NO TIME TO LOSE: SOLUTIONS TO INCREASE COVID-19 VACCINATIONS IN THE STATES

VIRTUAL HEARING

BEFORE THE

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C O N T E N T S

NO TIME TO LOSE: SOLUTIONS TO INCREASE COVID-19 VACCINATIONS IN THE STATES

TUESDAY, FEBRUARY 2, 2021

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

The subcommittee met, pursuant to call, at 11:00 a.m., via Cisco Webex online video conferencing, Hon. Diana DeGette (chair of the subcommittee) presiding.

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

Also present: Representatives Dingell, Soto, Walberg, and Carter.

Staff present: Kevin Barstow, Chief Oversight Counsel; Jeffrey C. Carroll, Staff Director; Austin Flack, Policy Analyst; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Deputy Chief Clerk; Rebekah Jones, Counsel; Chris Knauer, Oversight Staff Director; Mackenzie Kuhl, Digital Assistant; Kevin McAloon, Professional Staff Member; Kaitlyn Peel, Digital Director; Peter Rechter, Counsel; Tim Robinson, Chief Counsel; Chloe Rodriguez, Deputy Chief Clerk; Benjamin Tabor, Junior Professional Staff Member; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; William Clutterbuck, Minority Staff Assistant; Theresa Gambo, Minority Financial and Office Administrator; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Bijan Koohmaraie, Minority Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Brannon Rains, Minority Policy Analyst, Consumer Protection and Commerce, Energy, Environment; Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

Ms. DEGETTE. The Energy and Commerce Subcommittee hearing will now come to order.

I am very pleased to convene this first Oversight and Investigations hearing of the year. I believe it's one of the first in the U.S. Congress, and I want to welcome all of our new members. In particular, I want to welcome our new ranking member, Morgan Griffith, with whom I've worked on many, many issues, and I think will be a wonderful ranking member.

Before we actually go into business, Morgan, would you like to say a few words? I'll yield to you.

Mr. GRIFFITH. I'm just thrilled to be the Republican leader on this subcommittee. It's a subcommittee I've served on since I first got to the committee, and I love it and I think we're going to do some great work.

Ms. DEGETTE. Thank you.

As Mr. Dingell used to say, our charge is broad—rooting out waste, fraud, and, abuse wherever we may find it—and I'm sure we'll have many opportunities in the 117th Congress.

Our hearing today is entitled, "No Time to Lose: Solutions to Increase COVID–19 Vaccinations in the States." The purpose of the hearing is to examine the distribution and administration of COVID–19 vaccines in the United States.

Due to the COVID–19 public health emergency, as I have said, today's hearing is being held remotely, and so all Members, witnesses, and staff will participate via video conferencing. As part of the proceedings, we ask everybody to put their microphone on mute, unless you're speaking, so that—for the purposes of eliminating inadvertent background noise. And every time, of course, you need to speak, then we will ask you to unmute.

If at any time during the hearing I'm unable to chair, the chairman of the full committee, Chairman Pallone, who I see on my screen, will serve as chair until I'm able to return.

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

And the Chair now recognizes herself for an opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Today, the Oversight and Investigations Subcommittee holds its first hearing of the 117th Congress on an issue that holds the promise to finally end this pandemic: The rollout of the COVID–19 Vaccination Program. This committee has conducted relentless oversight of the COVID–19 pandemic response from the very start. Last year, we saw endless dysfunction and chaos, as our country was adrift by the absence of strong, competent Federal leadership. But, as bad as it was last spring, this winter has brought an even more dangerous stage.

In recent weeks, cases and hospitalizations have soared all over the country, and as many as 4,000 Americans per day have died from this awful virus. And now, as we're seeing, mutations of the virus are beginning to spread throughout the United States.

As the title of this hearing makes clear, we have no time to lose. We must act with a sense of urgency and use every resource available at the Federal, State, and local levels to fight the spread of this disease and to end suffering and death and to return to normalcy.

The Biden administration absolutely has its work cut out for it. Indeed, it faces the greatest and most immediate challenge of any Presidential administration in modern memory. But already we're

seeing signs that the ship is beginning to turn around. The administration recently announced a comprehensive national strategy for the COVID–19 pandemic, something this committee has long called for. The plan advances urgently needed solutions to mount a successful vaccination program, restore trust with the American people, and mitigate the spread of the virus, while at the same time providing the emergency relief that Americans desperately need. We will continue to engage with the administration on what the Federal Government needs from Congress to execute this plan and to get us back on track.

The key task that we're faced right now is the rollout of the COVID vaccines. The portion of Operation Warp Speed, the Federal-private partnership to research and develop the vaccines, test them in clinical trials for safety and efficacy, and get them authorized for use was an enormous undertaking, and it was a profound victory for our heroic scientists. But that was only the first step.

If we don't ensure that Americans also get vaccinated quickly, the efforts will have been in vain. Those charged with administering the COVID–19 vaccine program around the country, including our excellent witnesses today, have a tremendous opportunity and responsibility to ensure equitable and expeditious administration of these lifesaving vaccines. And that's why we're convened today, to hear from State leaders on the front lines about how we can significantly ramp up vaccinations.

As we will hear, States are mobilizing to expand who will be eligible to receive the vaccine next, with a special emphasis on ensuring equity for those most vulnerable to COVID–19 and historically marginalized communities. For instance, my home State of Colorado recently announced plans to hold pop-up vaccination clinics in 50 high-density, low-income communities of color, many in my congressional district.

Despite these efforts, we have already been seeing a lot of frustration and confusion. Since the rollout started in December, one consistent theme has been the lack of transparency about how many vaccines are coming and when. Compounding matters, surveys indicate that, while the majority of Americans want to get COVID–19, there are some who still have reservations. Thankfully, the Biden administration has committed to changes, like transparent data for the States and the public, that will address some of those issues so that we can build trust and work to get every available vaccine administered quickly and equitably.

In fact, the biggest challenge I'm hearing from States right now is simply a lack of supply. After some initial challenges in administering the vaccines, State and local communities are reporting that now the demand for the vaccine far exceeds the supply, and they stand ready to vaccinate many more Americans if we can just get them the doses they need.

As I said, we have an excellent panel today, representing five States that are aggressively working to end this pandemic. I want to thank each panelist for your efforts, and I'm grateful for the time you've committed to provide critical testimony on how we can improve our fight against this pandemic. I look forward to a candid discussion with the panel about what's working and what we can do better. And I hope that you will also elaborate on what more the

Federal Government and Congress can do to improve the partnership in this fight. The end of this nightmare is in sight. Now is the time to double down on our efforts and finally turn the corner on this pandemic.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Today, the Oversight and Investigations Subcommittee holds the first hearing of the 117th Congress, on an issue that holds the promise to finally end this pandemic: the rollout of the COVID–19 vaccination program.

This committee has conducted relentless oversight of the COVID–19 pandemic response from the very start. Last year, we saw endless dysfunction and chaos as our country was left adrift by the absence of strong, competent Federal leadership.

As bad as it was last spring, this winter has brought an even more dangerous surge.

In recent weeks, cases and hospitalizations were soaring all over the country, and as many as 4,000 Americans were dying every day from this awful virus.

As the title of this hearing makes clear, we have no time to lose. We must act with a sense of urgency and use every resource available—at the Federal, State, and local levels—to fight the spread of this virus, end the suffering and death, and return to a sense of normalcy.

The Biden administration has its work cut out for it. Indeed, it faces the greatest and most immediate challenge of any presidential administration in modern memory. But we are already seeing signs of the ship turning around.

The Biden administration recently announced a comprehensive national strategy for the COVID–19 pandemic, something this committee has long called for. This plan advances urgently needed solutions to mount a successful vaccination program, restore trust with the American people, and mitigate the spread of the virus, while providing the emergency relief Americans desperately need.

We will continue to engage with the administration on what the Federal Government needs from Congress to execute this plan and get America on track.

The key task we are faced with now is the rollout of COVID–19 vaccines.

The Federal-private partnership to research and develop these vaccines, test them in clinical trials for safety and efficacy, and get them authorized for use was an enormous undertaking and a profound victory for the country.

But that was only the first step. If we do not ensure that every American is able to get vaccinated quickly, those efforts will have been in vain. Those charged with administering the COVID–19 vaccine program around the country—including our excellent witnesses today—have a tremendous opportunity and responsibility to ensure equitable and expeditious administration of these lifesaving vaccines.

That is why we are convened today: to hear from State leaders on the front lines about how we can significantly ramp up vaccinations.

As we will hear today, States are mobilizing to expand who will be eligible to receive the vaccine next, with a special emphasis on ensuring equity for those most vulnerable to COVID–19 and historically marginalized communities.

For instance, my home State of Colorado recently announced plans to hold popup vaccination clinics in 50 high-density, low-income communities of color.

Despite these efforts, we have also been seeing a lot of frustration and confusion. Since the rollout started in December, one consistent theme has been the lack of transparency about how many vaccines are coming and when. Compounding matters, surveys indicate that, while the majority of Americans want to get the COVID–19 vaccine, some adults continue to have reservations.

Thankfully, the Biden administration has committed to changes—such as transparent data for the States and the public—that will address some of those issues, so that we can build trust and work to get every available vaccine administered quickly and equitably.

Indeed, the biggest challenge I'm hearing from most States now is simply a lack of supply. After some initial challenges administering the vaccines, States and local communities are reporting that the demand for the vaccine far exceeds the supply. And they stand ready to vaccinate many more Americans, if they are given the doses they need.

We have an excellent panel today, representing five States aggressively working to end this pandemic.

I thank them for their efforts, and I'm grateful for the time they've committed to provide critical testimony on how to improve our fight against this pandemic. I look

forward to a candid discussion with the panel about what is working and what is not working. I hope they will also elaborate on what more the Federal Government and Congress can do to improve the partnership in this fight.

The end of this nightmare is in sight. Now is the time to double down on our efforts, and finally turn the corner on this pandemic.

Ms. DEGETTE. And with that, the Chair is pleased to recognize the ranking member of the subcommittee, Mr. Griffith, for 5 minutes for the purposes of an opening statement.

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

Mr. GRIFFITH. Thank you very much, Chair DeGette. And I look forward to working with you, and thank you for holding this important hearing.

I want to thank the State public health officials for taking the time to join us today as your vaccination programs are well underway. The Federal Government and States are in the middle of a monumental task to vaccinate everyone that wishes to be vaccinated. I appreciate you all attending today as we work together to discuss ways to increase COVID–19 vaccinations.

It was just 1 year ago when this country identified the first case of a new virus that would rapidly spread throughout the Nation. In this past year, the Federal Government and States have come together to fight the pandemic, from providing testing to therapeutics and, ultimately, a vaccine for Americans. Pfizer and Moderna continue to manufacture vaccines at full capacity by releasing between 12 million to 18 million doses a week to fuel the overwhelming demand from the States.

Ending the pandemic hinges on the efficacy of the national vaccine distribution efforts. This effort includes not only sending vaccines to States, but also getting shots into arms. To date, the Federal Government has shipped more than 49 million doses of COVID–19 vaccines to States. States have administered almost 28 million of those doses through their State vaccination plans, with 3.1 million doses administered to people in nursing homes or long-term care facilities. Last week, the U.S. averaged 1.2 million doses administered each day across the U.S. Sixty-two percent of the vaccine supply has been administered, and that continues to trend upwards each week.

This progress is the product of Federal and State collaboration, especially extensive planning and investment from the initiative Operation Warp Speed. Operation Warp Speed was launched in May 2020, to accelerate the development, manufacturing, and distribution of COVID–19 vaccines while maintaining safety and efficacy standards. This was a massive undertaking that combined science, government, the military, and the private sector to provide viable vaccines several years earlier than typical timelines.

The Federal Government created toolkits and resources to States for planning COVID–19 immunization programs. For example, the CDC released a playbook to guide both States and their local partners on how to plan and operationalize a vaccination response. Additionally, in the summer of 2020, the CDC and Operation Warp Speed conducted site visits to develop model approaches for vac-

cinations through five pilot programs in California, Florida, Minnesota, North Dakota, and Philadelphia. The Federal Government also instructed States on how to use vaccines to control the coronavirus.

Due to the limited supply of vaccine available, the CDC's Advisory Committee on Immunization Practices recommended priority groups for vaccination. This included healthcare personnel and residents of long-term care facilities to be in the front of the line, followed by older adults and frontline essential workers, all groups with a higher susceptibility to coronavirus. States incorporated these recommendations to execute a deliberate and measured approach for vaccinations. The Federal Government worked diligently to distribute millions of doses across the United States. Now States are working diligently to administer these doses into arms.

States have varied in their performance when it comes to administering the vaccine doses that have been allocated and distributed to their State. For example, Virginia, my home State, administers 8.49 doses per 100, with 1.2 percent of the population fully vaccinated. In contrast, in West Virginia, they administer 13.53 doses per 100, with 3.3 percent of the population fully vaccinated.

States are under criticism for how their vaccination campaigns are responding to the demand for shots. States have noted the lack of resources and infrastructure for vaccinations, such as a lack of trained personnel to administer vaccines to eligibility groups. Additionally, miscommunication to States and providers on the number of doses available has created a chain of logistical issues. States appear to be addressing challenges as they learn lessons along the way, but there is work to be done to vastly improve the rate of doses administered. Additionally, 8.75 billion from the Consolidated Appropriations Act enacted at the end of last year with 4.5 billion specifically allocated to the States is on the way to the States and should be of some help.

As we continue to work on coronavirus stimulus packages, it is essential to hear State perspectives. As Justice Brandeis said, the States are the laboratories of democracy. By finding novel approaches to complex problems, a successful effort by a State can be a model for other States looking for solutions to similar problems.

I look forward to the testimony from these witnesses today and welcome them to the hearing.

[The prepared statement of Mr. Griffith follows:]

PREPARED STATEMENT OF HON. H. MORGAN GRIFFITH

Thank you, Chair DeGette, for holding this important hearing.

I also want to thank the State public health officials for taking the time to join us today as your vaccination programs are well underway. The Federal Government and States are in the middle of a monumental task to vaccinate everyone that wishes to be vaccinated. I appreciate you all attending today as we work together to discuss ways to increase COVID–19 vaccinations.

Ending the pandemic in this country hinges on the efficacy of the national vaccine distribution efforts. This effort includes not only sending vaccines to States, but also getting shots into arms. To date, the Federal Government has shipped 47 million doses of COVID–19 vaccines to States. States have administered 26 million of those doses through their State vaccination plans with 3.1 million doses administered to people in nursing homes or long-term care facilities.

Last week, the U.S. administered nearly 1.6 million doses in one day. This progress is the product of Federal and State collaboration, especially extensive planning and investment from the initiative Operation Warp Speed.

Operation Warp Speed was launched in May 2020 to accelerate the development, manufacturing, and distribution of COVID–19 vaccines while maintaining safety and efficacy standards. This was a massive undertaking that combined science, government, the military, and the private sector to provide viable vaccines several years earlier than typical timelines.

The Federal Government collaborated with States to lend toolkits and resources for planning COVID–19 immunization programs. For example, the CDC released an interim playbook to guide both States and their local partners on how to plan and operationalize a vaccination response. Additionally, in the summer of 2020, the CDC and Operation Warp Speed conducted site visits to develop model approaches for vaccinations through five pilot programs in California, Florida, Minnesota, North Dakota, and Philadelphia.

The Federal Government also instructed States on how to use vaccines to control the coronavirus. Due to the limited supply of vaccine available, the CDC's Advisory Committee on Immunization Practices (ACIP) recommended priority groups for vaccination. This included healthcare personnel and residents of long-term care facilities to be first in line, followed by older adults and frontline essential workers, all groups with a higher susceptibility to coronavirus. States incorporated these recommendations to execute a deliberate and measured approach for vaccinations.

The Federal Government worked diligently to distribute millions of doses across the United States. Now, States are working diligently to administer these doses into arms. States have varied in their performance when it comes to administering the vaccine doses that have been allocated and distributed to their States.

States have faced challenges in this complex, logistical operation that have contributed to slower than expected vaccination rates. This is especially true in my home State of Virginia. For example, in Virginia, the State administers 53 percent of the doses it receives from the Federal Government. In contrast, our neighbors in West Virginia administer 77 percent of their doses. States that are lagging in vaccinations fall in the 40 to 50 percent range, while those that are leading the country administer 60 to 70 percent of the doses they receive.

States are under criticism for how their vaccination campaigns are responding to the demand for shots. States have noted the lack of resources and infrastructure for vaccination, such as the lack of trained personnel to administer vaccines eligibility groups. Additionally, miscommunication to States and providers on the number of doses available has created a chain of logistical issues. States appear to be addressing challenges as they learn lessons along the way, but there is work to be done to improve the process. More resources from the Consolidated Appropriations Act enacted at the end of last year is on the way.

As we continue to work on coronavirus stimulus packages, it is essential to hear State perspectives. With new variants of the virus emerging and case numbers skyrocketing, we need to find solutions as quickly as possible.

I look forward to the testimony from these witnesses and welcome them to the hearing. I yield back.

Mr. GRIFFITH. And, Madam Chair—excuse me—Madam or Chair, I yield back. Trying to get it right.

Ms. DEGETTE. And you did.

The Chair now will recognize the chairman of the full committee, Mr. Pallone, for 5 minutes for purposes of an opening statement.

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

Mr. PALLONE. Thank you. Thank you, Madam Chairwoman.

And let me also thank Morgan Griffith, our ranking member. And I see the ranking member of our full committee is here as well, and I also notice we have a lot of our new Members on both sides of the aisle. I think the new Members are probably going to be more active than some of the older Members, unfortunately. But it's all right. We want you all to get involved as much as possible.

So, today, this is actually the first hearing of the Energy and Commerce Committee during the 117th Congress, and obviously the purpose of it is to examine the urgent need to increase COVID–19 vaccinations. This committee's top priority is to combat this pandemic, and in the coming months we'll push an aggressive agenda that will ensure the Biden administration has all the tools and resources it needs to crush the virus.

The goal is more pressing than ever. Thousands of Americans continue to die each day from COVID–19, while new, more contagious strains are emerging in the United States. I'm afraid that we're now in a race to keep vaccines ahead of the new virus variants, and the stakes could not be higher.

The pandemic's toll on the Nation is tragic. To date, more than 440,000 Americans have lost their lives from COVID–19, surpassing the total number of U.S. soldiers killed during World War II. More than 10 million Americans are unemployed, while one in three households struggle to make ends meet. It's no wonder Americans' assessment of their mental health is worse than at any point in the past two decades. And experts, of course, warned of a dark winter and, unfortunately, they were right in these dark days, but we're now seeing the rollout of some of the most powerful tools we have to contain the virus: That's safe and effective vaccine.

But, unfortunately, the initial rollout during the Trump administration was marked by confusion and delays. It's no secret that the demand for a vaccine is outpacing supply, leading to canceled appointments, endless lines, and mounting concerns, and limited transparency into the Nation's vaccine supply as well as conflicting accounts about a reserve held by the Federal Government have all contributed to uncertainty and frustration.

But, thankfully, the Biden administration is already taking action to address these issues, including purchasing additional doses that will increase our vaccine supply by 50 percent by the end of summer. And I hope to learn today what more Congress and the Federal Government can do to provide more certainty and help accelerate vaccinations across the country but at the same time ensuring equitable access for the most vulnerable to these vaccines.

And despite the issues we've encountered with the vaccine rollout and the painful road still ahead, I'm still optimistic, as I noticed Diana DeGette was, about that we can finally be on the path to beating the virus. We have to be optimists.

As I mentioned, there are currently two extraordinarily effective and safe COVID–19 vaccines authorized by the FDA, and more could be on the way soon, but States have stretched their limited resources to implement an unprecedented vaccination program, reaching 25 million Americans and counting. As you know, I've been very critical that during the Trump administration in the last year or so there really was no national strategy. States were forced to compete with each other, and that led to the confusion. There needs to be a national strategy.

But now, the Biden administration says they're going to be guided by science and they're going to have a national strategy to beat the pandemic. This is what we've been long calling for. But this nationwide vaccination campaign—it really is historic, but it's going to require substantial support from Congress to succeed.

To that end, Congress must move swiftly to pass the American Rescue Plan, the comprehensive proposal from the Biden administration that would fund vaccination efforts and provide Americans much-needed relief. This is the new COVID bill. Under that bill, we would invest an additional $20 billion in a national vaccination program to help ensure greater accessibility and availability of vaccines across the country. It includes critical financial support to State and local governments that have been pleading for more support from the Federal Government to assist in their efforts to combat this virus.

So I hope my Republican colleagues will join me without delay in supporting this new bill that the Biden administration is putting forward. I don't think there's any time to waste. And I welcome the State health officials with us. We're going to look forward to their assessments of the national vaccination effort. You are vital partners in this extraordinary campaign. You're being called upon to execute innovative solutions to unparalleled challenges, and I want to thank you. We understand that you should not have to do this without substantial help and a national coordinated effort, and we want to know what we can do to achieve that.

So thank you again, Madam Chairwoman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Today, we convene the Energy and Commerce Committee's first hearing of the 117th Congress to examine the urgent need to increase COVID–19 vaccinations across the country. This committee's top priorities this year are to combat this pandemic, provide relief to struggling families, and rebuild our economy. In the coming months, we will push an aggressive agenda that will ensure the Biden administration has all the tools and resources it needs to crush this terrible virus.

This goal is more pressing than ever. Thousands of Americans continue to die each day from COVID–19, while new, more contagious strains are emerging in the United States. We are now in a race to keep vaccines ahead of new virus variants—and the stakes could not be higher.

The pandemic's toll on the Nation is tragic. To date, nearly 440,000 Americans have lost their lives from COVID–19—surpassing the total number of U.S. soldiers killed during World War II. More than 10 million Americans are unemployed, while one in three households struggles to make ends meet. It's no wonder Americans' assessment of their mental health is worse than at any point in the past two decades. Experts warned of a dark winter, and unfortunately, they were right.

Amid these dark days, we're now seeing the rollout of some of the most powerful tools we have to contain the virus: safe and effective vaccines. Unfortunately, the initial rollout has been marked by confusion and delays. It's no secret that the demand for vaccine is outpacing supply—leading to cancelled appointments, endless lines, and mounting concerns.

Limited transparency into the Nation's vaccine supply, as well as conflicting accounts about a reserve held by the Federal Government, have all contributed to uncertainty and frustration.

Thankfully, the Biden administration is already taking action to address these issues, including purchasing additional doses that will increase our vaccine supply by 50 percent by the end of summer. I hope to learn today what more Congress and the Federal Government can do to provide more certainty and help accelerate vaccinations across the country, while ensuring equitable access for those most vulnerable to COVID–19.

Despite the issues we've encountered with the vaccine rollout and the painful road still ahead, I'm optimistic that we are finally on a path to beating the virus.

As I mentioned, there are currently two extraordinarily effective and safe COVID–19 vaccines authorized by the Food and Drug Administration—and more could soon be on the way.

States have stretched their limited resources to implement an unprecedented vaccination program, reaching 26 million Americans and counting.

And we now have a new administration that will be guided by science and a comprehensive national strategy to beat the pandemic—something I have long called for.

So there is hope on the horizon, but we have much work to do to get there. That starts with tackling the biggest challenges standing in the way of containing the pandemic: getting vaccines into as many arms as possible, as quickly as possible.

This nationwide vaccination campaign is truly historic, and it will require substantial support from Congress to succeed.

To that end, Democrats in Congress are moving swiftly to pass the American Rescue Plan—a bold, comprehensive proposal from the Biden administration that would fund vaccination efforts and provide Americans much-needed relief. Critically, the plan would invest $20 billion in a national vaccination program to help ensure greater accessibility and availability of vaccines across the country.

It includes critical financial support to State and local governments, which have been pleading for any support from the Federal Government to assist in their efforts to combat this virus.

I hope my Republican colleagues will join me, without delay, in supporting this bill for the American people. There is simply no time to waste.

I welcome the State health officials with us and look forward to their on-the-ground assessments of the national COVID–19 vaccination effort. You are our vital partners in this extraordinary campaign, and you are being called upon to execute innovative solutions to unparalleled challenges. Thank you for dedicating your valuable time to sharing your important perspectives with the committee today.

The COVID–19 vaccines authorized in the United States are potent tools in our fight against the virus. But vaccines in vials don't protect people—vaccines in arms do. We must act now to overcome the remaining logistical hurdles and strengthen the Nation's COVID–19 vaccination campaign. There is no time to lose.

Ms. DEGETTE. Thank you very much.

The gentleman yields back.

The Chair now is happy to recognize the ranking member of the full committee, Mrs. Rodgers, for 5 minutes for the purposes of an opening statement.

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

Mrs. RODGERS. Thank you, Madam Chair.

And the Republican leader, Mr. Griffith, as well as everyone, just I'm really pleased that we're coming together this morning to address the solutions to increase COVID–19 vaccinations in the United States. Welcome to our new Members.

And to those that are on the front lines, the State health officials that are with us today, thank you for your continued vigilance.

The development and the approval of several COVID–19 vaccines in less than a year is one of the greatest achievements in American history and modern science. I'm also grateful for the work that has been done in Congress. The fact that Congress passed, in a matter of days, the CARES Act almost a year ago, and then just in December an additional $900 billion that was passed by Congress—overwhelming bipartisan support, again, to meet the needs of Americans.

The Trump administration and the public-private partnership of Operation Warp Speed set ambitious goals that many doubted could be achieved. Yet less than a year into this pandemic, we have vaccinated tens of millions of Americans. Our work is not over, however, and there are many challenges ahead of us. We must vaccinate as many Americans as quickly as possible so that we can save lives, get our economy and schools back open, and get our lives back.

The distribution of these vaccines should be approached with the same level of ambition as Operation Warp Speed. We absolutely must continue to act with a sense of urgency. This is an extremely complex process involving a system of transportation, equipment, personnel, and 64 different jurisdictions, including all States and territories. We must recognize and appreciate that the distribution and administration of COVID–19 vaccines is one of the most ambitious, complex, and important logistical operations ever undertaken in the United States. Such an enormous operation was bound to run into difficulties.

But, as we look at solutions, it's important that we not just look at new ideas, but also take a look at the remarkable foundation that we're building on, as well as the assets and resources already in place that can be part of the solution.

The foundation of Operation Warp Speed is amazing. This effort to have two vaccines with about 97 percent efficacy in response to a novel pandemic virus before the end of 2020 is epic and historic. Many skeptics said it couldn't happen. Actions by Operation Warp Speed and the Department of Defense also ensured the supply of syringes, needles, and other essential supplies, to support the vaccination efforts that are underway. This has been and will continue to be an all-of-government approach, and we're eager to hear from our witnesses representing State governments.

As an oversight subcommittee, our job is to find out what's working, what isn't, and then find solutions to improve our COVID–19 vaccine distribution and administration efforts. E&C Republicans are committed to working on solutions to increased vaccinations, and we're ready to engage in a serious and credible way. I hope that the new administration, President Biden and the officials, will stop trying to rewrite history and stop, you know, saying that this was a dismal failure. Our goal needs to be continuing to build upon the great foundation.

President Biden's goal pace of 1 million doses administered a day was already reached. States such as Washington and New York are attempting to shift blame from their own significant shortcomings by complaining about the Trump administration and putting the entire onus for distribution and administration on the Federal response.

As we will hear from our witnesses today, a localized response can often best meet the unique challenges of individual States. West Virginia is very different from Washington State and has been successful.

Contrary to this administration and certain Governors' assertion, vaccine distribution plans did exist. In fact, as of January 31st, more than 49.9 million vaccine doses have been distributed, 31 million administered.

President Biden says our country is at war with the coronavirus. I agree. When we fight wars and do it successfully, we have to do it united, not by using partisan political tactics like budget reconciliation. Let's work together on boosting our COVID–19 vaccine distribution efforts and prepare for future pandemics so this doesn't happen again. I hope this hearing helps put Congress on a constructive path with the President to deliver results.

Thank you, Madam Chair. I yield back.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY MCMORRIS RODGERS

Thank you, Chair Eshoo and Republican Leader Guthrie, for holding this important hearing.

Exactly one year ago today, news outlets were reporting that the global death toll from the coronavirus was 362, with all but one of those deaths occurring in mainland China.

A year later, and this heartbreaking number has surpassed 2 million, with over 425,000 of these tragic deaths occurring in the United States.

This pandemic has wreaked havoc on our way of life. The loss of life has been devasting.

Our previously booming economy has been decimated.

Our mental health crisis has only worsened.

And the long-term impact on our children being kept out of the classroom is incalculable.

Last Congress, we put our political differences aside to make extraordinary investments in the fight against COVID–19 through five separate bipartisan relief packages.

These included providing over 30 billion dollars for States, territories, and Tribes for testing, vaccine distribution, contact tracing, and public health data infrastructure improvement.

And over 23 billion dollars to the Biomedical Advanced Research and Development Authority for the research, development, and manufacture of novel vaccines, tests, and treatments.

And 178 billion dollars for healthcare providers on the front lines of taking care of patients with COVID–19.

This investment and partnership with the private sector has led to the unprecedented development of innovative vaccines and treatments coming to market faster than we ever thought possible.

Operation Warp Speed is one of the most ambitious and successful undertakings in American history, and with two lifesaving vaccines now authorized by the FDA, and a third hopefully soon to follow, there is light at the end of this dark tunnel.

However, our hard work is not yet complete.

Vaccine distribution is ramping up, but we must ensure States have the resources and flexibility they need to immunize successfully as many people who want it, and meet the unique health needs of their individual populations.

We heard yesterday in the Oversight and Investigations Subcommittee from West Virginia, which has relied on community pharmacies to get the vaccines to people.

Unfortunately, Washington State has not been as successful. Gov. Inslee and others in Olympia spend a great deal of time pointing fingers at Washington, DC, for the State's slow distribution instead of figuring out strategies to get people vaccinated as West Virginia is doing.

Clearly, some States were better prepared and used the advice of the CDC career scientists to implement locally targeted strategies more successfully than he has done.

SUPPLY CHAIN

While vaccine distribution is critical to safely and responsibly reopen our economy and our schools, we also learned additional challenges during the response to COVID–19.

We learned that our medical supply chain is incredibly vulnerable and that we rely too heavily on adversarial countries such as China for critically important products, such as personal protective equipment.

We need to consider policies that will improve our domestic manufacturing without impacting cost and consumer access.

Our strategic national stockpile and medical supply distribution logistics also need to be strengthened.

While we have met this unprecedented crisis with an equally unprecedented response, our resources are not unlimited.

Congress has a responsibility to oversee the money we have spent, understand how it is being distributed and used, and learn what's working and what hasn't.

As Chairman Pallone said during our organizing meeting last week, this committee has a rich history of bipartisan cooperation and hard work, perhaps more so than any other committee in Congress.

Between the pandemic, the economic crisis, and the social and political unrest, last year was one of the most difficult in our Nation's history.

Yet, despite these incredible hurdles, Congress was able to come together on five separate occasions to give the American people the relief they needed.

This pandemic, and our Government's response, is bigger than any single administration or political party.

As we discuss these important issues and our path forward with our distinguished witnesses today, I hope our focus will be not about pointing fingers for our shortcomings, but an opportunity to learn what bipartisan steps we can take over the next several months to win the fight against COVID–19, restore our way of life, rebuild the greatest economy in history, and prepare for future pandemics so that a public health emergency of this magnitude never happens again.

Thank you to our witnesses for joining us today, and I yield back the balance of my time.

Ms. DEGETTE. I thank the gentlelady.

The Chair now asks unanimous consent that the Members' written opening statements be made part of the record, and without objection, so ordered.

I would now like to introduce our witnesses for today's hearing: Dr. Ngozi Ezike, who's the director of the Illinois Department of Public Health; Dr. Joneigh Khaldun, who's the chief medical executive and chief deputy director for Michigan's Department of Health and Human Services.

If people can please put their mics on mute.

Dr. Clay Marsh, the West Virginia COVID–19/coronavirus czar.

Mr. McKinley, I guess you guys have czars down there in West Virginia.

Dr. Courtney N. Phillips, the secretary of the Louisiana Department of Health; and Director Jill Hunsaker Ryan, who's the executive director of the Colorado Department of Public Health and Environment.

I want to thank all of our witnesses again for appearing in front of this committee. Every member of this committee appreciates it, because we know how busy you are.

I know all of you are aware that the committee is holding an investigative hearing, and as such we hold all of our hearings under oath. Does anyone here have any objection to testifying under oath?

Let the record reflect that the witnesses have responded no.

The Chair then advises you that, under the rules of the House and the rules of the committee, you are entitled to be represented by counsel. Does any of our witnesses ask to be represented by counsel?

Let the record reflect that the witnesses have responded no.

If you would, please, could you please raise your right hand so that I may swear you in?

You can unmute and say, "I do."

[Witnesses sworn.]

Ms. DEGETTE. Let the record reflect the witnesses have responded affirmatively. And you are now under oath and subject to the penalties set forth in Title 18, section 1001, of the U.S. Code.

The Chair will now recognize our witnesses for a 5-minute summary of their written statement. There's a timer on the screen right here that will count down your time, and it will turn red when your 5 minutes has come to an end. And so I will now recognize each of our witnesses.

Dr. Ezike, you are recognized first for 5 minutes, please.

STATEMENTS OF NGOZI O. EZIKE, M.D., DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC HEALTH; JONEIGH S. KHALDUN, M.D., CHIEF MEDICAL EXECUTIVE, STATE OF MICHIGAN, AND CHIEF DEPUTY DIRECTOR FOR HEALTH, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES; CLAY MARSH, M.D., VICE PRESIDENT AND EXECUTIVE DEAN FOR HEALTH SCIENCES, WEST VIRGINIA UNIVERSITY, AND COVID-19 CZAR, STATE OF WEST VIRGINIA; COURTNEY N. PHILLIPS, Ph.D., SECRETARY, LOUISIANA DEPARTMENT OF HEALTH; AND JILL HUNSAKER RYAN, EXECUTIVE DIRECTOR, COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

STATEMENT OF NGOZI O. EZIKE, M.D.

Dr. EZIKE. Thank you.

Chairwoman DeGette, Ranking Member Griffith, and distinguished members of the subcommittee, thank you for having me here today to speak about Illinois' response to the coronavirus pandemic.

Over the past year in Illinois, we've had more than 1 million cases of COVID–19 and, unfortunately, have lost more than 19,000 members of our Illinois family. But through efficient and effective distribution of the vaccine, coupled with a continued focus on masking, social distancing, and hand hygiene, we can suppress the spread of the virus and save many lives.

Within 24 hours of receiving our first allocation of over 40,000 doses, IDPH distributed the entire allocation to local health departments, with subsequent distribution to hospitals. We continue to build a statewide provider network to ensure vaccination occurs with both rapidity and equity.

From the outset, vaccination efforts in Illinois and throughout the States have been limited by vaccine supply and sometimes complicated by inconsistent messages regarding allocations. Operation Warp Speed's promise to Illinois and the Nation of a steady cadence of vaccine oftentimes fell short, with reduced or postponed allocations, which left Illinois receiving fewer than expected doses.

After meticulous planning to vaccinate the target population for Illinois' Phase 1B, which was shaped by the Advisory Committee on Immunization Practices' recommendations, the previous administration did change the priority groups without forewarning, further complicating our efforts by confusing the public and nearly doubling the size of the target population that now heard that they were eligible.

Last month, Governor JB Pritzker activated the Illinois National Guard to assist local health departments in administering vaccinations. The Biden administration supported that move by approving 100 percent of the cost, but we continue to need assistance.

With our significant engagement, Illinois pharmacies in the Federal Pharmacy Partnership program have vaccinated many of our long-term care residents in nearly 1,700 facilities assigned to them. And, as of January 25th, every resident and staff person in the Illinois skilled nursing facilities have been offered that first dose.

While we await additional vaccine supply, a multipronged approach supported by the Federal Government could help improve the effectiveness of nonpharmaceutical interventions, actions apart from getting vaccines and/or taking medicines that will slow the spread of the illness. Examples include aggressive expansion of genomic sequencing. That infrastructure is needed for accurate and timely assessment of the threat and the identification of new variants.

Another critical piece with heightened application in economically disadvantaged communities is the continuation of paid sick leave and direct financial support to encourage compliance with distancing, quarantine, and isolation orders.

As of yesterday, the 1 millionth dose was administered into an Illinois resident. But to accelerate immunizations we need our Federal partners to align our efforts—align their efforts with ours to help solve practical operational issues.

Of course, we need increased supply of vaccines as well as resources to quickly administer the vaccine. We need improved communication channels and fixes to tools provided to States. The Federal Government should provide States with clear, consistent projections for vaccine allocation to allow and enable planning weeks into the future, and continue to update the Tiberius system so that States are working with clear, accurate information and can make appropriate plans. We also need a robust IT solution connecting electronic medical records, pharmacy logs, and State registration tools so people can locate vaccines across the jurisdictions.

We're grateful for the influx of funding. And, as you consider the next round of emergency supplemental funding, I encourage you to provide additional funds to support the ongoing vaccination campaign and address emerging funding needs for State, local, Tribal, and territorial public health systems.

Thank you for the opportunity to share Illinois' experience. We will continue to let data, science, and equity guide our approach. And I'm honored to work with Congress and the new administration to get to the other side of this pandemic.

Thank you for your attention.

[The prepared statement of Dr. Ezike follows:]

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United States House Committee on Energy and Commerce
Oversight and Investigations Subcommittee

"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"

February 2, 2021

Testimony of
Ngozi O. Ezike, MD
Director
Illinois Department of Public Health

Chairwoman DeGette, Ranking Member Griffith, and distinguished members of the subcommittee, thank you for inviting me here today to speak about Illinois' response to the coronavirus pandemic. Over the past year in Illinois, we have had more than one million cases of COVID-19 and, unfortunately, more than 19,000 of our people have succumbed to this baleful disease.

From the outset of the pandemic, our response has been guided by a focus on data, science, and equity. The year 2020 was marked by required mitigations to help curb infection transmission and protect health care capacity but they also left an indelible mark on the state of Illinois and the lives of our residents. So, it is with great hope that we embrace the advent of vaccines that are a pathway to ending this calamitous period in our state and national history.

Through efficient and effective distribution of the vaccine, we can suppress the spread of the virus and save many lives. The Illinois Department of Public Health (IDPH) has been working in close partnership with our 97 local health departments, hospitals, retail pharmacies, federally qualified health centers, and many other partners across the state to ensure vaccination occurs with both velocity and equity. To date we have enrolled hundreds of new providers to receive and administer COVID vaccines. We have also expanded scopes of practice to allow more health care providers to administer vaccines, such as dentists, pharmacists and EMTs. Due to the initial supply of vaccine and the established priority groups, we initially directed our allocations of vaccine to local health departments (with subsequent distribution to hospitals) and our large retail pharmacy partners. As vaccine doses continue to increase, we have allocated across a growing, more expansive provider network throughout the state.

Unfortunately, from the very beginning, vaccination efforts in Illinois were hampered by conflicting federal messaging and, in some cases, no messaging. Operation Warp Speed's promise to Illinois and the nation of a steady cadence of vaccine distribution announced one week in advance seemed too good to be true. In fact, that promise was untrue. Reduced or postponed allocations and outright cancellations left Illinois receiving far fewer doses than

advertised. The amount of vaccine currently coming to Illinois is still but a trickle of what is necessary to make a steep change in our journey toward healing from COVID-19. While not as much as we want or need, we are working to get the supply we have into the arms of our people as quickly, equitably, and effectively as possible.

The first doses of the Pfizer-BioNTech COVID-19 vaccine arrived in Illinois on December 14, 2020, 72 hours after the Food and Drug Administration authorized its emergency use,[1] and 24 hours after ACIP issued an interim recommendation for its use in persons aged 16 years and older.[2] We began vaccinating frontline health care workers the very next day on December 15, 2020.[3] In fact, within 24 hours, Illinois distributed its entire first day's allocation of 40,950 doses[4] to four local health departments and then onto local hospitals. On December 16, 2020, we distributed another 44,850 doses[5] to 44 local health departments and our regional hospital coordinating centers, and additional Illinoisans were vaccinated that very day in a carefully orchestrated and well-executed operation. As of data reported on February 1, 2021, we have administered over one million doses.[5]

On January 25, 2021, the state moved into Phase 1B of our vaccine rollout.[4] Initial advice from the CDC Advisory Committee on Immunization Practices (ACIP) targeted frontline workers and older adults aged 75 years and older for Phase 1B.[6] Understanding the disparities in life expectancy, generally, and age at death from COVID-19 in Illinois specifically,[5] IDPH chose to expand our priority populations for 1B to include frontline workers and older adults aged 65 years and older. In doing so, Illinois sought to save lives in a truly equitable manner, recognizing that longstanding inequities as well as institutional racism has reduced access to care, caused higher rates of environmental and social risk, and increased co-morbidities for people of color.

Three weeks after the Phase 1B announcement from ACIP, as we were cementing our plans, high-level leaders from the previous Administration made public appearances announcing that Phase 1B would actually target older adults aged 65 years and older *and* adults aged 16 to 64

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[1] Food and Drug Administration. (2020, December 11). FDA takes key action in fight against COVID-19 by issuing emergency use authorization for first COVID-19 vaccine [Press release]. https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19

[2] Oliver, S. E., Gargano, J. W., Marin, M., Wallace, M., Curran, K. G., Chamberland, M., McClung, N., Campos-Outcalt, D., Morgan, R. L., Mbaeyi, S., Romero, J. R., Talbot, H. K., Lee, G. M., Bell, B. P., & Dooling, K. (2020, December 13). The Advisory Committee on Immunization Practices' interim recommendation for use of Pfizer-BioNTech COVID-19 vaccine – United States, December 2020. *Morbidity and Mortality Weekly Report*, *69*(50), 1922-1924. http://dx.doi.org/10.15585/mmwr.mm6950e2

[3] Illinois Department of Public Health. (2021, January 6). *Vaccine distribution: Phases 1A and 1B*. Retrieved from https://www.dph.illinois.gov/sites/default/files/Phases%201A%20and%201B%20of%20Vaccine%20Distribution%20in%20Illinois.pdf

[4] Does not include doses allocated to Chicago, Illinois.

[5] Illinois Department of Public Health. (2021, January 31). COVID-19 vaccine administration data. http://dph.illinois.gov/covid19/vaccinedata?county=Illinois

[6] Dooling, K., Marin, M., Wallace, M., McClung, N., Chamberland, M., Lee, G. M., Talbot, H. K., Romero, J. R., Bell, B. P., & Oliver, S. E. (2020, December 22). The Advisory Committee on Immunization Practices' updated interim recommendation for allocation of COVID-19 vaccine – United States, December 2020. *Morbidity and Mortality Weekly Report*, *69*(5152), 1657-1660. http://dx.doi.org/10.15585/mmwr.mm695152e2

years with high-risk underlying medical conditions.[7] Phase 1B in Illinois already includes more than 3 million people in the state. Changing priority groups without forewarning further complicated our efforts by confusing the public and creating a conundrum for state and local public health leaders with a substantially increased size of the target population, whom we had planned to target for Phase 1C in line with ACIP recommendations.[6]

Choosing priority populations to receive vaccine before others is already a difficult task, further compounded by operational issues such as how or if people will prove their eligibility in their particular phase and balancing vaccine allocations to channels targeting the previous phases as well as the next, which include even greater numbers of residents. It will take months at the current vaccine supply to get through this phase and onto the next. When we see the trickle of vaccine turn into a stream, we are prepared to ramp up immunizations accordingly and will further expand our network of providers to meet this need.

Illinois' Governor, JB Pritzker, announced the activation of the Illinois National Guard to assist local health departments in administering vaccinations; a move that was made possible by the Administration approving 100% federal coverage of the cost. Over the next few weeks, 25 National Guard teams will be deployed to expand access to vaccines in high-need areas across the state, in concert with clinics hosted by local health departments, hospitals and pharmacies. We are planning for additional National Guard teams when vaccine supplies support their deployment. We will continue to do everything within the capabilities of our state government to leap forward in our race against more infectious variants of COVID-19 and to return our state to prosperity, but we need more assistance from the federal government to establish additional mass vaccination sites and otherwise administer more vaccine faster.

The federal Pharmacy Partnership for Long-Term Care Program (PPP), while ultimately a benefit, left state health officials with little control of or input to the execution of long-term care immunization efforts. Consequently, Illinois has jockeyed allocations of vaccine between our partners to put vaccine doses in situations where it can be used rapidly. With significant engagement by IDPH, our PPP pharmacies in Illinois have successfully vaccinated many of our long-term care residents and are accelerating administration of vaccine to the more than 1,500 facilities assigned to them. As of January 25, 2021, every resident and staff person in a skilled nursing facility in Illinois was offered a first dose of COVID-19 vaccine.

In general, the systems provided by the federal government for the vaccine rollout have been hit-or-miss. The vaccine allocation tool used at the state level and developed by Operation Warp Speed, was designed to list public health jurisdictions, all eligible providers in the jurisdiction, and their vaccine-administration capacity to efficiently allocate the vaccine in real-time as information is received from the CDC. In practice, the system has been challenging to work with. The long-term care portion of the system is being built while we are using it. This has made use of the system difficult as the location of data and how it is presented are changing every day. Since the beginning, the data has not been timely or accurate, but it has gotten better over time. At the very least, communication with jurisdictions before any changes were made to

[7] Tolbert, J., Kates, J., & Michaud, J. (2021, January 21). The COVID-19 vaccine priority line continues to change as states make further updates. *Kaiser Family Foundation*. https://www.kff.org/policy-watch/the-covid-19-vaccine-priority-line-continues-to-change-as-states-make-further-updates/

the system would have given us time to prepare our reporting for the changes before they occurred.

Early on, IDPH recognized it would need adequate tracking tools to manage inventories and therefore implemented a statewide platform that enabled local health departments, hospitals, and other vaccine providers to easily schedule appointments, pre-screen individuals prior to arriving at vaccination sites, and send reminders for second doses. This valuable tool aids providers who do not have their own scheduling system and complies with state and federal reporting requirements.

The ultimate benefits of vaccination against COVID-19 will depend on how well we're controlling the spread of the virus and how swiftly and broadly we can implement the vaccine.[8] In Illinois, 781,536 people have received their first dose of vaccine as of January 31, 2021.[9] We are doing everything we can to vaccinate our share of the more than 200 million people necessary to achieve herd immunity against COVID-19.[10]

While we await additional vaccine supply and increase the provider network for distribution, we must continue the public health measures that will control the spread of the virus: masking, testing, and social distancing. A multi-pronged approach supported by the federal government that includes the following could improve the effectiveness of nonpharmaceutical interventions in Illinois and across the country:

- An aggressive expansion of genomic sequencing infrastructure to assess the threat of new variants, including the ability to analyze higher numbers of COVID-19 samples and easily transfer data between the CDC, state-run labs, and public health practitioners to inform mitigation efforts.
- Continuation of paid sick leave as required by the now-expired Families First Coronavirus Response Act (FFCRA), which one study found led to more than 400 fewer reported cases of COVID-19 per state per day compared to the pre-FFCRA period and to states that had already enacted paid sick leave.[11]
- Support for widespread molecular testing and isolation,[12] especially for high-priority populations, and rapid point-of-care testing in high-priority settings, including schools and workplaces.

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[8] Paltiel, A. D., Schwartz, J. L., Zheng, A., & Walensky, R. P. (2020). Clinical outcomes of a COVID-19 vaccine: Implementation over efficacy. *Health Affairs*, *40*(1). https://doi.org/10.1377/hlthaff.2020.02054

[9] Centers for Disease Control and Prevention. (2021, January 31). Number of people receiving 1 or more doses reported to the CDC by state/territory and for selected federal entities per 100,000 [Data set]. Retrieved from https://covid.cdc.gov/covid-data-tracker/#vaccinations

[10] Randolph, H. E., & Barreiro, L. B. (2020). Herd immunity: Understanding COVID-19. *Immunity*, *52*(5), 737-741. https://dx.doi.org/10.1016/j.immuni.2020.04.012

[11] Pichler, S., Wen, K., & Ziebarth, N. R. (2020). COVID-19 emergency sick leave has helped flatten the curve in the United States. *Health Affairs*, *39*(12). https://doi.org/10.1377/hlthaff.2020.00863

[12] Rannan-Eliya, R. P., Wijemunige, N., Gunawardana, J. R. N. A., Amarasinghe, S. N., Sivagnanam, I., Fonseka, S., Kapuge, Y., & Sigera, C. P. (2020). Increased intensity of PCR testing reduced COVID-19 transmission within countries during the first pandemic wave. *Health Affairs*, *40*(1). https://doi.org/10.1377/hlthaff.2020.01409

- Additional direct payments to individuals to encourage compliance with public health guidance for quarantine, isolation, and stay-at-home orders,[13] especially in economically marginalized communities.[14]
- Distribution of masks, preferably medical-grade,[15] to every person to enable universal masking.[16]
- Grants to improve indoor air ventilation[17] in high-priority settings, including schools and long-term care facilities.
- Promulgation of national standards and practices for contact tracing, especially for data collection.
- Workforce expansion strategies for vaccinators and other public health personnel, including deployment of federal personnel to Illinois as a force multiplier to our already substantial but inadequate immunization resources.
- Intentional community engagement and education strategies to promote vaccine science as a preventive method to thwart vaccine misinformation and distrust for any future campaigns.

In order to bring this pandemic to an end, states need support from the federal government and with new, highly contagious variants threatening our progress and more than 3,000 people, including about 100 Illinoisans, dying each day,[18] we cannot afford to start over. Illinois and other states have already established much of the necessary infrastructure to increase the pace of vaccination. What we need now is for our federal partners to align their efforts with ours to help solve practical, operational issues. We need transparent, timely, and consistent communication and guidance on distribution and administration.[19] The more information we have upfront about what is coming our way, especially regarding dose allocations, the better we can plan and more quickly vaccinate our residents. In order to bring this chapter to a close and vaccinate our population, we need the following from the federal government:

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[13] Wright, A. L., Sonin, K., Driscoll, J., & Wilson, J. (2020). Poverty and economic dislocation reduce compliance with COVID-19 shelter-in-place protocols. *Journal of Economic Behavior & Organization*, *180*, 544-554. https://dx.doi.org/10.1016/j.jebo.2020.10.008

[14] Chang, S., Pierson, E., Koh, P. W., Gerardin, J., Redbird, B., Grusky, D., & Leskovec, J. (2020). Mobility network models of COVID-19 explain inequities and inform reopening. *Nature*, *589*, 82-87. https://doi.org/10.1038/s41586-020-2923-3

[15] Tufekci, Z., & Howard, J. (2021, January 13). Why aren't we wearing better masks? *The Atlantic*. https://www.theatlantic.com/health/archive/2021/01/why-arent-we-wearing-better-masks/617656/

[16] Howard, J., Huang, A., Li, Z., Tufekci, Z., Zdimal, V., van der Westhuizen, H., von Delft, A., Price, A., Fridman, L., Tang, L., Tang, V., Watson, G. L., Bax, C. E., Shaikh, R., Questier, F., Hernandez, D., Chu, L. F., Ramirez, C. M., & Rimoin, A. W. (2021). An evidence review of face masks against COVID-19. *Proceedings of the National Academy of Sciences of the United States of America*, *118*(4). https://doi.org/10.1073/pnas.2014564118

[17] Noorimotlagh, Z., Jaafarzadeh, N., Martinez, S. S., & Mirzaee, S. A. (2020). A systematic review of possible airborne transmission of the COVID-19 virus (SARS-CoV-2) in the indoor air environment. *Environmental Research*, *193*, 110612. https://doi.org/10.1016/j.envres.2020.110612

[18] Centers for Disease Control and Prevention. (2021, January 27). United States COVID-19 cases and deaths by state reported to the CDC since January 21, 2020 [Data set]. Retrieved from https://covid.cdc.gov/covid-data-tracker/#cases_deathsinlast7days

[19] Shen, A. K., Hughes IV, R., DeWald, E., Rosenbaum, S., Pisani, A., & Orenstein, W. (2020). Ensuring equitable access to COVID-19 vaccines in the US: Current system challenges and opportunities. *Health Affairs*, *40*(1). https://doi.org/10.1377/hlthaff.2020.01554

- **Increased supply of vaccine and resources to quickly administer vaccine.** The federal government must leverage all resources and powers at their disposal to ramp up the manufacturing and purchase of additional vaccine and associated supplies and establish federally run mass vaccination centers in states to complement what we are already doing. The state of Illinois is rapidly expanding our network of providers so we can quickly vaccinate many more people in a short period of time, once the vaccine supply increases.
- **Improved communications channels and fixes to tools provided to states .** The federal government needs to provide states with clear, consistent projections for vaccine allocations to enable planning weeks into the future and the Tiberius system needs to be fixed so states are working with the most accurate information and can plan accordingly. Additionally, due to the delay of the VaccineFinder solution, Illinois has been forced to cobble together information from numerous databases to allow people to locate vaccine providers across the state. We need the federal government to launch this solution now, or urgently assist states with a robust IT solution that will allow us to connect electronic medical records, pharmacy logs and state registration tools. Over the long term, states need robust investment from the federal government in public health data systems that allow all systems to connect.
- **Funding.** While we are grateful for the influx of funding for federal, state, local, tribal, and territorial public health, there continue to be emerging funding needs of the public health system. As Congress considers the next round of emergency supplemental funding, I encourage Congress to provide supplemental funding to these jurisdictions to support the ongoing COVID-19 vaccination campaign.

Thank you for the opportunity to share Illinois' experience. We will continue to let data, science, and equity guide our approach and I look forward to working with Congress and the new Administration to see the other side of this pandemic.

Ms. DEGETTE. Thank you very much.

Our next witness is Dr. Joneigh Khaldun, who's the chief medical executive and chief deputy director of the Michigan Department of Health and Human Services.

Dr. Khaldun.

STATEMENT OF JONEIGH S. KHALDUN, M.D.

Dr. KHALDUN. Thank you.

Chairs Pallone and DeGette, Ranking Members Rodgers and Griffith, and distinguished members of the committee, thank you for the opportunity to speak with you today about Michigan's COVID–19 vaccination efforts. A focus on efficient and equitable distribution of these vaccines is the way that we are going to end this pandemic.

I have the honor of serving my State, not only helping to guide the battle against COVID–19 in my role as chief medical executive, but also as a practicing emergency physician on the front lines treating patients in Detroit, one of the hardest-hit cities by the pandemic early on. I've seen the terrible impact this pandemic has had on patients, families, and on my clinical colleagues. In fact, two colleagues that helped train me in New York City lost their lives to this pandemic last year. I only wish these vaccines were available sooner so that they might be alive today.

For me, this vaccination effort is personal, for my community, for my colleagues, and for my patients. Michigan is working hard to distribute the vaccine quickly, efficiently, and equitably to the nearly 10 million residents across the State. We have a robust network of over 2,000 enrolled providers and have the capacity to administer up to 80,000 vaccines a day. However, Michigan's biggest challenge with the vaccine rollout has been the limited supply of vaccine, lack of predictability regarding vaccine amounts week to week, and the lack of a national strategy until now.

Despite this, Michigan has made significant strides. Yesterday, we announced surpassing 1 million doses of vaccine being administered statewide, and we have jumped more than 20 places in the rankings over the past few weeks as it relates to our proportion of the population vaccinated.

Michigan has made this progress because we have been intentional and focused. We have set forth clear goals for our State and vaccinating partners, with the expectation that 90 percent of received vaccines are administered within 7 days.

We are also laser-focused on equity. We have set the ambitious but attainable goal of having no disparity in vaccination rates across racial and ethnic groups. It is important that vaccination efforts move forward expeditiously without compromising equity.

It's a tragedy but not a surprise that COVID–19 has disproportionately impacted communities of color. This disparity is directly related to structural inequities and historical racism that has caused communities of color to have less access to the resources needed to achieve optimal health. Michigan has been a leader in fighting COVID–19 disparities, essentially eliminating the disparity between African Americans and Whites when it comes to COVID–19 cases and deaths. We did this specifically by engaging trusted community members, using data to identify testing loca-

tions, and developing strategic messaging in collaboration with communities of color.

We are building on this success in our vaccination efforts, prioritizing allocation to socially vulnerable groups, mobilizing a diverse network of vaccinators that can go into neighborhoods, and launching an aggressive communications and engagement effort to address hesitancy and misinformation. What we need at the Federal level is a larger and consistent vaccine supply, as well as additional funding to specifically address barriers to access.

Data and reporting having been a challenge throughout this pandemic, with the vaccine rollout being no exception. States must manage multiple systems to understand, track, and report vaccines, and our providers are overburdened by onerous enrollment, tracking, and reporting systems. This has led to delays and inaccuracies in data reporting.

Additionally, the CDC website is often inaccurate, outdated, or does not fully reflect the work of States. Improvements in data reporting would ease the burden on States and allow us to focus on implementation of our vaccination strategies.

Finally, I'd like to thank Congress for passing emergency supplemental funding for the vaccination response, which will help Michigan build out its vaccination infrastructure. We have also requested additional support from FEMA to expand mass vaccination sites as well as mobile clinics. We look forward to continuing to partner with the Biden administration on these efforts.

Overall, I'm pleased with the progress that we've made in Michigan. We have built out capacity and a strategy that will prioritize speed without compromising equity. I'm grateful for our Federal partners, encouraged by the leadership and engagement demonstrated by President Biden and his team, and look forward to continuing to work together to end this pandemic.

Thank you very much.

[The prepared statement of Dr. Khaldun follows:]

WRITTEN TESTIMONY

OF

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive, State of Michigan
Chief Deputy Director for Health, Michigan Department of Health and Human Services

HEARING ON

"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives

February 2, 2021

Since the emergence of COVID-19 just over a year ago the world has eagerly awaited a vaccine that could help to end this unprecedented pandemic. Now, with two safe and effective vaccines approved for Emergency Use Authorization and additional vaccines on the horizon, Michigan is working to distribute the vaccine quickly, efficiently, and equitably to the nearly 10 million residents across the state. Like many other states, Michigan's single biggest challenge with the vaccine rollout has been the limited supply of vaccine available week to week and the lack of a national federal strategy until now. Despite this, Michigan has made significant strides in implementing our vaccination strategy.

The arrival of new and concerning variants of SARS-COV2 means that there is even more urgency in expediting vaccinations. As of January 30, Michigan has identified 22 cases of B.1.1.7 variant in Michigan, and we assume that there are possibly additional cases, and additional variants of concern, that have not yet been identified. The U.S. Centers for Disease Control and Prevention's (CDC) modeling indicates that the B.1.1.7 variant will become the predominant strain in the U.S. by March, in part because it is more efficiently transmitted.[1] Getting vaccines out quickly has become more important than ever, and we believe we can focus on this vaccination effort expeditiously without compromising equity.

Michigan's Vaccine Rollout
On December 14, 2020, the first COVID-19 vaccines were administered in Michigan. As of January 29, Michigan has administered 909,038 first and second doses of the Pfizer and Moderna vaccines. Michigan has prioritized operational efficiency and equity in our vaccination efforts, and we are working closely with our vaccine partners to build out mass vaccination sites and innovative, neighborhood-based vaccination strategies that reach marginalized communities such as the homebound, communities of color, homeless, and those who lack access to transportation. Michigan has outlined a comprehensive vaccination strategy[2] and has set out five ambitious but achievable goals:

- 70% of Michiganders age 16 and up vaccinated as quickly as possible,
- 90% of received vaccines are administered within 7 days,
- 95% of people get their second dose of vaccine within the expected time frame,
- No disparity exists in vaccination rates across racial and ethnic groups or by social vulnerability index, and
- No one has to drive more than 20 minutes to reach a vaccination site.

[1] Galloway SE, Paul P, MacCannell DR, et al. Emergence of SARS-CoV-2 B.1.1.7 Lineage — United States, December 29, 2020–January 12, 2021. MMWR Morb Mortal Wkly Rep 2021;70:95–99. DOI: http://dx.doi.org/10.15585/mmwr.mm7003e2
[2] Michigan's Interim Vaccination Strategy. Accessed on January 30, 2021. Available from: Coronavirus - COVID-19 Vaccine (michigan.gov)

To achieve these goals, Michigan has engaged a robust coalition of stakeholders to make sure our operational capacity is maximized, the voices and needs of marginalized groups are heard, and a robust communications effort is made to assure people have access to accurate and timely information.

Hospitals, health systems and local health departments were the first to receive the vaccine, prioritizing front line healthcare workers. Michigan was one of the first states to move forward with vaccinating its 1B populations on January 11, and we are currently vaccinating individuals over the age of 65 and some essential front line workers such as child care and K12 teachers and staff; staff in prisons, jails, and other congregate settings; and first responders. Because of this effort Michigan has jumped more than 20 places in the past few weeks as it relates to the proportion of our population vaccinated. We remain one of the top ten states when it comes to percent of allocated vaccine that is distributed. Every vaccine that the State of Michigan has control of is accounted for as either administered or scheduled to be administered. There are no vaccines sitting in freezers and unaccounted for. We have built out an operational ability to vaccinate at least 50,000 people a day and only need more vaccine to be able to fully utilize this capacity. We have found that having ambitious but concrete goals for our partners, providing frequent communications and technical assistance, and intentionally broadening eligibility groups has allowed Michigan to improve the efficiency of its vaccination efforts.

Health Equity and Vaccine Allocation

It is a tragedy that communities of color across the country have been disproportionally hard hit by the COVID-19 pandemic. This disparity is directly related to structural inequities and historical racism that has caused communities of color to have less access to the resources needed to achieve optimal health. Michigan was one of the first states to highlight this issue by releasing race and ethnicity data on COVID-19 cases and deaths. Through the work of our Coronavirus Task Force on Racial and Ethnic Disparities, Michigan has been able to essentially eliminate the disparity between African Americans and whites when it comes to COVID-19 cases and deaths. We did this specifically by engaging trusted community members, using data to target testing sites and bringing testing into neighborhoods, and developing and targeting messaging in collaboration with communities of color.[3]

Equity and fighting disparities has been woven into every part of Michigan's pandemic response, and we are building upon that work in our vaccination efforts. Many of the communities hardest hit by COVID-19 reside in areas with high rates of risk factors for severe COVID-19 outcomes. Michigan is utilizing this information, along with the CDC's Social Vulnerability Index (SVI), and the data on vaccination rates by race, to ensure we are deploying strategies that guarantee an equitable distribution of the COVID-19 vaccine. We are tracking race and ethnicity data on COVID-19 vaccinations but are challenged by significant gaps in the data being reported by our vaccinator partners. Michigan is implementing a plan to improve data systems and work with our local health department and hospital providers so that our race and ethnicity data is more robust.

As part of our efforts to target vulnerable populations for vaccinations, Michigan is partnering with Federally Qualified Health Centers, mobile clinics, local health departments, school-based health centers, and other community vaccinators. Every person in Michigan who wants to receive a vaccine will be able to. Michigan has no out-of-pocket costs for those wishing to receive a vaccine, nor do we have any citizenship requirements. We will also work with our partners to ensure all vaccination efforts meet national Culturally and Linguistically Appropriate Services (CLAS) standards.

To further ensure all Michiganders have equitable access to the vaccines, we will build a robust network of vaccination sites across the state in each emergency preparedness region with assistance from our

[3] Michigan Coronavirus Racial Disparities Task Force. (2020). Michigan Coronavirus Racial Disparities Task Force Interim Report. Lansing: Michigan Department of Health and Human Services.

federal and local partners and the Michigan National Guard. In each region, we will have at least one 24-hour drive through clinic and will leverage existing nontraditional spaces in communities such as barber shops, nail salons, casinos, and syringe service programs. Vaccines will also be available at existing neighborhood testing sites to further eliminate barriers to access. Michigan will leverage vaccinator partners to help reach our homebound populations and target hard to reach populations such as the incarcerated, homeless, those with disabilities, or those living with substance use disorders. Our strategy will utilize ride share programs to address transportation barriers and work to make vaccination sites no more than a 20-minute drive from a person's home, no matter if they live in an urban or rural area. Taken together, these efforts will help prevent disparities in vaccination rates across racial and ethnic groups and in rural and urban populations. We simply need more vaccine to be able to implement these strategies robustly.

Federal Long Term Care Program
Michigan has engaged in the Federal Pharmacy Partnership for Long Term Care (LTC) Program to vaccinate staff and residents in 4,440 facilities across the state. As of January 28, 104,209 doses of vaccine had been administered to LTC staff and residents. Despite challenges related to the speed and data reporting shortcomings with this program, we are proud to say that as of last week all of Michigan's skilled nursing facilities have completed their clinics for first doses of vaccine. We anticipate most of our LTC facilities will have received the first dose of the vaccine no later than February 28, 2021.

While we are thrilled that many in this population have quickly received this life-saving vaccine, the rollout has not been without its challenges. Facilities were not evenly distributed among the federal pharmacy partners, putting the burden of contacting thousands of small residential facilities onto one pharmacy. This resulted in significant challenges, such as identifying a contact who could complete the scheduling process, and general skepticism and concern that these calls were scams. Working closely with the CDC, we brought in an additional federal pharmacy partner, a local entity known to the facilities, to help lessen the load. We have been able to transfer 1,192 facilities to this new partner – with clinics already underway. This innovation will enable LTC facility residents to receive their vaccines sooner, protecting them from this deadly virus.

Our team's diligence also helped us to discover that the number of doses allocated to the federal LTC pharmacy program overestimated the number of residents in each facility, resulting in more vaccines being allocated to the program than necessary. We were able to work with the CDC to reallocate those doses statewide without affecting our LTC residents' ability to receive vaccines. One ongoing challenge is that LTC program data is only updated in the Tiberius system twice weekly. This makes it difficult for us to know what is happening on the ground on any given day. To help overcome this, Michigan has worked closely with the federal pharmacy partners in an attempt to gather data daily. However, we are still having challenges with the accuracy and speed of the data reporting.

Limitations in Vaccine Supply
Michigan is primed and ready to expand our COVID-19 vaccination program, but the limited supply of vaccine allocated to the state on a weekly basis continues to be our largest barrier. We have a short-term goal of administering 50,000 shots per day, but could administer more than 80,000 utilizing nearly 2,000 already enrolled providers across a vast network that reaches both urban and rural areas in the state.

We were pleased to hear last week that our state allocation would be increasing by 16% and that states would have three weeks of visibility into vaccine allocations, to support planning efforts. We were also glad to hear that the Biden Administration has agreed to purchase an additional 200 million doses;

increasing vaccine supply by 50%.[4] We support President Biden's recent actions to invoke the Defense Production Act to shore up needed supplies, including personal protective equipment (PPE), as protecting the supply chain is crucial to supporting the pandemic response and vaccine rollout.[5] Michigan is excited to support the Biden Administration's goal of vaccinating 100 million people in 100 days and has built the infrastructure to be able to support that goal.

Consistent and Transparent Communication

A challenge from the first days of the pandemic has been a lack of consistent and science-based messaging and transparency around decision-making from the federal government, with the vaccine being no exception. For example, on January 12, 2021, the Trump Administration announced it would be releasing Pfizer and Moderna vaccines that had been held in reserve,[6] only for reports to surface days later that no such reserve of vaccine existed, and states would not be receiving any additional doses.[7]

Communication failures, last minute changes, and conflicting messages have significantly limited every state's ability to effectively plan and communicate with our residents and vaccination partners. States need consistent and transparent information on our allocations with as much notice as possible to facilitate efficient planning and distribution.

Despite these challenges, we have made every effort to provide the public with transparent, accurate, and timely information to build trust. To this end, Michigan has already launched a robust communications effort to make it easier for the public to see how we're doing, know where to go to get vaccinated and when, and to bolster confidence in the vaccine's efficacy and safety.

Michigan will target communication efforts to communities with vaccine hesitancy and in populations where hesitancy creates the greatest risk, such as congregate care settings. Michigan will support broad and diverse coalitions to carry vaccine messages, including leveraging our Protect Michigan Commission, which was established to "heighten awareness of the safety and effectiveness of an approved COVID-19 vaccine, educate the people of this state, and help protect the health and safety of all Michigan residents."[8]

States need the federal government to amplify the safety and efficacy of the COVID-19 vaccine and restore public trust in our institutions. This includes messaging to historically marginalized communities and populations distrustful of the government, in part based on our country's history of scientific experimentation on vulnerable populations, but also due to the ongoing implicit and explicit bias that exists in the healthcare system.[9] People must not be shamed or stigmatized for their perspectives, and ample opportunities should exist to engage in robust and honest conversations so that people feel heard and can understand the science and facts about the vaccine development and distribution process. These efforts must be intentional and collaborative, engaging trusted community members and leaders and stewards of information. Failure to do this well will only exacerbate the tragedy of the way this terrible virus has disproportionately ravaged communities of color.

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[4] Stanley-Becker, I. McGinley, L. and Rowland, C. Biden administration seeks to buy 200 million more vaccine doses, to be delivered through the summer. *The Washington Post.* January 26, 2021. Accessed on 26 January 2021 from https://www.washingtonpost.com/health/2021/01/26/vaccine-supply-biden/.

[5] Executive Order on a Sustainable Public Health Supply Chain. The White House. Issued January 21, 2021. Accessed on 27 January 2021 from https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-a-sustainable-public-health-supply-chain/.

[6] Ebbs, S. Gittleson, B. and Martinez, L. Azar, Trump administration will no longer hold back 2nd shots, recommend 65 and older get COVID vaccine. ABC News. January 12, 2021. Accessed on 26 January 2021 from https://abcnews.go.com/Politics/azar-trump-administration-longer-hold-back-shots-recommend/story?id=75198254.

[7] Isaac Stanley-Becker, I. and Sun, L.H. "Vaccine reserve was exhausted when Trump administration vowed to release it, dashing hopes of expanded access." *The Washington Post* January 15, 2021. Accessed on 26 January 26, 2021 from https://www.washingtonpost.com/health/2021/01/15/trump-vaccine-reserve-used-up/.

[8] Executive Order 2020-193: Protect Michigan Commission https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-547153--,00.html.

[9] U.S. Public Health Service Syphilis Study at Tuskegee. Centers for Disease Control and Prevention. Accessed on 26 January 2021 from https://www.cdc.gov/tuskegee/index.html.

Health Care Workforce
Our heath care workforce in Michigan has risen to the unimaginable challenge of battling the COVID-19 pandemic over these long months. In spite of the ongoing hardships, we have had over 2,400 volunteers express an interest in assisting Michigan's COVID-19 vaccination efforts.

Southeast Michigan was hit particularly hard by the virus last spring, when PPE supplies were low to nonexistent and when treatment options were scarce. But our health care workforce met these challenges and provided critical care under unbearable conditions. It has been an honor to serve alongside them in the emergency department and see their dedication up close.

We cannot simply assume that our existing health care workforce – many of whom have been working almost nonstop in the COVID-19 trenches for a year – will be enough for this massive undertaking. That is why the State of Michigan strongly supports President Biden's call for mobilizing and expanding the public health workforce by 100,000. These individuals will assist with vaccine outreach and contact tracing in the near term and will bolster our public health capacity by transitioning into community health roles in the long-term.

The Michigan National Guard has also been a critical partner in our vaccine rollout. The Guard has partnered with local health departments across the state to address communities' needs, including supporting COVID-19 vaccination efforts in the communities in which they live; thereby, leveraging and fortifying existing community ties. The National Guard has maximized the ability of local health departments to administer their weekly vaccine allocation by increasing staff capacity that would not be possible without their support. They also engage in a variety of tasks encompassed within vaccination efforts, such as reconstituting the vaccine, entering vaccine information in Michigan's immunization system, providing patient observation, and as vaccinators. As of January 26, 2021, the Michigan National Guard has administered approximately 34,000 doses. To date, 578 Michigan National Guard-supported vaccination events have been scheduled.

In additional to the Michigan National Guard, we are actively pursuing a variety of avenues to augment our health care workforce in the state, including partnering with Emergency Medical Services, creating strike teams, and utilizing the Michigan Volunteer Registry.

Data and Reporting
Michigan has long been a leader in vaccine registries. The Michigan Care Improvement Registry (MCIR), first implemented in 1998, became Michigan's birth to death registry in 2006 – preparing Michigan to manage vaccine data from the H1N1 pandemic and setting us up for success with the COVID-19 vaccine. The MCIR system is equipped to manage the lifecycle of the vaccine, including vaccine ordering, inventory, and distribution. The system tracks all COVID-19 doses and shares data directly with the CDC to meet reporting requirements. MCIR securely contains more than 11-million-person records and over 160 million shot records.

Michigan has struggled with Operation Warp Speed's Tiberius system, which was originally voluntary, but later became essential to understand vaccine allocation and distribution. The system is very complex and required multiple staff to undergo training in a short period of time to learn how to navigate it effectively. The system also lacks details about vaccines in the pipeline, which hamstrings our planning.

Michigan has also been challenged by the reporting on the CDC's website. The website has often been significantly delayed or inaccurate, and includes first dose, second dose, and LTC data in a way that is confusing and does not accurately reflect the work states are doing to efficiently distribute vaccine. Efforts to improve accuracy and simplicity of reporting on the CDC website would be welcome.

Michigan has seen a dramatic drop in our childhood vaccinations due to the pandemic. Our team has had to shift focus to the rollout of the COVID-19 vaccine, leaving fewer individuals to focus on outreach and education related to childhood vaccinations. We strongly encourage the federal government to think through ways to help our children catch up on their missed vaccinations. Forgoing vaccinations will open the door to other viruses taking hold in our communities and increasing the disease burden on our younger population. We will need a strong, coordinated effort to bring our childhood vaccinations rates back to where they were pre-pandemic.

COVID-19 has wrought unimaginable death and destruction throughout the world. In the past 12 months, more than two million people have died from COVID-19 [10], including more than 14,600 people in Michigan. But we should also celebrate this historic turning point. Science has prevailed. We have two, safe and effective, COVID-19 vaccines available today with another likely coming in the weeks ahead. While these vaccines were developed in less than a year, they were built upon decades of scientific research. To develop a vaccine, rigorously test it, and bring it to market in less than a year is an incredible feat that should be celebrated. I am proud of the work of our state and local health departments and health care systems who have worked tirelessly to deliver vaccines while also fighting to bring down the curve. We must ensure every person in America that wants a vaccine can quickly and equitably receive one. We can end this pandemic, but it will require cooperation, hard work, transparency, and dedication from each and every one of us.

[10] World Health Organization. WHO Coronavirus Disease (COVID-19) Dashboard. Accessed 27 January 2021 from https://covid19.who.int/.

Ms. DEGETTE. Thank you so much, Doctor.

I'm now very pleased to recognize our colleague, Mr. McKinley, to introduce our next witness.

Mr. MCKINLEY. I have to unmute. There we go.

Thank you, Madam Chair. Did I say that properly? Madam Chair?

Ms. DEGETTE. That's perfect. Thank you.

Mr. MCKINLEY. Madam Chair, I'd like to introduce Dr. Clay Marsh. Dr. Marsh is the current virus czar for the State of West Virginia. And along with his role, he's also the vice president and dean for Health Sciences at West Virginia University, and is considered to be a national leader in healthcare.

He's published more than 140 papers in peer-reviewed journals, but I first met his father 40 years ago. Don Marsh was a longtime editor of the largest newspaper in West Virginia, one, quite frankly, not particularly friendly to Republicans. But Don was always fair and objective. So I expect nothing less than that from Clay as we welcome him to his presentation today.

Thank you.

Ms. DEGETTE. I thank the gentleman.

Dr. Marsh, you're recognized for 5 minutes.

STATEMENT OF CLAY MARSH, M.D.

Dr. MARSH. Thank you, and good morning, Chairman Pallone, Ranking Member Rodgers, Subcommittee Chairwoman DeGette, Subcommittee Ranking Member Griffith, and other members of the House Energy and Commerce subcommittee.

It is really a distinct pleasure and privilege to be here today, and I want to recognize and thank Congressman McKinley, who is unwavering in his support for West Virginia, and also to recognize Governor Justice, who's done a remarkable job as a leader.

What I'd like to do in my time here is to reflect what our strategies have been and talk a bit about the important components I believe could be shared, and certainly learn from other people.

I congratulate the other presenters.

In West Virginia, we recognize that ultimately it is culture that plays the most important role in outcome. We were very much impressed by a series of articles that we read at the beginning of the pandemic, one of which reflected four mathematical models, agent-based models, that demonstrated that doing nothing to mitigate the COVID–19 pandemic or doing things by force were not as effective as doing things collaboratively. And that's really been a hallmark of what we've tried to do, is really move toward a level of committed purpose and service to people in our State.

We recognized early that this pandemic was a "black swan" event, a rare event that had catastrophic perturbation of all of our systems, and therefore we knew we couldn't predict necessarily the future, but we wanted to become agile and be capable of changing and trying things and undergoing rapid learning.

We've created a team-of-teams kind of approach that's been led by our National Guard, our logistics experts, choosing the most expert people to lead the part of the response meta that we could muster in West Virginia. And the great thing about West Virginia

is, although people may represent different sectors, they all eventually wear the West Virginia hat.

As we started to focus and clarify our priorities, we agreed with the Advisory Committee on Immunization Practices but also were informed by data from the United Kingdom and also from the CDC that demonstrated truly that older patients were the most vulnerable for death and hospitalization. And the Governor gave us a directive to save lives, to improve well-being, and to maintain the capacity and the function of vital healthcare and industry sectors in West Virginia.

As we looked at our own data, we saw that the average age of death was 77 years old, 77.5 percent of our citizens who died were over 70, 92 percent over 60, 97 percent over 50. So we targeted this age group, along with the vulnerable populations outlined by the CDC.

And I'm really proud to say, as we started to look at our own State's needs, we figured out that we had about 250 pharmacies in West Virginia, half of which were privately owned. So, instead of activating the Federal programs, we went a different direction and started partnering these pharmacies with nursing homes, and we were able to immunize all of our nursing home/assisted living residents before the new year, and we just finished on our second dose, which has been great because we know half of our deaths come from this population.

And so, as we start to work to move vaccines quickly, our goal is to move every vaccine within 5 days to somebody's arm in West Virginia, answering the risk of our State as predicted and projected by the Kaiser Family Foundation, the most vulnerable State moving into this pandemic. We're really proud to say that we have now immunized 80,000 of 350,000 over-65-year-old West Virginians, and we're moving forward. And to try to reduce the confusion about vaccination, we have now started a preregistration system, and we're hoping to preregister every person in the State.

I would end by saying that we believe that we all shine brightest in the service to others, and the only way that we're going to succeed is together, not only as West Virginians, but as Americans, and I'm very proud to represent our State today. And thank you very much for what you're doing.

[The prepared statement of Dr. Marsh follows:]

Statement of Dr. Clay Marsh
West Virginia University, Vice President and Executive Dean for Health Sciences
and COVID-19 Czar for the State of West Virginia
To the U.S. House Committee on Energy and Commerce Committee
Subcommittee on Oversight and Investigations
Virtual Hearing: "No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
February 2, 2021, 11 a.m.

Good morning Chairman Pallone, Ranking Member Rodgers, Subcommittee Chairwoman DeGette, Subcommittee Ranking Member Griffith and members of the House Energy and Commerce Subcommittee on Oversight and Investigations. My name is Dr. Clay Marsh, and I am West Virginia University's Vice President and Executive Dean for Health Sciences and West Virginia's Coronavirus Czar as appointed by Governor Jim Justice. I am also a physician specializing in pulmonary and critical care medicine, and I have been invited by West Virginia Congressman David McKinley, a member of this distinguished subcommittee, to provide you with an overview of West Virginia's efficiency of COVID-19 vaccine delivery and detail critical elements of the state's approach. I appreciate the opportunity to be with you today, and I thank Congressman McKinley for his gracious invitation and his unwavering support for funding patient care, research and academic initiatives not only for West Virginia University, but for our partner institutions around the state.

Regarding the COVID-19 vaccine distribution, we believe there are a number of issues critical to West Virginia's successes:

1) Culture of service, commitment to higher purpose and resilience for West Virginia;
2) Creation of "Team of Teams" approach led by National Guard logistic experts to adapt, pivot and create rapid learning cycles in this dynamic "Black Swan" COVID-19 event;
3) Have clear and consistent guiding principles and priority scheme for vaccination;
4) Understand critical unique factors for West Virginia and solve these central problems;
5) Create Joint Interagency Communication team including social media behaviors to drive messaging, constant communication and evaluation.

West Virginia Culture
West Virginia is a state of approximately 1.75 million citizens where people know each other. The culture in the state strongly contributes to our success and drives service, hospitality and commitment to shared higher purpose. Other elements that are more visible simply reflect the willingness to sacrifice for the greater good, to come together as West Virginians often do, and as Gov. Jim Justice says, "run to the fire." In rapid learning cycles, as discovered in Google's Project Aristotle, high degrees of psychological safety are critical for team members. **The culture of our citizens and state is a critical success factor in our response to COVID-19. Our culture created the environment of sacrificing personal vaccine acquisition for our most vulnerable.**

National Guard Logistical Approach with "Team of Teams" Structure
We look at COVID-19 as a "black swan event." This is a reference to Nassim Taleb's book *The Black Swan: The Impact of the Highly Improbable*. He noted these types of events as rare, usually with a powerful negative impact (think 9/11, the Great Depression, flu pandemic of 1918.) Tremendous unease occurs that rocks the foundation of our social, cultural and financial stability. In these events, cause and effect are very difficult to define, and predicting outcomes is impossible. Thus, rapidly adaptable approaches, rapid cycle learning and transparent communication are key. Gen Stanley McKrystal wrote about this kind of adaptive learning model

in his book, *Team of Teams*. Breaking down barriers to communication and dissolving parallel structures to unite all individual agencies and business sector organizations to a single team is key for rapid adaptability in fluid environments like COVID-19. **We formed a Joint Interagency Task Force (JIATF) led by National Guard logistics experts to create a "team of teams." Carefully selected leaders representing all of prioritized sectors that sit on the JIATF contribute specific expertise, but the ultimate decision making focuses solely on West Virginia.**

Centralized Purpose and Priority
At the beginning of the pandemic, Governor Jim Justice established priorities to *save lives, promote wellbeing, and support capacity and function of vital healthcare and community assets.* We knew that 50% of our deaths from COVID-19 were from our nursing home population. In addition, our average age of death from COVID-19 in West Virginia is 77; 77.5% of our deaths are in residents greater than aged 70; 92% of our deaths are in residents greater than aged 60 years old; and 97% of our deaths are in residents greater than aged 50 years old. It was essential to make sure this vulnerable population was among the first to be vaccinated. Using guidance from the Advisory Committee on Immunization Practices/CDC, The United Kingdom and West Virginia state epidemiology data, we created a priority list that focused on hospital workers, nursing home and assisted living residents and staff, first responders at all ages; and critical workers over aged 50 and our most vulnerable citizens over aged 65 as our priorities for vaccination. **Our clearly stated centralized driving purpose and prioritization for West Virginia immunization is a key component of our success**.

In West Virginia, we have been able to successfully administer 83% of total doses allotted to us, and have currently administrated over 100% of first doses. Through "Operation Save our Wisdom," we were the first in the country to vaccinate our nursing home and assisted living residents and staff (finished first doses in arms before the new year and this week finished second doses). To date, we have also immunized 90,000 West Virginia residents over 65 years old.

Customized Distribution Network Based on West Virginia Unique Attributes
Through the JIATF, there is a spirit of innovation and bottoms-up solutions that are welcomed, as long as everyone is moving in the same direction. Gov. Justice calls this "pulling the rope in the same direction."

As has been shared, West Virginia was the only state in the country not to initially activate the Federal Pharmacy program. As a key clarifier, we did not make this decision based on any pre-conceived concept but came to this conclusion after the leadership of the long-term care association and pharmacy leadership on our JIATF explored the details of West Virginia's needs. We realized that the centralized federal pharmacy rollout plan would not work in our small state of rural communities and scattered long-term care facilities with limited or no access to the large, national pharmacy chains. We submitted information and logistics to Operation Warp Speed, and they agreed with our plan to engage the state's more than 200 independent pharmacies (many privately owned with pre-existing relationships with rural nursing homes). Led by the CEO of the Long-Term Care Association and the leadership of this sector to work with our representative from the West Virginia Pharmacy Board and WVU's School of Pharmacy, we designed a hub and spoke system where vaccines are delivered from Operation Warp Speed to five strategically-located hubs (north, east, central, southwest and southeast) that place vaccine within maximum 2 hours of driving time. The decentralized component was empowering nursing home/assisted living and pharmacy partners to determine how they would best immunize their population of residents and staff. The commitment was to immunize all

residents of nursing homes in our state in a three-week time frame. This series of contributions allowed us to plan on finishing our second doses in this highly vulnerable population before the end of January.

Joint Interagency Communications Team and Pre-Registration System
As part of the JIATF we also created a JIC (Joint Interagency Communications) team. This team is an integrated team that vets all external media requests and also helps shape messaging and listens to the requests of the populous. As part of this effort, we recognized that there was confusion about when people would be vaccinated, where they should go and if they were registered, understanding their place in line. To address this issue, West Virginia became the first state to partner and implement an online portal – Everbridge – that allows residents to pre-register to receive the vaccine. Within five days of launch, we have pre-registered more than 100,000 citizens who want to receive the vaccine when doses are made available. This interactive system facilitates ongoing communication with residents in this queue to let them know where they stand in line, contact them when they are eligible for vaccination and allow messaging to be customized and directed at each registered citizen.

Ideas for Federal support:

1) Augment supply of vaccine for COVID-19.
2) Centralized and robust molecular epidemiology program to monitor for variant strains of COVID-19 in states.
3) Secure networking site hosted by DHHS/CDC for state leaders to have immediate access to federal administrators to be able to weigh in on specific issues, including:
    a. exchange insights and learnings with other federal and state COVID-19 experts;
    b. an area outlining mistakes encountered with solutions;
    c. wicked problems area (for help solving the most vexing problems states are experiencing); and lessons learned.
    d. Need simple and real time access to other responsible state officials to use the "wisdom of the crowd" in a no-blame and psychologically safe environment.
4) Input from logistics experts from military, business and government sectors available to assist state planning (for most efficient distribution and supply chain issues).
5) Funding for ongoing infrastructure needs – testing, vaccine distribution, contact tracing, innovations.

Ms. DEGETTE. Thank you so much, Doctor.

I'm now pleased to recognize Dr. Courtney Phillips, the secretary of the Louisiana Department of Health.

Dr. Phillips.

STATEMENT OF COURTNEY N. PHILLIPS, PH.D.

Dr. PHILLIPS. Good morning, Chairwoman DeGette, Ranking Member Griffith, and members of the subcommittee. As mentioned, I'm Courtney Phillips, and I have the pleasure of serving as the secretary for the Louisiana Department of Health. First, thank you all for the invitation to share our journey in the distribution of COVID–19 vaccines, both our successes as well as opportunities we have working together for continual advancement.

With our continued partnership, we are confident we'll be able to clear these initial hurdles, namely through increased COVID–19 vaccine allocations, advanced notice of allocation amounts for planning, and continued flexibility around the long-term care partnership program.

Although Louisiana has a strong track record of hosting mass vac events and is ready to employ them once vaccine availability increases, from the start of our planning we put our energy towards a low-and-wide strategy for vaccine distribution. We work with our partners to get local providers across the State enrolled and comfortable with the logistics of vaccine receipt and administration. This allowed us to build a vast network of diverse providers, which was time and labor intensive, but we do know it was fundamental in achieving equitable coverage, which has been a top priority in our planning and rollout from the start.

Per CDC rankings, Louisiana currently ranks 14th for our first dose administering. While we're proud of the progress we've made over the past several weeks, we're not satisfied with where we stand, and we're determined to keep getting better, determined to be our best selves. Louisianans not only desire it, but they also deserve it. They're depending on us. Their lives are dependent upon all of us pulling together in getting this done.

To date, Louisiana has been allocated a little over 505,000 doses, first doses across our State. More than 93,000 of those first doses were diverted to the Pharmacy Partnership Long-Term Care Program, which left about 411,000 for in-State allocation. Thus far, if you back out this week's allocation, we've allocated more than 90 percent of our doses within the community. And we aim to release at least 90 to 95 percent of doses on a weekly basis when it's received.

This week's allocation is being spread across 406 providers in every parish in our State. On average, we've increased the number of provider sites by 65 per week. Our provider sites include hospitals, outpatient clinics, federally qualified health centers, rural health clinics, independent and chain pharmacies, home health agencies, and other healthcare facilities.

Over the past week, we've tested additional distribution models, including providing Pfizer vaccines in nonhospital settings. We're preparing for when increased supply is available, and that preparation isn't limited to just distribution models, but it also includes increasing the number of providers enrolled and ready to receive.

Although supply does not yet support the need for additional providers, we want to be ready when the time comes. We initially began this with 701 providers enrolled in week one and now have over 1,900 providers enrolled across our State. These providers are spread out all across Louisiana in urban, rural, and underserved communities. They are ready to receive and administer vaccine.

That being said, currently only 32 percent of these providers have been able to receive vaccines because of the limited supply. And although we have more than 1,900 providers ready and waiting, we still recognize that we do have some areas across our State that are healthcare provider deserts. And to combat this, we're working and gearing up with our local community partners to deploy mobile vaccine teams, and some of the recent funding will allows us to do this.

With additional supply, the proper time to strategically plan, and continued flexibility as to where our vaccine doses go, Louisiana will be able to significantly increase the number of residents vaccinated each week. So your continual support in these areas are needed. And we relayed to you increased supply, we're ready. I think most States are. Our provider partners and residents are equipped to handle this increased allocation.

When we talk about the extremely high level of COVID across our Nation and here in Louisiana—we recently surpassed 400,000 cases—take a moment to step back and think about it. That's every person in the New Orleans—and then some—area having had COVID–19.

The narrative across the country has been that vaccines are going unused and sitting on shelves, so we've worked very hard in our State to ensure that the limited supply that we've received from our Federal partners is going into eligible residents' arms each week, and we've done well. We pushed to a point where we range from 90 to 95 percent of first-doses vaccines in the arms of Louisianans within the week that they receive it. Our providers' weekly dose requirements requests top 150,000 doses each week. They are ready and asking for more, and we believe that an increased allotment we can handle in our State.

Our second area, as mentioned, advance notice. Providing advance-notice allocation notice would allow the State and our providers more time to strategically plan. Typically, our week begins on Tuesday when Louisiana receives an estimated allocation for the following week. Based on those numbers, the department works with local providers to determine the need for the coming week. This list is compiled on Wednesday. Once we receive firm numbers on Thursdays, we begin the order and load it into the system. We don't ever lock in before Thursday, because there's been a couple of instances that those numbers have changed from Tuesday to Thursday.

Once our order is loaded and submitted, we work with our providers over Friday and Saturday to make them aware of what's coming. Monday is shipment, and we begin our process all over again. But providing States with greater visibility on what's expected in weeks in advance allows States time to plan and distribute vaccines more efficiently. This also allows providers time to

adjust for staffing needs based on what they're going to receive and allow appointments to be scheduled further in advance.

We were definitely encouraged by the news last week from our Federal partners that States will be given more notice on what they can expect to receive, and we do hope that this will continue. This will be a help.

A third ask that we have is continued flexibility in the long-term care partnership with both CVS and Walgreens. This flexibility will allow us to get shots in arms even faster.

Let me begin by expressing our appreciation for these corporate partners for their responsiveness on issues as they surface. But continual improvements and proactive communication, awareness, and the speed of vaccinations are going to be key.

In recent weeks, we've received approximately 58,000 first doses, and a large allotment of that goes to a long-term care partnership. Fortunately, we requested and have received approval in the recent weeks to keep and utilize those doses that have gone to the partnership, which has allowed us to further expand our network within the community in vaccinations. We're grateful for this flexibility and ask that it continues.

Ms. DEGETTE. Doctor, if you could please wind up. Thank you.

Dr. PHILLIPS. Yes, ma'am. Thank you.

As we continue to move forward, we just want to thank you all for the financial assistance. Financial burden has been key in our State. And so the assistance that's been provided in terms of the FEMA reimbursement, the 100 percent reimbursement to the National Guard, and the grants have allowed us to be able to move forward. We need this continued relief as we try to support the challenges we're up ahead.

Thank you, Chairwoman and committee members, for this time and any questions, more than happy to once we wrap up. Thank you.

[The prepared statement of Dr. Phillips follows:]

LOUISIANA DEPARTMENT OF HEALTH

Witness Testimony
Dr. Courtney N. Phillips
Subcommittee on Oversight and investigations
February 2, 2021

Chairwoman Diana DeGette, Ranking Member Morgan Griffith and members of the subcommittee, thank you for the invitation and opportunity today to share the great State of Louisiana's journey in responding to the COVID-19 pandemic – both our successes and the opportunities to address challenges that currently hold us back. With your continued partnership, we are confident we will be able to clear these hurdles, namely through increased COVID-19 vaccine allocations, advance notice for planning, and continued flexibility around the long-term care federal partnership program.

First, I must recognize the toll that COVID-19 has had on families and individuals over the last year. This is a disease that has touched everyone in some way. Many of us know friends, colleagues or family members who contracted the illness and were able to return to their daily routine in just a few weeks. Others we know were admitted to hospitals, where doctors and nurses had to quickly adapt how they practiced medicine to fight this novel virus. Others got ill then recovered from their acute illness, only to be left with the lingering effects for an amount of time that is still uncertain. And then some paid the ultimate price – losing the battle, often alone in a hospital, after their body could take no more, altering the makeup of families for generations to come. In Louisiana, as of this past Sunday, we have lost 8,743 husbands and wives, brothers and sisters, fathers and mothers, daughters and sons to this virus.

From the outset, we adopted a "low and wide" strategy for vaccine distribution. Although Louisiana has a strong track record of hosting mass vaccination events and is ready to employ them once vaccines become more available, we put our energy towards working with several partners to get local providers all over the state enrolled and comfortable with the vaccine. Building a vast network of diverse providers is time and labor-intensive work, but we view it as fundamental to achieving equitable coverage, a top priority in Louisiana's planning and rollout from the very beginning.

We are proud of the progress our state has made to date, but we are determined to keep improving because we know our residents' lives depend on it. As of January 30, Louisiana has been allocated 438,100 first doses with 93,600 diverted to the *Pharmacy Partnership for Long-Term Care Program* (LTC partnership) leaving 344,500 available for in-state allocation. This week in Louisiana, we received 67,350 of first-dose vaccines that were shipped to 406 providers in all 64 parishes. This number of receiving providers has increased every week since the start of our vaccine distribution.

We have worked to increase the number of providers enrolled and ready to receive. We began with 701 providers enrolled in week 1 and we now we have 1,919 providers enrolled in all parts of the state who are ready to receive and administer vaccine, with only 32%, or 613 providers, receiving the vaccine so far because of limited supply.

Our efforts began the week of December 14, when Louisiana received 39,000 doses from Pfizer, which was distributed to five health systems across the state to begin vaccinating their

employees. In week 2, we received both Pfizer and our first allotment of Moderna doses for a combined allotment of 106,875, which included the LTC partnership doses. The addition of Moderna doses allowed us to increase distribution to our Tier 2 hospitals capturing those priority groups in Phase 1A, which continued for the next few weeks.

As we moved into week 4, we received a combined total of Moderna and Pfizer of 94,960 doses, which included 38,995 of Pfizer 2nd doses and the LTC partnership allotments. We began vaccinating individuals in our Phase 1B, Tier 1, which included persons 70 years old or older, dialysis patients, ambulatory and outpatient healthcare workers and allied health schools. This same week, we initiated a partnership with our Louisiana pharmacies in an effort to provide access across the state. This partnership allowed for 107 randomly selected chain and independent pharmacies to begin receiving the vaccine, with each pharmacy receiving an average of 100 doses. To prevent long lines from forming outside pharmacies, the state insisted providers and eligible residents make appointments.

The vaccine allocation remained consistent these last few weeks, where we have received approximately 58,150 doses per week and have continued to spread allocation across the state to an increasing number of enrolled providers. During week 6, we used social vulnerability mapping to inform our intentional effort of equitable distribution.

Providers receiving vaccine are added at an average of 65 providers per week, going from 118 to 406, including Federally Qualified Health Centers, Rural Health Clinics, Home Health agencies and other health facilities. Over the past few weeks, we have tested additional distribution models, including providing the Pfizer vaccine in non-hospital settings.

Louisiana continues to rank among the top tier of states when it comes to administering the vaccines. According to the CDC, we currently rank 18th among states for first doses of vaccine administered per 100,000 residents. With additional supply, the proper time to strategically plan and continue flexibility as to where our vaccine doses go, Louisiana would be able to significantly increase the number of residents vaccinated each week.

Louisiana is ready for increased allocations

The narrative across the country has been that vaccines are going unused, but we have worked very hard to ensure that the limited supply of vaccines received from the federal government is going into eligible residents' arms each week, and we have done well. We firmly believe with an increased allotment that the state will be ready to vaccinate. Within a week, between 90 to 95% of the vaccines shipped to Louisiana are in arms.

As previously stated, in recent weeks, Louisiana has received approximately 58,500 vaccines a week. From that allotment, Louisiana was required to deposit an average of 23,400 doses to the LTC partnership with Walgreens and CVS, leaving around 35,100 doses for the state to utilize. Fortunately, we have requested and been approved to keep and utilize doses that would

have gone to that partnership. That has allowed us to further expand our network of vaccine providers and increase Louisiana's overall vaccinated numbers.

With the increasing number of COVID-19 cases in Louisiana, the vaccine remains a critical tool in the toolbox. As of February 1, 2021, we are reporting 899 new COVID-19 cases for a total of 401,591 cases. We have administered a total of 5,328,079 tests across the state and the statewide percent positivity is 8.60%, with hospitalized COVID patients at 1,403 (34.4%).

We know COVID-19 has hit our communities of color hardest, exacerbating health inequities that go far back. It is no surprise to us that due to historical and even current harm, there is *earned* mistrust especially in our African American communities in particular. We hear that from our communities and now we see it in our early vaccine data. While we continue to work with our providers on the importance of entering race data in the system, the current data show that we still have work to do. While African American communities make up 32 percent of Louisiana's population, they account for 14.83% of those who have received a dose of the vaccine. Though 13.02% are listed as unknown and 21.59% are listed as other races in current data, we are continuing to work hard to ensure equitable access to the vaccines. We expect this reporting to improve over time with better data from our state system, improved provider practices and improved matching.

Communication and partnering with stakeholders, such as the Health Equity Task Force, created by our Governor, as well as other partners such as the Louisiana Public Health Institute will assist in our efforts to demystify the process, answer questions and dispel misinformation, with the goal of increasing vaccine confidence.

The state is making every effort to raise awareness and prepare future priority groups in Phase 1B, Tier 2, by building local evidence so we know where and how to target our efforts by utilizing tools such as rapid research opportunities, especially in underserved communities and building community listening into our processes. Additionally, the creation of four COVID Vaccine Community Engagement Councils -- healthcare, faith-based, community and public sector, are equipping community leaders and stakeholders with facts, data, and resources about the vaccine that address concerns and questions we are hearing in multiple languages.

Sleeves Up, Louisiana, our statewide vaccination campaign represents and speaks to Louisiana's many diverse communities. It is and will continue to be informed by the latest national and local evidence and feedback, and will build and expand as we move through the phases of distribution. In addition to all these more traditional tools, we are mapping out canvassing efforts with the goal of educating eligible and soon to be eligible populations (as well as the more vaccine hesitant) and connect them to resources.

Advance notice would allow for more strategic planning by state and providers

Typically, our vaccination week begins on Tuesday, when Louisiana receives an estimated allocation for the following week from the federal government. Based on those numbers, the department works with local providers to determine the need for the coming week. That list is compiled on Wednesday and finalized on Thursday, when the order is entered into the system. Once the order is submitted, our team works through the weekend contacting providers, making them aware of the coming week's allotment. Monday shipments begin to arrive and we begin the process over again for the following week.

The turnaround between learning the expected allocation and placing the order creates challenges as it relates to planning, as there have been instances when the expected allotment is different from the actual doses we are allowed to order. Providing states greater visibility on what to expect weeks in advance would allow states the time to plan and distribute vaccines more efficiently. This would also allow providers time to adjust staffing needs and allow appointments to be scheduled further in advance. We are encouraged by the news last week from our federal partners that states will be given more notice on what they can expect to receive, and hope this will continue.

Continued flexibility in the Long-Term Care Program for expeditious administration of vaccine
We have faced challenges involving our participation in the LTC partnership with Walgreens and CVS. First, let me state that we are appreciative of these corporate partners' efforts. Our corporate representatives have been responsive and have tried to resolve problems that have arisen. However, the overall lack of proactive communication, awareness and speed of vaccinations continues to be an area of concern. Facilities, residents' families and local elected officials look to states for answers on when vaccinations will occur at a facility.

The greatest assistance you can provide around this program is to provide continued flexibility and visibility to states when it comes to doses allocated to the LTC partnership. Previously, we have been required to deposit an amount into the program's dosage bank to help meet the demand in our state; however, due to the slow pace in vaccinating this population, the result has been federal doses unused. We are very grateful for the flexibility that has been granted in the ability to allocate the necessary amounts to pharmacies. **We recommend continued flexibility in the LTC partnership.**

Revising CDC reported data for increased clarity on vaccine doses administered
An area of concern that we believe could be remedied with increased clarity extends to the data reported on the CDC's website. Those numbers often do not match what states are reporting and leads to confusion and the perception that doses are going unused. Some of this is a result of second doses being reported as delivered and ready to use even though the 21 or 28-day mark for the person to receive the dose has not been reached yet. When those second doses are added into the overall reported numbers that are available it does not provide the full picture in terms of what is happening with those doses. It appears that many more doses are available to be administered when that is not the case. Adding to that confusion is the

inclusion of doses that are taken from states for the long-term care partnership. Finally, the total LTC doses administered is higher than any data that we as a state can see on our end or on the Tiberius system. **We would encourage the CDC to report out separately, the number of partnership doses, as well as second dose numbers, to provide a more realistic number of what is available to the public each week.**

And finally, the financial burden being placed on states is tremendous. As a nation, we are responding to a pandemic the likes we have not seen in 103 years. Extraordinary times call for extraordinary cooperation and collaboration between Louisiana and our federal partners. The resources provided to states, communities and families will allow us to come out the other side of this pandemic successfully and not looking at a new financial problem facing our country. We are very grateful for the resources that have been provided to date. The recent notification of the 100% FEMA reimbursement has provided great relief to our public health team, coupled with the 100% Louisiana National Grant reimbursement and the second tranche of federal grant funds has been the resources needed for us to adequately respond to this pandemic.

In closing, I must recognize the hard-working people in Louisiana. In particular, pharmacists and other healthcare providers throughout the state who have administered hundreds of thousands of vaccines. Thank you to our front-line heroes in hospitals, emergency rooms, doctor offices, laboratories and emergency services who respond daily in treating those with this virus. Thank you to our Governor for his leadership, our Louisiana Congressional Delegation for their continued support at the federal level and our state legislators and local elected officials who have been our eyes and ears in each community. And finally, thank you to the team at the Louisiana Department of Health, and our colleagues in our partnering state agencies for their work. All of these individuals have put in countless hours, sacrificing time away from their immediate families, as well as a full night's sleep for the past year.

Committee members, the past year has been tough. Sacrifices were made by many. With the continued partnership of Congress and our federal partners and the advocacy of the Louisiana Delegation, I am optimistic that the coming months will allow us to vaccinate our population so we can eventually begin to return to a semblance of life as we once remembered.

Thank you for your time and attention today and am happy to answer any questions at the appropriate time.

Ms. DEGETTE. Thank you so much, Doctor.

And last but surely not least is my wonderful executive director of the Colorado Department of Public Health and Environment, Dr. Jill Hunsaker Ryan.

Doctor, welcome. Glad to see you here. And you're recognized for 5 minutes.

STATEMENT OF JILL HUNSAKER RYAN

Ms. RYAN. Thank you, Madam Chair.

And just to clarify, I'm not a physician. So you all may call me Director Ryan. My background is epidemiology.

But thank you, Chairman DeGette, Ranking Member Morgan Griffith, and members of the subcommittee. I'm so happy to be with you here today, and thank you for all of your support so far.

I'm joining today from Eagle County in Colorado. In Colorado, we're very proud of our response to the COVID–19 pandemic. We currently have the fifth-lowest rate of transmission in the Nation and are ranked eighth in terms of the percentage of vaccine supplies used. Part of our success is a whole-government approach with the Colorado Department of Public Health and Environment in unified command with the Colorado Department of Public Safety, the Governor's office, and using the Colorado National Guard to support COVID–19 testing and vaccine distribution.

Colorado received the first shipment of vaccine on December 14th, with the Governor signing for it himself. We are moving as fast as the Federal supply chain allows and are grateful for every vaccine we receive. When the pandemic began, if you would have asked me or if you would have told me that we would have not only one but several vaccines would be in clinical trials within the year, with distribution starting before 2021, I would have been very skeptical, but here we are, and this is simply unprecedented.

Operation Warp Speed deserves our thanks and praise for the public-private partnership in developing these vaccines, which will be a game changer in supporting the long-term health and well-being of our schools, our families, and our communities.

General Perna and his team deserve credit too for efficient distribution. General Perna has told me that the vaccine is going from the conveyor belt directly to States.

Colorado's currently receiving about 80,000 doses per week, and we hear that will increase to 96,000 in mid-February. We do have the capacity to administer 300,000 doses a week now, with the goal of 400,000 by the beginning of March.

So our main ask is for more doses and, if possible, greater predictability in our weekly allotment, which simply helps our ability to plan. For example, if we knew our number of doses a month out, with increased supply we could plan even larger additional clinics and PODs, or points of distribution.

I wanted to take a minute to put in another ask, and that is simply that the public health system has been so underfunded for decades. In Colorado, we have a State Department of Public Health and Environment and then each county is served by a county local public health agency, 55 in all, and of course with this response we've all had to scale it massively. My department has a $600 mil-

lion-a-year budget. We've been awarded $1.2 billion in this response that we will push out.

But the problem is, if you can imagine having to scale up a workforce on the State and local level, trying to hire and onboard and train and get everybody an email address and coordinated during a pandemic is so hard. So we need to ongoingly support our public health system.

Back to vaccines, though, Colorado now has more than 770 providers to help distribute vaccines, and nearly 465,000 people have been vaccinated. Because Coloradans age 70-plus account for 78 percent of deaths in Colorado, our goal is to vaccinate 70 percent of them by the end of February.

Hospitals have carried much of the weight in getting this done. They have dazzling efficiency in reaching a high number of people quickly. But also, our local public health agencies have been coordinating the so-called last mile of distribution, helping determine where vaccine goes in their community, and setting up mass vaccination clinics or PODs.

Long-term care facilities in Colorado, with the exception of about 20 rural facilities, are relying on the Pharmacy Partnership for Long-Term Care Program. We've largely overcome delays with that program in Colorado by providing staffing assistance.

And then, finally, an important part of our vaccine distribution response is to make sure that no one is left behind. For example, we know people of color have been disproportionately impacted by COVID–19 in terms of number of cases, hospitalizations, and deaths. The pandemic has laid bare the societal disparities that have existed for generations but which COVID–19 has exploited.

Knowing the challenge, the State has a goal of ensuring there is a community-based clinic providing vaccines in 50 percent of the top 50 census tracts for high density, low-income, and minority communities. We'll achieve this goal through our community-based health centers, local public health agencies, statewide pop-up clinics in collaboration with community-based organizations and churches.

Coloradans are eager to get vaccinated, and we are eager to vaccinate everyone who wants to be vaccinated and end this crisis.

Thank you for your time today, and I appreciate being able to come before you to testify.

[The prepared statement of Ms. Ryan follows:]

02/02/2021

Energy and Commerce Oversight Committee
U.S. House of Representatives

Testimony: Jill Hunsaker Ryan, executive director, Colorado Dept. of Public Health and Environment.

Thank you for allowing me to speak today, Mr. Chairman. I'm joining today from Eagle County in Colorado. Colorado received the first shipment of vaccine on Dec. 14, with the governor signing for it himself. Since then, Colorado has distributed vaccines quicker than the vast majority of other states, according to the CDC. We are moving as fast as the federal supply chain allows, and we are grateful for every vaccine we receive. If the pandemic has taught us anything at all-- it's that we are all in it together, and we know that the more Coloradans who are vaccinated the safer we are as a state and as a nation.

We want to thank General Perna and everyone involved in his operation. It's a scientific miracle that we have vaccines available for public use.

The main ask we have now is for more doses and greater predictability in the federal supply, so that we can continue to execute the state's vaccine distribution plan. We would welcome at least 300,000 doses a week under our current system.

We now have more than 770 providers helping to distribute vaccines and nearly 465,000 people have been vaccinated.

We have a phased distribution process that is based on recommendations from the Advisory Committee on Immunization Practices (ACIP), and modified slightly to match Colorado's needs. The principle goal is to have the greatest impact as quickly as possible. To do that, we have begun by vaccinating health care providers-- starting with providers who have direct contact with COVID-19 patients and emergency responders, then other health care providers.

Because Coloradans age 70+ account for 78% of deaths in Colorado, we have been moving toward the goal of vaccinating 70% of Coloradans age 70+ by the end of February. Hospitals and grocery store pharmacies have carried much of the weight in helping get it done. We now estimate that 39% of Coloradans age 70+ have been vaccinated and are lowering the age requirement to 65+.

Long term care facilities are relying on the Pharmacy Partnership for Long-Term Care Program. We have largely overcome delays with that program, after offering to provide staffing assistance. According to the federal government's Tiberius database, we have come a long way.

It hasn't been easy trying to mobilize a logistical operation like we have-- but we've had the help of local public health and providers.

Together, with our partners, we are committed to ensuring an equitable distribution process. From the beginning, we have developed a distribution plan using an equity lens. It aims to be responsive to the disparities that have been so pervasive throughout the pandemic-- disparities that have plagued society for years upon years but are ever more prominent during crises.

We know that we must be deliberate about achieving equity, meeting communities where they are-- and addressing vaccine hesitancies that are rooted in historical injustices. We've seen these hesitances reveal themselves in our Oct. 2020 survey which showed that while 70% of White Coloradans planned to get the vaccine, only 53% of Black Coloradans and 56% of Hispanic Coloradans planned to get it. Knowing the challenges, the state also has the goal of ensuring there is a community based clinic providing vaccines in 50% of the top 50 census tracts for high density of low income and minority communities.

We are deeply committed to overcoming systemic barriers and having an equitable distribution process by:

- Allocating 10% of vaccines to providers that serve underserved populations.
    - Just this past weekend 1,200 does were administered thru 5 equity clinics. We have 8 additional equity clinics scheduled this week and anticipate over 3,400 doses administered.
- Collecting robust data to measure our objectives-- Our vaccine dashboard now includes vaccine administration by race/ethnicity, age group, and sex. The data available for race and ethnicity represents 78% of individuals receiving one or more doses because providers have not historically been required to report that data on all patients to the Colorado Immunization Information System (CIIS).
    - We have asked providers to collect race/ethnicity data when administering the vaccine, if the patient willingly gives the information. CDPHE will issue a public health order, providing further specificity about data collection.
- Establishing that providers should abide by an honor system, taking the individual's word on age, residency, and other eligibility criteria, and using their discretion to determine whether the individual is eligible for vaccination in the current priority phase.
    - Unnecessary ID requirements create a barrier for people who are unable to get identification or have trouble accessing services that issue IDs, such as those who are undocumented, experiencing homelessness, have a disability, or others on the margins of society who are unable to get an ID.
- Asking that providers consider every Coloradan who is currently eligible to get vaccinated fairly for the vaccine, without regard to their affiliation or history with the hospital, medical coverage status, or ability to pay.
- Leveraging community Based Organizations (CBOs) in underserved communities to advertise and host clicis. We are also working with Federally Qualified Health Centers to use their established infrastructure and community partnerships to pilot clinics.

- Coordinating with transportation providers to assist Coloradans with mobility barriers or without personal vehicles.
- Facilitating a Champions for Vaccine Equity program to provide information to communities of color about the safety and efficacy of vaccines, plus utilizing Promotoras, service providers, and crisis counselors to support vaccine literacy.
- Developing and are growing a vaccine media marketing campaign featuring medical professionals from diverse backgrounds and engaging influencers and local public health agencies to help get the word out to hard-to-reach communities.

Like many other states, we are continuously trying to grow our wayfinding systems-- scaling it as we get more vaccines. We've required large providers to establish a weblink and phone number specific for vaccinations-- emphasizing the need for both online and off-line communications. We also created a statewide hotline for Coloradans to use, which has been busy for days.

- Coloradans are eager to get vaccinated! And we are eager to vaccinate everyone who wants to be vaccinated and ending this crisis. We are grateful for the federal partnership, and are hopeful that when we look back at this 5 or 10 years from now-- we have lessons learned but also stories of great collaboration and innovation.

Thank you.

Ms. DEGETTE. Thank you so much, Director.

And now it's time for Members to have the opportunity to ask the panel questions. The Chair will now recognize herself for 5 minutes.

So I would just like to start with you actually, Director Ryan. You said in your testimony—and this was echoed in several of our other panelists' testimony as well—that vaccine supply and predictability have been a challenge. How are those challenges impacting the vaccination efforts in Colorado, and what do you need from the Federal Government to improve the rate of vaccinations in our State?

Ms. RYAN. Thank you for the question, Madam Chair. We simply need more supply. As I mentioned, we're getting about 80,000 doses a week. We have the capacity for 300,000 doses now and are ramping up to 400,000 in the next month. So we need supply, and then we need better predictability in terms of the number of weekly doses we will be receiving to help with our planning efforts.

Ms. DEGETTE. Yes. And, Dr. Khaldun, you also said in your testimony, in your written testimony, that Michigan's, quote, "single biggest challenge with the vaccine rollout has been the limited supply of vaccine available week to week and the lack of a national Federal strategy until now."

I'm wondering, Dr. Khaldun, how you expect the Biden administration's national COVID–19 strategy to impact vaccination efforts in your State.

Dr. KHALDUN. Yes. So I really appreciate the Biden administration's strategy. Last week, the State of Michigan actually updated our strategy that aligns with the Biden strategy, focused on getting shots in arms, building out a robust network, maximizing efficiency, personnel, and, of course, a mass communications effort.

And so what I'm pleased by—and I've had several conversations with the Biden administration—they will be supporting us in our strategy. They will be supporting building out more of the public health workforce and supporting us with some of our efforts when it comes to equity, whether it be mobile clinics or supporting personnel that are getting out into communities.

Ms. DEGETTE. Dr. Ezike, would you agree that the lack of a national Federal strategy until now has hamstrung the efforts in Illinois? And what's the top suggestion for how we can go forward?

Dr. EZIKE. Thank you for that question. I would say indeed it has. I think at the top of the list we could cite the confusing messages around the importance of masking. We need a focused, dedicated message that talks about the importance of masking. We know that there are other countries outside of ours that have controlled this virus even before a vaccine was in place. And so that attention and focus to masking, which I think I see that this administration absolutely puts at the top of its priorities, is very important and is one of the first steps, along with vaccination and promoting vaccination in all groups.

Also remembering that vaccination, there are lots of vaccine-hesitant groups. And so, as we are in this period of still waiting for the supply to increase the demand, we want to also build that foundation, that community engagement for those who are vaccine-hesitant. And so we have seen the attention to that with this adminis-

tration in the identification of an equity chair, a COVID equity chair, so that we can work on the vaccine hesitance as well so that we can bring all of us through this. We don't want to leave any group behind. And so, as much as rapidity is important, equity is important. Rapidity without equity will result in continued disparity.

Ms. DEGETTE. Thank you. Thank you. I think those are important points.

Dr. Phillips, you talked about the need for continuing flexibility and visibility when it comes to the doses allocated to the Federal long-term care pharmacy program. I wonder if you can just spend a few moments talking about that program and why flexibility is so important.

Dr. PHILLIPS. Absolutely. As we know, very early on, week by week we increased the number of doses that we were allocating to that program based on the methodology from our Federal partners. But we do know based on the rate of speed that they've administered the vaccine that doses have been left sitting there, waiting. So the speed of distribution is not keeping up with the speed of allotment that States have allotted to their partnership.

And so utilizing the most recent clawback availability—so in recent weeks it's been announced that we're able to pull back some of that vaccine to match the actual administering rates. Doing so has allowed us to be able to push more in the community and not have vaccines sitting anywhere. And so that flexibility been greatly appreciated.

Ms. DEGETTE. Thank you so much.

And last but surely not least, because West Virginia's efforts are a national model, Dr. Marsh, can you just tell us how Congress and the Federal Government can facilitate better collaboration between the Federal and State experts and how that would benefit your vaccination efforts for your State?

Dr. MARSH. Thank you, Madam Chair. Certainly, as the other experts have testified, that having more vaccine is very important for us as well. We get about 23,600 doses a week. Without expanding our infrastructure, we could handle about 125,000 doses a week. And we believe with a small increase in our infrastructure, it could go over 200,000 doses a week. So dosing is really important.

But I think also there's a really terrific opportunity for us to make sure that we're sharing our best practices and sharing our learnings, and right now I don't think that there is an integrated portal or pathway to allow each of the leaders of the States, along with the leaders of the Federal Government response and perhaps the coronavirus task force experts, to be able to come together to be able to freely and quickly exchange information so that we can all undergo this rapid cycled learning opportunity and also learn the things that don't work, because it's just as important not to keep doing the things that don't work as well as trying to adopt the things that do.

Ms. DEGETTE. Excellent suggestions. Thank you so much. My time's expired.

And I know now that the chair—or the ranking member of the full committee, Mrs. Rodgers, is going to go next.

And so you are recognized for 5 minutes.

Mrs. RODGERS. Thank you, Madam Chair.

And thank you all who have joined us as witnesses today. We thank you for your leadership, your commitment to the health of all in our communities. This is at a time when we need hope and healing in our country, and you're on the front lines. So thank you so much.

My first question is, it's a simple yes or no to all of our witnesses. I just wanted to ask: At the start of this pandemic, did any of you anticipate a safe and effective COVID–19 vaccine to distribute and administer only 10 months later?

Dr. MARSH. No.

Ms. RYAN. No.

Dr. EZIKE. No.

Dr. PHILLIPS. No.

Mrs. RODGERS. Thank you.

Next question to everyone: Has a vaccine distribution of this magnitude and complexity ever been attempted before in the United States?

Dr. MARSH. No.

Ms. RYAN. No.

Dr. EZIKE. No.

Dr. PHILLIPS. No.

Dr. KHALDUN. No.

Mrs. RODGERS. Thank you.

I wanted to ask Dr. Marsh also—and I think the last person was just talking about the importance of best practices and learning from the other States, which I think is part of the goal today.

And I just wanted, Dr. Marsh, if you would just speak to what you believe has been important in West Virginia as we anticipate this, the challenges with the vaccine distribution, but a pandemic this large. I just wanted to ask you to speak to the importance of a localized approach to the response, because we've heard from so many about a Federal approach.

And I know, in Washington State, you know, I've been frustrated with a one-size-fits-all approach, not even taking into consideration as much my region or, you know, we've had the same responses and restrictions across the State regardless of the facts on the ground. And my Governor, Governor Inslee, has continued to say, "Well, we need more Federal involvement."

I just wanted you to speak to the importance of a more State-by-State approach.

Dr. MARSH. Thank you, Ranking Member Rodgers. Well said. It's a pleasure to talk about our approach.

And I think that, you know, West Virginia, as a small State, 1.7 million people, that is very rural, largest city is 50,000, and as we start to look at our own needs in our State, we see that we have a very distributed location set of where people are in the State.

So we believe that, in order to best meet the needs of our citizens, we need to have local involvement at many levels, that we can share information, same way that we've talked about here, because, as this is so complex and there are so many issues that you need to deal with, that you can't really predict the future, you have to be able to become agile and respond.

And we're scrappy and resilient, and we have created our own supply chain for things. We have partnered local pharmacies with the places we want to vaccinate. We are controlling the supply chain of our vaccine. We believe pharmacists should be in charge of the vaccine because of the critical nature and difficulties in storing and transporting some of this.

But, to me, without absolutely casting any aspersions on anybody else, we are creating the solutions that work for West Virginia, and we are all committed to serving our citizens. And I think that that——

Mrs. RODGERS. Thank you.

I have one more question I want to get to all the witnesses. And I just wanted each of you to speak briefly about, what did CDC do to assist you in developing and exercising your plan before the vaccine was actually delivered to your State?

Maybe I'll start with Dr. Marsh since I cut him off, and then I'll go with the others. If you could just speak very quickly.

Dr. MARSH. Yes. Quickly.

We've had a lot of conversations with CDC, but we created our own program.

Mrs. RODGERS. OK. Thank you.

Colorado?

Ms. RYAN. Yes. We coordinated with CDC around creating our original plan in October.

Mrs. RODGERS. Very good.

Illinois?

Dr. EZIKE. Yes. We did have multiple CDC, FEMA, HHS interagency meetings for our region to discuss our plans and hear of other States in our region to hear their plans as well.

Mrs. RODGERS. Thank you.

And who am I missing here? I'm sorry. Michigan.

Dr. KHALDUN. Yes. We also had several meetings with the CDC and other Federal partners. We also worked very closely with our local health departments. We have over 45 local health departments across our very vast State, urban and rural populations. We worked very closely with them as well on our plans too.

Mrs. RODGERS. Very good. Thank you all again so much. This has been a tough, tough year, to say the least.

Ms. DEGETTE. Thank you so much.

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

Mr. PALLONE. Thank you, Madam Chairwoman.

I think I'm going to have to start out by saying that I definitely disagree with what our Ranking Member Rodgers said with regard to not having—you know, looking at this State by State or localizing it versus having more Federal involvement. I mean, I didn't—I have to take your word for what Governor Inslee said, but I think I agree with him that we need more Federal involvement.

I mean, part of the problem that I saw in the last 9 months under Trump was that States were essentially left alone, and they were competing with each other for gloves and masks and supplies and sometimes being gouged with prices.

And I do think, and I've said all along, that we need a national strategy, which is what Biden is trying to accomplish. So I under-

stand this one-size-fits-all, but I don't think that that necessarily works when you have a pandemic of this magnitude.

Now, that isn't to suggest that this isn't a Federal system where there is a national strategy and we still try to implement this, the response, State by State. But the fact that President Trump so much stressed that States were on their own and there wasn't a need for a national strategy, I think, was a huge mistake, and I think it was an ideological approach that led to the fact that we didn't have an effective response under the Trump administration. But, you know, whatever. That's my spiel.

Let me ask this question. Let me go to Dr. Khaldun.

What's happening now, of course, is Biden implemented a three-prong strategy last week, or started a strategy, where he said that we're going to give you notice 3 weeks in advance so you know what's coming. That's the transparency. He increased the number of vaccines that were coming weekly to the States. And then he set out a plan to actually vaccinate 300 million Americans beginning in the summer and certainly by the fall.

So I wanted to hear—I wanted to ask for your response to that, how that's going, and what you think about it.

And then, secondly, we have a bill. In other words, we have this bill, the American Rescue Plan, that we're going to try to do in the next few weeks that provides a lot more money for vaccines, for testing. And my understanding at the State level is that the States are still wanting with resources and need that additional money and need it soon, because many of them—you know, we didn't provide any State and local aid in general directly, and many of them are still using their own money and need Federal help.

So those are the two questions. One's what about what happened with that three-prong Biden plan, and whether we need another COVID bill because you're lacking resources.

Dr. KHALDUN. Thank you, Chairman, for that question.

So I have been very appreciative, actually, of the Biden administration, had several conversations with leadership.

We do for the first time have at least—have 3 weeks of transparency as far as how much vaccine will be getting into the State. That's very helpful, because now I can tell my providers that they get a certain amount of vaccine, and they can go ahead and schedule. So it's been incredibly helpful.

We also are very thrilled that potentially the American Rescue Plan will go through. We certainly need additional funding.

Right now, I'm at a point where I have contact tracers that are getting involved in my vaccination efforts. I have epidemiologists who work on lead and other things in the health department who are now being pulled into vaccine efforts. We absolutely need more funding to build our infrastructure, to bring in more staff to be able to support our vaccination efforts.

Mr. PALLONE. And then there is about a minute left. If I could ask the Colorado representative, Ms. Ryan, the same two questions about the last three-pronged Biden announcement and the need for another—more resources through another legislative—through another bill that we're planning.

Ms. RYAN. Thank you for the question.

I will say that the transparency and predictability is improving, as are the number of doses. We know those are slowly going to be increasing over the month of February.

Yes, we could absolutely use more Federal help. We are seeing the same things with our local public health agencies trying to decide do they put their staff as vaccinators or contact tracers, still lacking the resources, and pulling all the staff they have off of all their other duties as they've done all along.

So I think it speaks to the need for sustainable funding in addition to emergency funding. And we did just get some funds from the CDC and a new ELC grant and other funding, and we will be putting that to good use. But we anticipate, you know, this response is going to be with us for a long time, COVID is not going away, and we're going to need sustained dollars.

Mr. PALLONE. Thank you.

Thank you, Chairwoman DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

The Chair now recognizes the ranking member of the subcommittee, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you very much, Madam Chair.

Dr. Marsh, if I remember your comments earlier, that you all did not go with the Federal plan but created your own plan to suit West Virginia needs. Is that correct?

Dr. MARSH. Yes, that's correct.

Mr. GRIFFITH. All right, I appreciate that, because I think sometimes it's nice to have a Federal template, but some States need that ability to do what you all did in West Virginia.

Now, going on to the next question. Since distribution of COVID–19 vaccines—and I'm with you still, Dr. Marsh—since the distribution of COVID–19 vaccines started in December, there has been confusion as to why there is such a discrepancy between the number of doses distributed as compared to the number of doses administered by the States. For example, the CDC website notes that, as of January 31st, over 49.9 million doses have been distributed, but only 31.1 doses have been administered.

Can you explain the reason, if you know, for this discrepancy in doses distributed versus doses administered?

Dr. MARSH. Well, thank you for the question.

Certainly in West Virginia, by working to have local control of the doses, we've followed every dose and understand that. Certainly other States have adopted different strategies, and there are a significant, as I understand it, number of doses that are not accounted for in the current system. And whether those are some of the doses that have gone into various programs, like the Federal pharmacy program or others, I don't know off the top of my head, but certainly maintaining control and understanding where the doses are, are a critical component of success, I believe.

Mr. GRIFFITH. You raised that you all track them. How do you all track the vaccine, where it's been sent and how it's being used, and how quickly it's being used?

Dr. MARSH. We receive every dose into one of five hubs that are located around our State to bisect the State so that the shortest distance is required to move vaccine between places. We track each dose that's sent with a GPS tracker, and we then have an inven-

tory. We know, if the vaccine is not administered in 7 days, then the vaccine is brought back into the central hub and reallocated.

Mr. GRIFFITH. Thank you.

I mentioned the CDC website a few minutes ago. In addition, that website shows a map of the U.S. with COVID–19 vaccine administration data for each State and territory, including the total doses administered per hundred thousand. The States and territories range in their rate of total doses administered from 38,000—excuse me—3,826 per hundred thousand in the Federated States of Micronesia to 16,348 per hundred thousand in Alaska.

Since the Federal Government and its partners in the private sector have used the same process to ship vaccine doses to all of the States and territories in the U.S., what do you believe accounts for the variation among the States in what some have deemed the last mile in the vaccination administration efforts?

Dr. MARSH. Are you asking me again?

Mr. GRIFFITH. Yes. Yes, sir. I'm sorry.

Dr. MARSH. Yes. So I think that, as we go forward, you know, it's—it is easy to point fingers, but, as was said earlier, this is the most complex program and distribution plan that we've ever experienced in our country. And certainly having vaccine is amazing, and we have amazing vaccine, so that's great.

And I think that, you know, for us, it's really a matter of all of us working together to get the right priorities, to follow the doses, and make sure that every American who needs to have a vaccine in their arm in a priority status gets that vaccine.

Mr. GRIFFITH. Well, I appreciate that. And that's part of the reason that Madam Chair DeGette called this meeting.

Clearly there has been confusion about the safety and the efficacy of the shot and in some States confusion about the who-what-when-where details of getting the shot.

What methods of communication are you using—and we'll start with you, Dr. Marsh, and we'll see how much time we have to get to the others—but what methods—hang on. I don't have my eyeglasses on, and I lost track.

What methods of communication are you using to provide this critical information to get the information to constituents? And, as a part of that, specifically how have you made an effort to reach seniors and other hard-to-reach populations, many in my district, not unlike West Virginia, who do not have reliable access to the internet?

And, also, in December the FCC made an allowance for State government officials to reach constituents on their mobile phone for relaying critical information, and have any of your States used that technology?

So what are you all doing to reach out to folks who may not be aware that they're on the list to get the shot now?

Dr. MARSH. Very briefly, we have internet. We have television briefings three times a week. We have a call center. And we have reached out on different community-based approaches to reach all the vulnerable people in our communities that have—that should have access to vaccine.

Mr. GRIFFITH. And I appreciate that. And I will tell you, I get a mobile notification whenever schools are closed back home, and

the government there is using it for that. I would think that would be a good technology for this as well.

I don't have time for everybody else to jump in, but if you all could provide a written response to that last question about what kind of technology you're reaching out to these communities that may not be getting the word and who may be a little bit hesitant, I would greatly appreciate it.

And, with that, I yield back. Thank you for your patience, Madam Chair.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the gentlelady from New Hampshire, Ms. Kuster, for 5 minutes.

You need to unmute, Annie. Unmute.

Ms. KUSTER. That's what I'm doing. Sorry. Trying to unmute.

Thank you very much, Madam Chair.

Well, it's taken a Herculean effort to get COVID–19 vaccines developed, authorized, and distributed around the country. As you've heard today, it will be for naught if we can't get the vaccines into the arms quickly. And that's why I'm concerned by the CDC data showing, as of yesterday, only about 65 percent of vaccines distributed have actually been administered.

And so I wanted to jump in to legislation that I've introduced to bolster manufacturing capacity and meet the challenge, known as the Coronavirus Vaccine and Therapeutic Development Act, to ensure that enough doses get in the arms of the American people.

The issue of supply does not account for this large gap in doses allocated but not administered. And I understand there may be reporting delays and data challenges. But thousands of Americans are dying every day, and I believe it's unacceptable to delay getting the vaccine.

Dr. Phillips, according to CDC data, Louisiana has administered about 71 percent of the data. Can you confirm, is Louisiana still holding back vaccine for second doses?

Dr. PHILLIPS. Yes. We do make sure we allot the second doses wherever the first doses went to ensure that we have adequate supply for when those individuals present.

I will say that, in terms of the CDC data, it does include the first and second doses. So when you look at what has been allocated for a State, it's combining that first and second dose.

So, although I may have received my first dose and my second dose may have been shipped to the State, it may not be my 21- to 28-day timeframe. And so it does give the appearance that an available dose can be administered as a first dose when truly that is not the case. So I do think that is one of the asks that we have, for some clarification on the CDC data for stratification for those modules.

Ms. KUSTER. But how do you feel about the change in direction that the Biden administration is considering due to the urgency and due to the various COVID variants that are coming along with getting the doses into the arms immediately, knowing that we will have sufficient vaccine for those second doses?

Dr. PHILLIPS. Yes. Until we know for sure that we're going to have sufficient vaccine for those second doses, that would be a worry.

And so, again, this is our first time being able to even get advanced notice, 3 weeks advanced notice of what our allotment is going to be. Until that is confirmed and can be substantiated for some time, that would be a worry in terms of availability of the supply.

Ms. KUSTER. Dr. Ezike, could you respond to the similar question?

Dr. EZIKE. Yes, ma'am.

Ms. KUSTER. Would you consider giving those second doses now as first doses knowing that the remaining second doses would be manufactured and distributed within the 3-to-4-week timeframe?

Dr. EZIKE. Yes, we are understanding the very difficult and delicate balance between getting ahead of the variants and getting ahead of this virus as well as ensuring that we will have the vaccine 3 to 4 weeks later.

We are—that is the reason that we were able to take advantage of the ability to take doses—borrow doses from the long-term care facility and not at all interrupting the vaccination that would happen in the next 3 to 4 weeks, but borrowing from there to get more doses in the arms today.

We do know that two doses are required for full efficacy, as demonstrated in the trials, but even getting that first dose we know offers some protection, confers some protection, and so getting as many first doses as well.

So we have been striking this balance between promoting the first doses as well as the second doses, and we want to use as many available doses as quickly and effectively as possible.

Ms. KUSTER. Dr. Khaldun, maybe you could jump in here. How will increased transparency and improved data make sure that we can quickly administer the doses that are available?

Dr. KHALDUN. That's very important. Again, I speak to my local health departments and our healthcare systems frequently. Knowing ahead of time how much they can expect to receive will be incredibly helpful. It will actually make it go quicker, because they can schedule appointments. They can know they don't have to cancel appointments and they'll be able to plan for those first and second doses.

So that transparency and knowing ahead of time how many doses entities will receive is incredibly important.

Ms. KUSTER. Thank you.

My time is just about up, but I'll put in a plug for my bipartisan bill with Congressman Bucshon on this committee, the Immunization Infrastructure Modernization Act, to provide Federal support and guidance to the healthcare departments and providers at the State and local levels and, most importantly, to improve our healthcare information framework.

Thank you very much. I yield back.

Ms. DEGETTE. Gentlelady yields back.

The Chair now recognizes the gentleman from Texas, Mr. Burgess, for 5 minutes.

Mr. BURGESS. I thank the chair.

You know, it's interesting to me that, just a little less than a year ago, we had a committee briefing—we didn't have hearings on this in a timely way, but we did have a briefing. All of the experts

of public health were at that briefing, names that you would recognize. And Dr. Fauci was asked, "How long before we can get a vaccine?"

And he said, "Listen, if everything goes perfectly, 18 months. But I must caution you, everything never goes perfectly."

Now, I don't believe Dr. Fauci was misleading us a year ago. I think he was speaking as to the way the world was a year ago. But this became a priority, and the previous administration appropriately recognized that priority and began what we now know as Operation Warp Speed.

And, realistically, this vaccine was available—the emergency use authorization came right at the middle of December. So we're just talking 6 weeks ago.

Now, prior to the time, during September and October, various talking heads on the various television shows would talk about how the vaccine—it was not possible to deliver the vaccine in that timeframe. In fact, people were talking against accepting the vaccine because it's being developed so fast, it can't possibly be any good, or there may be problems.

And now there has been a massive shift of gears because, good news, 2 weeks after election day, there was not one, but two vaccines that were on their way to the FDA. And then, a month later, the FDA—which truly was lightning speed for them, provided the emergency use authorizations to bring us to the discussion today of, how can we do a better job about distribution?

But I would remind you that a year ago we were told that that distribution problem would still be 6 months in the future. So, really, we have to be grateful for where we are today.

My home State of Texas, the most recent data I received—and I will submit this, Madam Chair, for the record—but there's about 2 million doses have been administered in Texas. Now, I recognize we're a big State, we've got a lot of people, and we've got a long way to go, but that is a good start.

In fact, I participated with several of my State counterparts to encourage the creation of a vaccine hub in one of my counties, Denton County, and this replicated a hub, a vaccine hub, that was actually started in 2009 with the H1N1 epidemic, and it is now up and functioning. And, in fact, 32,000 doses allocated for Denton County this week, and they are setting up a drive-thru vaccination site in the parking lot of Texas Motor Speedway because, after all, that is one of the biggest locations where you have a big parking lot, one of the biggest in the country, so they're well set up to do that.

But how grateful we should be to be able to have not just the vaccine, but now, within such a short period of time, that level of distribution.

Several of the witnesses testified that they had worked with CDC. And, again, I need to stress this, because the approach in the previous administration was, yes, let's work on the vaccine, but let's also work on the manufacture of said vaccine even in advance of the emergency use authorization of the FDA. And the CDC was working with some local health departments to formulate the plans for administration of the vaccine when it did become available.

So I think those things were forward leaning and, in fact, if I recall correctly, quite different from the activity we saw in 2009 where the manufacture of the vaccine did not begin until the FDA had, in fact, issued its approval.

So we are several steps ahead of where we could be. That doesn't mean we're doing good enough. And I appreciate so much everyone on this panel who is working so hard to make certain that we do get the amount of vaccine out in the right amount of time.

Now, let me just ask—and I'd like to ask Doctor—Director Ryan from Colorado. I worked with your Governor when he was here at the House of Representatives on the House Rules Committee. My best to your Governor when you see him again. But how do you feel that you're doing with the visibility of the vaccine doses that are going to be coming your way? Are you hearing about it in a timely fashion?

Ms. RYAN. Thank you for the question.

The transparency is getting better. I think, you know, part of the issue is that, because it's going from conveyor belt to States, there is just not a lot of time to tell us the type of doses or the amount of doses that we're getting. But we know it's—we do have visibility into the next 2 or 3 weeks now.

Mr. BURGESS. And that's great.

And, Madam Chair, just if you'll indulge me for one second. A little bit of good news, reading in Barron's just the other day where Sanofi was going to begin to manufacture the Pfizer product to assist in getting doses out. Sanofi's own exercise with getting a vaccine was a bit delayed, and so they are joining the manufacturing side of a competitor's vaccine. And that's good news too. That's the type of cooperation we're seeing out there in industry, and I think that's important, and I believe it will continue.

And I'll yield back.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the gentlelady from New York, Miss Rice, for 5 minutes.

Miss RICE. Thank you, Madam Chairwoman.

Much of the confusion surrounding the rollout of COVID–19 vaccine seems to be driven—and I'm hearing this throughout this hearing—by poor communication. And we know that that, in the final weeks of the Trump administration, that was particularly acute.

And obviously what I'm hearing—what all of us are hearing here today—is how important that communication is between Federal, State, and local health officials. In fact, GAO has repeatedly noted that coordination and communication are critical to the successful implementation of COVID–19 vaccines.

So to you, Director Ryan. In the past your Governor has been critical of the Trump administration's lack of communication and maybe miscommunication with Colorado, particularly in the first months that the vaccines were being shipped to the States. How would you describe the communication and coordination that Colorado has had with Federal officials related to vaccine program planning and implementation in recent weeks, and have you found it to be more effective, less effective? How would you rate it?

Ms. RYAN. Thank you for the question.

I have to tell you, you know, General Perna, who has been the tip of the spear for the vaccine distribution, has been very supportive from the start. He got on a call with States. He called me personally and said, "Here is my number. You tell me if things aren't going well."

So, while I, you know, do have a list of complaints from the last year around communication issues, I have to tell you that was the first time that I felt like I had someone in charge that I could go to and that was keeping us updated, and there was a lot of transparency.

So I can't say—I can't complain too much about the vaccine rollout and our communication with the general and Operation Warp Speed. I actually think that's gone pretty well, and, as they've gotten more visibility, they've given it to us.

Miss RICE. Great.

Dr. Phillips, would you agree? Is there more that can be done to improve communication between the Federal Government and the States at this critical time of vaccine distribution?

Dr. PHILLIPS. I think ongoing continued communication is what we need. I mean, I think you've heard it from everybody in the hearing today and other States who are not present, is what we've been asking for, and I think we're continuing to see that increase, and we're thankful for that.

That allows us to be able to communicate with our local partners, our local providers, who are asking for the same information so, when we get it, we're able to share with them. And if we have to do it with a caveat that this is a draft, this is the model of it, then we can put those caveats on it. But the more information we have on the front end, the better we are in terms of the planning purposes.

Miss RICE. So, you know, we've heard that many cities and local health departments have been left in the dark by both Federal and State officials when it comes to distribution of vaccination plans, relying instead on local hospitals or providers to confirm if vaccines are available in their community. I know in New York State, where I'm from, there have been people who it takes forever for them to get an appointment, and then, you know, a week or sometimes days before, their appointments are canceled because of this lack of communication about how many vaccines were available, when they're going to arrive, et cetera.

Dr. Ezike, what is your State doing to communicate with local leaders and public health agencies? And is there room for greater coordination across all levels of government? And, if so, what would you recommend?

Dr. EZIKE. Yes. Thank you for that question.

Of course, collaboration and communication against all levels of government, from Federal to State to local health departments, is key to overcoming this pandemic. You know, between the State and the local health departments, we understand that those local health departments are literally our hands and feet. They, the 97 different local health departments, are actually the boots on the ground that are getting this work done as we support them with the funds that are provided and the additional State resources that we may have.

So communication—and overcommunication, if there even is such a thing—is the name of the game, and their success is directly tied to how much they understand about their future allocations. We have a rule at the State that anything that we are doing in their State, whether if we are directly supporting their efforts or trying to do additional efforts to augment their existing efforts, that we have to let them know.

If we're coming into your backyard, we're going to let you know so that you can make sure you direct us in the best way that it can be done. We want that same kind of partnership and collaboration, we want to be at the table as decisions are being made, so that we can help inform things that might not be top of mind.

I am actually very encouraged with the current administration, as they have actually taken one of the State health officers to be a part of the administration, and I think that will help establish the importance and the communication between the State health officials as well as with the Feds, which in turn creates better communication. We have appropriate, accurate, timely information to share to our boots on the ground, our local health departments.

Miss RICE. Thank you, Dr. Ezike.

And, Madam Chairwoman, I see that my time is up. I had one more question, but I will yield back. Thank you.

Ms. DEGETTE. I thank the gentlelady.

The Chair is now pleased to recognize the gentleman from West Virginia, Mr. McKinley, for 5 minutes.

Mr. MCKINLEY. There we go. Thank you, Madam Chair.

Look, we've heard a lot of criticism today of the Trump strategy, but I want to remind people that on September 16th the States were given a 57-page guidance document—57 pages in how to set up a program—and they were asked to respond by October the 16th, just a month later. So for people to say there are no plans, that just means the States didn't create one that works.

So, for those of you that can't resist the temptation to criticize the former administration and even going so far as to say that the Biden administration was starting from scratch and there was no national strategy, Dr. Fauci has refuted that very clearly. So take a deep breath.

Look, Operation Warp Speed created the vaccine. The State, it's the job of the States to put it in people's arms. But it seems that States can't even get that right.

Here is a chart, unfortunately, that the majority party had rules that we had to submit this 24 hours prior to this, but this chart indicates that there were some States that can't get it right. Some of you, some States have been complaining they need more vaccines, but have only given out more than 50 percent.

Look at Illinois. Illinois' vaccination rate is half of what it is in Alaska at 8.3 people per hundred. But Alaska is 16.8. Or West Virginia is almost 15 per 100, and Illinois, 8; Colorado, 10; Michigan, 10.

But then they don't—they're not using it. Their use of the vaccine in Illinois is only 62 percent as compared to North Dakota, 91 percent.

So apparently they didn't develop a plan that it was flexible enough to work. So I'm just concerned about that.

Now, unlike New York—and that's a key thing—unlike New York's Governor, who ignored the vulnerable in their long-term facility and recommendations of his public health experts, West Virginia prioritized its long-term care residents and their staff. West Virginia also finished vaccinating all of their long-term care facility and staff. Meanwhile, States like Michigan won't even—won't finish until the end of this month.

So, interestingly enough, no one has given—and no one really, I think, has given proper attention to Operation Warp Speed.

Remember, Dr. Fauci testified before the Senate committee in May of last year that it would take a year to 18 months before a vaccine could be developed—think about that—a year to 18 months in May that, through the hard work of the pharmaceutical companies, researchers, and scientists, a vaccine was available in December, just 7 months later. So just 7 months after the creation of Warp Speed we had a vaccine.

So I guess what I want you all to take away is complaining about not getting enough vaccine is like complaining about the size of your meal when you should be grateful to having food on the table.

So, Dr. Marsh, I'd like to turn to you, and just in the remaining time that we have here can you expound just a little bit more about what was the magic in West Virginia, being not only at a rate of 15 per hundred vaccination rate, but also at almost 87, 88 percent used of the vaccine? What can we say to the other States how they can improve on that?

Dr. MARSH. Well, thank you, Congressman.

Ultimately, West Virginia made a plan that worked for us, and it was really a matter—and we've talked about this at this testimony—it's a matter of clear communication, breaking down parallelisms and sectors. Everybody wore the same hat. We were operating for a higher purpose. And, as we go forward, we constantly iterated and are iterating our approach so that we are moving in a most expeditious and quick way possible.

I just want to reinforce one thing that the Congressman said as well, and I say this in as an apolitical way as I can. The fact that we have these vaccines are game changers. This is the most complex, you know, problematic response probably in the history of modern-day America and the world. And so staying together and working together and sharing with each other best practices is really key for our global and country's success.

Thank you.

Mr. MCKINLEY. Thank you. I yield back.

Ms. DEGETTE. The gentleman yields back.

The gentleman from New York, Mr. Tonko, is recognized for 5 minutes.

Mr. TONKO. Thank you, Madam Chair. Can you hear me?

Ms. DEGETTE. We can hear you, sir.

Mr. TONKO. OK. Thank you so much.

Since the start of the vaccine rollout, the challenges and issues facing State and local health departments have been endless. Whether it's a lack of transparency in how much vaccine will be allocated to States each week, shifting guidance on who to prioritize for vaccinations, questions about vaccine reserves, or just

a simple lack of vaccines, it seems there has been one constant throughout this process—that being confusion.

Dr. Phillips, in my district in upstate New York we are currently seeing more COVID infection cases than we've had at any time during the pandemic, and the rate of spread is faster than the rate of vaccinations. At the current rate, it will take New York State roughly 7 months to vaccinate all eligible individuals in its phase 1 priority group.

My question to you, is your State facing similar concerns? And, if so, how can we get more people vaccinated more quickly?

Dr. PHILLIPS. Thank you for that question, sir.

Yes, we do see the rate in terms of the vaccine and the extended time period and the worries around that. One of the things that we are doing is looking at the available doses, first doses that are in the long-term care partnership, and pulling those back to push into the community so we have an increased availability in the community, in addition to the increase announcement that was made last week for vaccine doses.

But that is going to be a big help to our State, being able to pull some of that back and utilize it immediately so it's not sitting there.

Mr. TONKO. Thank you.

Dr. Marsh, one of the main concerns we've heard from States is the need for greater transparency from the Federal Government into the vaccine supply chain. Now, I heard your talk of coordination and communication, but the Biden administration has taken a crucial first step in promising a 3-week allocation forecast. But transparency alone will not get shots in the arms.

So, Dr. Marsh, aside from increased supply and greater transparency, what would you change to make this process run more smoothly?

Dr. MARSH. Well, thank you for that question, Congressman.

You know, certainly we are very grateful to the administration before and this administration for their work to move vaccines in a more rapid way, to produce more vaccinations.

A question was asked earlier, which I think is a critical question for our country, if we could be guaranteed that we will see more vaccines in the future. Emerging data is suggesting that a single dose of Pfizer, Moderna, and apparently Johnson & Johnson may have a significant protective effect on severe illness and death from COVID–19.

So ultimately we would like to move forward in immunizing first doses in as many Americans and as many West Virginians as we can, as FDA and CDC have recommended, that we want to make sure that that supply is there for the second doses, even if they're a little bit later than the 21 days for Pfizer and the 28 days for Moderna.

And so I think that a strategy once we see sufficient supply chain will be to get as many vaccines in the arms—first vaccines in the arms—as we can, because we are racing with the variant forms of the virus that look like that they're going to have a lot more problems for the immediate future coming up.

Mr. TONKO. Thank you, Doctor.

In the capital region of New York, like many places across the country, the number-one challenge is a consistent, adequate supply of vaccine. The Biden administration is increasing weekly supply by 16 percent and has purchased enough vaccine to ensure 300 million Americans could be vaccinated by the end of the summer.

Dr. Khaldun, in your testimony you state that Michigan has the short-term goal of administering 50,000 shots a day but could be administering up to 80,000 vaccinations per day. So my question is, will the 16 percent increase in supply be enough to meet that $80,000—excuse me—80,000-count-a-day projection?

Dr. KHALDUN. Yes. Thank you for that question.

So we certainty appreciate the increase in the supply that's coming into the State. It will absolutely help us to meet our goals. Actually, our data on our website over the past couple of days, we've actually had about 50,000 shots in arms per day, so we are really pleased with that.

What that increase also does, though, is help us to really target and focus based on equity. We are actually—we have a pot off the top that we take and target towards areas that have a higher Social Vulnerability Index so we can really make sure minority populations and those who are living in poverty have access to the vaccines, so when we have more, we are more easily able to allocate based on that.

Mr. TONKO. Thank you.

Madam Chair, I see that my time has run down, and I yield back.

Ms. DEGETTE. OK. I thank the gentleman for yielding.

The Chair now recognizes and welcomes Mr. Dunn to the committee for 5 minutes.

Mr. DUNN. Thank you very much, Madam Chair. It's an honor to be here. And I appreciate the opportunity to evaluate the solutions and ideas to improve vaccine distribution at the State level.

I think we're all acutely aware of the challenges accompanying distribution of these vaccinations. It's important to acknowledge that each State faces a set of challenges that are unique to its characteristics and demographics, and that requires flexibility and creativity to approach that, not one size fits all. The needs of Florida are not the same as the needs of Illinois, for example.

I also want to echo the panel's comments that Operation Warp Speed produced effective vaccine in record time, and volumes of those vaccines at a speed logarithmically faster than ever in history. In fact, the entire universe of virology research and treatment has experienced a quantum leap forward.

We just this last day or two reached an important milestone where we have now vaccinated with at least one shot of the series more people in America than have been tested positive since the beginning of the pandemic.

And, with that, I'm going to turn to my questions.

Dr. Marsh, I will try to be brief with my questions. I encourage you to do the same with your answers.

Do you believe that public-private partnerships allow States to use their own resources more effectively than might have been possible with a far-reaching Federal mandate?

Dr. MARSH. Thank you, Congressman.

I do believe that these types of relationships could be very useful. I think that the optimal circumstance is a top-down meets a bottoms-up approach related to shared governance in this way.

Mr. DUNN. Thank you. So do you believe, in general, that there are areas where private industry can meet the needs of a State better than the Federal Government?

Dr. MARSH. Is that to me again, Congressman?

Mr. DUNN. Yes, sir. Yes, sir.

Dr. MARSH. Yes. Certainly I think that there are circumstances where private partnerships can meet the needs of a State in unique ways.

Mr. DUNN. Excellent. So what is your assessment of the Federal vaccination reporting requirements and infrastructure currently in place for States to relay information to CDC? Is it good, bad, or adequate?

Dr. MARSH. I think that, as all of the responses, this is an evolving issue. I think that it is improving and probably needs to continue to improve to make it easier on the States to be able to report more easily.

Mr. DUNN. I was impressed that you got your community pharmacists on board so quickly with the infrastructure. That says real planning on your part. Congratulations.

Do you believe that all the shots that have been put in arms of the people in West Virginia or nationally—opine on either—do you think that all of those shots have been properly recorded and submitted to the CDC?

Dr. MARSH. Thank you again for your question.

I don't know the answer to that. Certainly I hope that we have an accurate reporting system, because documenting and following each dose of vaccine is critical for our country.

Mr. DUNN. Yes, I don't know the answer either. I just thought you're so much closer to the delivery than I am, you would be able to point me there. And I don't fault you for that. I'm curious to know what it looks like, because I've been on the other end of that, I'm a physician as well, so I know how hard sometimes it can be to live up to the burdens of reporting to the Federal Government.

Is there anything we can do here in Congress to reduce the burdens on those providing the vaccinations? Any recommendations you have on that?

Dr. MARSH. I think that, certainly, Congressman, part of what we need to do is to continue to work with our Federal Government and States to make sure that we build the capabilities for appropriate logistics and supply chain management. This is such a complicated sort of issue, and each State needs to keep track, in my opinion, of their own vaccines and their own reporting, but we need to have a coordinating function that is very much professional as we are going forward.

Mr. DUNN. Well, I'd like to associate myself with those comments. Very good, sir.

So your independent pharmacies really leaned in and helped you a lot. West Virginia has a mostly rural population. I have a rural part of Florida is my—where I represent, and I think it actually mirrors West Virginia in a lot of ways in terms of its rural nature.

Do you think that the system you set up can work well in other areas, perhaps like my district?

Dr. MARSH. Thank you for the question.

Certainly I think that each State can come up with their own strategies. But I do believe that the idea about setting clear expectations and priorities, making sure you have open communication and working as a single team, and making this a learning mode, not something where it's top down, but you're inviting the creativity of your team.

Mr. DUNN. I appreciate that very much.

Do you think that there are some specific successful strategies for reducing vaccine waste? And I don't know how much—as we've said, some of this isn't waste. It's just second doses being held, appropriately or inappropriately. But how do we reduce waste if, indeed, waste is as bad as we think?

Dr. MARSH. Thank you, Congressman.

I know we're over time, and I would just say I think there are some strategies we could pursue together to be able to accomplish that goal.

Mr. DUNN. Thank you very much.

Madam Chair, I yield back.

Ms. DEGETTE. Thank you.

Dr. Marsh, we'd love to hear your ideas for how to improve, if you'd like to submit them to our committee.

The Chair now recognizes the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you, Madam Chair.

Health disparities are symptoms of a failed healthcare system, and this pandemic has highlighted those inequities and failures.

We see disparities with Latinos, African Americans, Native Americans, high-risk essential workers having a disproportionate burden of infections, hospitalizations, and deaths from COVID–19. And we are seeing disparities in who has access to care.

We saw it with access to testing. I have been sounding the alarm on this issue for months, long before a vaccine was available for use. I warned that, without aggressive intervention and strategic planning, we would see the same disparities play out with access to vaccines.

And now we are seeing the inoculation process unfold exactly as I feared it would, where the highest-risk individuals do not have proper access to the vaccines, even if they qualify. A good public health approach prioritizes groups according to risk of contracting and dying from COVID–19.

Last year, multiple efforts focused on how to determine a fair and equitable way to prioritize who should have initial access to COVID–19 vaccines. This planning was crucial. We know the disease affects some communities at higher rates and with more severe consequences than others: Black and Latino communities, high-risk essential workers, such as farm workers, the elderly, and people with underlying medical conditions.

Yet, despite those efforts to prioritize the highest-risk groups, there are stark disparities among who has been vaccinated so far. A Kaiser Family Foundation analysis found that, among the 17 States reporting race and ethnicity vaccination data, the share of

vaccinations among Black and Hispanic people is significantly less than these communities' respective share of COVID–19 cases in their States.

And, despite having disproportionate more infections and deaths compared to their White counterparts, they are disproportionately vaccinated less than their White counterparts.

In Mississippi, Black people account for 15 percent of vaccinations despite having 45 percent of deaths. In Nebraska, Hispanics account for only 4 percent of vaccination even though they represent 25 percent of cases.

Furthermore, prioritizing high-risk groups on paper is not effective if those individuals are not able to actually access the vaccine. Underserved, hard-working communities in my district lack clinics and providers. Many people in my district don't have access to broadband to schedule a vaccine online. They don't have hours to spend on the phone trying to get an appointment. They don't have transportation to the vaccine site. They don't have access to information in a language they understand to help them navigate the system.

I saw those issues firsthand yesterday when I went to a collaborative, nonprofit grower, and public health collaborative farm worker community vaccination clinic in the fields to make sure that the people tasked with protecting our food supply chain were getting vaccines. And I know I'm not alone. I hear similar stories from communities all across our Nation.

Dr. Ezike, you and Governor Pritzker have committed to putting equity at the forefront of Illinois' COVID–19's response efforts, crafting the State's plan while keeping in mind, quote, "the very structural inequalities that allowed COVID–19 to race through our most vulnerable communities in the first place."

Dr. Ezike, how has focusing on equity influenced the State's decision on vaccine eligibility and ways to reach those vulnerable communities?

Dr. EZIKE. Thank you, sir, for that thoughtful question.

So of course we know that to get past this pandemic and to eliminate disparities, that equity lens has to be at the forefront. We know that the CDC has put out information that Black and Brown communities are three times more likely to die than their White counterparts. And so that's why we have had an equity focus, and that has looked in—that has been carried out by having lots of virtual townhalls, partnering with minority communities to have innumerable number of virtual townhalls in Spanish as well as English, working with Telemundo and Univision, many——

Mr. RUIZ. Dr. Ezike, I have 10 seconds left.

I want to ask Dr. Khaldun, who in their State have been partnering with Federal Qualified Health Centers, mobile clinics, local department, school-based health centers, and other community vaccinators. How will you monitor these efforts to ensure they actually result in increased vaccinations among vulnerable communities? And what can the Federal Government do to encourage the exchange of best practices across State lines?

Dr. KHALDUN. Yes. We are really proud of our strategy in Michigan, that we have set out a goal publicly of having no disparities when it comes to vaccination rates.

We are working very closely with our partners on the ground. They do—they are going to be sharing with us how they are vaccinating in areas that have a higher Social Vulnerability Index. And we are holding all of our partners accountable for how they are not only receiving the vaccine, but what they're doing with it as far as addressing these disparities.

Mr. RUIZ. Thank you.

Ms. DEGETTE. I thank the gentleman.

The Chair is now pleased to recognize another new member of our committee, Congresswoman Schrier, for 5 minutes.

Ms. SCHRIER. Thank you, Madam Chair.

Well, we've heard repeatedly that the biggest concerns across the country are the lack of COVID vaccine and also the confusion caused by the Trump administration's lack of guidance for States in the early days of their vaccination campaign. And I am hopeful that the Biden administration's national COVID–19 strategy and the steps it's already taken will get this country back on course. And, despite all these challenges, public health leaders, like our witnesses today, have been able to vaccinate tens of millions of Americans, and I want to thank you.

Now, Kittitas County in my district has proven to be a great model for rural communities, much like in West Virginia, Dr. Marsh. They have administered 98 percent of their vaccine doses, have not wasted a drop, and they have a solid second dose set of appointments already booked.

But here is the thing. Kittitas County is successful because Dr. Larson, their public health official, designed a nimble distribution system from the ground up, keeping specific community needs in mind. And I asked Dr. Larson whether he got any specific guidance from the Federal Government in setting up this vaccination program, and he said he had not. That 57-page document didn't have the specifics that he would have appreciated.

Now, in my pediatrics practice, we, over time, designed a fine-tuned system for immunization so there would be no wait times. But this is the largest vaccination program the world's ever seen, and we shouldn't be asking each city, county, State to dream up their own plans and manage their own supply chains. It was a disaster when States were bidding against each other for PPE at the start of the pandemic, and we still have these supply chain issues.

Now, I personally have had the opportunity to experience two community vaccination sites. Both got the CDC manual. One ran like a finely tuned machine. The other was limping along terribly. And this is a place where I feel like every community should have access to best practices, and those can evolve over time. The Federal Government could facilitate that.

Now, because of our experience and the sheer scale of this operation, Dr. Larson is now concerned about the supply chain. He is concerned that we won't have enough of the low dead space needles that squeeze that sixth dose out of a Pfizer vial and an eleventh dose out of a Moderna vial. And this is not a trivial problem.

And so the question is for Director Ryan. Given that the vaccine supply will hopefully be increasing in the upcoming months, there's more approved, and the whole world needs the same supplies,

which supplies are you most concerned about? And, in your opinion, how can Congress help stabilize the supply chain?

Ms. RYAN. Thank you for the question. And it's a good point about the specialized needles, because we absolutely are counting those sixth and eleventh doses in our planning.

You know, I would say we worry about the supply chain in general, not just vaccines, but all the equipment that goes along with it. And it's probably, you know, from the beginning of the pandemic when we were absolutely choked by the lack of PPE and testing.

And so I think, you know, a great role of the Federal Government is just ensuring that those supply chains don't seize up, as everybody around the world needs the same supplies, that, you know, we are doing additional manufacturing where we can, because it's one thing to have the doses and then, to your point, if you don't have all of the other supplies that go with it, then it just absolutely slows down or hampers your response.

Ms. SCHRIER. Thank you.

And, Dr. Marsh, the country has marveled at how well your State has rolled out its vaccination program. Are you also concerned about the availability of PPE and needles and, you know, testing equipment and the like, and what would you suggest for Federal support?

Dr. MARSH. Well, thank you, Congresswoman. I think that's a particularly important point to make. Certainly in West Virginia, we have tried to become more self-sufficient, but we are actually making our own PPE. We've designed our own N95 equipment masks, our own PCR testing, our own antibody testing. We're working on doing molecular virology testing for the mutant viruses.

But I think that, as you point out, as the governments of South Korea and others learned through their SARS/MRSA experience, the more self-sufficient we get as a country, the more we start to make our own stuff so we don't have to rely on other supply chains, the better off we'll be throughout not only this pandemic but I believe in the future.

Ms. SCHRIER. Thank you. I completely agree. Yes, to vaccinate 300 million Americans by the end of the summer, the availability of all supplies is going to need to keep up with the supply vaccine. That means we have to be manufacturing here. I am just so grateful that this administration's already taking actions to make sure that our supply chains are solid.

Thank you. I yield back.

Ms. DEGETTE. The gentlelady yields back.

The Chair now recognizes the gentleman from Pennsylvania, Mr. Joyce, for 5 minutes.

Mr. JOYCE. Good afternoon. Good afternoon. I'd like to thank Madam Chair DeGette, Ranking Member Griffith, as well as Chair Pallone and Ranking Member McMorris Rodgers and the witnesses for appearing here today. Truly, it's an honor to be serving on Energy and Commerce Committee in the 117th, and I look forward to continuing this strong bipartisan tradition of Energy and Commerce.

The COVID–19 outbreak and the global spread has created public health challenges unlike anything we've ever seen in our lifetime and, as a physician, unlike anything I had ever seen. Presi-

dent Trump, and along with Congress, worked together in a bipartisan manner to pass several relief packages last year to respond to the pandemic, including billions of dollars in support of a vaccine. This includes nearly $30 billion that was passed at the very end of last year in the Consolidated Appropriations Act.

Last year, the partnership of Operation Warp Speed started by President Trump produced multiple safe and effective vaccines in record time, and millions of doses were shipped across our country. These vaccines are the silver bullet out of this pandemic, and we must act now to ensure their quick distribution.

This is why it is so disturbing to me that in my home State of Pennsylvania we remain behind the national average for doses administered, in a lowly 37th in doses administered as a percentage of population. Furthermore, I hear from my constituents every day who are eligible to receive the vaccine, but they simply cannot find a dose.

Dr. Marsh, thank you for appearing today. As a doctor myself, I am concerned about Pennsylvania's vaccine rate of less than one-half of what you've achieved in West Virginia. West Virginia's success story should be applauded and needs to be replicated across our country.

Could you please elaborate—and I know that you've been asked this previously but ran out of time. Could you please share what are committee's efforts that need to be made to ensure that the vaccine deployment occurs, especially like in rural communities where I represent?

Dr. MARSH. Thank you, Congressman. I will try to be brief. I do think that there's three parts to your question that are really, really important.

So, number one, I think that everybody needs to get on the same page and be committed to a single team's efforts. Just really briefly, CDC's data from August says that in comparison to 18-to-29-year-olds who get COVID, that if you're 50 to 65, your risk of death is 30 times higher, risk of hospitalization 4 times higher. If you're 65 to 75, risk of death 90, 9–0, times higher, risk of hospitalization 5 times higher; 75 to 85, risk of death 220 times higher, risk of hospitalization 8 times higher. Over 85, your risk of death is 630 times higher, risk of hospitalization 13 times higher.

Once you understand what your purpose is, once everybody throws together on the team and sacrifices to make sure you can push doses to the most vulnerable parts of your population, what saves lives, reduces hospitalizations, then things start to work well. So I think open communication, you know, everybody on the same page, clear and where we're going.

And then I think that having the logistics expertise is so important. We've turned to our National Guard because they're our experts, but I think federally starting to think about supply chain and logistics will be very important.

Mr. JOYCE. Dr. Marsh, continuing on that all-hands-on-deck attitude that you've brought forth in West Virginia, are there additional Good Samaritan safeguards for qualified volunteers that could help augment the administration of the vaccine?

Dr. MARSH. Absolutely. We're vaccinating our students as well, who are becoming part of our vaccination team. We've called it

"vaccinate the vaccinators," because we want to continue to expand our infrastructure so, when additional vaccine comes available, we'll be able to turn that very quickly and expand our capacity to vaccinate more West Virginians.

Mr. JOYCE. And I'd like to conclude by asking each of the panel today, do you feel that additional vaccine and their administration is the light at the end of the tunnel?

Dr. Marsh, I'll ask you to answer first.

Dr. MARSH. Yes.

Mr. JOYCE. Dr. Phillips.

Dr. PHILLIPS. Yes.

Mr. JOYCE. Dr. Khaldun.

Dr. KHALDUN. Yes.

Mr. JOYCE. And, Director Ryan, do you agree that the light at the end of the tunnel is being implemented by the administration of the vaccine that was developed during Operation Warp Speed?

Ms. RYAN. Absolutely.

Mr. JOYCE. Thank you all for participating.

Chair—Madam Chair—I yield back.

Ms. DEGETTE. Thank you.

The Chair now recognizes another new member of the committee, Congresswoman Trahan, for 5 minutes.

Mrs. TRAHAN. Thank you, Madam Chair.

And it's wonderful to hear from all of you to make contagious the successful programs that you've led in your respective States.

I fully share the sentiment that we all need to be on the same page, on the same team, when it comes to battling COVID. And, as we celebrate the miracle of having two highly effective vaccines, we must be focused on dramatically accelerating distribution while also addressing the fact that we've fallen behind on developing treatment and therapies. We've fallen behind on innovating and creating capacity and testing, which is integral to our opening of schools and businesses. And we've fallen behind on investment in genomics research, specifically sequencing surveillance that identifies new variants, ceding our leadership to other countries.

I suspect that all of us would agree that, as we accelerate vaccination, it's essential for us to close the gaps in access, especially among our communities of color. And I associate myself with every syllable that Dr. Ruiz spoke in his remarks about equity.

Additionally, we mustn't allow the well-being of residents at long-term care facilities to fall behind. As everyone knows, these folks are especially vulnerable to COVID–19. In the State of Massachusetts, of the 14,000 COVID-related deaths, nearly 8,000 have been reported in these facilities. And the disproportionate impact of COVID–19 isn't limited to the residents of these facilities. A considerable share of our long-term care services workforce is composed of immigrants, some of whom have limited English proficiency and lack access to internet-only vaccine signup systems.

So I'd like to use my time to discuss the challenges you're facing and the best practices you're using to protect not just the residents of long-term care facilities but also the staff.

Dr. Marsh, as Ranking Member Griffith mentioned, West Virginia elected not to participate in the Federal Pharmacy Partnership, and yet you completed second-dose vaccinations in long-term

care facilities in West Virginia last week. Why did West Virginia opt out of the Federal program, and how were you able to vaccinate your long-term care facility residents so quickly? Are the staff also vaccinated as well? And are there any lessons that other States and pharmacy partners can take from your success?

Dr. MARSH. Well, thank you for the question, Congresswoman. That is a very important one. We know in West Virginia 50 percent of our deaths are from residents of nursing homes. And so, as we went forward, we wanted to understand what was the most rapid, expeditious way that we could move vaccine to the arms of, as you've mentioned, not only the residents but the staff and the support folks there.

And what we did is we turned—as I said, in our joint interagency task force, in our open team-of-teams mode—we turned to the leader of the long-term care association and our member from the pharmacy board and we asked them what was the best way to go, and they came back and told us we have 250 pharmacies located all over the State, half of which are privately owned and that the Federal program would not get us to where we want to go as quickly.

And so we went with this approach: We met with General Perna, with Dr. Patel from Operation Warp Speed, we told them what we planned to do, they said, "Good. That sounds great for West Virginia." And, ultimately, we did not get rid of the Federal program, we just didn't activate it.

When it came to immunizing our residents, 85 percent or more agreed to get immunized, but only about 65 percent of the staff. And what's really heartwarming is, after we've been through this round of vaccines, first and second round, we have a lot of staff now that are coming back and saying, "We want to be vaccinated now." So that makes me feel really good about the future for vaccine hesitancy.

Mrs. TRAHAN. That's helpful. Yes, the recent data from the Federal Pharmacy Partnership shows that roughly 37 percent of staff participating in long-term care facilities, a workforce that is disproportionately comprised of people of color, decided to get vaccinated.

And so, Dr. Khaldun, what is the State of Michigan doing to address the equity and hesitancy concerns among healthcare workers, including staff at nursing homes and other long-term care facilities?

Dr. KHALDUN. Yes, absolutely. So we, of course, prioritize our most vulnerable residents of our skilled nursing facilities, our long-term care facilities, and, of course, the staff. We actually had over 4,400 facilities that were enrolled, are enrolled in this long-term care program. And so we similarly were challenged with the speed of the program. We had to take doses out of the allocation, engage additional pharmacies as well.

But we've also been challenged by hesitancy. We actually have a robust paid media effort. We're engaging with members of the community. We just last week launched our Protect Michigan Commission, which includes more than 60 people who are distributed across the State that are really going to be the messengers that have that information about the safety and efficacy on the vaccines.

So we are using something similar to what we did with our Racial Disparities Task Force and how we were able to actually essentially eliminate the disparity between African Americans and Whites for COVID–19 cases and deaths.

Mrs. TRAHAN. Thank you. I appreciate your time. Appreciate your efforts.

I'm out of time. I yield back.

Ms. DEGETTE. I thank the gentlelady.

The Chair now recognizes the gentleman from Alabama, Mr. Palmer, for 5 minutes.

Gary, we can't hear you. It says you're not muted. Try again.

You have headphones on, I think. We still can't hear you. I'm going to go—Gary, I'm going to go on to the next person, then we'll get you in. OK?

Great. Thanks.

I'll now recognize Mr. O'Halleran from Arizona for 5 minutes.

Mr. O'HALLERAN. Thank you, Madam Chair and Ranking Member, for having this meeting.

There's an urgency on the ground into getting vaccine doses out. Over the past several weeks, I've heard consistently from Arizona public health officials that we need more vaccine.

You know, back in December, I asked Dr. Fauci and the head of the CDC and the logistics head, "Are we ready, going to be ready in the fall? In the winter?" They said, "We hope so."

In September, I asked Dr. Fauci, "Are we going to be ready soon?"

"I hope so."

We are still hoping, because of the lack of a coherent national plan.

And, you know, I've heard testimony today about transparency, data systems, the public education campaigns, none of which are where they need to be at this point in time for this vaccine program to work at all.

As of yesterday, only 65 percent of shots have been used nationally. My home State of Arizona lags behind at just 61 percent. Notably, these numbers have improved in recent weeks and are trending upwards.

I'm trying to understand where the disconnect is here. With such a large demand for shots, we need to understand why more than one-third of shots distributed nationally have been unused. And I believe hesitancy from priority individuals needs to be discussed. Just today, it was reported that only 37 percent of nursing home staff have received their COVID–19 vaccine, in spite of what was going on in West Virginia.

But I think that we have—solving the second-shot issue, I don't know where we're going to be with that. Six weeks, eight weeks, elderly people, nonelderly people, who. Recent developments regarding the variants of COVID–19, including those from South Africa and the United Kingdom, have emphasized the importance of being vaccinated.

When it comes to these more easily transmitted strains, using every available dose as soon as possible will help ensure that these variants do not continue to evolve in a way that may cause vaccines to become less effective. However, this will prove problematic

if delays in getting these second shots happen. But protection against these variants will be even worse if individuals do not get their second shot of the vaccine within the recommended time or soon afterwards. We have cases of the second shots being delayed up to 6 weeks already. I hope that this does not continue.

Many rural communities, which have been talked about, Tribal communities and communities of color, often have been hit the hardest by COVID. Tribal communities like Navajo, White Mountain Apache Tribe, and others in my district have had some of the highest rates within the United States. Likewise, our healthcare resources in rural and underserved communities have been stretched thin, to say the least.

To overcome systematic and long-term standing trust issues, the roots of which we have seen—yet to see again during this pandemic, we must work with these communities in an educational process, as well as a professional, medical process.

Dr. Ezike, you have touched a bit on resources needed to promote confidence in the COVID–19 vaccines. What resources can the Federal Government provide to help States in overcoming the hesitancy with COVID–19 vaccines? What would you like to see in a national public education campaign?

Dr. EZIKE. Thank you, sir, for the points raised and that important question.

So these things, as you said, predate COVID but have been highlighted by COVID. And so one of the things that is pretty fundamental is in the area of health promotion and health education, making sure that even from very young ages we talk about the importance of vaccines, explain vaccinology, the science of vaccines, relate even to youngsters how they don't know about measles, even chicken pox now, polio. No children are doing double Dutch with braces on their legs, because polio and so many diseases have been eradicated by vaccines. Many people don't understand where we've come from to be able to appreciate the vaccines that they have been able to receive or not receive in some cases.

So starting with that, again, that's a long—that's a long haul. That's infrastructure building that may not give us the full fruits for this vaccine, for this pandemic, but actually will help us towards the next.

Mr. O'HALLERAN. Thank you, Doctor. My time is up. I'm sorry. I just want to point out we're still hoping, and I hope that we are able to get some of the basics done in a short time.

Thank you very much, Chairwoman.

Ms. DEGETTE. I thank the gentleman.

OK. Mr. Palmer, back to you. Let's see if your sound is working.

Mr. PALMER. Can you hear me now, Madam Chairman?

Ms. DEGETTE. Yes. You're recognized for 5 minutes.

Mr. PALMER. Thank you.

Dr. Marsh, part of your State's success in vaccine distribution, as has been pointed out already, is due to the decision not to participate in the Federal Pharmacy Partnership Program. How did you guys arrive at that decision?

Dr. MARSH. Well, thank you, Congressman. As I mentioned earlier, we tasked our leadership from our long-term care association, along with our pharmacy leadership. As I mentioned, we had made

the initial decision to have all of our vaccine run through our pharmacists and pharmacies because of the critical nature of the storage of the Pfizer vaccine as we started. And so those two individuals went out and gave us the information that having an arrangement network of local pharmacies with long-term care facilities that were located throughout the rural parts of our State was the best strategy, and that's how we came to that decision.

Mr. PALMER. I want to go back to a point raised by my colleague, Mr. Ruiz, about the number of minorities that are not getting the vaccination. And some of my own research into that area indicates that there is a reluctance on the part of minorities to get vaccinated, and it's particularly true among Hispanics and Blacks. I think there was a Pew study from last fall that showed that only 42 percent of Black Americans were willing to get vaccinated, and among Whites and Hispanics, it was 61, 63 percent, somewhere in that range.

And I just wonder what your experience, Dr. Marsh, has been in West Virginia in terms of being able to get the vaccination to minorities.

Dr. MARSH. Well, thank you, Congressman. As perhaps people on this call recognize, West Virginia is primarily Caucasian, 95 percent, but we recognize that we have underserved communities of color—African American, Hispanic, Latino, even Native American Indian—and we have created a task force that meets under the Department of Health and Human Resources weekly. And we have funded now faith-based community members and professionals of color to be able to administer testing and vaccination into the communities of color where there is perhaps some distrust that exists, from, you know, Tuskegee and other experiences, so that we are trying to make sure that we are giving folks the comfort and the trust of the providers to be able to reduce hesitancy and to enhance the uptick of testing and vaccination.

Mr. PALMER. Well, I grew up in rural northwest Alabama, dirt poor, and I remember as a child when they were rolling out the polio vaccine and they were taking us to get vaccinated, and I was deathly afraid of needles—something that has persisted to this day, I'm ashamed to admit.

But I also want to point out a couple of other reports, another group had done a study, and they said that—and NBC News reported that, particularly among Blacks, it's a—a high percentage are unwilling to get the vaccine, while others said they want to wait and see how the rollout, the first wave goes before they choose to get vaccinated.

But my concern is, as my colleague pointed out, a disproportionate number of minorities are really suffering from this disease. And maybe this is a question for the entire panel. What is being done to educate people, first of all, about the dangers that they face? It should be very apparent by now, and the necessity of going ahead and getting vaccinated. And this is true not just of minorities, because when you look at among the White population and you consider that only about 61 or 63 percent are willing to get vaccinated, that's still, I think, a shockingly high number of people who are unwilling to be vaccinated.

That's for the entire panel, if anyone wants to take a shot at that.

Go ahead.

Dr. KHALDUN. I can start. Thank you for that important question. I can say it's important when we talk about hesitancy that we understand that the history in why communities of color may be hesitant, it's Tuskegee, but it's also when communities of color engage with the health system today and what they experience in the lack of diversity in the healthcare system and the bias that exists still in the healthcare system.

I think it's important that we recognize that and we not shame people for being hesitant. And so what does that mean? That means creating spaces for conversations, using trusted community members. We have a large cohort of people, faith-based community leaders, leaders who are community members who are of color who are writing op-eds and leading conversations in the community to make sure people have a space to ask their questions and get those questions answered.

Ms. DEGETTE. The gentleman's time has expired, and I want to thank the gentleman and also the witness.

The Chair now recognizes Ms. Schakowsky from Illinois for 5 minutes.

Ms. SCHAKOWSKY. Thank you so much, Madam Chairman, and thank you so much for holding this hearing.

You know, there's been a lot of talk about what could be done at the Federal level. Well, fortunately, our new President, Joe Biden, announced right away a whole package of things that the Federal Government could actually do.

And I just want to say State and local governments are having a hard time. Yes, some are doing better than others in terms of the COVID pandemic, but the truth of the matter is that, in the big COVID relief package, I'm happy to see that the President of the United States has understood the plight of State and local governments who have lost their revenue because of the economy virtually shutting down, who have had trouble just making the trains go and helping their healthcare workers and their first responders to have enough money.

All of the costs of the—or most of the costs, anyway—of the pandemic have fallen on local governments, not-for-profits. And, fortunately, our President has said that the big package, the $1.9 trillion, is going to address the needs of State and local government. And what have we seen from the Republicans? No, a fraction of that, and to take out all the money to help State and local governments.

And so I wanted to ask Dr. Ezike—and thank you. I want to thank you, Doctor, for coming today, for the work that you're doing to try and help all of the people in the State of Illinois and to get vaccine where it needs to go.

If we were able to get more State and local help, how do you think that that would alleviate some of the problems that we have been seeing?

Dr. EZIKE. Thank you so much, Congresswoman, and thank you for your continued support along this pandemic journey.

So we know that the expansion of the network will increase the reach. That means that more people will be able to access. That will give opportunities for, you know, mobile vans to go to hard-to-reach populations. That will allow people to focus and have a specific POD for seasonal workers or migrant workers. So the expansion of efforts, the expansion of the network just allows the reach to get more corners, every nook and cranny of our State, and to get it quickly, and also apply that equity lens so that we're clear and intentional about the groups that are often left behind—that have been left behind, to intentionally go after them, both with the appropriate messaging, the appropriate messenger, and the appropriate language, to be able to get those people on board as well.

Ms. SCHAKOWSKY. Thank you.

You know, I have focused a lot on the elderly since I've been in Congress, and it is so important that we're able to get the vaccine to older Americans. And I know that in Illinois now we're in 1B, that is, that people 65 years old and older. But we have seen some difficulties, and I've certainly heard calls at my office of people of that age and way more that are having a hard time just navigating the system. And I'm just wondering what kinds of things that you are doing and that the State is doing to make sure that our older population is having access to the vaccines.

Dr. EZIKE. Thank you, Congresswoman, for that important issue as well. We know that everyone is not able to use the internet and to access vaccines doing that way, and so all of the local health departments are being encouraged to use resources, to expand the phone lines, so that there can be people that can call and have that warm hand to help them through it. People are creating waiting lists of people who are trying to get the vaccine and then reach out personally and help schedule that vaccine so they can call back with an actual time.

So we need more people, not just vaccinators, but navigators and community organizations, that can help with identifying people who have to get the vaccine that can't do it through the traditional methods that have been established and can be led to the vaccine, and including using the additional resource that are needed for even transporting people who want to get vaccinated to the site.

So all of those things are part and parcel for getting our most vulnerable populations vaccinated as well.

Ms. SCHAKOWSKY. And all of those things cost money to do, and I'm looking forward to some help from the Federal Government as well.

Thank you, and I yield back.

Ms. DEGETTE. I thank the gentlelady.

I believe all the members of the subcommittee have now asked questions, and so we will—we want to thank the members of the full committee who have joined us for this important hearing. And, as per committee practice, we will now call on them to ask questions.

Congresswoman Dingell, I will call on you first. Thank you for coming.

Mrs. DINGELL. Thank you, Chairman DeGette. I have Michigan in the house—it's important—and Ranking Member Griffith for convening this important hearing.

And, you know, we all [inaudible] are right now into three categories. One, which is what I'm going to get more into detail, is just a shortage of the supply. We had good news today from the Biden administration [inaudible].

Ms. DEGETTE. Debbie, we're having some trouble hearing you.

Mrs. DINGELL. Can you hear me?

Ms. DEGETTE. Yes, OK. Let's try that.

Mrs. DINGELL. Can you hear me?

Ms. DEGETTE. You're freezing. I'll come back to you. I'll come back to you.

Let's go to Mr. Walberg for 5 minutes.

Mr. WALBERG. I thank the Chair for waiving us on. This is an important hearing that we have here today. And I thank each of the panelists for being here as well, and for the work that you are charged with doing in States. It's not an easy time. We understand that, whether we have disagreements or not or whether this sometimes feels a bit like Groundhog Day as we talk about things going wrong.

Director Marsh, I appreciate so much your testimony of how you took control and found creative ways, working with pharmacies and getting things done.

And, Director Ryan, I appreciate your testimony of how well the rollout process went in getting the logistics and then the ability for the State to do what it needs to do.

But I think there are other things that come into play as well as we look forward to the fact that a million doses per day has already been achieved as a result [inaudible]. So that goal is not necessary anymore. We need to expand beyond that. The fact that we're able to produce the doses before even approval has taken place. Just think, if that forethought hadn't been put in place to work with public and private sector to say, "We're going to let you produce doses before we give you the final approval just in case it might work," and thank God it did and we are getting those doses out.

Dr. Khaldun, I have the benefit, I guess, of representing a district that has its southern border which borders the northern borders of Indiana and Ohio. So I have the opportunity to see the difference in the way Michigan has handled it as compared to those two States. It gives me a little perspective. Allows my wife to take me out to dinner in Ohio on Friday night when I couldn't do it in Michigan. It allows me to see what's taking place in keeping things closed in our State as opposed to what took place in Indiana and Ohio and the impact on our economics as a result of that. So those are all good things.

Let me ask you a question. Just a couple of weeks ago, the CDC ranked Michigan in the bottom 10 among all States in vaccines administered per 10,000 residents. In early January, we were ranked in the bottom five. Weeks after, the State received more than 500,000 doses of the Moderna and Pfizer vaccine. Only 27 percent of available doses had been administered, with the State data showing a substantial lag between doses shipped out and those injected. And, according to the State's own dashboard, there were more than 500,000 doses of vaccine sitting on shelves unused while

Governor Whitmer repeatedly said the State was ready to administer as many as 50,000 doses per day.

Now, in all honesty, it's good to hear. The numbers have improved in the last week or so, but State health officials have not been able to tell us why Michigan has fared so much worse than others, including the bordering States.

Dr. Khaldun, can you explain to me why Michigan in particular lags so far behind other States in getting the vaccine out? And was this the reason for the resignation of the Michigan Department of Health and Human Services Director Gordon?

Dr. KHALDUN. So thank you for that question. I'm very proud of the work that we've done in Michigan. We're actually one of the top-tier States today when it comes to vaccinating our population. I'm quite proud of that.

I think there are a couple of reasons why in the beginning it appeared that Michigan was one of the bottom 10 States. One of those things was actually data. There was data that actually was not coming into the CDC, and we found more than 30,000 doses that actually we were not getting credit for. So we actually found those, submitted those to the CDC. So we were actually doing better than what it appeared.

We also—and we had more than 4,400 facilities in the Federal Long Term Care program. There were no doses sitting on shelves in the State of Michigan that were in the Long Term Care program. So we, just like other States, were able to take out of that allocation, put those shots in arms across the State, while adding additional pharmacies to be able to vaccinate our individuals in long-term care facilities.

Mr. WALBERG. Now, adding to that specifically, as we're looking at rolling out the doses for teachers, we want to open our schools and schools that are open. I think of one. I was talking with a superintendant yesterday who has opened his school for testing as well as administering of the vaccine, and yet he's been unable to get his teachers registered to be put on the list to get the vaccine. Why is that?

Dr. KHALDUN. So thank you for that. We're actually pleased that we were able to move forward with having our childcare staff and our teachers to be part of this 1B population right now. We think it's incredibly important for our students to be back in school. We are actually working very closely with our local health departments to be able to vaccinate our teachers across the State. And so those superintendents are working closely with their local health departments.

Mr. WALBERG. My time has expired. I yield back. Thank you.

Ms. DEGETTE. I thank the gentleman.

I don't—I think we lost Mrs. Dingell. And so—are you there, Debbie?

OK. We're going to go to Mr. Soto for 5 minutes.

And I will say, for those of you who are new on this committee, Mr. Soto frequently waives onto this committee, and he waits till the bitter end, and I so appreciate it, because your input is very valuable. You're recognized for 5 minutes.

Mr. SOTO. Thank you, Madam Chair.

First, I want to thank the Biden administration for increasing Florida's weekly allocation 16 percent, up from 266,000 to 307,000 for our weekly allotment. That's key. I want to thank our colleagues who supported the COVID–19 relief so far. FEMA just awarded $245 million to our State to pay for 100 percent of vaccine costs for the next 90 days, but we need to keep it up. Florida is 25th per capita in vaccinations—and we need the help—2 million shots in arms and counting.

I do want to set the record straight. Pfizer was the first vaccine approved. It was approved on December 11th, 2020. It was not part of Operation Warp Speed. I'm going to repeat that: Pfizer was not part of Operation Warp Speed. So it's really important to keep the record corrected.

The real lesson, I think, is we've had bipartisan support for NIH funding for years. And that created the health technology for making these new vaccines, like with Pfizer, like with Moderna eventually. Really important for us to make sure that record's clear.

And outreach is critical, particularly rural communities, many of them rural Anglo communities in my district, as well as communities of color. We know the history of distrust. It was mentioned briefly, but it's important to discuss.

The Federal Government last century deliberately infected Black men with syphilis in the Tuskegee experiment. It sterilized Puerto Rican women during the '30s and '40s. So we know that this distrust is there from history, which is all the more reason why each of us as Members of Congress need to work with the bipartisan effort with the Biden administration to do our own outreach.

Local hospitals in Central Florida, such as AdventHealth, Orlando Health, and BayCare, Osceola Regional, have given me a list of concerns—hospitals from Central Florida—like retaining and recruiting expert nurses, concerns of mental health for healthcare workers, patient Medicare admission criteria for nursing and ALF patients, and citizens in rural areas and communities of color. We see retail sites like Publix that are doing their best, but it's not present in every community across Florida.

So we've seen uneven allocations like in east Polk County. Local African-American cities have been left behind. In Osceola County, a majority Hispanic county has been left behind in allocations. So I look forward to working with Biden's equity task force.

I want to first ask Dr. Khaldun. In your testimony, you state we cannot simply assume our existing healthcare workforce, many of whom have been working nonstop, will have enough for this massive undertaking.

Dr. Khaldun, what does your State need for the Federal Government to help address these workforce issues?

Dr. KHALDUN. All right. So one thing I'd say—and thank you for that question. One thing I'd say is that I'm incredibly grateful for the support of the Michigan National Guard. They have been partners throughout this pandemic supporting us with testing and now with our vaccination efforts across the State. I think we also need to bring in more community vaccinators. We need to be using clinical students, and that's what we're working on as well, just like Dr. Marsh from West Virginia. So those are the types of things

that we are working on to be able to support our healthcare workforce.

Mr. SOTO. And, Dr. Ezike, we know you've mentioned workforce capacity challenges. How are you addressing those challenges, and how can Congress help you with these workforce issues?

Dr. EZIKE. Thank you. So we are expanding the pool, as my esteemed colleagues have mentioned. We've increased the ability to vaccinate to EMTs, emergency medical technicians. We're working to expand to—you know, we have pharmacists, of course. We're looking to put phlebotomists in this as well. Dentists can be part of this. So we're trying to use as many vaccinators. And we're looking even at our partners in other countries that are just doing just-in-time trainings and trying to bring even nonhealthcare professionals and see if that is a possibility under direct supervision.

So we do need the ability to expand training programs that we might be able to have no limitation on the number of vaccinators and then just be waiting for the vaccine.

Mr. SOTO. Thank you.

We saw President Biden bringing up the National Guard, enlisting FEMA, 100 percent reimbursement, 100 vaccination sites throughout the Nation.

Dr. Phillips, will this additional workforce help Louisiana's COVID–19 program? And what other resources will you all need to make sure your residents are eligible for the vaccine?

Dr. PHILLIPS. I think, as mentioned, the National Guard has been a critical partner here in Louisiana from the start to the end. As we faced COVID, we also faced several hurricanes this past year, and they were lockstep with us as we went about those efforts. And the 100 percent funding is going to be critical as that continues. They are our logistical arm, our planning force, and our operational specs on the ground. And so having that has been extremely critical.

The other thing that's helpful is that 100 percent FEMA funding, which will allow us to tap into those community mobile strike teams that are able to go into underserved communities using our Social Vulnerability Index tool. Those are going to be important to have the funding to be able to support the needs that we've identified, in addition to volunteers who are retired clinical workers. They've already mentioned students and faculty of allied health schools. Looking at our first responders, including EMT and fire personnel. Making sure we have access to all available individuals who are medically trained to be able to provide a vaccine.

And that flexibility. As we learn more, we may have to adjust to what we need to do. And having the guidance and the funding to be able to support that flexibility is going to be critical.

Mr. SOTO. Thank you. My time's expired.

Ms. DEGETTE. I thank the gentleman.

I still don't see Mrs. Dingell.

So, Mr. Carter, we're going to go to you for 5 minutes.

Ms. DEGETTE. Mr. Carter, we can't hear you.

Mr. CARTER. I'm here on the side of the——

Ms. DEGETTE. OK. You're frozen.

Mr. CARTER. I'm sorry.

Ms. DEGETTE. OK. You want to try?

No. OK. We've lost Mr. Carter.

If the panel doesn't mind, we will allow Mr. Carter and Mrs. Dingell to submit any questions for the panel that they might have by written questions, and we would ask you to submit your answers to those questions.

Is that agreeable to you, Mr. Griffith?

Mr. GRIFFITH. Yes, it is, Madam Chair.

Ms. DEGETTE. OK. In that case, I believe that all of the Members have asked questions.

And I really want to thank all of the witnesses for participating in this hearing today. Your testimony and your ideas are really helpful and instructive as we try to move forward to get the entire population of the United States vaccinated.

I want to remind Members that, pursuant to the committee rules, they have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared today. And I ask that the witnesses agree to respond promptly to any such questions, should you receive any.

We only had one document request today in this hearing. It was the request by Mr. Burgess for the Texas data generated by the Data Strategy and Execution Workgroup dated January 31, 2021.

And, without objection, that document will be entered into the record.

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

Ms. DEGETTE. Again, thank you to all of our witnesses and Members.

Mr. GRIFFITH. Madam Chair, if I might correct my one point, just so we've got it all down.

Ms. DEGETTE. Sure.

Mr. GRIFFITH. It is true that Pfizer did not receive any R&D money as a part of Operation Warp Speed. But, as they stated in November, for communication purposes and for logistics and obviously because they got a giant contract, they did consider themselves a part of Operation Warp Speed, although they received no money for R&D.

Ms. DEGETTE. All right. Thank you for your comments, Mr. Griffith.

And with that, this subcommittee is adjourned.

[Whereupon, at 1:48 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

COVID-19

TEXAS

STATE PROFILE REPORT | 01.31.2021

	STATE	STATE, % CHANGE FROM PREVIOUS WEEK	FEMA/HHS REGION	UNITED STATES
NEW COVID-19 CASES (RATE PER 100,000)	118,739 (410)	-14%	167,793 (393)	1,075,727 (324)
VIRAL (RT-PCR) LAB TEST POSITIVITY RATE	12.8%	-3.6%*	11.9%	8.8%
TOTAL VIRAL (RT-PCR) LAB TESTS (TESTS PER 100,000)	520,563** (1,795**)	-37%**	752,107** (1,761**)	10,241,016** (3,085**)
COVID-19 DEATHS (RATE PER 100,000)	2,281 (7.9)	+1%	3,327 (7.8)	22,555 (6.8)
SNFs WITH ≥1 NEW RESIDENT COVID-19 CASE	26%†	-3%*	25%	23%
SNFs WITH ≥1 NEW STAFF COVID-19 CASE	40%†	-6%*	39%	37%
SNFs WITH ≥1 NEW RESIDENT COVID-19 DEATH	16%†	-1%*	15%	14%
CONFIRMED AND SUSPECTED NEW COVID-19 HOSPITAL ADMISSIONS (RATE PER 100 BEDS)	13,956 (22)	-16% (-15%)	20,858 (22)	130,573 (18)
CONFIRMED NEW COVID-19 HOSPITAL ADMISSIONS (RATE PER 100 BEDS)	9,421 (15)	-18% (-17%)	13,851 (14)	82,072 (11)
NUMBER OF HOSPITALS WITH SUPPLY SHORTAGES (PERCENT)	88 (19%)	+17%	217 (25%)	1,073 (21%)
NUMBER OF HOSPITALS WITH STAFF SHORTAGES (PERCENT)	123 (27%)	-7%	229 (26%)	877 (17%)

COVID-19 VACCINE SUMMARY	DOSES DISTRIBUTED		1ST DOSE ADMINISTERED		FULL COURSE ADMINISTERED	
	TOTAL	RATE PER 100,000	TOTAL	PERCENT OF POPULATION	TOTAL	PERCENT OF POPULATION
	3,659,550	12,620	1,928,227	6.7%	478,812	1.7%

* Indicates absolute change in percentage points.
** Due to delayed reporting, this figure may underestimate total diagnostic tests and week-on-week changes in diagnostic tests.
† 85% of facilities reported during the most current week.

DATA SOURCES and METHODS
Note: Some dates may have incomplete data due to delays in reporting. Data may be backfilled over time, resulting in week-to-week changes.
Cases and Deaths: State values are aggregated data provided by the states to the CDC. Data is through 1/29/2021; previous week is 1/16 - 1/22.
Testing: CELR (COVID-19 Electronic Lab Reporting) state health department-reported data through 1/27/2021. Previous week is 1/14 - 1/20.
SNFs: Skilled nursing facilities. National Healthcare Safety Network. Data is through 1/24/2020, previous week is 1/11-1/17.
Admissions: Unified Hospitals Dataset in HHS Protect.
Shortages: Unified Hospitals Dataset in HHS Protect. Values presented show the latest reports from hospitals in the week ending 1/29/2021.
Vaccinations: CDC COVID Data Tracker. Data includes both the Moderna and Pfizer BioNTech COVID-19 vaccines and reflects current data available as of 13:11 EST on 01/31/2021. Data last updated 06:00 EST on 01/31/2021.
METHODS – details available on last page of report

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Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations

Hearing on

"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"

February 2, 2021

Ngozi Ezike, M.D., Director, Illinois Department of Public Health

The Honorable Frank Pallone, Jr. (D-NJ)

1. **To date, has Illinois faced a shortage of the necessary supplies providers need to safely administer COVID-19 vaccines? Do you anticipate shortages as your efforts continue?**

Early on, there were issues when we learned that extra doses were able to be drawn from vials. We soon realized that we did not have enough ancillary supplies to cover the additional doses. However, McKesson did eventually increase the ancillary supplies to account for the additional doses and the state, through the Illinois Emergency Management Agency (IEMA), has procured 1 ml and 3 ml syringes to augment where necessary.

2. **Do you think there is more Congress or the federal government can, or should, be doing to ensure that there is a sufficient number of ancillary supplies available to support vaccination efforts in the coming months?**

We would ask that the federal government increase the number of 1-inch needles in the ancillary kits to support vaccination efforts.

The Honorable Kathleen Rice (D- NY)

1. **How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?**

Adolescents as young as age 16 who have comorbidities that increase their risk for severe COVID-19 illness or who have a disability, are included in Phase 1B+ in Illinois, which is the current phase. They could have also been eligible if they fall into a Phase 1A or 1B category, such as grocery store workers.

a. How do families and caregivers of children with medical complexity fit into your distribution plans?

Family caregivers of children with medical complexity are eligible for vaccination in Phase 1A as "health care workers" in the category of "Home Health" or "Home Aide/Caregiver" providers, depending on the disability and medical complexity of the child. There is considerable variation in medical complexity among this population of children,[1] a group of about 14 million nationwide in 2017-2018, about 27% of whom had functional limitations.[2] Those who are most medically fragile, and likely most susceptible to severe COVID-19 illness, are captured in the (non-exhaustive) list of conditions that qualify a family caregiver as a health care worker, which includes cerebral palsy, Down Syndrome, epilepsy, and specialized health care needs, such as dependence upon ventilators, oxygen, and other technology.[3]

b. Once a vaccine is safe and effective for younger children, what are your plans for distribution and administration of vaccine doses for this population?

We are closely following CDC/ACIP guidance and will continue to monitor any guidance on vaccine use in children. When we hear that a vaccine for safe and effective use in children is on the horizon, we will assess the distribution process at the time and adjust accordingly. Fortunately, we have experience with the Vaccines for Children program and have an existing provider network that we can deploy when the time comes.

The Honorable Morgan Griffith (R-VA)

1. **Are you aware of the COVID emPOWER program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death from COVID?**

In Illinois, vaccines are currently distributed according to the population of each county, adjusted to ensure health equity using the COVID-19 Community Vulnerability Index (CCVI), a measure of vulnerability to COVID-19 at the state, county, or census tract level that combines health determinants such as epidemiology of underlying chronic conditions and access to care with the CDC Social Vulnerability Index.[1]

a. If so, are you using this program to help identify and vaccinate those at greatest risk?

N/A

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[1] Cohen, E., Kuo, D. Z., Agrawal, R., Berry, J. G., Bhagat, S. K. M., Simon, T. D., & Srivastava, R. (2011). *Pediatrics*, *127*(3), 529-538. https://dx.doi.org/10.1542/peds.2010-0910

[2] Health Resources and Services Administration. (2020, July). *Children with special health care needs*. https://mchb.hrsa.gov/sites/default/files/mchb/Data/NSCH/nsch-cshcn-data-brief.pdf

[3] Patrick, R., & Stark, A. (2021, January 21). *Caregiver IDHS letter*. Retrieved from https://www.dhs.state.il.us/page.aspx?item=131557

2. **According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.1 Disability advocates say guidance should be interpreted to include all people with disabilities who receive long-term care, whether in large institutions, or in smaller group homes. Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. How do you plan to inoculate this group of individuals?**

Ensuring that people with intellectual and developmental disabilities receive COVID-19 vaccination is a priority for the State of Illinois. The 195 ICF/DD and 10 MC/DD facilities, which are long-term care facilities for persons with disabilities, were in Phase 1A and have been provided vaccinations for staff and residents. The Illinois Department of Public Health (IDPH) has worked closely with the Illinois Department of Human Services (IDHS) to provide COVID-19 vaccinations at the 7 State Operated Developmental Centers (4000 residents and 1700 staff) and 3,000 Community Integrated Living Arrangements (11,200 residents and staff). We are now moving on to vaccinate Home Health staff and Community Day Services staff and attendees. We will conclude with homebound individuals (along with homebound seniors). Phase 1B (Phase 1B+) in Illinois now also includes those with disabilities under the age of 65.

   a. **Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?**

IDPH is working closely with IDHS, advocacy and support groups, and professional organizations to disseminate information and offer assistance. The State has also launched a call center to assist individuals who live outside of these congregate settings who may need assistance with making vaccine appointments.

3. **One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't.**

   Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.

The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

I do not believe at this point that another contract is needed. However, the federal government could direct federal retail pharmacy partners to reserve a portion of their appointment slots for healthcare workers eligible in Phase 1A, similar to how they have been directed to prioritize school staff and childcare workers in the month of March. For long-term care settings, IDPH is enrolling LTC pharmacies as COVID-19 vaccine providers and will pick-up vaccination for long-term care facility staff and residents when the federal pharmacy partnership program concludes.

4. **How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?**

Roughly $33 million of the $90 million in funding is going to local health departments. The remainder of the funding will be used to set up a state-wide call center to assist individuals with making vaccine appointments, establishing mobile vaccination teams, additional contractual support for vaccination implementation efforts, among other needs.

5. **What is your state's strategy to reach the level of immunization needed for herd immunity?**

Mass vaccination.

   a. **What evidence will your state be looking for to determine whether herd immunity has been reached?**

IDPH receives results from the Multi-State Assessment of SARS-CoV-2 Seroprevalence (MASS) survey conducted by the Centers for Disease Control and Prevention, which estimate the proportion of Illinoisans with antibodies to SARS-CoV-2.[4] Those data, in combination with vaccine administration, provide information on Illinoisans with some level of immunity against COVID-19. Researchers estimate we can reach herd immunity for SARS-CoV-2 at about 70% of people,[5] [6] but there are uncertainties that may make herd immunity a moving target. People previously infected with SARS-CoV-2 maintain immunity

[4] Centers for Disease Control and Prevention. (2021, March 3). Nationwide commercial laboratory seroprevalence survey [Data]. https://covid.cdc.gov/covid-data-tracker/#national-lab
[5] Fontanet, A., & Cauchemez, S. (2020). COVID-19 herd immunity: Where are we? *Nature Reviews Immunology*, *20*, 583-584. https://doi.org/10.1038/s41577-020-00451-5
[6] Randolph, H. E., & Barreiro, L. B. (2020). Herd immunity: Understanding COVID-19. *Immunity*, *52*(5), 737-741. https://doi.org/10.1016/j.immuni.2020.04.012

for approximately eight months,[7] [8] [9] [10] and potentially fewer for roughly half[11] [12] of previously infected who had asymptomatic or mild cases.[13] [14] The circulation of SARS-CoV-2 variants may further limit post-infection immunity,[15] especially if we relax our mitigations too much too soon and facilitate further spread. Recent research suggests [16][17] we do not yet know how long post-immunization immunity will last and our current vaccines are not yet authorized for use in children. Rather than using herd immunity, with all its uncertainties, as the goal of mass vaccination, a more meaningful target might be preventing serious illness and death.

6. **Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high-quality tests as part of your vaccine roll-out and follow-up?**

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[7] Poland, G. A., Ovsyannikova, I. G., & Kennedy, R. B. (2020). SARS-CoV-2 immunity: Review and applications to phase 3 vaccine candidates. *The Lancet*, *396*(10262), 1595-1606. https://doi.org/10.1016/S0140-6736(20)32137-1

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IDPH reports the number of serology tests conducted statewide and by region. Our current antibody assay confirms whether antibodies to SARS-CoV-2 are detectable but does not quantify the levels of anitbodies or immunity.

a. If yes, how are you using the tests?

N/A

b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

Yes, Illinois would benefit from quantitative serology tests and we are considering it.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

The process of vaccinating the millions of people it will take to achieve herd immunity will require an "all-hands-on deck" approach, as you mention. In Illinois, we are enrolling as many providers as possible and expanding the scope of practice for certain healthcare providers to increase the pool of providers who can administer vaccine. It will take everything from mass vaccination clinics to eventually offering COVID vaccines at small local pharmacies to vaccinate our population.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

In order to reach populations that have been disproportionately impacted by COVID, IDPH has been intentional about engaging hard hit communities across the state, including some rural counties in northern and southern Illinois. We have held population-specific townhall events where we answer questions and provide information, particularly around vaccine hesitancy and distrust. False narratives abound—especially in our communities of color— and we must come together to create confidence and trust in the available vaccines.

We have also launched a COVID-19 Ambassador program to support state efforts to stop the spread of COVID-19 by enlisting individuals to promote and share information among their friends, family, peers and neighbors on prevention measures, testing resources, vaccines and other relevant information. Through this initiative and regular engagement with hard hit groups, we hope to see information spread to communities across the state, including those with limited internet connectivity.

The State will also be launching a paid media campaign that will include television, radio and billboard ads across the state.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. **Given our hope and expectation that states will soon receive larger allocations of vaccines and supplies, I am focused on the need for states to ramp up their vaccine delivery capabilities. In my home state of Florida, for example, private companies are stepping up to make their expertise and resources available for cold chain purposes. I know other companies across various industries are actively working to find ways to lend their expertise. What specific advice or guidance can you offer companies and organizations who want to assist your state with these efforts, cold chain or otherwise?**

Illinois has also been grateful to hear from local companies offering their expertise in response to this pandemic. I would say to companies in Illinois that would like to assist, to know that we appreciate their offer, but that we may not be able to take all offers for assistance. As a state we also want to ensure we are following proper procurement processes and ask for patience as we respond to offers for assistance.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"

February 2, 2021

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive, State of Michigan
Chief Deputy Director for Health, Michigan Department of Health and Human Services

The Honorable Frank Pallone, Jr., (D-NJ)

1. To date, has Michigan faced a shortage of necessary supplies providers need to safely administer COVID-19 vaccines? Do you anticipate shortages as your efforts continue?

   No.

2. Do you think there is more Congress or the federal government can, or should, be doing to ensure that there is a sufficient number of ancillary supplies available to support vaccination efforts in the coming months?

   As more vaccines become available, it will be important that we continue to assure sufficient availability of supplies including syringes, needles, and PPE. To this end, Michigan is especially appreciative of the funding and extensive supports provided under the December stimulus package and the recently passed American Rescue Plan to boost vaccine deployment and rapidly expand health care workforce mobilization.

   Michigan has had a good line of communication to the federal government since the Biden Administration took office and has not had any issues communicating our concerns. The Biden Administration has shown that it will not hesitate to take action to increase necessary supplies to end this pandemic and we would continue to encourage them to act as is determined necessary.

The Honorable Diana DeGette (D-CO)

1. How is Michigan balancing the goal of maximizing first doses with the need to ensure second doses of the vaccine are reliably available to administer at the indicated time?

   The Michigan Department of Health and Human Services (MDHHS) interfaces with our provider colleagues regularly to ensure proper disseminations of first and second doses and has engaged in a process of ordering and allocating to these providers based on the reported number of first doses to ensure proper timing of second doses. We encourage providers to communicate with us if they run into issues when second doses are used for first doses which has become less of an issue with more engagement and as supply has increased.

2. In your testimony you noted that one of Michigan's top goals is to ensure that "95 percent of people get their second dose of vaccine within the expected time frame." How are you proactively engaging with Michiganders, so they know where and when to return for their second dose?

   Engaging Michiganders on the front end is the first step in ensuring residents' timely return for their second dose of Moderna or Pfizer. First, the state has worked to communicate the safety and efficacy of the vaccines along with an understanding of possible side effects of the vaccines. Vital to our goals of ensuring proper timing between doses is the scheduling of the second dose appointments at the time of an individual receiving their first dose. Each provider, at the time of the first dose of a two-dose series, is making sure patients know when to receive that dose and schedule their second dose visit before leaving after receiving their first dose. Our immunizations registry also has a texting platform that reminds people of their second dose appointment, and we are encouraging people to enroll in V-Safe, the CDC program that also sends text alerts to remind people to return for their second dose.

The Honorable Kathleen Rice (D-NY)

1. Your testimony highlights that Michigan will leverage the state's Protect Michigan Commission to "target communication efforts to communities with vaccine hesitancy and in populations where hesitancy creates the greatest risk." According to the Biden Administration's national COVID-19 strategy, the Administration plans to lead public education campaigns on topics like vaccinations and vaccine hesitancy.
   a. How are you working with local providers to ensure Michigan's communication efforts, and the administration of vaccine doses, are reaching marginalized communities?

      The Protect Michigan Commission is a bipartisan group spanning across multiple sectors that focuses on making sure all people in Michigan have the information they need about vaccines. We are actively engaging the Commission in multiple venues including in town halls and earned and paid media efforts. We also are working with Michigan's Coronavirus Task Force on Racial Disparities, which has led the way on developing recommendations for an equitable approach to inform our entire COVID-19 response and whose members also serve as trusted sources of information in their respective communities. Our statewide vaccine strategy focuses on equity in vaccine distribution and education.

   b. How would a national public education campaign help support Michigan's efforts?

      Any opportunity to elevate key messages around the safety and efficacy of the COVID vaccines will support our efforts in Michigan.

2. How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?

   The State of Michigan announced on March 12, 2021 that all Michiganders age 16 and up, and their caretaker family members and guardians, will become eligible for the vaccine on March 22, 2021. We have identified several COVID providers who are federally enrolled to administer vaccines to target for vaccine distribution based on their service to these populations. We are

also working with our Medicaid program to work with health plans to do outreach to special populations.

a. How do families and caregivers of children with medical complexity fit into your distribution plans?

In addition to what was stated above, we are working to make sure those who are homebound or have complex medical needs have access to the vaccine. We are also working with our disability community and have plans to train our providers in how to best serve those who have unique needs in accessing the vaccine.

b. Once a vaccine is safe and effective for younger children, what are your plans for distribution and administration of vaccine doses for this population?

We are hopeful and excited for the development and approval of a safe and effective vaccine for younger children. For children we would engage our network of over 2600 federally enrolled COVID providers to provide vaccines. That would include pediatricians, FQHCs, and pharmacy partners. We would continue to engage with our local health departments to ensure that we are reaching children and their families in the most appropriate venue and that we are able to provide education and information about the vaccines.

The Honorable Tim O'Halleran (D-AZ)

1. We know that seniors over the age of 65 are at greater risk of requiring hospitalization or dying if diagnosed with COVID-19. Long term care communities have been some of the of the hardest hit in terms of infections and deaths due to COVID-19 given their congregate nature. Senior living providers, those who operate Independent Living, Assisted Living, Memory care and CCRCs, are doing everything they can to keep their residents and staff safe during this public health crisis and have anxiously awaited the approval of a COVID-19 vaccine. Now as the scarce supply of vaccine is being rolled out to most long term care communities, providers are educating both residents and staff about the benefits of the vaccine and the importance of protecting all who live and work in the community. Striving for a risk free senior living community is the goal but it is only achievable if all at risk, participate. Many senior living providers are finding that not unlike other residential care communities, there is strong demand from residents for the vaccine but the take up rate among staff reflects a high degree of vaccine hesitancy.

    a. What considerations are going into educating employees of long-term care facilities about the importance of the COVID-19 vaccine?

    MDHHS has engaged in broad education strategies focused on addressing issues that may result in vaccine hesitancy including but not limited to safety and racial history associated with vaccines. These strategies are useful with the general population and long-term care facilities staff. Communicating the safety and efficacy of the vaccine and using appropriate messengers have been key in this work. We have also engaged with stakeholders including unions and associations who have also been highly effective messengers. MDHHS has additionally hosted collaborative calls with nursing

facilities to allow for a constructive and welcoming exchange of information and best practices for engagement.

b. Are we seeing numbers trend in the right direction among these communities?

Yes. Some facilities did not vaccinate all staff during the first clinics to avoid any staffing challenges that may have resulted from negative side effects which may have resulted in lower uptake initially. This decision by the facilities coupled with staff seeing co-workers respond positively, excitedly, and with limited side effects has resulted in increased uptake by long-term care staff. To date, 258,587 vaccines have been administered through the Federal Pharmacy Partnership for Long-Term Care Program in Michigan. Through the program, 3,636 facilities with first dose clinics and 2,821 facilities with second dose clinics have been completed, with 146,504 first doses and 112,083 second doses administered. In total, 159,844 residents and 98,743 staff have been vaccinated in long-term care facilities in Michigan through the program.

c. What other policies are being considered to ensure that vaccine uptick in facilities, like long-term care communities, increases to properly protect those living there?

MDHHS' goals are to educate and inform individuals about the vaccines to ensure they understand the safety and efficacy of them. We continue to work with our long-term care facilities to make sure people are getting vaccinated and have access. This includes working with hospitals to encourage vaccinating patients at the time of discharge from a hospital to a facility.

The Honorable Morgan Griffith (R-VA)

1. Are you aware of the COVID Empower program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death form COVID?

As you know, HHS' emPOWER program is a partnership between ASPR and CMS that provides numerous tools including federal data, mapping, and artificial intelligence tools, as well as training and resources, to help communities nationwide protect the health of at-risk Medicare beneficiaries, including 4.2 million individuals who live independently and rely on electricity-dependent durable medical and assistive equipment and devices, and or essential health care services.

Public health authorities and their partners in all 50 states, 5 territories, and the District of Columbia use emPOWER Program data and tools to strengthen emergency preparedness, response, recovery, and mitigation and take action to protect at-risk populations prior to, during, and after incidents, emergencies, and disasters. Since the onset of COVID-19, emPOWER now offers COVID-19 At-Risk population and a suite of datasets, GIS and dashboard tools, and resources to support state, territorial, and local public health COVID-19 response and community mitigation efforts, including vaccination campaigns.

a. If so, are you using this program to help identify and vaccinate those at greatest risk?

The State of Michigan utilizes several database sources to determine outreach strategies for those needing vaccinations and to support multiple efforts in collaboration with the Protect Michigan Commission, Aging and Adult Services, and Communications, including:

- **Postcard mailing in development to assist older adults with vaccine registration that also provides info on safety, eligibility, vaccine locations, and telephone assistance (211). Michigan will partner with community partners on distribution.**
- **AARP training for phone trees to assist older adults**
- **Area agencies on aging / Medicaid / Behavioral Health identifying clients**

2. According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.1 Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. For your state, how do you plan to inoculate this group of individuals?

   The State of Michigan has engaged in robust and thorough outreach to congregate care facilities where some of these individuals may live through the Federal Pharmacy Partnership for Long-Term Care Program. We are also partnering with local health departments, community organizations, and with the Protect Michigan Commission to identify and communicate with family members and others about how to access vaccines. Our vaccine prioritization guidance expands eligibility as of March 8 to individuals age 50+ living with disabilities as defined by the Americans with Disabilities Act, as well as to caretakers of children with special health care needs. Beginning March 22, the State of Michigan is expanding vaccine eligibility to all individuals with disabilities, underlying medical conditions, substance use disorders, or severe mental illness, regardless of age.

   a. Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?

      We are working with stakeholders and our local health departments to reach out to individuals who may be eligible but may not be able to access information or scheduling portals. We have also worked with 211 to launch services via phone that allow people to schedule vaccine appointments. We are also working with our Medicaid Health Plans and Community Mental Health providers to assure access to vaccines for these populations.

3. One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system

on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't.

Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.

The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

I understand how challenging the past year has been for our frontline workers. We owe it to them to ensure that they have access to these lifesaving vaccines. Michigan worked hard to initially allocate our limited supply first and foremost to our state hospital systems to ensure that the vast number of medical personnel in those settings and associated with those systems could receive vaccines. We also partnered with local health departments to coordinate vaccines for other medical professionals that were included in the 1A priority group. From a Michigan standpoint, I do not think a new or expanded contract with CVS or Walgreens at this stage for patient facing health care workers is needed as we have been successful at getting medical personnel vaccinated. Healthcare providers are still part of our 1A vaccination priority group and we have emphasized to all of our active vaccine providers that they should continue to prioritize them. As more vaccines are made available to Michigan, we also expect more and more providers to be able to receive vaccine to be able to vaccinate their own staff as well as patients.

4. How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?

   Michigan's ability to utilize the much-needed funds provided by Congress in December has been significantly slowed by our state legislature. The Michigan legislature just sent the Governor a supplemental appropriations bill for her signature the week of March 8 to make some of the funds provided by Congress from the December stimulus available. The Governor signed this bill on March 10, 2021 while vetoing certain pieces not specific to the public health response. The legislature has made it clear that it intends to release funding at our request and with proof of its necessity, but the limited scope and this piecemeal approach significantly hinders our ability to support mass vaccination sites, our local health departments, and critical testing and tracing operations, especially among our most vulnerable populations. The legislature has stated that the funding being allocated initially will be used for testing and tracing, vaccine distribution, and rental assistance, among other items.

5. What is your state's strategy to reach the level of immunization needed for herd immunity?

   a. What evidence will your state be looking for to determine whether herd immunity has been reached?

The exact threshold for herd immunity for the coronavirus is unknown, but recent estimates range from 70 percent to 90 percent. However, other factors are also involved and will need to be considered, including how long immunity lasts, the possibility of new virus variants, and the fact that we are not yet immunizing those under the age of 16. We will factor in these considerations as new information becomes available, but the goal remains to immunize as many individuals as possible. We will also consider national guidance on herd immunity thresholds as that becomes available.

6. Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high-quality tests as part of your vaccine roll-out and follow-up?
    a. If yes, how are you using the tests?
    b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

    We are not currently using serology to track or inform our vaccination strategy. We do know that the vaccines are safe and effective, and ongoing research is occurring across the world to be able to understand how long immunity from vaccination lasts. The Michigan Bureau of Laboratories is a national leader in sequencing of COVID-19 to identify possible instances of variants in the state and assuring quick response is taken by the state and local health department to limit exposure to these more contagious strains.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

    Michigan has set a goal of equitably vaccinating 70 percent of Michiganders as safely and quickly as possible. We have over 2600 providers enrolled in the federal program as providers, and we have established public-private partnerships to support our operational efforts for vaccine distribution. I applaud the Biden Administration's vaccine strategy to date with increasing allocations to states every week and assuring that all doses available are distributed to states.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

Our decentralized local health system plays an important role in communicating locally and in understanding the needs of the community. The state is using 211 as a resource for individuals to call and ask questions or schedule an appointment. We will also be implementing a full earned and paid media communications plan for radio, television, digital and social media, direct mail, phone calls, and regional press events intended to target rural communities and populations.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Given our hope and expectation that states will soon receive larger allocations of vaccines and supplies, I am focused on the need for states to ramp up their vaccine delivery capabilities. In my home state of Florida, for example, private companies are stepping up to make their expertise and resources available for cold chain purposes. I know other companies across various industries are actively working to find ways to lend their expertise. What specific advice or guidance can you offer companies and organizations who want to assist your state with these efforts, cold chain or otherwise?

   We are pleased with the increased allocation of vaccines to Michigan over the past several weeks and are working to expand the number of providers to administer vaccines across the state. We are also working with operational leadership at our health systems, as well as engaging in public-private partnerships to support vaccine distribution and allocation efforts.

Additional Questions for the Record

Subcommittee on Oversight and Investigations
Hearing on
"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
February 2, 2021

Clay Marsh, M.D., West Virginia COVID-19/Coronavirus Czar

The Honorable Frank Pallone, Jr. (D-NJ)

1. Do you believe there are other ways communication and coordination around states' vaccine orders and federal government allocation and shipping could be improved?

   The consistency and accuracy of the weekly federal vaccine supply to states has stabilized as has the accurate projection of additional vaccine doses over time. This is an improvement that correlates with a more predictable and mature vaccine production line. In West Virginia, we have been among the best states in the nation in using our weekly inventory, and we appreciate being supplied with additional doses that we are using in a highly disciplined vaccination priority basis to immunize our oldest and most vulnerable population. To date, we have seen an 85% reduction in deaths over the first 7 weeks of 2021, along with a 75% reduction in hospitalizations and marked reduction in ICU admissions for COVID-19.

The Honorable Kathleen Rice (D- NY)

1. How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?

   How do families and caregivers of children with medical complexity fit into your distribution plans?

   a. Once a vaccine is safe and effective for younger children, what are your plans for distribution and administration of vaccine doses for this population?

      In West Virginia, we have prioritized saving lives and preserving health and hospital bed capacity as our central target of our vaccination priority. As such, we identified that our average age of death from COVID-19 is 77; 77.5% of deaths in West Virginia are in citizens aged 70 and older; 92% of deaths in West Virginia are in those 60 and older; and 97% of deaths in West Virginia occur in those aged 60 and older. Half of our deaths were from nursing home residents. With our focus, we were the first in the country to immunize our nursing home population and currently have immunized about 160,000/350,000 over age 65 with one dose and 80,000 with two doses. We have recently included those with co-morbidities, including caregivers of children that need chronic care and those 16 and older who are at high risk for COVID-19 severity (Down syndrome; sickle cell anemia;

cystic fibrosis; congenital or acquired disability needing chronic caregiving; solid organ transplant) in our priority phase. These individuals are currently being served through doses available at pharmacies via the Federal Pharmacy Partnership and the state's community clinic model.

a) We will continue our priority scheme directed at saving lives and reducing hospitalizations. Thus, our older West Virginia residents and those with high-risk co-morbid disease will be prioritized for vaccination. As vaccine supply increases, we will turn to WV in critical workforce jobs, like education professionals, to be vaccinated at all ages. As we continue to fully immunize teachers and service personnel in schools, we await data being generated now to assess the safety and efficacy of vaccinating younger residents. Currently, Pfizer is approved for those aged 16 and older and Moderna/J&J for those aged 18 and older.

The Honorable Morgan Griffith (R-VA)

1. Are you aware of the COVID emPOWER program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death from COVID?

    a. If so, are you using this program to help identify and vaccinate those at greatest risk?

    HHS emPOWER is a powerful tool, but to date, we have not used it in West Virginia to contact the Medicare population. We have relied on self-registration, vaccination of all nursing home and assisted living residents, and for those aged 65 and older via their primary care practices and health system rosters to reach out to our most vulnerable population. With this question, we are now looking at this resource, too.

2. According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.[1] Disability advocates say guidance should be interpreted to include all people with disabilities who receive long-term care, whether in large institutions, or in smaller group homes. Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. How do you plan to inoculate this group of individuals?

    a. Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?

As indicted, we have included these West Virginia individuals and their caregivers in our most recent priority vaccination guidelines. We are working with the DHHR, medical systems, primary care networks, Center for Excellence in Disabilities (at West Virginia University), West Virginia Fair Shake Network and other volunteer advocacy efforts on behalf of disabled individuals and their caregivers. Appointments

can be arranged by their advocates/families/caregivers by calling our hotline number for vaccinations and efforts are also underway to bring vaccines to those living in congregate settings with approval for vaccination. We are also partnering with pharmacies and IDD waiver program to administer vaccine on site at congregate care settings.

3. One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't.

   Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.

   The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

   West Virginia uses an interagency approach to identify healthcare workers eligible for vaccinations that include sector experts in areas of hospital, outpatient and home health fields. We have extensively immunized front-line hospital workers and staff and primary care providers. We have delineated home health workers, hospice, physical/occupational/speech therapists as essential workers and have vaccinated those aged 50 and older as part of our Phase 1-C priority and are now anticipating expanding access to those aged 50 and older as more vaccines become available. We have used a state registration system to identify these individuals but are working closely with our Federal pharmacy program recipients to continue to identify and immunize these essential workers.

4. How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?

   We continue to train and hire staff to expand our vaccination capacity. In addition, we have also focused on improving the supply chain in West Virginia to include purchase and replacement of any needle/syringe in ancillary kits that do not contain low dead-space syringes to gain the sixth dose from Pfizer and also extra doses from Moderna and J&J. Additional uses of the recent stimulus funding is to maintain individuals at the state level for expanded IT functions, like vaccine tracking, distribution, projecting doses for individual clinics and for extended National Guard personnel focusing on transport, supply chain handling and storage of vaccines. In West Virginia, we also expanded free testing to all state residents, including higher education, and PPE for front-line and essential workers, teachers, school service personnel and for home health

providers.

5. What is your state's strategy to reach the level of immunization needed for herd immunity?

    a. What evidence will your state be looking for to determine whether herd immunity has been reached?

    We will monitor transmission rates, hospitalizations, deaths and outbreaks in congregate settings like nursing homes, assisted living facilities and schools. While we have vaccinated about 21% of our population with one shot and completely vaccinated 13%, we have identified the UK variant of COVID-19, as well as the CA variant in West Virginia. Since a state would need to be approximately 75-85% immune for herd immunity with COVID-19 without impact of variant viruses that may evade native or vaccination-associated immunity, we do not think we are at that level yet, despite very favorable reduction in transmission, outbreaks, hospitalization and death over the past 8 weeks.

6. Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high-quality tests as part of your vaccine roll-out and follow-up?

    a. If yes, how are you using the tests?

    This is certainly an aspiration we have for the near future. We are piloting a study in some of our nursing home residents to assess their antibody titers following vaccination, our focus has been solely on acceleration and efficiency around vaccination of our most vulnerable citizens to date.

    b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

    Yes, this is an important issue. One complicating factor is that other parts of our immune system, including T-cell, macrophage and gamma-interferon production may be critical in controlling the severity and risk of death from COVID-19, which are not detected by antibody testing.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

Yes, the vaccines we have available at record speed are incredibly effective in reducing risk of COVID-19 infection, spread and particularly against hospitalization and death. As vaccines become more plentiful, then all Americans should have broad access. That goes for any additional boost doses that may be needed if variant viruses in the future evade our vaccine-driven immunity.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

We have multiple means to reach our target populations, including three-times a week updates from Gov. Justice and our leadership team; newspaper; radio; videos; website, information call line, social media and messages from local health departments and over 200 public health partners in the state across various sectors. We partnered with the West Virginia University Public Interest Communication Research Lab and the Center for Rural Health Development to use mixed-methods social science through quantitative inquiry (statewide surveys, particular population surveys, message/appeal testing experiments) and qualitative inquiry (focus groups, in-depth interviews, intercept interviews, direct observation, social sentiment analysis) to identify beliefs, concerns, and perceptions among West Virginians about COVID-19 vaccines to inform development and ongoing evaluation of the statewide COVID-19 Vaccine Communication Campaign. This allows continuous, adaptive data collection across all phases, based on behavior change theory and resources from CDC and others.

The Honorable Michael C. Burgess, M.D. (R-TX)

1. The distribution of the COVID-19 vaccine has highlighted the importance of drug delivery, and the precision and logistics that are required to make it successful. Waste has been a topic of concern lately, with many conversations surrounding the need for low dead-volume syringes to extract the 6th dose from the Pfizer vials. Are there any other causes or contributors to vaccine doses being wasted, and how might these factors be addressed?

I would say that low, dead-volume syringes and appropriate needles are key, but also empowerment of vaccinators and disciplined control of processes that are needed to track vaccine supplies, clarify efficiency of vaccination of all doses and back-up plans if additional doses result from missed appointments or unforeseen circumstance. Our goal is to vaccinate an alternate person who fits the priority guidelines for West Virginia, but in the absence of such an individual, making sure that every shot is used on a West Virginia citizen is critical.

2. On a similar topic of waste, there have been instances of long-term care facilities, or the pharmacies that are helping to administer the vaccines at long-term care facilities, receiving a supply that exceeds demand in these facilities for various reasons. For example, my understanding is that allocations were made to account for 100 percent capacity, yet not all facilities are at 100 percent capacity. Are there guidelines for these facilities and the pharmacies to follow when this happens? Additionally, what do you believe is the most efficient practice for facilities to follow if they have more doses than are needed?

We were one of the few states that did not initiate the federal pharmacy program and instead, received vaccines centrally and used our pre-identified network of small, local and family-owned pharmacies and long-term care facilities to receive just-in-time amounts of vaccine commensurate with the numbers of patients and staff at each facility.

a. How might allocation methodology shift to address this issue for the administration of second doses?

It's important to project increases in numbers of second vaccines so that we can focus on getting as many first vaccines in the arms of our most vulnerable without risking missing second doses.

3. It has been reported that one reason many long-term care facilities have extra doses is due to vaccine hesitancy. Often this hesitancy is even higher among the staff than

the residents. This is an issue of bipartisan concern, as Dr. Schrier and I worked together on the VACCINES Act last Congress. I have heard anecdotally that vaccination rates are getting better among staff when pharmacies return for their second visit at a facility, but more work is needed to reduce vaccine hesitancy overall. What can states and facilities do to address this hesitancy and build trust?

Our initiation with networks of local and family-owned pharmacies reduced vaccine hesitancy and improved the numbers of residents and staff that agreed to vaccination.

4. West Virginia has clearly been successful in distributing the COVID-19 vaccine, with much of this success being an example of states and localities knowing what will work best in their own communities. How can the federal government coordinate better with states without infringing upon flexibility and state control?

This is obviously a decision for each Governor and state leadership team. As stated, we have looked at COVID-19 as a Black Swan event that requires agility, flexibility, rapid learning and a mindset of trial and assessment. We try to identify critical system requirements, reduce bottlenecks, use commander's intent (clarify desired outcomes, facilitate empowerment and creativity of team members to solve this).

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[1] *People with disabilities desperately need the vaccine. But states disagree on when they'll get it*, The Washington Post (Jan. 13, 2021).

5. President Biden invoked the Defense Production Act in an effort to increase the supply of materials necessary for COVID-19 vaccination. Regardless of implementing the DPA, there is only so much manufacturing capacity, and we must remain cognizant of the ongoing routine health care. In the event that all supplies are dedicated to COVID-19 vaccination efforts, are there strategies or contingency plans to supply other areas of the market, such as childhood vaccinations, which depend on many of the same supplies used for administering the COVID-19 vaccine?

   An extremely important point. It is also a critical point for post COVID-19 opportunities in public and population health to both ready the United States for the next pandemic, but to also focus on improving the health and well-being of our state and country.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Given our hope and expectation that states will soon receive larger allocations of vaccines and supplies, I am focused on the need for states to ramp up their vaccine delivery capabilities. In my home state of Florida, for example, private companies are stepping up to make their expertise and resources available for cold chain purposes. I know other companies across various industries are actively working to find ways to lend their expertise. What specific advice or guidance can you offer companies and organizations who want to assist your state with these efforts, cold chain or otherwise?

   This is a critical point, and we need to harvest the capacity and capability of our private business partners but need to also make sure that we are all focusing on the same targets. Alignment on goals to be reached and on processes to avoid duplication of efforts is key. In this way, private industry partners and state agencies need to work in constant and transparent communications (a Team of Team approach) so that parallel structures that produce more bottlenecks are not created. This is where clear state leadership response structure needs to be enhanced with expertise from the private sector, but still move with agility and not be afraid to change together.

Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations
Hearing on
"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
February 2, 2021

Courtney N. Phillips, Ph.D., Secretary, Louisiana Department of Health

The Honorable Frank Pallone, Jr. (D-NJ)

1. Once COVID-19 vaccine supply is better aligned with demand, do you think vaccine hesitancy will be an additional hurdle in achieving herd immunity in Louisiana? What plans does Louisiana have in place now to build public confidence in the COVID-19 vaccines and encourage vaccination?

Louisiana continues to use data in determining where there might be vaccine hesitancy, as well as areas that are socially vulnerable and might not have easy access to the vaccine. The State of Louisiana has partnered with the Louisiana Public Health Institute and the Louisiana Health Equity Task Force to help identify the many barriers that exist, as is common across the country, on people receiving the vaccine. Through the partnership, Louisiana has conducted two statewide surveys in an ongoing effort to gauge hesitancy. As of March 22, around 15 percent of Louisiana's population is fully vaccinated, with 23 percent of the population having received their first dose of vaccine.

The Louisiana Department of Health (LDH) has teamed up with 21 initial partners to kick off *Bring Back Louisiana #Sleeves Up*, a bold grassroots campaign that will bring COVID-19 vaccines to communities of concern through targeted pilots and outreach. The campaign will begin with 9 pilots – one in each public health region of the state – with community vaccination events taking place the third and fourth weekends of April. LDH is using the CDC's Social Vulnerability Index, data on vaccination rates by census tract, and COVID-19 data to determine where efforts should be focused.

At its heart, *Bring Back Louisiana #SleevesUp* is about meeting people where they are to break down barriers. This initiative is urgent, it is community-based, and it will make sure that *no community* gets left behind when it comes to getting a vaccine.

The charge of this campaign is to follow the data and work with local partners to meet people where they are, especially in our underserved, on-the-fence and hard-to-reach communities, to listen to their needs and break down barriers so that every Louisianan has the opportunity to get the COVID vaccine.

The nine vaccine pilots are just the beginning. Just like any campaign, we will build and learn as we go. You'll see all the hallmarks of a political campaign – the yard signs, the door-knocking, and obviously the stickers. But most importantly, you will see more shots in arms as we meet our goal to end this pandemic.

The Honorable Diana DeGette (D-CO)

1. How will increased certainty surrounding Louisiana's vaccine supply help you maximize the number of first doses you can administer, while also ensuring second doses are available at the right time?

While vaccine levels are still not where they are needed, the change by the federal government over the past months of giving states more visibility on the upcoming allocation of doses has allowed for greater planning, as well as helped us plan more strategically on where certain types of vaccines are placed. The expansion of the federal retail pharmacy program has also allowed the state to provide more vaccines to the more than 2,120 providers registered with the state, with 66 percent of those providers having received the vaccine to distribute. This increased certainty around vaccines has also allowed providers time to adjust staffing needs and allow appointments to be scheduled further in advance.

In a report by the Centers for Disease Control and Prevention (CDC) released on March 15, 2021, Louisiana was ranked first among states at administering second doses of the coronavirus vaccine within the recommended timeframe. This has been accomplished through our partners across the state, made up mainly of independent pharmacies and hospital systems, to ensure that a second dose appointment was scheduled while the individual was receiving their first dose.

The Honorable Kathleen Rice (D- NY)

1. How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?

On March 9, 2021, Louisiana Governor John Bel Edwards made all Louisianans 16 and older with identified health conditions that make them more likely to suffer a serious complication from COVID eligible to receive the vaccine.

   a. How do families and caregivers of children with medical complexity fit into your distribution plans?

Unpaid family caregivers to people who are receiving licensed home and community-based services are eligible to be vaccinated. Professional home care providers (including hospice workers) and home care recipients (including older and younger people with disabilities over the age of 16 who receive community or home-based care, as well as clients of home health agencies) are also available to receive the vaccine in Louisiana. The individuals receiving services all have support coordinators, and the Department has provided talking points and resources for the support coordinators to engage with these individuals, helping them with scheduling and transportation if needed. The support coordinators have spoken to all individuals about vaccination who are age 16 and above.

   b. Once a vaccine is safe and effective for younger children, what are your plans for distribution and administration of vaccine doses for this population?

Our goal is to provide the vaccine to as many individuals who are qualified to receive the vaccine according to CDC guidelines, as quickly as possible. This will include partnering with our Department of Education, Board of Elementary and Secondary Education as well as with pediatricians, to provide education and vaccine access to this population across the state.

The Honorable Morgan Griffith (R-VA)

1. Are you aware of the COVID emPOWER program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death from COVID?

Yes, we are aware of the emPower program and its benefits, including identifying Medicare beneficiaries at greatest risk from COVID-19.

   a. If so, are you using this program to help identify and vaccinate those at greatest risk?

Anyone enrolled in the emPower program is eligible for vaccination in Louisiana. We currently use the data behind emPower in the same manner that we are using both the social vulnerability index and hospitalization/mortality data to identify areas where the greatest risk might exist.

2. According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.[1] Disability advocates say guidance should be interpreted to include all people with disabilities who receive long-term care, whether in large institutions, or in smaller group homes. Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. How do you plan to inoculate this group of individuals?

The State of Louisiana has made individuals over the age of 16 with disabilities who receive home/community based services AND providers of home-based care eligible to receive the COVID-19 vaccine under Phase 1b, Tier 1.

   a. Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?

Individuals with disabilities can access the vaccine at more than 1,800 locations across the state. Louisiana has also provided information to those providers regarding best practices for communicating with and accommodating individuals with disabilities. Some of those practices include:

- Talk directly to the individual. Ask permission to speak with a caregiver or assistant first.
- Do not pretend to understand someone if you cannot. Let them know you are having trouble and try again.
- Use plain language when speaking with patients and caregivers about the COVID-19 vaccine.
- If speaking to someone who uses a wheelchair, try to be at their eyelevel.

- Provide accommodations so that all people in the eligible vaccine group have equal access to COVID19 vaccinations. This includes accommodations for behavioral, intellectual, or physical disabilities

3. One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't.

   Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.

   The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

The federal program to administer vaccines in nursing homes has been a success, as well as the expansion of the federal retail pharmacy program.

We are appreciative of these corporate partners' efforts. Our corporate representatives have been responsive and have tried to resolve problems that have arisen. However, the overall lack of proactive communication and awareness of where vaccines were being distributed through these federal programs, and the amount of doses available has been a source of frustration and has left states spending valuable time trying to gather this information. Louisiana would welcome additional federal programs to provide vaccines if it fit with the state's overall vaccination plan, as well as did not reduce the number of vaccine doses the states receive on a weekly basis.

4. How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?

The Louisiana Department of Health received $307 million as a result of the Congress' passage in December 2020 of the Bipartisan-Bicameral Omnibus COVID Relief Deal. The funds received are being used to:

- establish or enhance the ability to aggressively identify COVID cases, conduct contract tracing and follow up, as well as implementing appropriate containment measures;
- improve morbidity and mortality surveillance;
- enhance testing capacity;
- helping control COVID-19 in high-risk settings to protect vulnerable or high-risk populations;
- working with healthcare systems to manage and monitor system capacity; and

- implementing a large-scale COVID-19 vaccination campaign that includes extensive planning, staffing and enhancements to the Immunization Information System, implement mobile vaccination teams and communication outreach to identified vulnerable populations.

5. What is your state's strategy to reach the level of immunization needed for herd immunity?

    a. What evidence will your state be looking for to determine whether herd immunity has been reached?

Louisiana has a strong track record of hosting mass vaccination events prior to this pandemic and has partnered with the faith-based community to help hold mass vaccination community events in areas that are underserved, are located in pharmacy deserts or identified using the Social Vulnerability Index. These events are driven at the local level by LDH's Regional Medical Directors who are familiar with the needs, potential distribution sites and partners in their area of the state. Louisiana began in January building a "low and wide" strategy for vaccine distribution, working with our strategic partners to get local providers all across the state enrolled and comfortable with the logistics of vaccine receipt and administration. Building a vast network of diverse providers was fundamental in working to achieve equitable coverage, which has been a top priority in Louisiana's planning and rollout from the start.

As we work toward herd immunity, as we have done throughout this pandemic, we look at data on a daily basis determining how many people have received vaccine doses and in what parts of the state. This data is examined at the state, regional and parish levels where we can quickly identify areas that have lower than expected vaccination rates. By targeting these areas we will move closer to herd immunity. We have been transparent in this process, posting information on our COVID-19 dashboard, which can be found at https://ldh.la.gov/covidvaccine/.

6. Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high-quality tests as part of your vaccine roll-out and follow-up?

    a. If yes, how are you using the tests?

    b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

Louisiana is not currently using serology test as part of our vaccine roll-out. As we continue to learn more about the COVID-19 virus and the overall long-term effectiveness of the vaccines, we explore all possibilities to ensure that the residents of Louisiana are protected from this and other viruses in the future.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that

we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

Louisiana has utilized an all-hands-on-deck approach as we have tackled COVID-19. This includes working with hospital systems in our state, independent pharmacies, faith-based groups, the National Guard, other state agencies and more than 2,120 providers to get vaccines in arms, in both urban and rural communities, helping us work toward equitable coverage.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

Louisiana has relied on a number of technologies in providing information to the public. The Louisiana Department of Health website has served as a source of truth for people and the media. The state has been transparent in posting information on our COVID-19 dashboard, which can be found at https://ldh.la.gov/covidvaccine/. This information can be drilled down to the parish level, as well as list locations where vaccines can be located, community-wide vaccine events and additional information for specific groups – such as individuals with developmental disabilities, business owners and educational facilities.

The state also has teamed up with the United Way so any citizen, no matter where they are located in the state, can dial 211 to receive information on where vaccines can be found and answer any concerns and questions they may have. In coordination with LDH, the Governor has held weekly news conferences to update the public on the latest with COVID-19 and available vaccines and eligible groups.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. Given our hope and expectation that states will soon receive larger allocations of vaccines and supplies, I am focused on the need for states to ramp up their vaccine delivery capabilities. In my home state of Florida, for example, private companies are stepping up to make their expertise and resources available for cold chain purposes. I know other companies across various industries are actively working to find ways to lend their expertise. What specific advice or guidance can you offer companies and organizations who want to assist your state with these efforts, cold chain or otherwise?

Since first receiving the vaccine, the State of Louisiana has contracted with Morris & Dickerson, who is a wholesale pharmaceutical distributor, with more than 180 years of experience serving hospitals and pharmacies in Louisiana. While a portion of the state's allocation of vaccine is sent directly to larger hospital systems, Morris & Dickerson receive the state's remaining allocation, distributing the doses to smaller hospitals, pharmacies and other vaccination providers. The partnership has been successful, with the contractor delivering allocations within the same or next day after receiving the vaccine.

House Committee on Energy and Commerce

Subcommittee on Oversight and Investigations
Hearing on
"No Time to Lose: Solutions to Increase COVID-19 Vaccinations in the States"
February 2, 2021

Jill Hunsaker Ryan, M.P.H., Executive Director, Colorado Department of Public Health and Environment

Ms. Ryan's responses to questions submitted for the record follow.

1. How will the 50 pop-up COVID-19 vaccination sites Colorado intends to stand-up in high-density, low-income communities of color fill the gaps in the existing health care system and ensure those at higher risk of the disease can, in fact, get vaccinated?

The state allocates 15% of its vaccine allocation to health equity clinics every week. The state works directly with community-based organizations, providers, local public health agencies, and Tribes to set up events and ship doses directly to providers in the top census tracts that have a high density of low-income and minority communities. We know that especially in communities of color there is a lack of trust in the vaccines so having trusted community partnerships is key to reach as many Coloradans as possible. We have had community clinics already in more than 30 counties, as well as throughout the Denver metro area, with plans for more. We are also working with 9Health to use their established infrastructure and community partnerships to pilot clinics in some of these same communities. The Vaccine Equity Outreach Team typically supplies the vaccine doses, staffing support, and technical assistance. The team works with community organizations who execute outreach to their community members and registration.

2. What actions is Colorado taking to communicate with the public to ensure they return for their second dose for the full vaccination regimen?

Providers typically schedule the second dose when individuals receive their first dose. Providers send reminders to ensure individuals keep their second appointment.

1. How do adolescents – those currently able to receive the Pfizer vaccine – and specifically adolescents with complex medical needs fit into your state's vaccine distribution plans?

Individuals 16 and up with certain higher risk conditions now are eligible to receive the vaccine. Individuals 16 and up with no higher risk conditions should be able to schedule their first dose by the end of May

a. How do families and caregivers of children with medical complexity fit into your distribution plans?

Caregivers could fall under Phase 1B.1 -- Health care workers with less direct contact with COVID-19 patients (e.g. home health, hospice, pharmacy, dental, etc.) and EMS.

- Different agencies may use the term "home care workers" to describe all in-home assistance for people who are aging and/or have disabilities. For the purposes of Medicaid reimbursement, it means nearly all Home and Community Based Services (HCBS) workers, including Consumer Directed Attendant Support Services (CDASS) and In Home Support Services (IHSS). Family caregivers, privately paid caregivers, and private insurance and Medicare funded caregivers are all included as well.

b. Once a vaccine is safe and effective for younger children, what are your plans

for distribution and administration of vaccine doses for this population?

We are closely following vaccine advancements and will distribute safe vaccines that the FDA has approved for Emergency Use Authorization.

1. Are you aware of the COVID emPOWER program that permits identifying the Medicare beneficiaries who are at greatest risk for hospitalization and death from COVID?

The U.S. Department of Health and Human Services manages the emPower Program, which primarily works to alert first responders about individuals who require electricity-dependent medical devices. In the event of a large scale power outage, the program can alert first responders to these individuals' specific needs.

While individuals participating in the emPOWER program might qualify in our top vaccination phases, it would depend on their individual circumstances.

If so, are you using this program to help identify and vaccinate those at greatest risk?

We know that individuals 70 and up are at a much higher risk of death if they contract COVID-19. That population, along with staff and residents of long-term care facilities, were the first in Colorado to receive the vaccine.

2. According to The Washington Post, tens of thousands of Americans with intellectual and developmental disabilities — who are two to three times as likely to die of COVID-19 — are waiting for an answer to when they will receive a COVID-19 vaccine.Disability advocates say guidance should be interpreted to include all people with disabilities who receive long-term care, whether in large institutions, or in smaller group homes. Most states make no mention of disabilities in their vaccine plans, leaving people confused about how long they and those for whom they care will have to wait. How do you plan to inoculate this group of individuals?

It is good news that so many Coloradans want to get vaccinated as soon as possible; and we understand many families have unique circumstances that have them worried about their loved ones contracting COVID-19. Although we wish we could, because of a limited federal supply, we simply cannot vaccinate everyone right now. The timeline is subject to change based on the federal supply chain. Prioritization is subject to change based on data, science, and availability.

Individuals in Phase 1B.4 are now eligible for the vaccine, which includes some high risk conditions, including Downs syndrome. Others might have become eligible in 1B.3. If a developmental disability prevents someone from safely/adequately wearing a mask, they would be eligible for Phase 2.

Everyone who wants a vaccine will eventually be able to get one. We hope that everyone who wants a vaccine will be able to get at least the first dose by the end of May.

a. Since this group of individuals may not be able to independently access the state's current information and scheduling portals, what type of avenues will your state use to notify people with disabilities when they become eligible and offer them assistance when booking appointments?

We have several resources for anyone who needs help finding an appointment. Our vaccine hotline - 1-877-CO-VAX-CO or 1-877-268-2926 - operates around the clock. Our website also lists vaccine providers in the state. Community partners also work with individuals in their communities to ensure they have access to vaccine appointments.

3. One of the issues we are hearing about as the vaccination campaign unfolds is the difficulty some non-hospital-based health care providers are having in accessing the vaccine for their staff. In some states, the rollout for health care providers does seem to be going relatively smoothly. However, in others, it is a real struggle. Employers are not able to help sign their health care workers up for vaccinations. Instead, employees have to navigate an ad hoc system on their own without any centralized access point. Depending on local distribution realities, these health care providers are told to check with county health departments, to sign up on state websites, or to call local hospitals. Sometimes it works, sometimes it doesn't. Health care providers are on the front lines, not only as it relates to exposure but also as potential spreaders of infection to the patients they serve, many in home settings. We have to figure this out and we need to act quickly.
The federal government has contracted with CVS and Walgreens to make COVID-19 vaccines available to nursing home patients and staff. Would it make sense to expand this contract, or set up additional contracts with national health care providers, to permit other patient facing health care workers organized and predictable access to the vaccine?

The Federal Retail Pharmacy Program provides vaccines directly to select pharmacies so they can administer the vaccine. This program is one component of the Federal government's strategy to expand access to vaccines for the American public.

Our website lists more than 1,000 vaccine providers across the state who can administer the vaccine. We also are operating six mass vaccination clinics across the state.

4. How does your state plan to use the funding from the recent stimulus package to secure surge resources to help improve vaccine administration in your state?

We do not yet know what funds we will be receiving or what spending parameters might be included.

5. What is your state's strategy to reach the level of immunization needed for herd Immunity?

Everyone who wants a vaccine should be able to get at least their first dose by the end of May.

a. What evidence will your state be looking for to determine whether herd immunity has been reached?

We will closely monitor statewide disease transmission and hospitalization rates. It likely will be some time before we learn whether we've achieved community immunity, and it will depend on the length of time the vaccinations provide immunity, whether people have lasting immunity from previous infection, and when vaccinations are available for children 16 and under.

6. Another tool that is available as we move to vaccinate Americans as quickly as possible – high-quality serology tests. Certain serology tests, called quantitative or semi-quantitative tests, can measure the approximate level of antibodies in a person's body. These tests can be used to track the immune system's response to a COVID-19 vaccine – helping to identify when a booster shot may be needed among other benefits. Are any of your states using, or have you considered using, these high quality tests as part of your vaccine roll-out and follow-up?

a. If yes, how are you using the tests?

b. If no, do you see a benefit to tracking the durability of the immune response, particularly considering some of the mutated strains like those from South Africa, Brazil, or United Kingdom?

We are tracking the number of people who have completed their vaccination series and who still contract COVID-19. We provide that information to the Centers for Disease Control and Prevention and are using the information to track disease transmission trends. As is the the case with any vaccine, some individuals who get vaccinated still will contract COVID-19.

7. One of the issues we hear about is the difficulty states and providers are having at the last mile, actually getting shots into arms. Once Phase 1 has been completed, do you agree that we should have an all-hands-on deck approach, using all of America's commercial distribution resources, customer connectivity, expertise and end-to-end logistics across a multitude of provider settings, to ensure the American public has expedited and equitable access to a vaccine once we get to broad distribution?

We want to distribute the vaccine as equitably and efficiently as possible, and that's becoming easier with the increased federal supply chain. Ultimately, we want the COVID-19 vaccine to be as easy to obtain as a flu shot.

We have made incredible progres in our vaccination efforts. So far, 80 percent of those 70 and up have received at least one dose of the vaccine. By the end of May, we hope everyone who wants a vaccine will have received at least their first dose.

We also are operating six mass vaccination clinics across the state.

8. What technologies or other resources is your state using to provide the public with information about COVID-19 vaccines? In particular, how are you connecting with those rural communities, where internet-based communication is often less reliable?

We have several resources for anyone who needs help finding an appointment. Our vaccine hotline - 1-877-CO-VAX-CO or 1-877-268-2926 - operates around the clock. Our website also lists vaccine providers in the state. Community partners also work with individuals in their communities to ensure they have access to vaccine appointments.

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Our Joint Vaccine Task Force is managing our vaccination rollout.