summary based on what I state below (or some agreed upon version) for this below is the main finding, NOT that children are at risk for severe COVID-19...that is a statement that does not match the analysis....I will re-insert CDC's summary and make my additions for my additions actually are the key findings...my insertions are in yellow among their blue; note I removed the severe illness for it is not accurate; I include what parents need to know in summary format...the first line under "What are the implications for public health practice" is the key message parents want and CDC did not state this or stated all but this and this statement is supported by the data:

Box 2: Proposed summary

What is already known about this topic?

Most reported SARS-CoV-2 infections in children aged <18 years are asymptomatic or mild. Less is known about severe COVID-19 in children requiring hospitalization.

What is added by this report?

Analysis of pediatric COVID-19 hospitalization data from 14 states found that although the cumulative rate of COVID-19-associated hospitalization among children (8.0 per 100,000 population) is low compared with that in adults (164.5), one in three hospitalized children was admitted to an intensive care unit.

208 of 576 hospitalized children with COVID-19 in the US were analyzed (March 1–July 25); 5.8% of ICU admissions needed mechanical ventilation and nine (10.8%) of 83 children with completed chart reviews had a diagnosis of MIS-C; all 208 children had a reported discharge disposition (assumed discharged based on the reporting and included those with MIS-C) and one died (0.5%) in hospital and was reported to be very ill with multiple underlying conditions.

Among the 208 hospitalized children, the case-fatality rate (deaths) remains low, even among children hospitalized in this report with more severe COVID-19-associated complications, such as MIS-C; the reporting revealed that approximately 40% of the children were obese.

Median duration of hospitalization was 2.5 days (IQR = 1–5 days); ICU stay was a median of 2 days (IQR = 1–5 days).

In children hospitalized with seasonal influenza virus infection annually, estimates of ICU admissions with underlying medical conditions is similar to this present COVID-19 report on children and, in-hospital influenza deaths are also as rare (<1%) as those reported here for COVID-19.

What are the implications for public health practice?

Importantly, this report reveals that COVID-19 infected children typically have no or mild symptoms and those who are hospitalized do not predominantly get severely ill and do not die.

Public health authorities and clinicians should continue to track pediatric SARS-CoV-2 infections. Reinforcement of prevention efforts is essential in congregate settings that serve children, including childcare centers and schools.

I do not pretend to be smarter or more skilled than anyone, I just want this administration or any administration fairly treated and the tax payer be respected and informed given they pay CDC people high salaries and expect a certain competence.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC

Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 8/11/2020 7:27:38 PM
To: [REDACTED]@YAHOO.COM; S R [REDACTED]@gmail.com]
Subject: FW: Children and school...my view...

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Tuesday, August 11, 2020 3:27 PM
To: Witkofsky, Nina (CDC/OD/OCS) [REDACTED]; Caputo, Michael (HHS/ASPA) [REDACTED];
Hubbard, Madeleine (OS/ASPA) [REDACTED]; Traverse, Brad (HHS/ASPA) [REDACTED]
Pratt, Michael (OS/ASPA) [REDACTED]; Brennan, Patrick (OS/ASPA) [REDACTED]; Gordon
Hensley [REDACTED]@gmail.com>; McKeogh, Katherine (OS/ASPA) [REDACTED]; Oakley,
Caitlin B. (OS/ASPA) [REDACTED]; Wagner, John (FDA/OC) [REDACTED]
Baldassarre, Natalie (OS/ASPA) [REDACTED]
Subject: Children and school...my view...

Let me be as clear as I could be and yes, I am talking against the CDC guidance...we should not, NOT be putting our children, especially those under 10/11 etc. into face masks and social distancing in school, NOT, no distance in desks, no turned the same way, not...not masks in class, or to play...NONE...zero...WE ARE SCARING AND HAVE SCARED OUR PARENTS NEEDLESSLY and we are harming our children irreparably; we are at risk of damaging their immune systems...when we finally let them out to play they would get sick from pathogen that typically was no issue for their immune systems...if we are to follow the data, then lets follow the data....right now we are being illogical and at times nonsensical...

This is the data and it is clear (and if you wish to debate me, show me the data that refutes what I write below...not what tv tells you, show me the data, not what Fauci tells you, show me the data; Dr. Fauci has no data, no science to back up what he is saying on school re-open, none...he is scaring the nation wrongfully):

- 1) Yes, children can get COVID, but they get much more influenza infection, much more at risk for influenza, each year and we do not shut down schools...
- 2) But the data shows they do not, NOT get severely ill, do not; children get severely ill from influenza; were at high risk from H1N1 in 2010...we did not shut down schools or mask them
- 3) The data shows they do not die, or are at very very low risk of death from COVID...they are at high risk from seasonal influenza...was for H1N1 in 2010...we did not shut down schools or mask them
- 4) The data says children do not spread to other children, so why mask them? Tell me....
- 5) The data shows children do not spread to teachers or to their parents...so why mask them???
- 6) The data shows they don't take it home to granny...so why mask them????
- 7) The data by CDC and globally yearly show children are the principle drivers of influenza yearly...we now know NOT COVID....children take influenza and common colds home, NOT COVID...
- 8) 99.9% of all deaths in the US due to COVID have been in people >24 years of age....NOT children...
- 9) The data shows the teachers spread to children...so the teachers are to be masked...not the children...its illogical
- 10) Most teachers are younger than 45 etc...so they too are not at risk for severe illness...hell, a pathogen arrived and we deal with it...we do not do things 'at all costs' to destroy the nation and world...we do not further put minority communities deeper into a hole they were climbing out of with this administration good economic policies and jobs...why have we done this???
- 11) If a teacher has underlying conditions or a child, then the parent or teacher home, get special teaching etc...but you don't punish the entire set of children...and if your argument is 'well, are we not trying to help granny at home'??? I would say hell yes if children took it home but the science says NO...a big NO....granny gets it from the adults...not the kids...
- 12) And when I say kids, I don't mean 18 years olds like how CDC reports it...what insanity...

One more time, children should be sent packing to school, no masks, no social distance, free to play in the yard and read and do math and learn and get their social skills on and their fun and learning and growing and development...we cannot deal with COVID 'at all costs'...this is insanity.

I get my kids to breath the real air and all pathogen they can at all times so that their immune systems can remain on deck and tuned up...and sunlight and if cant, a multivitamin with D in it and C....its insane what we are doing...there is no science, none...to underpin this...

We need people to be sensible now, calm, commonsense, look at the science...

High risk folk yes, take steps, but all else, carry one...and the worst that can happen is we save our functional immune systems and we drive herd immunity...as we work on a vaccine and drugs...

The President is right, open up the schools...

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)

Tel: [REDACTED] (Cellular)

Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 8/12/2020 8:04:25 PM
To: [REDACTED]@YAHOO.COM; S R [REDACTED]@gmail.com]
Subject: Need to whittle this down...
Attachments: CDC MMWR op-ed Aug 12 FINAL sent to Madeleine for Michael.doc



CDC MMWR
op-ed Aug 12 FI...

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

CDC's MMWR report suggests a lower risk of severe illness from COVID-19 in US children: some good news for school re-opening

While schools in Europe and Canada are reopening, in the United States, government officials are arguing how to reopen, if at all. The evidence so far however suggests that a safe re-opening of schools in the USA is possible once sensible decisions are made and [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html)] are followed. Many are unsure what will happen if their child is infected with COVID and are quite rightly concerned about severe illness or even death.

When compared to seasonal influenza and the H1N1 pandemic, COVID seems very mild for children. In the 2018-2019 influenza season, the CDC reports that [[HYPERLINK "https://www.cdc.gov/flu/about/burden/2018-2019.html"](https://www.cdc.gov/flu/about/burden/2018-2019.html)] were hospitalized from the flu. So far, [[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s"](https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s)] have been reportedly hospitalized with COVID based on this CDC reporting. Less than 600 children hospitalized due to COVID-19 across the US. Tragically, [[HYPERLINK "https://data.cdc.gov/NCHS/Deaths-by-Sex-Ages-0-18-years-a4b-4ozv"](https://data.cdc.gov/NCHS/Deaths-by-Sex-Ages-0-18-years-a4b-4ozv)] under 18 in the US have died from COVID according to the CDC. This number pales in comparison to the over 600 children estimated to have died from the flu in the 2017-2018 season. During the [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html)] pandemic, [[HYPERLINK "https://www.cdc.gov/flu/about/season/flu-season-2017-2018.htm"](https://www.cdc.gov/flu/about/season/flu-season-2017-2018.htm)]. According to [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html)], data indicates that, children <18 years of age comprise under 7% of COVID-19 cases and less than 0.1% of COVID-19-related [[HYPERLINK "https://www.cdc.gov/covid-data-tracker"](https://www.cdc.gov/covid-data-tracker)]. Accessed on July 23, 2020"] We did not close down schools during H1N1 nor have we ever done for seasonal influenza that causes appreciable illness in children yearly.

Putting the risk of COVID-19 death in children into perspective, the chances of a child dying from COVID are actually extremely low. For example, [[HYPERLINK "https://www.cdc.gov/safeschools/pdf/nap_drowning_injuries-a.pdf"](https://www.cdc.gov/safeschools/pdf/nap_drowning_injuries-a.pdf)] that over 1,000 US children died of unintentional drowning in 2010 and that far greater children 1-4 years old die from drowning yearly when compared to all other causes, except for birth defects. A child is currently over 10x more likely to die from drowning than from COVID. Children are currently over [[HYPERLINK "https://www.cdc.gov/injury/wisqars/LeadingCauses.html"](https://www.cdc.gov/injury/wisqars/LeadingCauses.html)] than COVID. A recent article from JAMA Psychiatry suggested that the current shutdown could be the perfect storm for [[HYPERLINK "https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2764584"](https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2764584)].

[[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s"](https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s)] tracking March 1 to July 25, 2020, looking at children under 18 in the US hospitalized with COVID-19. Of the 298 children in the report who were hospitalized, favorable indications show hospitalized children are at low risk for severe illness, they recover very well, and very few die from COVID. It is

important to analyze the very few cases of children with severe COVID so parents can know what to expect in the absolute worst case.

In this MMWR, a third of the 208 children were admitted to an intensive care unit (ICU) for about 2 days. CDC reported that invasive mechanical ventilation was required by 5.8% of children, [[HYPERLINK "https://pubmed.ncbi.nlm.nih.gov/32674114/"](https://pubmed.ncbi.nlm.nih.gov/32674114/)] with COVID-19. 42% of these children had one or more underlying medical conditions, with 40% being obese. All of these children were reportedly discharged after spending, on average, 2.5 days in the hospital. One hospitalized child died and this child reportedly had several comorbidities.

The [[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s"](https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s)] MMWR report demonstrates that the case-fatality rate remains extremely low in children, and in this case, even among children hospitalized with more severe COVID-19 symptoms. The reporting of [[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s"](https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s)] by CDC for all hospitalized children is incredibly positive, and no indications of remaining hospitalized or being discharged for additional care was reported. The same goes for the small number of children reported with [[HYPERLINK "https://www.cdc.gov/mis-c/index.html"](https://www.cdc.gov/mis-c/index.html)] inflammatory condition (CDC is currently studying the cause of this new condition that is quite similar to [[HYPERLINK "https://www.cdc.gov/kawasaki/index.html"](https://www.cdc.gov/kawasaki/index.html)] in children. The outcome for children with COVID-19 based on this reported data, overall, is very favourable when compared to seasonal influenza and the H1N1 pandemic.

Compared to children hospitalized with seasonal influenza, estimates of influenza linked ICU admissions are 25% among hospitalized children with underlying medical conditions, and reports of [[HYPERLINK "https://pubmed.ncbi.nlm.nih.gov/30358877/"](https://pubmed.ncbi.nlm.nih.gov/30358877/)] Based on this data, the risk of severe illness and death for children due to COVID-19 is demonstrably less than seen in yearly influenza and this is very good news for parents who are quite rightly, anxious.

In addition, evidence has emerged to indicate that children do not readily pass on the SARS-CoV-2 infections that causes COVID-19 to [[HYPERLINK "https://www.nccmt.ca/uploads/media/media/0001/02/4e5a72a568475f4c87962d5316c726c825a44602.pdf"](https://www.nccmt.ca/uploads/media/media/0001/02/4e5a72a568475f4c87962d5316c726c825a44602.pdf)]. This is very promising and especially important for parents as the new school year approaches. Evidence from the National Collaborating Centre for Methods and Tools indicates that children are not a major source of transmission of COVID-19 and for children who were infected, transmission can be reliably traced back to community settings or adults, rather than other children in daycares or schools. Within households, adults were far more likely to spread COVID than their children. There is also new evidence that children demonstrate less expression of the ACE2 enzyme involved in the binding to [[HYPERLINK "https://jamanetwork.com/journals/jama/fullarticle/2766522"](https://jamanetwork.com/journals/jama/fullarticle/2766522)] that's facilitates entry of the virus into human cells. This may explain why children do not readily get infected or spread the virus, nor develop severe illness. Similar findings of exceedingly small risk of severe illness to children emerged in an analysis of 131 studies involving COVID-19 infected children from 26 countries (n=7,780 pediatric cases), concluding that the vast majority of children do just fine. Key findings are that 75% contracted infection from a family member at home, and only 3% needed ICU admission. MISC-emerged in 0.1% and there were [[HYPERLINK "https://www.expressnews.com/news/local/article/A-Texas-review-of-more-than-100-studies-worldwide-15368833.php"](https://www.expressnews.com/news/local/article/A-Texas-review-of-more-than-100-studies-worldwide-15368833.php)].

All age groups are at risk of getting coronavirus and it would be reckless to conclude that children do not get infected or transmit pathogen, however, evidence suggests far less than assumed. The data seems to support this. This [[HYPERLINK "https://www.nccmt.ca/uploads/media/media/0001/02/4e5a72a568475f4c87962d5316c726c825a44602.pdf"](https://www.nccmt.ca/uploads/media/media/0001/02/4e5a72a568475f4c87962d5316c726c825a44602.pdf)] is very [[HYPERLINK "https://www.medicalnewstoday.com/articles/children-not-a-major-source-of-covid-19-finds-rapid-review"](https://www.medicalnewstoday.com/articles/children-not-a-major-source-of-covid-19-finds-rapid-review)] \l "Rapid-review"].

Compared to other respiratory illnesses such as seasonal influenza (and H1N1 flu), reporting and modelling by CDC of the illness and death [[HYPERLINK "https://www.cdc.gov/flu/highrisk/children.htm"](https://www.cdc.gov/flu/highrisk/children.htm)], shows that children at present are at less risk for severe illness and death from COVID-19. This does not go without noting that there is still much to learn about this virus. This [[HYPERLINK "https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s"](https://www.cdc.gov/mmwr/volumes/69/wr/mm6932e3.htm?s)] helps however, by highlighting areas requiring much needed research and providing a more optimistic view of COVID when compared to the flu, as we move to re-open schools.

All this to say that the benefits of re-opening the schools such as the nutritious, social, physical, emotional and mental well being of children far outweigh the low risk of getting severely ill from COVID-19. There are potentially huge costs if we do not move to re-open schools. As parents and a society, we must weigh the health risks against the detriment of being kept home. We also know that this impacts low income and minority children differentially including children with disabilities that desperately need the programs provided as part of the regular school setting. Socialization and maturation is impacted and even routine vaccinations will be impacted.

We cannot dismiss any level of risk but we must put it in perspective as we make important societal decisions for our children. This CDC MMWR report is positive as part of the toolkit [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html)] as it addresses some of the uncertainty that parents rightly would have based on this novel virus. In closing, the risk of children having problems with COVID-19 is exceedingly low and the risk of death is near zero. Older teachers who may have co-morbid conditions may make decisions to stay at home or teach online, but as for children, they should not be kept out of the school environment given the very negligible risk of severe outcomes. Schools can and should be [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/prepare-safe-return.html)] in line with CDC's expert guidance, combined with sensible decision making and common sense, and in conjunction with [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/schools.html"](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/schools.html)]. Our actions must not be 'at all costs' and must not cause harm to our children's development.

Paul Alexander, Ph.D., is Senior Advisor for COVID-19 Pandemic Policy to the Assistant Secretary for Public Affairs at the U.S. Department of Health and Human Services, Washington, DC

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 8/30/2020 2:20:34 PM
To: Witkofsky, Nina (CDC/OD/OCS) [REDACTED]
Subject: thoughts on the MMWR reporting CDC

The last 2 MMWR reports have been more positive than usual and I find encouraging. I am not asking for CDC to give their opinion but I am asking that they report not just the doom but a balanced report. You can make data say what you want it to say based on what you chose to report and to the novice, they have no clue you are shaping the narrative. In a biased manner. There are always good news and they seem to omit these as it pertains to COVID and so these last 2 are showing positives. Have we been able to at last to impress upon them that it is easy to see how they report? And now they are forced to balance? To me all we want is the right information for the public to be informed. No biases, on either side. No agenda. Maybe they are not deliberately espousing an agenda and this is how they do it all the time. So no ill intent but if so, then this is not the right way to do things. And so this change I have seen, even if short lived, is very refreshing.

So have you seen this shift? Maybe you are having a huge impact and this is tremendous. Well done!

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] Office)
Tel: [REDACTED] Cellular)
Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/3/2020 3:19:58 PM
To: Atlas, Scott W. EOP/WHO [REDACTED]
Subject: op-ed on possible damage to children immune systems with lock downs and masks

I think a short 400 word op-ed on this will help people push back to school, I do think locking down our kids (and healthy adults) and masking them can dampen their functional immune systems.

Do you think this can be done??? Would this add value?

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/8/2020 5:16:44 PM
To: HHS Staff Sec (HHS/IOS) [REDACTED]; ASPA-Deputies [REDACTED]; OGC Covid-19 (HHS/OGC) [REDACTED]; Gianturco, Elizabeth (HHS/OGC) [REDACTED]; Cramer, Lindsay (NIH/NCI) [E] [REDACTED]; Pence, Laura (HHS/IOS) [REDACTED]; Brennan, Patrick (OS/ASPA) [REDACTED]; Ladak, Naayab (CDC/ONDIEH/NCBDDD) [REDACTED]; Brady, Will (HHS/IOS) [REDACTED]; Beckham, Tammy (HHS/OASH) [REDACTED]; Stannard, Paula (HHS/IOS) [REDACTED]
CC: Agnew, Ann (HHS/IOS) [REDACTED]; Harrison, Brian (HHS/IOS) [REDACTED]; Bird, Catherine (OS/IOS) [REDACTED]; Stecker, Judy (OS/IOS) [REDACTED]; Mango, Paul (HHS/IOS) [REDACTED]; Puesan, Cesar (HHS/OS/IOS) [REDACTED]
Subject: RE: For Review: Draft op-ed by Dr. Scott Atlas re: opening colleges/universities (revised) DUE HHS Staff Sec BY 3:00 PM TODAY 9/8
Attachments: How To Open Universities + DS v9swa REVISED Paul Alexander Sept 8.doc

Hi, see my minor edits for your consideration. Very nicely done by Scott!

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: HHS Staff Sec (HHS/IOS) [REDACTED]
Sent: Tuesday, September 8, 2020 12:47 PM
To: ASPA-Deputies [REDACTED]; OGC Covid-19 (HHS/OGC) [REDACTED]; Gianturco, Elizabeth (HHS/OGC) [REDACTED]; Cramer, Lindsay (NIH/NCI) [E] [REDACTED]; Pence, Laura (HHS/IOS) [REDACTED]; Brennan, Patrick (OS/ASPA) [REDACTED]; Alexander, Paul (HHS/ASPA) [REDACTED]; Ladak, Naayab (CDC/ONDIEH/NCBDDD) [REDACTED]; Brady, Will (HHS/IOS) [REDACTED]; Beckham, Tammy (HHS/OASH) [REDACTED]; Stannard, Paula (HHS/IOS) [REDACTED]
Cc: Agnew, Ann (HHS/IOS) [REDACTED]; Harrison, Brian (HHS/IOS) [REDACTED]; Bird, Catherine (OS/IOS) [REDACTED]; Stecker, Judy (OS/IOS) [REDACTED]; Mango, Paul (HHS/IOS) [REDACTED]; HHS Staff Sec (HHS/IOS) [REDACTED]; Puesan, Cesar (HHS/OS/IOS) [REDACTED]
Subject: FW: For Review: Draft op-ed by Dr. Scott Atlas re: opening colleges/universities (revised) DUE HHS Staff Sec BY 3:00 PM TODAY 9/8

Good afternoon,

Attached is a revised version of the op-ed that incorporates feedback from our previous circulation.

Please review and send any critical edits to HHS Staff Sec by 3:00pm today.

Thank you,
HHS Staff Sec

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

America's Universities Should Stay Open

World class colleges and universities are among America's most treasured institutions. Higher education is a gateway to opportunity and integral to the economic development and future leadership of our society.

Unfortunately, several universities have recently announced their plans to shut down in response to new COVID-19 cases among students. This is the wrong decision – colleges and universities should stay open, even when they see an increase in cases.

We know that virtual learning is a poor substitute for the education and development that happens on campus. Students most at risk of falling behind from distance learning are from lower and middle income families. Minority students are 50 percent [[HYPERLINK "https://www.insidehighered.com/admissions/article/2020/04/29/colleges-could-lose-20-percent-students-analysis-says"](https://www.insidehighered.com/admissions/article/2020/04/29/colleges-could-lose-20-percent-students-analysis-says)] than others to return if colleges close campuses. We cannot afford a generation forever disadvantaged by decisions of higher education institutions to limit in-person classes. As President Trump has said repeatedly, the cure cannot be worse than the disease.

Science tells us that young adults have an extremely low risk of serious illness or death from COVID-19. [[HYPERLINK "https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm"](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm)] data shows that of 164,280 deaths, only 0.2% of death have been in those under 25 years old. For those 18 to 29 years old, that risk is 10 times less than for people 40 to 49, 30 times less than for those 50 to 64, 90 times less than for those 65 to 74, 220 times less than for those 75 to 84, and 630 times less than for those 85 and older. John Ioannidis, renowned Stanford University epidemiologist, recently [[HYPERLINK "https://fee.org/articles/modelers-were-astronomically-wrong-in-covid-19-predictions-says-leading-epidemiologist-and-the-world-is-paying-the-price/"](https://fee.org/articles/modelers-were-astronomically-wrong-in-covid-19-predictions-says-leading-epidemiologist-and-the-world-is-paying-the-price/)] what the entire world's data and science consistently demonstrate: the risk for children and young adults dying from Covid-19 is "almost zero."

CDC data confirms that [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html"](https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html)] for those 18 to 29 are very small compared to older age groups: one-fourth the rates of people 50 to 64, one-fifth of those 65 to 74, one-eighth of those 75 to 84, and one-thirteenth of those over 85. At its peak week, hospitalization [[HYPERLINK "https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html"](https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html)] for those 18 to 29 equaled 4.9 per 100,000 population, compared to the peak of 66.7 of those 85 or older.

Tragically, the negative impacts from closing schools are being ignored, and the damage to college students and our society will be severe if we do not change course. Not only will we fail to educate our next generation of leaders, but we will hinder their entry into the workforce.

We are already seeing the negative effects of students not attending school. At least one adverse mental health symptom was reported by almost three-fourths of those aged 18 to 24 at the end of June. Shockingly, serious thoughts of suicide were entertained by 25 percent of that age group in the previous 30 days.

Closing schools for in-person learning is not the right thing to do. And these decisions are harmful to students, their families, and the entire country.

Schools should publish plans based on their unique circumstances that diligently protect high-risk populations on campus, including students, teachers, administrators, and staff. Overall, though, universities are relatively low-risk, [[HYPERLINK "https://nces.ed.gov/programs/coe/indicator_csb.asp"](https://nces.ed.gov/programs/coe/indicator_csb.asp)] – 90 percent of full-time students in public degree-granting colleges are under 25, and 98 percent are under 34; that's similar to private universities, where 87 percent and 95 percent respectively match those demographics. And most university faculty are not at significant risk, two-thirds of whom are under 55 years old, and only [[HYPERLINK "https://www.cupahr.org/wp-content/uploads/CUPA-HR-Brief-Aging-Faculty.pdf"](https://www.cupahr.org/wp-content/uploads/CUPA-HR-Brief-Aging-Faculty.pdf)] are older than 65.

We fully anticipate that cases will arise in young people as they have more social interactions, but that should not be a cause for panic if people adhere to CDC mitigation measures to protect the vulnerable. Indeed, the sensationalistic phrase “school outbreaks” itself is misleading – these are typically “cases” detected by testing, not clinically significant illnesses.

In fact, if students test positive and are sent back home, we will actually create greater risk. Homes are higher-risk settings than schools and are more likely to include older family members. The data consistently show that [[HYPERLINK "https://www.medrxiv.org/content/10.1101/2020.04.04.20053058v1"](https://www.medrxiv.org/content/10.1101/2020.04.04.20053058v1)] are where most cases emerge from and spread, verified by data throughout the world.

When students are sick, they should stay away from class, as they do with other illnesses. Instead of panicking about cases with either no symptoms or mild symptoms that will generally resolve, schools should implement mitigation measures to diligently protect high-risk students and faculty; maintain limits on indoor groups; hold large group activities outside; and treat the symptomatic patients. University leadership, faculty, staff, and students should follow CDC's newest [[HYPERLINK "https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html"](https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html)] on testing and school protocols, as well as continue to monitor local hospital capacity and protect the at-risk populations on campus and in the community. These measures, including testing, are aimed at protecting the

vulnerable, preventing the spread into high-risk environments, and keeping students in the low-risk campus environment, not at detecting spread among low-risk students.

The strategic focus of President Trump is exactly as the science demands and is based on common sense that everyone understands. Our universities, the best in the world, should think through their policies and use their resources to stay open - it's critical to our nation, it's safer, and it will achieve the most important goal of all, educating our young people, the nation's most precious resource.

Scott W. Atlas, MD is Special Advisor to the President, a member of the White House Coronavirus Task Force, and a senior fellow at Stanford University's Hoover Institution.

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/9/2020 7:58:21 PM
To: [REDACTED]@YAHOO.COM
Subject: FW: Examples of CDC adjusting writing based on my inquiry

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC

Tel: [REDACTED] (Office)

Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Wednesday, September 9, 2020 2:12 PM
To: Caputo, Michael (HHS/ASPA) [REDACTED]
Subject: Examples of CDC adjusting writing based on my inquiry

So a couple of examples from the past I may not have shared with you, of my queries to CDC on their reporting. 2 months ago.

1) This was the report on SARS-CoV-2 Transmission and Infection among Attendees of an Overnight Camp — Georgia, June 2020

This was the opening statement in the MMWR which was meant to extrapolate this camp to schools to hit the administration on safe school re-open:

"Understanding transmission of SARS-CoV-2, the virus that causes coronavirus infectious disease 2019 (COVID-19), among youth is critical for developing guidance for schools and institutes of higher education. During June 17–20, an overnight camp in Georgia (Camp A) held orientation for trainees and staff; staff remained for the first camp session, scheduled from June 21–27, and were joined by campers and several senior staff on June 21."

I argued no, a camp where you crammed 25 kids per cabin and no mitigation is not the same as a school and here is their reply related to the key opening sentence...small victory but a victory nonetheless and yippee!!!:

"Dr. Alexander,

Many thanks for your comments. This report shares preliminary findings from an ongoing investigation... In response to thoughtful comments from CDC leadership and you, the opening sentence of Georgia's report has been reframed. "

2) This report was on a Rebound in Routine Childhood Vaccine Administration Following Decline During the COVID-19 Pandemic — New York City, March 1–June 27, 2020.

I wrote them because again, it was written to make the Mayor of NY look good and reflect badly on the administration as all their reports on COVID do (those that are not basic epi reports). See my input.

"The mayoral news conference May 20 is prior stated and makes it read as if the increase in vaccination was due to the Mayor (para) but based on the dates you reported, it should be placed after May 17 as the increase appears to be a result of the terrific consequence of public health partners etc. and those experts and not the Mayor (para)."...

Their response...claim it is a matter of 'incongruence' but the key is they recognize that we are seeing the reporting:

"Dear Dr. Alexander, in response to your first comment on the NYC vaccination report, I see how the information in the summary appears incongruent."...

Best,

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/11/2020 6:04:48 PM
To: Atlas, Scott W. EOP/WHO [REDACTED]
Subject: FW: (CUI/SBU) One MMWR COVID-19 Response Early Release Scheduled for Tuesday, September 15

Heads up, CDC is asking clearance of this and as usual, sent only a few lines and not the full report. Then they send the full report and give us (me) 2 hours or so to respond with edits, with 5 other reports accompanying. I don't understand the 121 descendants number. It is ludicrous to lump 10-20 as a child. Note they did not indicate that the deaths were mostly in 18 and above. Note they did not talk about the 21 year olds.

Know this is coming out in the next couple days if not this weekend and CNN and Fox will be running the CDC indicated caption of "deaths in children elevated due to COVID" etc. This is very duplicitous to damage the administration. Can you help me craft an op-ed and I will ask to put out disputing the reporting for on face value, it is meant to mislead. E.g. I have a real problem with the lumping of 0-21 years as pediatric deaths. Its misleading, when I hear 'children' I think of 2, 4, 7, 9, 10 maybe 12 years old, even 13. A 20 year old is an adult, albeit young. Age bands should be <1, 1-5, 6-10, 11-15, and 16 to 20, and 21+. Its very misleading and I will guarantee you all the deaths (most) will clump near 20. By saying the pediatric population makes up 26% of the US population is very misleading as children as we know it do not make up 26%. That is comprised of adolescents and young adults. This is timed for the election and the push to re-open schools safely and rationally and with needed mitigations using CDC sensible guidance. The timing of this is meant to interfere with school re-opening and we need to get something out fast to pre-empt this in the next day or so and I can work with you on it. Please advise.

This is your heads up as sent to me internally. Let us advise the President and get permission to pre-empt this please for it will run for the weekend so we need to blunt the edge as it is misleading. I seek for this administration, any administration, that simply we follow the data and not mislead so that the public is well informed for their decisions. The nation just wants the truth, that's all, not spin or deceit.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Kent, Charlotte (CDC/DDPHSS/CSELS/OD) [REDACTED]
Sent: Friday, September 11, 2020 1:34 PM
To: Redfield, Robert R. (CDC/OD) [REDACTED]; Schuchat, Anne MD (CDC/OD) [REDACTED]; Galatas, Kate (CDC/OD/OADC) [REDACTED]; Bunnell, Rebecca (CDC/DDPHSS/OS/OD) [REDACTED]; Richards, Chesley MD (CDC/DDPHSS/OD) [REDACTED]; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) [REDACTED]

Cc: Cono, Joanne (CDC/DDPHSS/OS/OD) [REDACTED]; OADS Clearance (CDC) [REDACTED] Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) [REDACTED]; Stephens, James W. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Clark, David W. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Clark, Cynthia K. (CDC/OD/OCS) [REDACTED]; Caudwell, Kerry M. (CDC/OD/OCS) [REDACTED]; Blowe, April R. (CDC/OD/OCS) [REDACTED]; King, Veronnica (CDC/DDPHSS/CSELS/OD) [REDACTED]; Phifer, Victoria (CDC/DDPHSS/CSELS/OD) [REDACTED]; Mitchell, Donyelle R. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Tumpey, Abigail (CDC/DDPHSS/CSELS/OD) [REDACTED]; Brower, Melissa (CDC/DDPHSS/CSELS/OD) [REDACTED]; Fisher, Angela H. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Bonds, Michelle E. (CDC/OD/OADC) [REDACTED]; Heldman, Amy B. (CDC/OD/OADC) [REDACTED]; Haynes, Benjamin (CDC/OD/OADC) [REDACTED]; Gaines, McCollom, Molly (CDC/OD/OADC) [REDACTED]; DeNoon, Daniel (CDC/OD/OADC) (CTR) [REDACTED]; Bedrosian, Sara (CDC/OD/OADC) [REDACTED]; Gindler, Jacqueline (CDC/DDPHSS/CSELS/OD) [REDACTED]; Rutledge, Terisa (CDC/DDPHSS/CSELS/OD) [REDACTED]; Weatherwax, Douglas (CDC/DDPHSS/CSELS/OD) [REDACTED]; Hood, Teresa M. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Dunworth, Soumya (CDC/DDPHSS/CSELS/OD) [REDACTED]; Damon, Glenn (CDC/DDPHSS/CSELS/OD) (CTR) [REDACTED]; Meadows, Donald (CDC/DDNID/NCEH/OD) [REDACTED]; Boyd, Martha F. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Dott, Mary (CDC/DDPHSS/CSELS/OD) [REDACTED]; Branam, Ian (CDC/DDPHSS/CSELS/OD) [REDACTED]; Bartley, Shelton (CDC/DDPHSS/CSELS/OD) [REDACTED]; Patsch, Joseph (CDC/DDPHSS/CSELS/OD) [REDACTED]; Sen, Oishee (CDC/DDPHSS/CSELS/OD) [REDACTED]; Casey, Christine G. (CDC/DDPHSS/CSELS/OD) [REDACTED]; Hop, Elizabeth (CDC/OD/OCS) [REDACTED]; Dennehy, Heather (CDC/OD/OCS) [REDACTED]; Lepore, Loretta (CDC/OD/OCS) [REDACTED]; Witkofsky, Nina (CDC/OD/OCS) [REDACTED]; Johnson, Marsha (CDC/OD/OCS) (CTR) [REDACTED]; Warner, Agnes (CDC/OD/OCS) [REDACTED]; Harmon, Carrie E. (CDC/OD/OADC) [REDACTED]; Messonnier, Nancy (CDC/DDID/NCIRD/OD) [REDACTED]; Jernigan, Daniel B. (CDC/DDID/NCIRD/ID) [REDACTED]; Bialek, Stephanie R. (CDC/DDPHSS/CGH/DPDM) [REDACTED]; Reynolds, Mary (CDC/DDID/NCEZID/DHCPP) [REDACTED]; CDC IMS JIC Emergency Clearance-2 [REDACTED]; Protzel Berman, Pamela (ATSDR/OPPE) [REDACTED]; CDC IMS 2019 NCOV Response Policy [REDACTED]; CDC IMS 2019 NCOV Response Incident Manager [REDACTED]; Walke, Henry (CDC/DDID/NCEZID/DPEI) [REDACTED]; CDC IMS 2019 NCOV Response Deputy Incident Manager [REDACTED]; Kadzik, Melissa (CDC/DDID/NCEZID/OD) [REDACTED]; Beach, Michael J. (CDC/DDID/NCEZID/DFWED) [REDACTED]; Christie, Athalia (CDC/DDPHSS/CGH/OD) [REDACTED]; CDC IMS 2019 NCOV Response ADS [REDACTED]; CDC IMS 2019 NCOV Response MMWR and Publications [REDACTED]; Promoff, Gabbi (CDC/DDNID/NCCDPPH/OD) [REDACTED]; CDC IMS JIC Lead -2 (cdc.gov) [REDACTED]; CDC IMS JIC Media -2 [REDACTED]; CDC IMS JIC OADC LNO -2 [REDACTED]; Khabbaz, Rima (CDC/DDID/NCEZID/OD) [REDACTED]; Jernigan, Daniel B. (CDC/DDID/NCIRD/ID) [REDACTED]; Butler, Jay C. (CDC/DDID/OD) [REDACTED]; Birx, Deborah (nsc.eop.gov) [REDACTED]; McGuffee, Tyler A. (ovp.eop.gov) [REDACTED]; Pence, Laura (HHS/IOS) [REDACTED]; Steele, Danielle (HHS/IOS) [REDACTED]; Giroir, Brett (HHS/OASH) [REDACTED]; Abel, Vadim Daniel (HHS/IOS) [REDACTED]; Alexander, Paul (HHS/ASPA) [REDACTED]; Montero, Jose (CDC/DDPHSS/CSTLTS/OD) [REDACTED]; Baldwin, Grant (CDC/DDNID/NCIPC/DOP) [REDACTED]; Briss, Peter (CDC/DDNID/NCCDPPH/OD) [REDACTED]; Fox, Kimberley (CDC/DDID/NCIRD/DBD) [REDACTED]; Honein, Margaret (Peggy) (CDC/DDNID/NCBDDD/DBDID) [REDACTED]; Rose, Dale A. (CDC/DDID/NCEZID/DPEI) [REDACTED]; Liburd, Leandris C. (CDC/DDPHSS/OMHHE/OD) [REDACTED]; Carter, Melissa (CDC/DDNID/NCEH/DLS) [REDACTED]; Marandet, Angele G. (CDC/DDID/NCHHSTP/DHPRS) [REDACTED]; Raziano, Amanda J. (CDC/DDID/NCEZID/DPEI) [REDACTED]; Walker, Misha (Nikki) (CDC/DDNID/NCBDDD/OD) [REDACTED]; Martin, Laura Yerdon (CDC/DDPHSS/CSELS/OD) [REDACTED]; CDC IMS 2019 NCOV Response MMWR and Publications [REDACTED]; Moeller, Chester (CDC/OD/OCS) [REDACTED]; Joshi, Namita (CDC/DDPHSS/CGH/DPDM) [REDACTED]; CDC IMS 2019 NCOV Response STLT Policy and Public Health Partnerships [REDACTED]; Herrera, Rosa L. (CDC/DDPHSS/OS/OD) [REDACTED]; Lambert, Stephanie (CDC/CGH/DGHP) [REDACTED]

Subject: (CUI/SBU) One MMWR COVID-19 Response Early Release Scheduled for Tuesday, September 15

***** CONTROLLED UNCLASSIFIED INFORMATION (CUI) — SENSITIVE BUT UNCLASSIFIED (SBU) — FOR INTERNAL CDC USE ONLY *****

One *MMWR* Early Release related to the COVID-19 Response is scheduled for Tuesday, September 15, with the planned embargo lifting at 1 pm. Please note that the title, content, and timing might change.

SARS-CoV-2–Associated Deaths Among Children, Adolescents, and Young Adults Aged <21 Years — United States, February 12–July 31, 2020

Since February 12, 2020, approximately 6 million cases of SARS-CoV-2 infection, the cause of coronavirus disease 2019 (COVID-19), and 189,000 SARS-CoV-2–associated deaths have been reported in the United States. SARS-CoV-2–associated illness in the pediatric population (persons aged <21 years) is usually mild. The pediatric population constitutes 26% of the U.S. population, and this report describes characteristics of U.S. persons in that population who died in association with SARS-CoV-2 infection. Among approximately 120 SARS-CoV-2–associated deaths reported to CDC among persons aged <21 years in the United States during February 12–July 31, 2020, 6 in 10 occurred in males, 1 in 10 of decedents were aged <1 year, 2 in 10 were aged 1–9 years, 7 in 10 were aged 10–20 years, 1 in 9 were Hispanic/Latinx (Hispanic) persons, 1 in 3 were non-Hispanic Black (Black) persons, and 1 in 20 were non-Hispanic American Indian or Alaska Native (AI/AN) persons. Among these 121 decedents, 3 in 4 had an underlying medical condition. These data show that nearly three quarters of pediatric SARS-CoV-2–associated deaths have occurred in persons aged 10–20 years, with a disproportionate percentage among among Hispanics, Blacks, AI/ANs, and children with underlying medical conditions. Careful monitoring of deaths and other severe outcomes associated with SARS-CoV-2 infection among children, adolescents, and young adults remains particularly important as schools reopen in the United States.

Charlotte Kent, PhD, MPH

Editor-in-Chief, *Morbidity and Mortality Weekly Report (MMWR)* Series
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/13/2020 5:57:16 PM
To: [REDACTED]@YAHOO.COM; S R [REDACTED]@gmail.com]
Subject: FW: CDC report published a few hours ago conclusions are incomplete

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Sunday, September 13, 2020 1:57 PM
To: Caputo, Michael (HHS/ASPA) [REDACTED]
Subject: CDC report published a few hours ago conclusions are incomplete

This is how CDC is misleading the public and putting out incomplete misleading inaccurate reporting. Basic epidemiology will tell you the parents more certainly were infected by the school personnel and teachers when they went to pick their children up, and not the from the child. Note CDC is trying to get away with a slight of hand by using terms like 'likely' and 'probably' for they know its inaccurate or at the very least, incomplete reporting. There are other possibilities that are more likely to account for the spread. Their conclusion is wrong how written and meant to scare the nation and damage the safe school reopen; it is plain to see. The timing of the report B and the faulty conclusion. In my view, the parents got it more likely when they picked up the kids and came into contact with the school personnel or teachers as happens with my wife and I when we pick our kids form school. This is what I mean by CDC is using these reports and putting out incomplete conclusions. This is why I am telling you how the transmission (if this data is accurate) more likely occurred. At the least we must ask CDC to consider this in the conclusion and update it please. For them to consider for it is a likelihood or more likely explanation for the spread. For more complete or balanced reporting. In addition, parents may have gotten it while interacting outside the home. They cannot conclude it was from the children ONLY or be declarative and they are coy with words like

'likely'. The data does not support children spreading to adults or parents at the home but rather kids getting it from home. The data is clear. This is a report that is flawed and meant to mislead.

Again, I refer you to below, two reports (see blue highlight), 3 hours apart. But the key issue in the comparison of these two reports is the vastly varying age classifications and for report A 0-21 (we do not yet have the full data, just these few lines and asked to clear based on this and that is why I have been asking CDC for full reports) vs report B 0-17 pediatrics and 18 and older as adults. My contention is that report A is done this way methods wise to lump the deaths from older persons (young adults) as occurring in children, and using CDC's term 'pediatrics'. An 18, 19, 20, 21 year old is not a pediatric. This is meant to mislead the public and parents as we consider the safe re-open of schools and following the CDC guidance. It is as if they are producing reports to undermine their own guidance.

Report A (pediatrics 0-21 years old)

One *MMWR* Early Release related to the COVID-19 Response is scheduled for Tuesday, September 15, with the planned embargo lifting at 1 pm. Please note that the title, content, and timing might change.

SARS-CoV-2–Associated Deaths Among Children, Adolescents, and Young Adults Aged <21 Years — United States, February 12–July 31, 2020

Since February 12, 2020, approximately 6 million cases of SARS-CoV-2 infection, the cause of coronavirus disease 2019 (COVID-19), and 189,000 SARS-CoV-2–associated deaths have been reported in the United States. SARS-CoV-2–associated illness in the pediatric population (persons aged <21 years) is usually mild. The pediatric population constitutes 26% of the U.S. population, and this report describes characteristics of U.S. persons in that population who died in association with SARS-CoV-2 infection. Among approximately 120 SARS-CoV-2–associated deaths reported to CDC among persons aged <21 years in the United States during February 12–July 31, 2020, 6 in 10 occurred in males, 1 in 10 of decedents were aged <1 year, 2 in 10 were aged 1–9 years, 7 in 10 were aged 10–20 years, 1 in 9 were Hispanic/Latinx (Hispanic) persons, 1 in 3 were non-Hispanic Black (Black) persons, and 1 in 20 were non-Hispanic American Indian or Alaska Native (AI/AN) persons. Among these 121 decedents, 3 in 4 had an underlying medical condition. These data show that nearly three quarters of pediatric SARS-CoV-2–associated deaths have occurred in persons aged 10 – 20 years, with a disproportionate percentage among among Hispanics, Blacks, AI/ANs, and children with underlying medical conditions. Careful monitoring of deaths and other severe outcomes associated with SARS-CoV-2 infection among children, adolescents, and young adults remains particularly important as schools reopen in the United States.

Report B (pediatrics 0-17, and 18 and > is adult)

Transmission Dynamics of COVID-19 Outbreaks Associated with Child Care Facilities — Salt Lake City, Utah, April–July 2020

Early Release / September 11, 2020 / 69

Adriana S. Lopez, MHS¹; Mary Hill, MPH²; Jessica Antezano, MPA²; Dede Vilven, MPH²; Tyler Rutner²; Linda Bogdanow²; Carlene Claflin²; Ian T. Kracalik, PhD¹; Victoria L. Fields, DVM¹; Angela Dunn, MD³; Jacqueline E. Tate, PhD¹; Hannah L. Kirking, MD¹; Tair Kiphibane²; Ilene Risk, MPA²; Cuc H. Tran, PhD¹ ([View author affiliations](#))

[View suggested citation](#)

Summary

What is already known about this topic?

Children aged ≥ 10 years have been shown to transmit SARS-CoV-2 in school settings.

What is added by this report?

Twelve children acquired COVID-19 in child care facilities. Transmission was documented from these children to at least 12 (26%) of 46 nonfacility contacts (confirmed or probable cases). One parent was hospitalized. Transmission was observed from two of three children with confirmed, asymptomatic COVID-19.

What are the implications for public health practice?

SARS-CoV-2 Infections among young children acquired in child care settings were transmitted to their household members. Testing of contacts of laboratory-confirmed COVID-19 cases in child care settings, including children who might not have symptoms, could improve control of transmission from child care attendees to family members.

Article Metrics

Altmetric:

https://www.altmetric.com/details.php?domain=www.cdc.gov&citation_id=89914193

Reports suggest that children aged ≥ 10 years can efficiently transmit SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19) (1,2). However, limited data are available on SARS-CoV-2 transmission from young children, particularly in child care settings (3). To better understand transmission from young children, contact tracing data collected from three COVID-19 outbreaks in child care facilities in Salt Lake County, Utah, during April 1–July 10, 2020, were retrospectively reviewed to explore attack rates and transmission patterns. A total of 184 persons, including 110 (60%) children had a known epidemiologic link to one of these three facilities. Among these persons, 31 confirmed COVID-19 cases occurred; 13 (42%) in children. Among pediatric patients with facility-associated confirmed COVID-19, all had mild or no symptoms. Twelve children acquired COVID-19 in child care facilities. Transmission was documented from these children to at least 12 (26%) of 46 nonfacility contacts (confirmed or probable cases). One parent was hospitalized. Transmission was observed from two of three children with confirmed, asymptomatic COVID-19. Detailed contact tracing data show that children can play a role in transmission from child care settings to household contacts. Having SARS-CoV-2 testing available, timely results, and testing of contacts of persons with COVID-19 in child care settings regardless of symptoms can help prevent transmission. CDC guidance for child care programs recommends the use of face masks, particularly among staff members, especially when children are too young to wear masks, along with hand hygiene, frequent cleaning and disinfecting of high-touch surfaces, and staying home when ill to reduce SARS-CoV-2 transmission (4).

Contact tracing* data collected during April 1–July 10, 2020 through Utah's National Electronic Disease Surveillance System (EpiTrax) were used to retrospectively construct transmission

chains from reported COVID-19 child care facility outbreaks, defined as two or more laboratory-confirmed COVID-19 cases within 14 days among staff members or attendees at the same facility. EpiTrax maintains records of epidemiologic linkage between index patients and contacts (defined as anyone who was within 6 feet of a person with COVID-19 for at least 15 minutes ≤ 2 days before the patient's symptom onset) and captures data on demographic characteristics, symptoms, exposures, testing, and the monitoring/isolation period. A confirmed case was defined as receipt of a positive SARS-CoV-2 real-time reverse transcription–polymerase chain reaction (RT-PCR) test result. A probable case was an illness with COVID-19-compatible symptoms, epidemiologically linked to the outbreak, but with no laboratory testing. For this report, the index case was defined as the first confirmed case identified in a person at the child care facility, and the primary case was defined as the earliest confirmed case linked to the outbreak. Pediatric patients were aged <18 years; adults were aged ≥ 18 years.

Persons with confirmed or probable child care facility-associated COVID-19 were required to isolate upon experiencing symptoms or receiving a positive SARS-CoV-2 test result. Contacts were required to quarantine for 14 days after contact with a person with a confirmed case. Facility attack rates were calculated by including patients with confirmed and probable facility-associated cases (including the index patient) in the numerator and all facility staff members and attendees in the denominator. Overall attack rates include facility-associated cases (including the index case) and nonfacility contact (household and nonhousehold) cases in the numerator and all facility staff members and attendees and nonfacility contacts in the denominator; the primary case and cases linked to the primary case are excluded.

During April 1–July 10, Salt Lake County identified 17 child care facilities (day care facilities and day camps for school-aged children; henceforth, facilities) with at least two confirmed COVID-19 cases within a 14-day period. This report describes outbreaks in three facilities that experienced possible transmission within the facility and had complete contact investigation information. A total of 184 persons, including 74 (40%) adults (median age = 30 years; range = 19–78 years) and 110 (60%) children (median age = 7 years; range = 0.2–16 years), had a known epidemiologic link to one of these three facilities with an outbreak; 54% were female and 40% were male. Among these persons, 31 confirmed COVID-19 cases occurred (Table 1); 18 (58%) cases occurred in adults and 13 (42%) in children. Among all contacts, nine confirmed and seven probable cases occurred; the remaining 146 contacts had either negative test results (50; 27%), were asymptomatic and were not tested (94; 51%) or had unknown symptoms and testing information (2; 1%).

Among the 101 facility staff members and attendees, 22 (22%) confirmed COVID-19 cases (10 adult and 12 pediatric) were identified (Table 2), accounting for 71% of the 31 confirmed cases; the remaining nine (29%) cases occurred in contacts of staff members or attendees. Among the 12 facility-associated pediatric patients with confirmed COVID-19, nine had mild symptoms, and three were asymptomatic. Among 83 contacts of these 12 pediatric patients, 46 (55%) were nonfacility contacts, including 12 (26%) who had confirmed (seven) and

probable (five) COVID-19. Six of these cases occurred in mothers and three in siblings of the pediatric patients. Overall, 94 (58%) of 162 contacts of persons with facility-associated cases had no symptoms of COVID-19 and were not tested. Staff members at two of the facilities had a household contact with confirmed or probable COVID-19 and went to work while their household contact was symptomatic. These household contacts represented the primary cases in their respective outbreaks.

[Top](#)

Facility A Outbreak

Facility A, which had been deemed an essential business and had not closed before the outbreak occurred, required daily temperature and symptom screening for the 12 staff members and children and more frequent cleaning and disinfection; staff members were required to wear masks. Two COVID-19 cases in staff members were associated with facility A (Figure). The index case at facility A (patient A1) occurred in a staff member who reported symptom onset on April 2, self-isolated on April 3, and had a positive SARS-CoV-2 RT-PCR test result from a nasopharyngeal (NP) swab specimen obtained on April 6. Three days after patient A1's symptom onset, a second staff member (patient A2) experienced symptoms and had a positive SARS-CoV-2 test result 1 day later. Ten facility contacts (nine children aged 1–5 years and one staff member) remained asymptomatic during the monitoring period and were not tested. The last reported exposure at facility A was on April 3, when the facility closed. Among the 15 nonfacility contacts of patients A1 and A2 (including four children aged 1–13 years), 10 remained asymptomatic throughout their monitoring period and were not tested, and three received negative test results; the symptom and testing information for two nonfacility contacts was unknown. The primary patient, a household contact of the index patient, reported symptom onset 9 days before symptom onset in patient A1 and received a positive SARS-CoV-2 test result from an NP specimen collected on April 6. The facility attack rate (excluding the primary case) for facility A was 17% (two of 12) and was 7% overall (including contacts) (two of 27).

[Top](#)

Facility B Outbreak

Facility B was closed during March 13–May 4. Upon reopening, temperatures of the five staff members and children were checked daily, and more frequent cleaning was conducted; only staff members were required to wear masks. Five COVID-19 cases in three staff members and two children were associated with facility B (Figure). The index case (B1) occurred in a staff member who was tested on May 31 while presymptomatic (because of a household contact with COVID-19) and received a SARS-CoV-2-positive test result; patient B1 experienced mild COVID-19 symptoms on June 3 and last worked on May 29. A second staff member (patient B2), experienced symptoms on June 8, was tested, and received a positive test result 2 days later. Patients B3 and B4, children aged 8 months and 8 years, respectively, experienced mild

signs and symptoms (fever, fatigue, runny nose) 7 and 8 days, respectively, after symptom onset in patient B2; both children were tested and received positive test results the day after their symptoms commenced. A third staff member, patient B5, experienced symptoms 9 days after symptoms occurred in patient B4, was tested, and received a positive test result 1 day later. The two children likely transmitted SARS-CoV-2 to their contacts including two confirmed cases (in one child's mother and father, both symptomatic 2 and 3 days, respectively, following the child's illness onset) and three probable cases (in two adults, including one mother and a child). The index patient (B1) was a household contact of the primary patient who had symptom onset May 26, was tested on May 29, and received a positive SARS-CoV-2 test result. The facility attack rate for facility B was 100% (five of five) and the overall attack rate was 36% (12 of 33).

[Top](#)

Facility C Outbreak

Facility C was closed during March 13–June 17. Upon reopening, the facility requested that 84 staff members and children check their temperature and monitor their symptoms daily; masks were not required for staff members or children. Fifteen COVID-19 cases (in five staff members and 10 children) were associated with facility C (Figure). Two staff members and two students reported symptoms on June 24 and self-isolated. The index case occurred in a staff member (patient C1), who had a positive test result from an NP specimen obtained on June 25. The second staff member, patient C2, was tested 2 days later and received a positive SARS-CoV-2 test result, and the two students (aged 7 and 8 years) were tested on June 28 and 29, respectively and received positive test results. Over the subsequent 8 days, an additional eight students (aged 6–10 years), three of whom were asymptomatic, and three staff members (all symptomatic) received positive SARS-CoV-2 test results. Pediatric patients at the facility likely transmitted SARS-CoV-2 to their contacts, including five confirmed cases in household contacts (three mothers, one aunt, and one child) and two probable household cases (one mother and one child). Symptoms developed 3 and 5 days following the child's illness onset when onset date was known. One mother who was presumably infected by her asymptomatic child was subsequently hospitalized. Among the seven cases in symptomatic children, fever was the most common sign, followed by symptoms of headache and sore throat. The source for this cluster was not identified. The facility attack rate for facility C was 18% (15 of 84) and the overall attack rate was 19% (24 of 124).

[Top](#)

Discussion

Analysis of contact tracing data in Salt Lake County, Utah, identified outbreaks of COVID-19 in three small to large child care facilities linked to index cases in adults and associated with transmission from children to household and nonhousehold contacts. In these three outbreaks, 54% of the cases linked to the facilities occurred in children. Transmission likely

occurred from children with confirmed COVID-19 in a child care facility to 25% of their nonfacility contacts.

Mitigation strategies⁵ could have helped limit SARS-CoV-2 transmission in these facilities. To help control the spread of COVID-19, the use of masks is recommended for persons aged ≥ 2 years.⁷ Although masks likely reduce the transmission risk (5), some children are too young to wear masks but can transmit SARS-CoV-2, as was seen in facility B when a child aged 8 months transmitted SARS-CoV-2 to both parents.

The findings in the report are subject to at least three limitations. First, guidance for contact tracing methodology changed during the pandemic and could have resulted in differences in data collected over time. Second, testing criteria initially included only persons with typical COVID-19 signs and symptoms of fever, cough, and shortness of breath, which could have led to an underestimate of cases and transmission. Finally, because the source for the outbreak at facility C was unknown, it is possible that cases associated with facility C resulted from transmission outside the facility.

COVID-19 is less severe in children than it is in adults (6,7), but children can still play a role in transmission (8,9). The infected children exposed at these three facilities had mild to no symptoms. Two of three asymptomatic children likely transmitted SARS-CoV-2 to their parents and possibly to their teachers. Having SARS-CoV-2 testing available, timely results, and testing of contacts of patients in child care settings regardless of symptoms can help prevent transmission and provide a better understanding of the role played by children in transmission. Findings that staff members worked while their household contacts were ill with COVID-19-compatible symptoms support CDC guidance for child care programs recommendations that staff members and attendees quarantine and seek testing if household members are symptomatic (4). This guidance also recommends the use of face masks, particularly among staff members, especially when children are too young to wear masks, along with hand hygiene, frequent cleaning and disinfecting of high-touch surfaces, and staying home when ill to reduce SARS-CoV-2 transmission.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dep't of Health and Human Services

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/13/2020 5:04:07 PM
To: [REDACTED]@YAHOO.COM; S R [REDACTED]@gmail.com]
Subject: FW: CDC is adjusting children age ranges in COVID deliberately; an official request by Dr. Paul Alexander from HHS

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Sunday, September 13, 2020 1:04 PM
To: Caputo, Michael (HHS/ASPA) [REDACTED]
Subject: CDC is adjusting children age ranges in COVID deliberately; an official request by Dr. Paul Alexander from HHS

Hello Michael, I am making a formal request for CDC to provide us with complete reports when asking for our clearance and input. Providing clearance on a paragraph without the full report is a flawed process and not accurate. We must also be allowed ample time to review before publishing. In my reading of 2 recent reports and one focusing on COVID-19 deaths, the CDC classified 'pediatrics' as 0-21 years and in a second report a few hours after, classified pediatrics as 0-17/18 and adult as 18 years and above. My contention is particularly for the 0-21 age classification, they are lumping adult deaths with children (younger persons) so that the deaths from COVID can be reported as higher than it is in 'legitimate' children.

Parents, the American people, and public health policy makers need accurate data and information. I am concerned if this has been the manner of reporting historically for CDC, then the conclusions drawn could be inaccurate. I am also finding that the nature of the conclusions or message by CDC at times do not match the underlying data. It would be good for us to officially conduct a review of all CDC MMWR reporting in the last 6 months for this COVID pandemic. I have asked CDC for the full reporting before but to no avail. I am also finding that for H1N1 2009 pandemic reporting (surface bluish), CDC produced 20 odd MMWRs yet for COVID for the same period (first 6 months), there are approximately 100 MMWRs. The question is why, given both are pandemics and H1N1 2009 was even more severe on

children. I am also asking if we can ask CDC to commission a CDC MMWR report to explain why they stopped testing during H1N1 2009 pandemic and stopped reporting of cases, hospitalizations, and deaths. The current reporting by the administration is daily for COVID-19 and completely, yet 3 months into 2009 H1N1, CDC stopped the testing and reporting of active cases or deaths. We need an accounting for this action in H1N1 2009 pandemic by CDC if it can be informative to what the current administration is doing for COVID-19.

Specifically, in the report (report A) titled "Transmission Dynamics of COVID-19 Outbreaks Associated with Child Care Facilities — Salt Lake City, Utah, April–July 2020"

https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e3.htm?s_cid=mm6937e3_w, CDC stated "Pediatric patients were aged <18 years; adults were aged ≥18 years".

Now compare this to a recent summary they asked for ASPA to clear, again not the full report, but consider this statement in the report (report B) titled "SARS-CoV-2–Associated Deaths Among Children, Adolescents, and Young Adults Aged <21 Years — United States, February 12–July 31, 2020" that "SARS-CoV-2–associated illness in the pediatric population (persons aged <21 years) is usually mild. The pediatric population constitutes 26% of the U.S. population, and this report describes characteristics of U.S. persons in that population who died in association with SARS-CoV-2 infection".

The key issue is in report A, adults are 18 and older, whereas in the second report (report B), adults are aged 21 and older. The individuals aged 18 and older are captured as children in report B. Most of the deaths we know in COVID occur in older persons, not children.

Why would CDC have two widely different age classifications for children when the 0-21 age classification (report B) can only but lump adults as children and thus skew and mislead the findings. What is the reason in my estimation other than to lump extra deaths in the 0-21 age group (report B) to indicate more severe illness and deaths in children. The term 'pediatric' is also very wrong and meant to confuse. A person 18, 19, 20, 21 is not a pediatric. Parents, the nation, and policy developers need the accurate information. Something is confusing in their reporting and it is very concerning if this has been done all along by CDC. The reports thus can be entirely misleading.

I close by stating that the recent media reports based on leaks of our internal private discussions have been painful given the media is leaking one word or a line and not the full discussion. This is unfair and my reputation is at stake and I am being maligned with simple lines leaked and taken out of context.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC

Tel: [REDACTED] (Office)

Tel: [REDACTED] (Cellular)

Email: [REDACTED]

Message

From: Alexander, Paul (HHS/ASPA) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BC4EDA8AD333439EB3D296AE0E0F9634-ALEXANDER,]
Sent: 9/14/2020 3:27:39 PM
To: [REDACTED]@YAHOO.COM
Subject: FW: POLITICO - HHS comment on Democratic investigation?

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Alexander, Paul (HHS/ASPA)
Sent: Monday, September 14, 2020 11:28 AM
To: Oakley, Caitlin B. (OS/ASPA) [REDACTED]
Subject: RE: POLITICO - HHS comment on Democratic investigation?

I had no intentions but did not know of this and so wanted to reach out to you as to what is needed.
Just tell me what I need to do.

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)

Email: [REDACTED]

From: Oakley, Caitlin B. (OS/ASPA) [REDACTED]
Sent: Monday, September 14, 2020 11:27 AM
To: Alexander, Paul (HHS/ASPA) [REDACTED]
Subject: Re: POLITICO - HHS comment on Democratic investigation?

I will handle. Please do not reply

Sent from my iPhone

On Sep 14, 2020, at 11:25 AM, Alexander, Paul (HHS/ASPA) [REDACTED] wrote:

Hi Caitlin, how is responding to this handled? I am not responding as per awaiting your or Michael's next steps.

I see in it there is a request for an interview. I did not know this. On my part I have no issue being interviewed etc. and await how this is done as per instructions.

Is this right?

Dr. Paul E. Alexander, PhD
Senior Advisor to the Assistant Secretary
For COVID-19 Pandemic Policy
Office of the Assistant Secretary of Public Affairs (ASPA)
US Department of Health and Human Services (HHS)
Washington, DC
Tel: [REDACTED] (Office)
Tel: [REDACTED] (Cellular)
Email: [REDACTED]

From: Dan Diamond [REDACTED]
Sent: Monday, September 14, 2020 11:11 AM
To: Caputo, Michael (HHS/ASPA) [REDACTED]; Oakley, Caitlin B. (OS/ASPA) [REDACTED]
Cc: Alexander, Paul (HHS/ASPA) [REDACTED]
Subject: POLITICO - HHS comment on Democratic investigation?

Hi all – checking on this announcement by congressional Democrats.

ASPA Caputo, do you plan to comply with the subcommittee's request for an interview?

Senior adviser Alexander, do you plan to comply with the subcommittee's request for an interview?

Will the ASPA team continue to review MMWRs and push for changes, given this investigation and ongoing scrutiny?

I'll standby to update the story with comment.

Subject: BLAST: Democratic lawmakers to investigate Trump officials' meddling with CDC reports

Democratic lawmakers to investigate Trump officials' meddling with CDC reports

<https://www.politico.com/news/2020/09/14/democrats-investigate-trump-cdc-414272>

By Dan Diamond

House Democrats are launching an investigation into how Trump appointees have pressured officials at the Centers for Disease Control and Prevention to change or delay scientific reports on coronavirus, citing POLITICO reporting that found political interference in the publishing process.

"During the pandemic, experts have relied on these reports to determine how the virus spreads and who is at greatest risk," Rep. Jim Clyburn, chair of the House Select Subcommittee on the Coronavirus Crisis, and his Democratic colleagues write in a letter shared first with POLITICO. "Yet HHS officials apparently viewed these scientific reports as opportunities for political manipulation."

The Democrats' investigation focuses on the CDC's Morbidity and Mortality Weekly Reports, the agency's long-running series of scientific articles that researchers have looked to for the most current and reliable information on the coronavirus. POLITICO reported on Friday that Health and Human Services public affairs chief Michael Caputo and his scientific adviser Paul Alexander have pressured CDC officials to change the reports, in some cases retroactively, to align with President Donald Trump's more optimistic message about the outbreak.

"The reports must be read by someone outside of CDC like myself, and we cannot allow the reporting to go on as it has been, for it is outrageous. Its lunacy," Alexander wrote to CDC Director Robert Redfield and other officials in an Aug. 8 email obtained by POLITICO.

CDC officials have fought the most sweeping demands and continued to publish the reports, but have increasingly allowed Caputo and his team to review draft reports and even compromised on some wording.

Democrats on the House coronavirus subcommittee said they're moving swiftly to probe Trump appointees' involvement with the CDC reports, which have traditionally been published without political interference. The panel is demanding that the administration provide communications sent or received by Redfield regarding the reports, as well as additional documents from Caputo, Alexander, HHS Secretary Alex Azar and HHS public relations aide Brad Traverse.

For the first time, the subcommittee — which was stood up in April to evaluate the government's pandemic response — is also requesting transcribed interviews with political and career CDC and HHS officials, beginning on Sept. 22. Among the list of requested interviews: CDC's deputy director Anne Schuchat, acting chief of staff Nina Witkofsky, acting deputy chief of staff Trey Moeller, acting communications director Kate Galatas and MMWR editor-in-chief Charlotte

Kent. The subcommittee is seeking additional interviews with Alexander and Caputo, following the tentative round of interviews with CDC staff.

"We need to hear directly from the people who are most responsible," said a Democratic subcommittee staffer. "We can't afford to wait."

Public health experts have been outraged by the Trump administration's interventions with CDC's reports, noting that the MMWRs have been a cornerstone of global public health work for decades, including a famed 1981 report that revealed the existence of HIV.

Political appointees "should have no role in scientific publications. None," well-known surgeon and author Atul Gawande wrote on Twitter.

Caputo over the weekend defended his team's involvement with the reports as he accused a "deep state" at the CDC of working to undermine the president. Caputo also said Alexander, an assistant professor at McMaster University near Toronto, is an "Oxford-educated epidemiologist" who was qualified to critique the CDC's reports. POLITICO reported last week that Alexander separately attempted to prevent infectious disease expert Tony Fauci from speaking about the risks of coronavirus to children.

Meanwhile, House Energy and Commerce Chair Frank Pallone and Oversight subcommittee Chair Diana DeGette on Monday said they will request a briefing with Azar, who over the weekend defended Trump "as receptive to the data and science presented by me and other members of the [coronavirus] task force." But the HHS secretary has been largely silent on reports of his communications staff pressuring scientists like Fauci and those at the CDC.

Produced to House Select Subcommittee on Coronavirus Crisis Pursuant to Oversight Request,
Do Not Disclose Without Permission from Dept of Health and Human Services