

A SHOT AT NORMALCY: BUILDING COVID-19 VACCINE CONFIDENCE

VIRTUAL HEARING

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INVESTIGATIONS
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¹Dr. Omer's statement has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF02/20210526/112684/HHRG-117-IF02-Wstate-OmerS-20210526-U1.pdf>.

A SHOT AT NORMALCY: BUILDING COVID-19 VACCINE CONFIDENCE

WEDNESDAY, MAY 26, 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, Peters, Schrier, Trahan, Pallone (ex officio), Griffith (subcommittee ranking member), Burgess, McKinley, Long, Joyce, Palmer, and Rodgers (ex officio).

Also present: Representatives Bilirakis and Carter.

Staff present: Kevin Barstow, Chief Oversight Counsel; Jesseca Boyer, Professional Staff Member; Jeffrey C. Carroll, Staff Director; Austin Flack, Policy Analyst; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Clerk; Rebekah Jones, Counsel; Chris Knauer, Oversight Staff Director; Mackenzie Kuhl, Digital Assistant; Kaitlyn Peel, Digital Director; Peter Rechter, Counsel; Tim Robinson, Chief Counsel; Chloe Rodriguez, Clerk; Caroline Wood, Staff Assistant; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; Diane Cutler, Minority Detailee, Oversight and Investigations; Theresa Gambo, Minority Financial and Office Administrator; Marissa Gervasi, Minority Counsel, Oversight and Investigations; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Olivia Shields, Minority Communications Director; Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

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

Today the hearing—the committee is holding a hearing entitled, “A Shot at Normalcy: Building COVID–19 Vaccine Confidence.”

Today’s hearing will explore strategies for increasing confidence in and uptake of COVID–19 vaccines.

Due to the health emergency, as I noted, today's hearing is being held remotely. All witnesses, Members, and staff will be participating via video conferencing.

And, as is usual for our proceeding, microphones will be set on mute for the purposes of eliminating inadvertent background noise. Members and witnesses, don't forget you will need to unmute each time you wish to speak.

Now, if at any time I am unable to continue as chair, which has happened because of technology, the vice chair of the subcommittee, Mr. Peters, will serve as chair until I am able to return.

Documents for the record can be sent to Austin Flack at the email address that all of the staff has. And all of the documents will be entered into the record at the conclusion of the hearing.

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 we continue our oversight of the Nation's COVID-19 response efforts.

Throughout the pandemic, this subcommittee has conducted robust oversight over a range of critical issues, including vaccine development and distribution [audio malfunction] enter a new phase of the pandemic, today's hearing addresses one of the most consequential COVID-19 issues that this subcommittee has examined: the pressing need to increase COVID-19 vaccine confidence and uptake in the United States. And it is simple, why. If not enough people get vaccinated, the massive investments that we have made to develop the vaccines and the extraordinary efforts that we have made to make them widely available will never reach their full potential.

Now, fortunately, we are making significant progress. In just 5 months, more than 160 million Americans have received at least 1 COVID-19 vaccine. And over 85 percent of seniors have received at least 1 dose. In the 2 weeks since the FDA authorized Pfizer's vaccine for children ages 12 to 15, more than 2 million children in this age group received their first dose.

Thanks to the millions of Americans who have chosen to get a safe and effective COVID-19 vaccine, we do have a shot at returning to normalcy. So, if you want to take off your masks, if you want to get together with friends and family safely, if you want to go on vacation, then join the millions of Americans who have done it, and get vaccinated.

Here is the bad news, though: We are not out of the woods yet. Although it is easier to get a vaccine, millions of Americans remain unvaccinated, and immunization rates in many places remain alarmingly low. In some States, less than 30 percent of the population has received even—I am sorry, less than 40 percent of the population has received even a single dose. And since peaking in mid-April, we have seen a decline in the number of daily doses administered across the country.

This is worrying. And, frankly, it is going to take a collective push to get to the Biden administration's goal of 70 percent of American adults having at least 1 shot by the Fourth of July. That

is why this subcommittee is working tirelessly to support vaccination efforts nationwide, including today's hearing, which explores why some people so far haven't gotten vaccinated.

So that is the big question: Why haven't some people gotten vaccinated?

Polling indicates that many unvaccinated Americans have safety concerns or unanswered questions about how the vaccines work. Compounding these problems, rampant misinformation and outright lies are spreading on social media platforms, in many cases igniting viral hoaxes and fueling vaccine hesitancy.

But low vaccine confidence isn't the only reason for the slow uptake. Some unvaccinated Americans, especially in rural areas and communities of color, still confront access challenges, like the inability to take off of work or to get a vaccine from a trusted source.

Additionally, far too many Americans—in particular, young adults—they just don't have the urgency or motivation to get vaccinated. They don't understand that, while they are likely to have a mild case, they could get a serious case or even die—and worse, infect others who are at risk.

Clearly, this is not a one-size-fits-all solution. It often takes the right message, from the right source, delivered at the right time. We are going to need a variety of strategies and incentives to overcome the range of reasons keeping unvaccinated Americans on the fence.

I believe that our witnesses today can shed light on these challenges, and I want to thank every single one of them for being with us. I look forward to discussing, at the end, what is working and what needs to be done.

And so I just want to say a few things, in conclusion.

If you are worried about the vaccine's safety, you should know millions of doses have been administered throughout the country and around the world. The data is in. The vaccines are safe.

If you are unsure about the vaccine's efficacy, you should know extensive, real-world data is available, and it shows the vaccines are extremely effective. They prevent hospitalization and severe illness, and they save lives.

And if you question the benefit of getting vaccinated, you should know that fully vaccinated Americans can resume their prevaccine lives and go around without wearing a mask or physical distancing. So you can get back to your normal life. I was at a press conference yesterday at the State legislature, and everybody had a vaccine, and nobody had a mask, and it was wonderful.

The facts are not in dispute. The only question is, how can we help unvaccinated Americans get their shots? I know, if we work together in a bipartisan fashion, we can do just that, and that is why I am so pleased again to have our witnesses.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Today, we continue our oversight of the Nation's COVID-19 response efforts.

Throughout the pandemic, this subcommittee has conducted robust oversight over a range of critical issues, including vaccine development and distribution challenges.

As we enter a new phase of the pandemic, today's hearing addresses one of the most consequential COVID-19 issues this subcommittee has examined: the pressing need to increase COVID-19 vaccine confidence and uptake in the United States.

Because if not enough people actually get vaccinated, the massive investments made to develop these vaccines, and the extraordinary efforts to make them widely available, will never reach their full potential.

Fortunately, we are making significant progress. In just five months, more than 160 million Americans have received at least one dose of a COVID-19 vaccine. Over 85 percent of American seniors have received at least one dose.

And, in the two weeks since FDA authorized Pfizer's vaccine for children ages 12 to 15 years old, more than 2 million children in this age group received their first dose.

Thanks to the millions of Americans who have chosen to get a safe and effective COVID-19 vaccine, we now have a shot at returning to normalcy. So if you want to take off your masks, get together with friends and family safely, or go on vacation, then join these millions of Americans—and go get vaccinated.

But here is the bad news: We are not out of the woods yet.

Although it is easier than ever to get a vaccine, millions of Americans remain unvaccinated—and immunization rates in many places remain alarmingly low.

In some States, fewer than 40 percent of the population has received even a single dose. And, since peaking in mid-April, we have seen a decline in the number of daily doses administered across the country.

This is worrying, and it will take a collective push to reach the Biden administration's goal of 70 percent of American adults having at least one shot by the Fourth of July.

That's why this subcommittee has been working tirelessly to support vaccination efforts nationwide—including by holding today's hearing exploring why some Americans have, so far, not gotten vaccinated.

So why are some people still not getting vaccinated?

Polling indicates that many unvaccinated Americans have safety concerns or unanswered questions about how the vaccines work.

Compounding these problems, rampant misinformation and outright lies are spreading on social media platforms—in many cases, igniting viral hoaxes and fueling vaccine hesitancy.

But low vaccine confidence is not the only reason for the slowing uptake.

Some unvaccinated Americans—especially in rural areas and communities of color—still confront access challenges, such as the inability to take off work or obtain a vaccine from a trusted source.

Additionally, far too many Americans—particularly younger adults—do not have the sense of urgency or motivation to go get vaccinated.

Clearly, there is not a one-size-fits-all solution. It often takes the right message from the right source, delivered at the right time. We will need a variety of strategies and incentives to overcome the range of reasons keeping unvaccinated Americans on the fence.

Thankfully, our witnesses here today can shed light on these challenges. I look forward to discussing what is working and what more needs to be done to increase vaccine confidence and uptake.

At the end of the day, I hope that any American watching this hearing who is unsure whether to get vaccinated takes away these key facts:

If you are worried about the vaccines' safety, you should know that hundreds of millions of doses have now been administered throughout the country. The data is in. The vaccines are safe.

If you are unsure about the vaccines' effectiveness, you should know that extensive, realworld data is available and shows the vaccines are extraordinarily effective. They prevent hospitalization and severe illness, and they save lives.

And, if you question the benefit of getting vaccinated, you should know that fully vaccinated Americans can resume their pre-pandemic lives without wearing a mask or physically distancing. So, if you get vaccinated, you can start getting back to normal life.

These facts are not in dispute. The only question is how we can help unvaccinated Americans get their shots. I am confident that if we work together, in a bipartisan fashion, we can build trust and increase uptake—and make our shot at normalcy a reality.

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

We have got some background noise somewhere. Everybody needs to make sure they are muted.

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

Mr. GRIFFITH. Thank you, Madam Chair. I appreciate that. If I may take a brief moment of personal privilege, and just say that all of us in Virginia are mourning the passing of former Senator John Warner, who served Virginia ably and was a very nice man. And so we are mourning his passing overnight.

That being said, I do appreciate you holding this hearing on building COVID-19 vaccine confidence.

I also want to thank the witnesses for taking the time to join us today, especially Dr. Karen Shelton, who is from the 9th District of Virginia and doing some great work to serve all of the people in southwestern Virginia.

We have come a long way since the first confirmed case of COVID, as SARS-CoV-2, which causes COVID, and that was diagnosed in January of 2020. Today we have three safe and effective vaccines with enough supply for every American aged 12 and up who wants one. So far, over 61 percent of the U.S. population have received at least 1 dose. While we are well on our way to returning to normalcy, we still have to work to reach the higher rates of vaccinations necessary to eliminate the virus. The virus is a significant threat to our public health.

At the beginning of the national vaccination campaign, demand exceeded supply. Now the U.S. faces the opposite problem: the vaccine supply is plentiful and exceeds the number of people in line to be vaccinated. The current unvaccinated population varies in its demographics, intentions, and concerns about the COVID-19 vaccines.

There are about 13 percent of individuals who say they will definitely not receive the COVID-19 vaccine, yet there is a slightly larger share of individuals, 15 percent, who are waiting to see how the COVID-19 vaccine is working on other people before they receive their shot. These individuals could be persuaded to get COVID-19 vaccines by receiving answers to their questions and concerns. The leading concerns that contribute to vaccine hesitancy are that COVID-19 vaccines are not safe as they are said to be and that individuals will experience side effects following vaccination.

Individuals are also concerned about what is actually misinformation about infertility and other possible long-term effects from getting the COVID-19 vaccines. Trusted messengers need to meet these Americans where they are, by listening to their concerns and asking permission to share accurate information to help them reach the right decision for each individual, while reinforcing their safety, dignity, choice, and autonomy.

My home district is a region of rural communities. The Centers for Disease Control and Prevention released a study last week that people in rural areas are receiving the COVID-19 vaccines at a lower rate than those in urban areas. My district is actually doing fairly well, but this study demonstrates a need to identify the barriers in many rural communities and to find solutions to remove them.

Additionally, I have heard from my district on reasons why there are lower rates of vaccination. Two common factors contributing to

the lower rates are a lack of information on the technology of the COVID-19 vaccines as well as a lack of access to receive the vaccine. The good part about these barriers is that they can be removed. We can provide accurate information on the decades of development for the mRNA technology in two of the vaccines, and that there were no cuts in safety requirements, just cuts in red tape.

We find innovative ways—we can find innovative ways to bring vaccines to the people through mobile vaccination clinics. Public health practitioners should continue collaborating with healthcare providers, pharmacies, employers, faith leaders, and other community partners to identify and address barriers to COVID-19 vaccination in rural areas and other communities.

Another key group of individuals who benefit from receiving the vaccine are children. Yes, COVID-19 is usually milder in children as compared to adults, but some children can get very sick and suffer complications from COVID-19. It is crucial to target messaging and provide accurate information and resources to this population so parents can make the best decisions for their children.

According to the CDC, more than a half-million children between ages 12 and 15 received a Pfizer vaccine just 1 week after it was approved for this age group. This is a great accomplishment, and I hope we can continue to work with advocacy groups to provide parents with the necessary information to make this decision so they are confident in getting their children vaccinated. I look forward to hearing from our witnesses today on what messages and strategies work best to remove barriers to a much higher level of COVID-19 vaccination throughout the United States so that we can all return to normalcy.

Thank you, Madam Chair, and I yield back.

[The prepared statement of Mr. Griffith follows:]

PREPARED STATEMENT OF HON. H. MORGAN GRIFFITH

Thank you, Chair DeGette, for holding this hearing on building COVID-19 vaccine confidence. I also want to thank the witnesses for taking the time to join us today, especially Dr. Karen Shelton, who is from my district, and doing some great work to serve southwestern Virginia.

We have come a long way since the first confirmed cases of SARS-CoV-2, the virus that caused COVID-19, were diagnosed in the U.S. in January 2020. Today, we have three safe and effective vaccines with enough supply for every American age twelve and up who wants one. So far, over 61 percent of the U.S. population has received at least one dose.¹ While we are well on our way to returning to normalcy, we still have work to do to reach the higher rates of vaccinations necessary to eliminate the virus' significant threat to our public health.

At the beginning of the national vaccination campaign, demand exceeded supply. Now, the U.S. faces the opposite problem—the vaccine supply is plentiful and exceeds the number of people in line to be vaccinated.

The current unvaccinated population varies in its demographics, intentions, and concerns about the COVID-19 vaccines. There are about 13 percent of individuals who say they will “definitely not” receive the COVID-19 vaccine.² Yet, there is a slightly larger share of individuals, 15 percent, who are waiting to see how the COVID-19 vaccine is working on other people before they receive their shot.³ These

¹ <https://covid.cdc.gov/covid-data-tracker/#vaccinations>.

² <https://www.kff.org/coronavirus-covid-19/dashboard/kff-covid-19-vaccine-monitor-dashboard/messages/messages/information>.

³ <https://www.kff.org/coronavirus-covid-19/dashboard/kff-covid-19-vaccine-monitor-dashboard/messages/messages/information>.

individuals could be persuaded to get COVID-19 vaccines by receiving answers to their questions and concerns.

The leading concerns that contribute to vaccine hesitancy are that the COVID-19 vaccines are not as safe as they are said to be, and that individuals will experience side effects following vaccination. Individuals are also concerned about what is actually misinformation about infertility and other possible long-term effects from getting the COVID-19 vaccines. Trusted messengers need to meet these Americans where they are, by listening to their concerns and asking permission to share accurate information to help them reach the right decision for each individual while reinforcing their safety, dignity, choice, and autonomy.

My home district is a region of rural communities. The Centers for Disease Control and Prevention (CDC) released a study last week that people in rural areas are receiving the COVID-19 vaccines at a lower rate than those in urban areas.⁴ My district is actually doing pretty well, but this study demonstrates a need to identify barriers many rural communities are facing and find solutions to remove them.

Additionally, I have heard from my district on reasons why there are lower rates of vaccination. Two common factors contributing to the lower rates are a lack of information on the technology of the COVID-19 vaccines as well as a lack of access to receive the vaccine. The good part about these barriers is that they can be removed. We can provide accurate information on the decades of development for the mRNA technology in two of the vaccines and that there were no cuts in safety requirements, just cuts in red tape. We can find innovative ways to bring vaccines to the people through mobile vaccination clinics. Public health practitioners should continue collaborating with health care providers, pharmacies, employers, faith leaders, and other community partners to identify and address barriers to COVID-19 vaccination in rural areas or other communities.

Another key group of individuals who benefit from receiving the vaccine are children. Yes, COVID-19 is usually milder in children as compared to adults, but some children can get very sick and suffer complications from COVID-19. It is crucial to target messaging and provide accurate information and resources to this population so parents can make the best decision for their children. According to the CDC, more than half a million children between ages 12 to 15 received a Pfizer vaccine just one week after it was approved for this age group. This is a great accomplishment, and I hope we can continue to work with advocacy groups to provide parents with the necessary information to make this decision so that they are confident in getting their children vaccinated.

I look forward to hearing from our witnesses today on what messages and strategies work best to remove barriers to a much higher level of COVID-19 vaccination throughout the U.S. so that we can all return to normalcy.

Thank you, Madam Chair, I yield back.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the chair of the full committee, Mr. Pallone, for an opening statement for 5 minutes.

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

Mr. PALLONE. Thank you, Chairwoman DeGette, and thanks for this continued effort of the Oversight and Investigations Subcommittee to do critical oversight of the COVID-19 vaccination campaign in our country.

Through the collective efforts of the American people over the past year, we have overcome the initial challenges of developing, producing, and distributing safe and effective vaccine. But now we face the more difficult task of reaching those Americans who have yet to embrace this important tool.

The fact is, vaccine doubts and fears are not new challenges. In fact, this committee has a history of addressing these issues in a bipartisan manner. In 2019, for example, we held a hearing on the

⁴ <https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e3.htm?s=cid=mm7020e3—x>.

measles outbreak and renewed our efforts to provide resources to support vaccine confidence and uptake throughout the Nation. And we followed that with bipartisan legislation led by Representative Schrier. It finally passed late last year. And that bill authorized a campaign to educate and inform Americans on the benefits of vaccine. Earlier this year we significantly expanded upon those activities in the American Rescue Plan, which invested \$160 billion in COVID-19 response efforts, and that included \$20 million in dedicated resources for vaccine distribution clinics, mobile units, and an awareness campaign.

So, while these issues of awareness and confidence are not new, the gravity of the challenges facing us today is unprecedented because of the pandemic. Millions are stricken ill, more than a half a million lives tragically lost, and the enormous toll on the mental and financial well-being of Americans.

But in the face of all this, we have risen to the occasion. We have worked together at a Federal, State, and local level through public and private partnerships and across political lines to develop several safe and effective vaccines. And we have solved supply issues and continue our work to ensure equitable distribution. And the result of this collective effort, if you are 12 years or older and you want a COVID vaccine, there is one waiting for you now.

So I just wanted to mention not only decisive action by Congress and the Biden administration's leadership, now we have more than 116 million Americans who have received at least 1 dose of the vaccine, and more than 130 million of those are fully vaccinated.

So the number of new daily cases and deaths have fallen significantly since the start of the year. This is, obviously, cause for celebration. But we can't stop until more Americans are protected from COVID-19, and that is what we are going to hear about today. What are the next steps?

What we know so far is there is no single factor causing eligible unvaccinated Americans to sit on the sidelines. Some people are skeptical of the vaccine's safety or worry about long-term effects. Some have been misled by bogus and misleading information. Still others have a distrust of the medical system or the government's role in developing vaccines. And many Americans, particularly in rural communities and in communities of color, are open or even eager to be vaccinated, yet continue to face barriers to access. So this—there is not one reason, Madam Chair, why some Americans remain unvaccinated, and there is no single solution.

But the encouraging news is that our efforts have been successful so far. Poll after poll shows increasing confidence in the COVID-19 vaccines. And that progress, though, did start to plateau relatively recently. So that is why we have to redouble our efforts to understand who could be reached and how best to reach them. We have to do a lot of hard work, really, to just go out and meet people where they are.

As we enter this vaccine campaign and its new aspects of it, I am pleased to be working alongside our Republican colleagues to encourage Americans to roll up their sleeves. I think that if we really want to be—go back to normalcy, we need every eligible American to make the right choice, get a shot, protect themselves, their community, and the Nation.

So, again, I am just looking forward to the witnesses. I want to say to everyone—they may already know—that Chairwoman DeGette has been outspoken in continuing this oversight of the vaccine campaign, and today is a manifestation of that.

And I appreciate your prioritizing this in your subcommittee. It is very important.

And thanks to Morgan Griffith, as well.

I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Today we continue our critical oversight of the COVID-19 vaccination campaign in the United States—our best shot at containing the virus and beating this pandemic.

Through the collective efforts of the American people over the past year, we have overcome the initial challenges of developing, producing, and distributing safe and effective COVID-19 vaccines. But we now face the difficult task of reaching those Americans who have yet to embrace this life-saving tool.

Vaccine doubts and fears are not new challenges. In fact, this committee has a history of addressing these issues in a bipartisan manner.

In 2019, for instance, we held a hearing on the measles outbreaks and renewed our efforts to provide resources to support vaccine confidence and uptake throughout the Nation. We followed that with bipartisan legislation led by Representative Schrier, finally passed late last year. The legislation authorized a campaign to educate and inform Americans on the benefits of vaccines and increase our understanding of how best to reach unvaccinated individuals.

Earlier this year, we significantly expanded upon those activities in the American Rescue Plan, which invested \$160 billion in COVID-19 response efforts. This included \$20 billion in dedicated resources for vaccine distribution and administration, vaccination clinics, mobile vaccination units, and a vaccine awareness campaign.

While issues surrounding vaccine confidence are not new, the gravity of the challenges facing us today is unprecedented as we continue to combat this pandemic. Millions stricken ill. More than half a million lives tragically lost. And enormous tolls taken on the mental and financial well-being of too many Americans.

In the face of all this pain and hardship, this Nation has again risen to the occasion. We have worked together at the Federal, State, and local levels; through public and private partnerships; and across political lines to develop several safe and effective vaccines. We have also solved supply issues and continue our work to ensure equitable distribution throughout the country.

As a result of this collective effort, if you are 12 years or older and you want a COVID-19 vaccine, there is one waiting for you.

And, thanks to decisive action by Congress, combined with the Biden administration's bold leadership and determined commitment to science, more than 160 million Americans have received at least one dose of a vaccine, and more than 130 million of those are fully vaccinated.

Because of this, the number of new daily cases and deaths have fallen significantly since the start of the year.

This is cause for celebration. Our efforts, however, must not stop until more Americans are protected from COVID-19. And, as we will hear today, more work is needed.

Today, there is no single factor causing eligible, unvaccinated Americans to sit on the sidelines. Some people are skeptical of the vaccines' safety or worry about long-term side effects. Some have been misled by bogus and misleading information that pollutes social media. Still others have an understandable distrust of the medical system or the government's role in developing the vaccine. Many more Americans—particularly in our rural communities and in communities of color—are open, or even eager, to be vaccinated, yet continue to face barriers to access.

Just as there is no one reason why some Americans remain unvaccinated, there is no single solution to building vaccine confidence to get more people vaccinated.

The encouraging news is that our efforts have been successful so far: Poll after poll has shown increasing confidence in COVID-19 vaccines since the first one was authorized more than five months ago. But that progress has begun to plateau while millions of unvaccinated Americans still remain vulnerable to the virus.

That's why we must redouble our efforts to understand who can be reached and how best to reach them. We must do the hard work of meeting people where they are.

The importance of this work cannot be overstated. As we enter a critical juncture of our vaccination campaign, I am pleased to be working alongside our Republican colleagues to encourage Americans to roll up their sleeves.

If we are to have a true shot at normalcy, we need every eligible American to make the right choice: Get a shot and protect themselves, their community, and the Nation.

Thank you to our witnesses for being here today, I yield back.

Ms. DEGETTE. Thank you so much, Mr. Chairman, and the Chair is now pleased to recognize the ranking member of the full committee, Mrs. McMorris Rodgers, for 5 minutes for 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 Republican Leader Griffith. Thanks to the innovative work of the private sector, the Trump administration, Operation Warp Speed, and the continued work of the Biden administration, America has led the way with safe and effective vaccines. It is a historic and remarkable example of American innovation that is giving people the courage to dream again.

As we work to get a vaccine to every person who wants one, building trust and confidence is foundational. Our goal today is to equip people with the information they need to make the best decisions for themselves, their children, and their families. That is the American way: to lead with trust, not fear.

So I want to thank our distinguished panel for being here to share their expertise and answer questions people may have about the COVID-19 vaccines.

I would now like to yield the remainder of my time to Dr. John Joyce, who is leading, with other doctors in Congress, to encourage people to talk to their doctors about the safety of COVID-19 vaccines.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY McMORRIS RODGERS

Thank you, Chair DeGette and Republican Leader Griffith.

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... America has led the way with safe and effective vaccines.

It's a historic and remarkable example of American innovation that is giving people the courage to dream again.

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... and answer questions people may have about the COVID-19 vaccines.

I would now like to yield the remainder of my time to Dr. John Joyce, who is leading with other doctors in Congress to encourage people to talk to their doctors about the safety and efficacy of COVID-19 vaccines.

Mr. JOYCE. I would like to thank——

Ms. DEGETTE. The gentleman is recognized.

Mr. JOYCE. I would like to thank Ranking Member McMorris Rodgers for yielding me time, and for Chair DeGette and Ranking Member Griffith for holding this hearing on such an important topic.

Safe and effective vaccines are critical tools as our Nation seeks to eradicate the COVID-19 pandemic and restore our normal way of life as Americans. Thanks to the success of Operation Warp Speed under President Donald Trump's leadership, multiple safe vaccines were developed and produced in record time.

As a physician, I believe that every American who wants a vaccine should be able to get one, and this choice must remain between an individual and their doctor and pharmacist. Alongside other doctors in Congress, I have encouraged every American to talk to their own doctor or healthcare provider or pharmacist. Discuss the vaccine. I chose to get the vaccine as soon as it was available to me. Doctors, nurses, and pharmacists nationwide recommend that the COVID-19 vaccine is received by their patients, and over 90 percent of doctors in the U.S. have already chosen to become vaccinated.

There are many reasons that some people, even those who want to be vaccinated, still have not been vaccinated. This is a concern to all of us. These include those who do not have the time; those who do not have the ability to sign up to get a vaccine; and those who are concerned about taking time off from work, especially if they have side effects; those who still have questions about concerns of the safety and effectiveness of vaccines. These are all individuals who have yet to be vaccinated.

We have also heard about access challenges, including for those who live in rural areas of the country. For instance, there are people who do not have internet, a computer, or a smartphone. They don't know how to sign up for an appointment without those resources. We have also heard instances of people who live far away from the closest place offering COVID-19 vaccines. These are some of the hurdles that need to be overcome so that those who live in rural areas are not disproportionately impacted in their ability to get a COVID-19 vaccine, simply because of where they live.

Widespread vaccination is the key to restoring our freedom and getting our communities back to normal. I look forward to working with the members of this committee in achieving these goals.

Thank you, and I yield back, Madam Chair.

Ms. DEGETTE. I thank the gentleman. Does the gentlelady yield back, as well?

Mrs. RODGERS. Yes, Madam Chair, I yield back the remainder of our time.

Ms. DEGETTE. Thank you. OK, thank you.

The Chair will ask unanimous consent that all Members' written opening statements be made part of the record.

And without objection, so ordered.

I am now going to introduce our witnesses for today's hearing. But before I do, I just want to note so often—just yesterday, for example, I was in a panel discussion where people were lamenting the lack of bipartisanship in Congress. This is the Oversight Sub-

committee of Energy and Commerce, and I just want to say how anybody watching this should recognize that, in a strong bipartisan way, the leadership of this committee, which has oversight over healthcare policy in the U.S. Congress, is bipartisan in their strong urging of all Americans to get the vaccine. And I want to thank my colleagues for their strong commitment, and Dr. Joyce, and all the other doctors on the committee, for being so outspoken.

With that, I want to introduce our witnesses.

Our first witness is Nick Offerman, and my sheet here says “Actor and Woodworker.” And I would like to say welcome. I am a big fan, and I know the other members of this committee are, as well.

Dr. Saad Omer, who is the director of Yale Institute for Global Health at Yale University.

Dr. J. Nadine Gracia, executive vice president and chief operating officer of the Trust for America’s Health.

Amy Pisani, executive director of Vaccinate Your Family.

And now I am going to recognize Mr. Griffith to introduce our last witness.

Mr. GRIFFITH. Thank you, Madam Chair.

Ms. DEGETTE. Mr. Griffith, you are muted.

Mr. GRIFFITH. Thank you, Madam Chair, I appreciate it.

It is my pleasure to welcome Dr. Karen Shelton. A native of Bristol, Virginia, she received her bachelor of science in biology from Wake Forest and her doctor of medicine from the University of Virginia. She practiced for 19 years in OB/GYN, as an OB/GYN, before joining the public sector. Today she serves the Virginia Department of Health as director of the Mount Rogers Health District and acting director of Lenowisco and Cumberland Plateau Districts.

And Dr. Shelton, we are glad to have you here today, and so proud of the work you are doing for southwestern Virginia. Thank you.

Ms. DEGETTE. I thank the gentleman.

To the witnesses, I know you are all aware that the committee is holding an investigative hearing. And when we do so, we have the practice of taking testimony under oath.

Does any witness have an objection to taking—to testifying under oath today?

Let the record reflect the witnesses have responded no.

The Chair will then advise you that, under the rules of the House and under the rules of this committee, you are entitled to be accompanied by counsel. Does any witness request to be accompanied by counsel today?

Let the record reflect the witnesses have responded no.

And if you would, then, would you [audio malfunction] sworn in?
[Witnesses sworn.]

Ms. DEGETTE. Let the record reflect the witnesses 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 now—the Chair will now recognize our witnesses for 5-minute summaries of their written statements.

As you can see, there is a timer on the screen that counts down your time, and it turns red when your 5 minutes has come to an end.

And so now I would like to start with our first witness.

Mr. Offerman, you are recognized for 5 minutes.

STATEMENTS OF NICK OFFERMAN, ACTOR AND WOODWORKER; SAAD B. OMER, Ph.D., DIRECTOR, YALE INSTITUTE FOR GLOBAL HEALTH, YALE UNIVERSITY; J. NADINE GRACIA, M.D., EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, TRUST FOR AMERICA'S HEALTH; AMY PISANI, EXECUTIVE DIRECTOR, VACCINATE YOUR FAMILY; AND KAREN SHELTON, M.D., DIRECTOR, MOUNT ROGERS HEALTH DISTRICT, VIRGINIA DEPARTMENT OF HEALTH

STATEMENT OF NICK OFFERMAN

Mr. OFFERMAN. Thank you, Subcommittee Chairwoman DeGette, Ranking Member Griffith, and members of the subcommittee. Thank you so much for this opportunity to discuss this issue of vaccines.

As an actor, author, and woodworker, I will not be offering medical advice today. I will leave that to the scientists and medical experts on the panel, also known as the smart people. Instead, I would like to lead with my ignorance in these matters to represent the rest of the citizens who are not epidemiologists and doctors, but feet-on-the-ground, hands-in-the-dirt people across our country whose lives and livelihoods have taken a pounding from this pandemic.

Ignorance is an area in which I can claim some authority. And it is from that perch I would like to communicate that I am not only an actor and author and woodworker, but I am also a small business owner and a proud Midwesterner. It is from those personal perspectives I would like to communicate why it is so important we all get vaccinated.

Now, I understand that some Americans with experiences and backgrounds similar to my own are hesitant to get the vaccine. So I wanted to jump on this opportunity to get a positive message out to them. There is nothing more positive than the vaccine itself. I even hear people refer to it as a miracle. Now, this makes sense, given the magnitude of death and destruction that the virus has caused and the speed with which the vaccine prevents that death and destruction once it is administered.

But I don't think that "miracle" is quite accurate. A miracle is something inexplicable that appears from nowhere, sent by unseen forces. The vaccine is not a miracle. The vaccine is a gift from the world's greatest scientists and thinkers and activists. It is the product of human ingenuity, the absolute pinnacle of achievement created out of whole cloth by a bunch of dang geniuses who have saved us from endless death and destruction by solving a complex problem of microbiology in record time.

Now, as we have heard, unfortunately, the very expedience with which the vaccine has arrived is also a source of confusion, causing people to fear that it was rushed. Well, you are damn right, folks. It was rushed. It is a pandemic. But you can rest assured the

hustle was not applied to the safety of the vaccine. The science didn't arrive overnight. The science is based on 40 years of work. The hustle was just applied to getting that science to you and me by bypassing the usual bureaucratic hurdles, the red tape.

So when the pandemic hit, all of my own acting work was canceled. But after a few months we were able to start up again, carefully shooting TV and film. And the reason for this is because, on each show, about 200-odd crew members looked each other in the eye, and we all agreed to behave like we loved each other. We were ignorant to the medical science, so we agreed to trust the world's smartest doctors and follow every strict protocol so that we could go back to making our livings and taking care of our families. Three different shows I completed because we listened to the doctors and we thought about each other.

I also run a small custom furniture outfit in Los Angeles called Offerman Woodshop that was crippled by the pandemic. The vaccine is going to save our business. We at Offerman Woodshop also help run a nonprofit called Would Works that trains individuals experiencing homelessness to be wood workers. Now, because of the heightened medical vulnerability of the unhoused population we serve, that program has been officially closed since March of 2020, losing us a year of revenue and leaving our artisans out in the cold. But now, due to the ubiquity of vaccines in L.A. County, we are poised to relaunch all of our programs this summer.

Finally, I am close with my family of 38 people in the village of Minooka, Illinois. Unfortunately, because of disinformation from social media platforms with no oversight, a few of them have refused masks from the get-go, and they now refuse the vaccine. We also have a couple of immunocompromised nephews, which means we all have to avoid the antivaxxers, whom we love, for the safety of the rest of the family. It breaks my heart, and we can't wait when we—so we can all be reunited.

On January 5th of this year, Los Angeles County had 8,098 people hospitalized with COVID-19. A few days ago that number was 319. That is more than 96 percent lower in just 4½ months. That is the gift of this vaccine.

I urge anyone who has not yet been vaccinated to catch my enthusiasm and hear the smart people who are about to speak. Medicine doesn't care who you voted for. We amazing humans have created a vaccine that serves the common good. The vaccine doesn't take sides, unless you count alive versus dead.

I am so sincerely grateful to the committee for hearing me today. Thank you very kindly.

[The prepared statement of Mr. Offerman follows:]

**WRITTEN TESTIMONY OF MR. NICK OFFERMAN
ACTOR AND WOODWORKER**

**BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTAGATIONS**

A SHOT AT NORMALCY: BUILDING COVID-19 VACCINE CONFIDENCE

May 26, 2021

Subcommittee Chairwoman DeGette, Ranking Member Griffith, and members of the Subcommittee, thank you for the opportunity to discuss an issue on everyone's minds right now: vaccines. As an actor and a woodworker, I will not be offering medical advice today. I will leave that to the scientists and medical experts on the panel, aka the "smart people". Instead, I would like to represent the rest of the citizens who are not epidemiologists, also known as "the ignorant". Ignorance is an area in which I can claim some authority, and it is from that perch I would like to communicate why it's extremely important that we all get vaccinated.

I understand that some Americans are hesitant to get the vaccine, so I wanted to jump on this opportunity to get a positive message out to them. I am also aware that many people are confused about different aspects of the vaccine, both bad and good, including people who refer to it as a "miracle". While this seems to make sense, given the magnitude of death and destruction the virus has caused, and the speed with which the vaccine prevents that death and destruction when administered, I don't think that "miracle" is accurate. A "miracle" is something inexplicable that appears from nowhere, sent by unseen forces. The vaccine is not a miracle, but a gift. From the world's greatest scientists and thinkers and activists. It's the product of human ingenuity, the absolute pinnacle of achievement, created out of whole cloth by a bunch of dang geniuses who have saved us from endless death and destruction by solving a complex problem of microbiology in record time.

Unfortunately, the very expedience with which the vaccine arrived has also been a source of confusion, causing people to fear that it was rushed. Well, damn right they were rushed, folks, it's a pandemic. But you can rest assured the hustle was not applied to the safety of the product – the science didn't arrive overnight, it was based on 40 years of work – the hustle was just applied to getting that science to you and me, by bypassing the usual bureaucratic hurdles – the red tape.

I get it. I know I'm ignorant, and this subject is very scary. When the pandemic hit, I had a comedy tour cancelled, and then a sci-fi series. Live audiences were done, and still are, but after a few months we were able to start up again carefully shooting tv and film. The reason for this

was because on each show about 200-odd people looked each other in the eye and agreed – we knew how to make a show, but we were ignorant to the medical science – so we agreed to listen to the world’s smartest doctors and then trust each other to follow every strict protocol so that we could go back to making our livings and taking care of our families. 3 different shows I completed because we listened to the doctors. We thought about each other.

I am a small business owner of a custom furniture outfit in Los Angeles called Offerman Woodshop. All of our employees were sent home for 6 months when the pandemic began, and only by utilizing the safety protocols outlined by the CDC had we been able to trickle back to partial output. Now that everyone is vaccinated, we can relax the guidelines and work as productively as we did before the virus struck.

I am also on the board of a Los Angeles based, non-profit enterprise that trains and employs individuals experiencing homelessness to be woodworkers, called Would Works. Because of the heightened medical vulnerability of the unhoused population we serve, the program has been officially closed since March of 2020, losing us a year of revenue, and leaving our artisans out in the cold. But now, due to the ubiquity of vaccines in LA county, we are poised to re-launch all of our programs this summer.

I am close to my large family in the village of Minooka, Illinois. Unfortunately, because of disinformation from social media platforms with no oversight, a few have refused masks from the get-go, and now refuse the vaccine. We also have a couple of immune-compromised family members, which means we have to avoid these members of our own family, whom we love, for the safety of all.

On January 5 of this year, Los Angeles County had 8,098 people hospitalized with COVID-19. A few days ago on May 23, that number was 319. Thanks to the gift of this vaccine. I urge anyone who has not yet been vaccinated to catch my enthusiasm for the smart people who are about to speak. Medicine doesn’t care who you voted for. We amazing humans have created a vaccine that serves the common good. The vaccine doesn’t take sides unless you count alive vs. dead.

I am sincerely grateful to the committee for hearing me today. Thank you very kindly.

Ms. DEGETTE. Thank you so much. I don't think any of us could have said it better. But now it is time for the smart people to talk, and I am first going to recognize Dr. Omer for 5 minutes. Doctor?

STATEMENT OF SAAD B. OMER, PH.D.

Dr. OMER. Hi, my name is Saad Omer, I am the director of Yale Institute for Global Health, and it is my privilege to be here. Thank you.

With the U.S. vaccine supply outpacing the number of doses being administered, there is no shortage of diagnosis for what ails the—or what are the barriers to increasing this coverage even further.

However, 20 years of research on vaccine acceptance and data from this pandemic show that the reality is a bit nuanced. And a lot of these things were appropriately covered by the various Members who spoke before me. Here are a few observations based on this research.

First of all, we must recognize that vaccine acceptance behavior is a spectrum. On the one end, we—of this spectrum—are individuals who actively demand vaccines, and on the other hand are people who would refuse vaccines in all situations. Even if you put Mom and apple pie in a shot, some people would refuse it.

Then, you know, in this pandemic, active vaccines—seekers were so vociferous that it created the impression that, as soon as the supply improves and major delivery bottlenecks are resolved, there will be persistent increases in immunization rates until herd immunity is reached. However, for several weeks there is more vaccine available in the U.S. than there are seekers.

Fortunately, we must recognize that strict refusers are a relatively small group, estimated to be approximately 10 to 13 percent of eligible adults. This is larger than other vaccines. But nevertheless, it is not 20, 30, 40 percent of the population.

There is much larger—there is a much larger group of so-called fence sitters, who have questions about the vaccine but can be persuaded with the right interventions.

And then there are those who do not have a lot of concern about immunization but are not particularly enthusiastic about it, either. They don't wake up every morning and think about vaccines, unlike some of us, whose job is to think about vaccines when we wake up every morning. So—but they are still susceptible to—amenable to nudges, and that is good news.

So, given the range of enthusiasm about vaccines, there is an interplay between vaccine demand and vaccine access. Those who actively demand vaccines go the extra mile of—for getting it, sometimes traveling long distances to be vaccinated. However, now that most of the vaccine enthusiasts have been immunized, practical issues such as how easy it is to get an appointment have become relatively prominent reasons for nonvaccination.

So we know from data that ethnic and racial minority groups in the U.S. have been disproportionately harmed by the pandemic. African Americans, for example, had a COVID-19 mortality rate twice that of White Americans. And many nascent efforts to bring vaccines directly to communities, including programs that work

with local, civic, and religious leaders, are playing a role in addressing barriers for getting vaccinated. These programs need to be sustained and scaled up.

Getting communities engaged with the vaccine will be easier with a scalable template. And I have proposed an approach that involves pairing a community validator—for example, a church leader—with an expert—for example, a physician—with roots in the same community, and replicating this model across the country.

Another group that the data have identified are conservative men, who have emerged as another group particularly hesitant to vaccines against COVID-19. Trying to persuade this group through messages that don't speak to their values could be counter-productive. And we have done some research on how to speak to people who emphasize liberty, and there are ways to doing so.

Overall, vaccines have traditionally enjoyed bipartisan support, and our data show that support is important in instilling and increasing confidence in COVID-19 vaccines, as well.

One of the things that I would highlight that—irrespective of the reason for nonvaccination, healthcare providers are the most trusted source of vaccine information, even among those who are highly hesitant. A strong endorsement by a healthcare provider is a consistent predictor of vaccine acceptance. And so how do we make—enable our healthcare providers to do so?

And one idea is to have a national continued medical education program that trains them in these up-to-date, evidence-based communication methods that have been developed and evaluated through Federal funding over the last 5, 10 years, generally around vaccines, and then scale it up at the national level. Yale is developing such a program, and others are welcome to do so, as well.

While physician and healthcare providers are best suited to persuade vaccine-hesitant individuals, having an effective vaccine conversation requires time. And currently, doctors can charge for administering a vaccine, but they—if the vaccination doesn't happen, there is no reimbursement. So, since they cannot predict the future, it would be useful to make this counseling itself reimbursable.

So I will stop here and would be happy to answer questions as my turn comes.¹

Ms. DEGETTE. Thank you so much, Doctor. I am now pleased to recognize Dr. Gracia for 5 minutes.

Dr. GRACIA. Thank you—

Ms. DEGETTE. Doctor?

STATEMENT OF J. NADINE GRACIA, M.D.

Dr. GRACIA. Thank you, good morning. My name is Nadine Gracia, and I am the executive vice president and chief operating officer at Trust for America's Health, which is also known as TFAH.

TFAH is a nonprofit, nonpartisan public health policy, research, and advocacy organization which has focused attention on the importance of a strong and effective public health system as well as on making health equity foundational to policymaking at all levels.

¹ The prepared statement of Dr. Omer has been retained in committee files and is available at <https://docs.house.gov/meetings/IF/IF02/20210526/112684/HHRG-117-IF02-Wstate-OmerS-20210526-U1.pdf>.

I am honored and very pleased to be before you today to discuss the issue of vaccine confidence during this critically important time in our Nation.

By way of background, I previously served as the Deputy Assistant Secretary for Minority Health and the Director of the Office of Minority Health at the U.S. Department of Health and Human Services.

The COVID-19 pandemic is an unprecedented and devastating pandemic for the U.S. and the world. While we have certainly seen disparities in public health emergencies in the past, the COVID-19 pandemic has greatly exposed our Nation's systemic inequities. Prior to the pandemic, communities of color already faced inequitable opportunities for health and well-being. And we urge policymakers not to lose sight of the need for continued outreach, education, and access for communities that are both at higher risk from COVID-19, and may have greater barriers to vaccination.

In October of last year, TFAH, in partnership with the National Medical Association and UnidosUS, cohosted a national convening on building trust in and access to a COVID-19 vaccine in communities of color and Tribal nations. As an outcome of the convening, we published a brief in December with recommendations for policy action. Our recommendations addressed six key areas:

First, ensuring the scientific fidelity of the vaccine development process.

Second, meaningfully engaging and providing resources to trusted community organizations and networks in vaccination efforts.

Third, providing communities the information they need to understand the vaccine, make informed decisions, and deliver messages from trusted messengers and pathways.

Fourth, ensuring that it is as easy as possible for people to be vaccinated. And vaccines must be delivered in community settings that are trusted, safe, and accessible.

Fifth, ensuring complete coverage of the cost associated with the vaccine.

And sixth, funding and requiring disaggregated data collection and reporting.

Now, while these recommendations are most immediately applicable to the COVID-19 vaccine, many will remain essential beyond this pandemic and will be important in earning vaccine trust in these communities into the future.

While the focus of this hearing is on vaccine confidence, the data also show that access remains an issue for many populations. A recent Kaiser Family Foundation survey highlighted that Latinos are most eager to get the vaccine but continue to face barriers in access. In another example, vaccination sites may be inaccessible for people who are homebound, including many older adults and people with disabilities.

TFAH released an issue brief in March on ensuring that this population and their caregivers are prioritized for vaccination. The report highlights innovative programs such as one in the chair's home State of Colorado, where the Health Department partnered with a service that provides primary care at home to administer thousands of doses of the vaccine to people who are homebound. Leveraging community partnerships and trusted services that en-

gage with the population can provide important lessons for building community resilience before the next emergency.

Some of the COVID-19 vaccination funding provided in the last Congress and through the American Rescue Plan Act has been targeted to increasing vaccine confidence and access in communities of color in rural and underserved communities. And it appears that this focus is paying off. Last week the White House announced that, after months of receiving a disproportionately smaller share of vaccinations, 51 percent of those vaccinated in the U.S. were people of color in the prior 2 weeks. We urge Congress and policy-makers to carry forward these lessons for funding and preparedness programs to ensure equity is central to the responses.

In closing, we urge Congress to build upon the lessons of the pandemic. We must modernize public health infrastructure and workforce. We must invest in community organizations that work with underserved populations and maintain these partnerships long after the pandemic. And we must provide long-term investments, both in the systems that develop and deliver the vaccines and those that build bridges to the communities that are most affected. Now certainly is the time.

Thank you.

[The prepared statement of Dr. Gracia follows:]



Written Statement of Dr. J. Nadine Gracia

**Executive Vice President and Chief Operating Officer
Trust for America's Health**

“A Shot at Normalcy: Building COVID-19 Vaccine Confidence.”

**House Committee on Energy and Commerce, Subcommittee on Oversight and
Investigations hearing**

May 26, 2021

Good morning. My name is Dr. Nadine Gracia, and I am the Executive Vice President and Chief Operating Officer of Trust for America's Health, or TFAH. TFAH is a nonprofit, nonpartisan public health policy, research, and advocacy organization which, among other priorities, has focused attention on the importance of a strong and effective public health system. At TFAH, we envision a nation that values the health and well-being of all and where prevention and health equity are foundational to policymaking at all levels. I am honored and very pleased to be before you today to discuss the issue of vaccine confidence during this critically important time in our nation. By way of background, I previously served as the Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health at the U.S. Department of Health and Human Services. My remarks today focus on building confidence, equity, and access for the immediate COVID-19 vaccination effort as well as the importance of strengthening our nation's vaccine response for future outbreaks.

Health Disparities Place Communities of Color at Higher Risk

The COVID-19 pandemic is an unprecedented and devastating pandemic for our nation and the world – the likes of which has not been experienced in a century. While we have certainly seen disparities in past public health emergencies, the COVID-19 pandemic has greatly exposed our nation's systemic inequities. Prior to the pandemic, communities of color already faced unequal opportunities for health and well-being, deeply rooted in long-standing structural inequities. It is important to note that the drivers of health inequities are not inherent to one's race or ethnicity, but the societal factors built around race, such as income and physical environment.¹ For example, residential redlining has led to intergenerational, concentrated poverty and

¹ James Weinstein, et al. “Communities in Action: Pathways to Health Equity.” National Academies of Science, Engineering and Medicine. 2017. <https://www.nationalacademies.org/news/2017/01/new-report-identifies-root-causes-of-health-inequity-in-the-us-outlines-solutions-for-communities-toadvance-health-equity>

environmental health risks and has been tied to higher rates of asthma,² obesity,³ and higher mortality rates from chronic disease.⁴ In turn, these are also risk factors for hospitalization and death due to COVID-19. The pandemic demonstrated the clear connection between access to healthy housing, safe employment, nutrition, income, and quality healthcare and one's underlying health as well as risk for contracting COVID-19 and for severe outcomes from the virus.

Without concerted planning and engagement, response to the pandemic can also leave many behind. We urge policymakers not to lose sight of the need for continued outreach, education, and equitable access for communities that are both at higher risk from COVID-19 and may have greater barriers to vaccination.

Building Trust and Access in Communities of Color and Tribal Nations

My organization has been working on equitable access to the COVID-19 vaccine even before a vaccine was approved. In October 2020, TFAH, in partnership with the National Medical Association and UnidosUS, co-hosted a national convening on building trust in and access to a COVID-19 vaccine in communities of color and Tribal Nations. As an outcome to the convening, we published a report in December 2020 with recommendations for policy action.⁵ While these recommendations are most immediately applicable to the COVID-19 vaccine, many will remain essential beyond this pandemic and will be important in earning vaccine trust in these communities into the future. Our recommendations address six key areas:

1. Ensure the scientific fidelity of the vaccine development process.
2. Equip trusted community organizations and networks within communities of color and tribal communities to participate in vaccination planning, education, delivery, and administration. Ensure their meaningful engagement and participation by providing funding.
3. Provide communities the information they need to understand the vaccine, make informed decisions, and deliver messages through trusted messengers and pathways.
4. Ensure that it is as easy as possible for people to be vaccinated. Vaccines must be delivered in community settings that are trusted, safe and accessible.
5. Ensure complete coverage of the costs associated with the vaccine.
6. Fund and require disaggregated data collection and reporting by age, race, ethnicity, gender identity, primary language, disability status, and other demographic factors on

² Nardone, A et al. Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study. *The Lancet Planetary Health*, Vol. 4, Issue 1, E24-E31, Jan 1, 2020.

³ Bower, Kelly M et al. "Racial Residential Segregation and Disparities in Obesity among Women." *Journal of Urban Health: Bulletin of the New York Academy of Medicine* vol. 92,5 (2015): 843- 52. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608933/>

⁴ Goodman MS and KL Gilbert. "Segregation: Divided Cities Lead to Differences In Health." Washington University in St. Louis and Saint Louis University. Nov. 2013.

⁵ Trust for America's Health, *Building Trust in and Access to a COVID-19 Vaccine Within Communities of Color and Tribal Nations*. <https://www.tfah.org/report-details/trust-and-access-to-covid-19-vaccine-within-communities-of-color/>

vaccine trust and acceptance, access, vaccination rates, adverse experiences, and ongoing health outcomes.

Convening national experts across sectors affirmed that trust in a vaccine must be earned, and we are seeing some of those challenges today as the vaccine is rolled out. Stakeholders and community leaders must have authentic opportunities to engage in the vaccination campaign and have the resources to fully participate in vaccine outreach, education, and delivery.

Current State of Vaccine Confidence

Based on recent polling, vaccine confidence is growing nationwide: According to the most recent Axios poll, 67% of American adults have either gotten a COVID-19 vaccine or will get it as soon as possible,⁶ and Kaiser Family Foundation (KFF) has similarly found the percentage of people interested in getting the vaccine is steadily increasing since December.⁷ The KFF poll also found similar levels of vaccine enthusiasm among Black, Hispanic, and white adults. It appears we are on track to reach President Biden's goal for 70% of adults to receive at least one dose by July 4th with approximately 60% of adults having received at least one dose as of May 18, 2021. However, vaccine confidence remains lower in rural counties, while residents of these counties have higher rates of disability, chronic medical conditions, lack of insurance and less access to care.⁸ We should not give up on these communities. Research led by the de Beaumont Foundation found that individuals who have concerns about the vaccine, including conservative voters, could change their minds if they received appropriate information from a doctor, pharmacist or other medical professional they knew and trusted.⁹

Vaccine Access Issues Persist

While the focus of this hearing is on vaccine confidence, the data show that access remains an issue for many populations. Policymakers and vaccination stakeholders must address barriers to access – real or perceived – as well as outreach and education if we hope to increase vaccine uptake.

1. COVID-19 Vaccine Disparities

Throughout this pandemic, it has been reported by the Centers for Disease Control and Prevention (CDC) that Black, Hispanic and Native Americans are dying from COVID-19 at

⁶ Axios/IPSOS Poll- Wave 45. May 2021. <https://www.ipsos.com/sites/default/files/ct/news/documents/2021-05/topline-axios-coronavirus-index-W45.pdf>

⁷ Kaiser Family Foundation. KFF COVID-19 Vaccine Monitor - April 2021. <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-april-2021/>

⁸ Centers for Disease Control and Prevention. *Disparities in COVID-19 Vaccination Coverage Between Urban and Rural Counties — United States, December 14, 2020–April 10, 2021*. https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e3.htm?s_cid=mm7020e3_w

⁹ de Beaumont. *Focus Group Participants Reveal How They Overcame Doubts about COVID Vaccines*. <https://debeaumont.org/news/2021/focus-group-participants-reveal-how-they-overcame-doubts-about-covid-vaccines/>

more than twice¹⁰ the rate of white Americans. In addition, non-Hispanic Black and Asian health care workers are more likely to contract COVID-19 and to die from it than white workers. In the demographic data available on COVID-19 vaccination thus far, we have seen lower rates of vaccination for Black and Latino populations than for white populations¹¹ despite similar levels of interest in seeking the vaccine across demographics.¹² A March examination by CDC found that in the first 2.5 months of the U.S. vaccination program, high social vulnerability counties had lower COVID-19 vaccination coverage than counties with lower social vulnerability.¹³

The most recent data show¹⁴ that these disparities are not just about vaccine hesitancy but access as well. Issues such as lack of culturally and linguistically appropriate information and services, less access to technology required to sign up, less access to transportation, and lack of paid sick leave may be hindering vaccine access for some populations. For example, approximately 13% of in the U.S. who have received at least one vaccine dose are Hispanics, though they make up about 17% of the overall population.¹⁵ These disparities are wider in some states. These numbers show why data are so important. If we only look at the population as a whole, we may be missing significant barriers to access and information. Among unvaccinated Hispanics, 64% were worried about missing work because of vaccine side effects, and 52% were concerned about potential cost barriers even though the shots are administered without any payment required. These numbers are even higher for Hispanics who lacked lawful permanent resident status. These represent both real barriers (ability to miss work) and perceived barriers (cost), showing that building vaccine confidence must also include education, addressing misinformation, and engagement about the questions on the minds of different populations. There are also misinformation campaigns targeting Latinos, Black people, and other communities, spreading false claims about the vaccines.^{16 17}

Even the data itself has been a challenge. Race/ethnicity has only been reported to CDC for 56.4% of people with at least one dose administered, compared to data about age (reported for

¹⁰ Centers for Disease Control and Prevention. *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity*. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>

¹¹ Kaiser Family Foundation. *Latest Data on COVID-19 Vaccinations Race/Ethnicity*.

<https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/>

¹² Kaiser Family Foundation. *KFF COVID-19 Vaccine Monitor*. <https://www.kff.org/coronavirus-covid-19/dashboard/kff-covid-19-vaccine-monitor-dashboard/#intentions>

¹³ Hughes MM, Wang A, Grossman MK, et al. County-Level COVID-19 Vaccination Coverage and Social Vulnerability — United States, December 14, 2020–March 1, 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:431–436. DOI: <http://dx.doi.org/10.15585/mmwr.mm7012e1>

¹⁴ Kaiser Family Foundation. *Latest Data on COVID-19 Vaccinations Race/Ethnicity*.

<https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/>

¹⁵ Kaiser Health News. *Latinos Are the Most Eager to Get Vaccinated, Survey Shows — But Face Obstacles*.

<https://khn.org/news/article/latinos-are-the-most-eager-to-get-vaccinated-survey-shows-but-face-obstacles/>

¹⁶ Guynn J and Marcos CM. “COVID-19 crisis: Vaccine conspiracy theories, hoaxes in Spanish targeting Hispanic community breed fear, hesitancy.” *USA Today*. March 16, 2021.

<https://www.usatoday.com/story/tech/2021/03/16/facebook-whatsapp-covid-vaccine-misinformation-spanish-hispanic-hesitancy/4711556001/>

¹⁷ Frenkel S. “Black and Hispanic Communities Grapple With Vaccine Misinformation.” *The New York Times*. March 10, 2021. <https://www.nytimes.com/2021/03/10/technology/vaccine-misinformation.html>

92% of people with at least one dose) and sex (91.4%).¹⁸ These challenges illustrate the deficiencies in our immunization information systems, in our training about the importance of collecting this information, and in educating the public about the importance of providing the information. The lack of data has real world consequences: without understanding the extent of disparities, it is difficult to tailor culturally and linguistically appropriate outreach and education and situate vaccination sites in underserved areas. In the March CDC study of vaccination coverage in areas with social disadvantage, states like Arizona and Montana achieved better vaccination coverage in high vulnerability counties, using practices such as actively monitoring and addressing barriers to vaccination in higher risk communities, directing vaccines to these communities, offering free transportation, and collaborating with community partners and tribal health organizations.¹⁹

There are bright spots, however, that show that concerted policies to address disparities can have impact. Last week, HHS announced that more than 10 million COVID-19 vaccine doses had been administered by community health centers, with 61% provided to racial and ethnic minorities.²⁰ Community health centers represent a trusted and accessible source of health care for many groups, including non-English speaking populations.

2. Barriers Caused by Inequities in Social Determinants

Adult vaccine access issues pre-date the COVID-19 pandemic, especially in communities of color. For example, adult vaccination rates, including for hepatitis B, seasonal flu, pneumococcal, and shingles, remain far below targets in Healthy People 2030.²¹ These numbers are even more concerning for people of color as racial and ethnic disparities continue in vaccine coverage among adults, and the underlying reasons are many – from higher rates of being uninsured or underinsured, to lack of access to health care, to mistrust of medical systems that stems from both historical and present day experiences of maltreatment, discrimination, and bias.

3. Homebound Older Adults and Individuals with Disabilities

Vaccination sites may be inaccessible for people who are homebound, including many older adults and people with disabilities. TFAH released an issue brief in March 2021 providing recommendations to ensure that this population and their caregivers are prioritized in accessing the COVID-19 vaccine.²² The report highlights an innovative program in the Chair's home state

¹⁸ Centers for Disease Control and Prevention. Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States. May 23, 2021. <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic>.

¹⁹ Hughes et al. *MMWR* March 2021.

²⁰ HHS Press Release. More Than 10 Million COVID-19 Vaccine Doses Administered by Community Health Centers. May 19, 2021. [More Than 10 Million COVID-19 Vaccine Doses Administered by Community Health Centers | HHS.gov](https://www.hhs.gov/press/2021/spe0519-01)

²¹ Centers for Disease Control and Prevention. *Surveillance of Vaccination Coverage Among Adult Populations — United States, 2018*. <https://www.cdc.gov/mmwr/volumes/70/ss/ss7003a1.htm>

²² Trust for America's Health. *Ensuring Access to COVID-19 Vaccines for Older Adults and People with Disabilities Who Are Homebound: Recommendations and Considerations for Federal, State, and Local Agencies and their Partners*. <https://www.tfah.org/report-details/covid19-vaccine-access-older-adults-people-with-disabilities-homebound/>

of Colorado, where the health department partnered with a service that provides primary care at home to administer thousands of doses of the vaccine to people who are homebound. Leveraging community partnerships and services that engage with target populations, like Meals on Wheels, can provide important lessons for building community resilience before the next emergency. In addition, the report includes the following recommendations:

1. Prioritize the administration of COVID-19 vaccination for people who are homebound and their caregivers (both paid and unpaid) by providing sufficient vaccines and the resources needed to administer them in the shortest time possible.
2. Develop a standardized operational definition of “people who are homebound” in order to identify this population and prioritize their vaccination. A range of data sources should be used to identify the population while respecting privacy rights.
3. Ensure that the COVID-19 vaccine is equitably available across the homebound population and that no subset of the population is less served due to race, ethnicity, socioeconomic status, urban or rural locations, or other factors. Use data to identify pockets of under-vaccination.
4. Develop and actively promote multiple communications channels for vaccine appointments scheduling, including use of channels that minimize reliance on computers and internet access.
5. Ensure, to the degree possible, that in-home vaccination teams include people who are trusted by those being vaccinated and who represent the diversity of the population they serve.
6. Government agencies and private payors should ensure that all costs associated with in-home vaccinations are covered including administrative expenses, travel time and transportation costs, and observation time.

Results of Emergency Funding on Vaccine Confidence

Some of the COVID-19 vaccination funding provided in the last Congress and through the American Rescue Plan Act has been targeted to increasing vaccine confidence and access in communities of color, rural, and underserved areas. It appears this focus is paying off: last week, the White House announced that after months of receiving a disproportionately smaller share of vaccinations, 51% of those vaccinated in the U.S. were people of color in the prior two weeks.²³ We urge Congress and policymakers to carry these lessons forward for funding and preparedness programs to ensure equity is central to responses.

Addressing Root Causes of Vaccine Hesitancy

As my fellow witnesses will attest, the root causes of vaccine hesitancy are numerous, from simple lack of information to the detrimental impact of vaccine misinformation. We applaud Representatives Schrier and Burgess for your leadership on the passage of and funding for the VACCINES Act, which will aid research into vaccine hesitancy and support public education

²³ CNN. *Covid-19 vaccination rate among people of color was 51% the last couple of weeks, White House says.* https://www.cnn.com/world/live-news/coronavirus-pandemic-vaccine-updates-05-18-21/h_6332ac8e72420b34c4aaf4e48480db6e

campaigns on vaccines. We must continue to prioritize this research and ongoing public education, communications, and social media efforts to impede misinformation before it has a chance to take hold.

Risk communications are a major challenge during any public health emergency when the science and understanding of the situation are rapidly changing. Last year, TFAH began a collaboration with the CDC Foundation, the de Beaumont Foundation, and public health partners to form the Public Health Communications Collaborative (PHCC).²⁴ The PHCC coordinates and amplifies public health messaging on COVID-19 to increase confidence in public health guidance and help public health agencies answer tough questions from their constituents.

Preparing for the Next Public Health Emergency

In addition to our COVID-19 specific work, TFAH has published an annual report called *Ready or Not: Protecting the Public's Health from Diseases, Disasters and Bioterrorism* over the past nearly two decades. Our most recent report was published in March 2021 and provides an assessment of states' level of readiness to respond to public health emergencies and recommends policy actions to ensure that everyone's health is protected during such events.²⁵ Unfortunately, the pandemic has placed into stark relief how much work we must do to protect the nation from health threats. The repeated cycle of starving the public health system, followed by an influx of supplemental funding, has weakened our response and our ability to effectively vaccinate all residents.

While this year's report findings are not a measure of any state's COVID-19 response, the findings demonstrate that while states' readiness is important, national health emergencies on the scale of a pandemic require strong federal leadership and coordination, and long-term investment in public health infrastructure and workforce that has been previously lacking. States alone, even those that rank in the high-performance tier in this report, are not sufficiently equipped to respond to a pandemic without federal guidance and funding. The following are the policy recommendations that apply to the current outbreak:

1. **Rebuild and modernize the public health system, including by creating a mandatory \$4.5 billion per year Public Health Infrastructure Fund to support foundational public health capabilities at the state, local, territorial, and tribal levels (STLT).** The pandemic has highlighted longstanding gaps in our public health infrastructure and workforce, including gaps in risk communications, equity, and surveillance. This funding is critical to help build public health capacity in the long run, after the COVID-19 response funding has expired.
2. **Invest in sustained public health data modernization.** Due to years of underfunding, the CDC and state, local, tribal and territorial public health departments were forced to rely on archaic systems that produced delayed and disjointed disease surveillance during this deadly pandemic. Consistent investments in data modernization will help build the

²⁴ Public Health Communications Collaborative (About). <https://publichealthcollaborative.org/about/>

²⁵ Trust for America's Health. *Ready or Not 2021: Protecting the Public's Health Against Diseases, Disasters, and Bioterrorism*. <https://www.tfah.org/report-details/ready-or-not-2021/>

foundations for data sharing across public health, modernize the CDC's services and systems, provide better demographic data, and ensure public health can act on innovative data analytics.

3. **Support the vaccine infrastructure.** The CDC's immunization program, sometimes called the "317 program," supports state and local immunization systems to increase vaccination rates among uninsured and underinsured adults and children, to respond to outbreaks, to educate the public, to target hard-to-reach populations, to improve vaccine confidence, to establish partnerships, and to improve information systems. Yet due to years of underfunding, state, local, territorial, and tribal health departments were depending on this underfunded infrastructure to distribute and dispense the COVID-19 vaccine, while COVID-specific funding was not distributed until January 2021. Consistent funding for vaccine infrastructure would provide the building blocks for a more effective vaccine response in future pandemics.
4. **Invest in policies and capacity to address the social determinants of health (SDOH):** People at highest risk during disasters and those who have the hardest time recovering are often those with unstable or unhealthy housing, those with limited access to transportation, and those who live in low-socioeconomic status communities, all of which bore out during the COVID-19 pandemic. Congress should fund a public health approach to address SDOH, such as the approach proposed in the Improving Social Determinants of Health Act. The legislation would strengthen SDOH capacity at the CDC and enable grants to public health agencies to build cross-sector partnerships and develop community solutions to SDOH.
5. **Provide significant, long-term funding for the entire Medical Countermeasure (MCM) enterprise:** The MCM enterprise involves research, manufacturing, surveillance, delivery, training, and monitoring. Long-term coordinated and transparent funding to the Biomedical Advanced Research and Development Authority, Strategic National Stockpile, CDC, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and other components of the Public Health Emergency Medical Countermeasure Enterprise would strengthen the kind of public-private partnerships that resulted in multiple successful COVID-19 vaccines.

Conclusion

In closing, we urge Congress to carry forward the lessons of this pandemic: we must modernize public health infrastructure and workforce; we must invest in community organizations that work with underserved populations; we must maintain partnerships long after the pandemic; we must make equity central to preparedness and response; and we must provide long-term investments both in the systems that develop and deliver the vaccines and those that build bridges to the communities most affected. Now is the time.

Ms. DEGETTE. Thank you so much, Doctor.

Ms. Pisani, now I am very pleased to recognize you for 5 minutes for your opening statement.

STATEMENT OF AMY PISANI

Ms. PISANI. Thank you, Chairwoman DeGette and Ranking Member Griffith and members of the subcommittee, including Congressman Burgess, who has hosted several Vaccinate Your Family briefings over the years on vaccines and disinformation, as well. My name again is Amy Pisani, and I have had the pleasure to serve as the executive director of Vaccinate Your Family for the past 25 years.

Vaccinate Your Family was founded by former First Lady Rosalynn Carter and former First Lady of Arkansas Betty Bumpers, who was the wife of Senator Dale Bumpers. That was 30 years ago this summer. And they founded our organization on the heels of a massive measles outbreak that took the lives of many children and hospitalized over 10,000 people. Our founders traveled to every State in the Nation, building statewide immunization coalitions which continue to thrive. And one thing was clear to them back then and remains true today: Vaccination efforts need Federal support and guidance for certain, but they are best implemented at the local level, where community members can work together to make the greatest impact on their neighbors.

I want to take this moment to thank the Members of Congress and both administrations for the work that you have done to protect and promote public health and to really protect us and keep us from economic ruin while we awaited those lifesaving vaccines that Mr. Offerman so clearly, generously spoke about.

As you know, everyone is now eligible at 12 years and older, and families are being tasked with making a monumental decision. So—whether to vaccinate their family members of all ages, and where to go to access those vaccines, which is not always a simple procedure in this country.

Now, I know that having access to science-based information is really essential to building confidence, and that is what we are going to be talking about a lot today. I actually experienced hesitancy while I was pregnant with my first child 20 years ago, in the year 2000. Just after a few years in my role as executive director, I attended the House Committee on Oversight and Government Reform hearings where Andrew Wakefield, who has since been stripped of his medical license, was given the opportunity to share his now-retracted Lancet study that proclaimed that MMR vaccines caused autism. And that became a spotlight of the Nation.

As a pregnant person who was really learning the science of vaccines still, I became susceptible to the gravitas of Wakefield, and I became bewildered by the data he was presenting to members of the committee. But fortunately, I was able to reach out to Vaccinate Your Family's board members, including Dr. Walter Orenstein and Dr. Paul Offit, renowned vaccine experts, and they answered each one of my questions with patience and compassion. And they helped me to move from hesitancy to confidence by the time my child's vaccines were due.

So my confidence was built on information provided by experts that I trusted, and from that experience I became even more committed to ensuring that our organization builds educational and social media efforts that bring the science to the public so that they, too, can make informed decisions on vaccines for their own families.

Now, we have learned the two key tenets to building confidence are transparency and respect. Since the beginning of the pandemic, our organization has focused not on encouraging people to just blindly accept an eventual vaccine but to learn about the safety systems in place that ensure the ongoing safety of our vaccines.

We called for companies developing vaccines to hit all the usual milestones in the development, keeping in mind that some steps could be conducted simultaneously, and that would speed up the process without compromising their safety or efficacy, as many of the Members have discussed this morning.

We also called on the FDA to adhere to the normal review process, ensuring that each vaccine would be vetted in the public eye, as it would be for any other product.

And to build trust in COVID-19 and routine vaccines, we are collaborating with who we consider—who we think are trusted stakeholders in their communities, one of which is the Good Health WINs program, Women's Immunization Networks. And we are doing so with the National Council of Negro Women to reach their 12 million members with vaccine resources for their family, friends, and neighbors.

We have also begun working with Día de la Mujer Latina, to not just translate materials into Spanish but to create culturally relevant resources that engage and motivate Spanish-speaking people.

We are also continuing to work with immunization coalitions to develop new programs to raise vaccination rates in both rural and conservative areas, enlisting new partners, such as agricultural extension workers and evangelical leaders.

So, Congress, you can help us on the path to good confidence to—confidence by supporting great public health policies.

First, let's improve access. Plain and simple, poor children and those in rural areas are up to a third less likely to receive some vaccine. And among adults, we spend \$27 billion preventing—on vaccine-preventable diseases that could have been prevented through vaccines.

Public health officials need good, timely data to evaluate their efforts, and you can help us by supporting four bills, which—many of which are sponsored by E&C Committee members, actually: the Strengthening Vaccines for Children Act; the Black Maternal Health Momnibus Act; the Helping Adults Protect Immunity, or HAPI, Act, and that helps eliminate cost-sharing for vaccines for Medicaid beneficiaries; and the Immunization Infrastructure Modernization Act.

Finally, it is important to remember that people need other life-saving vaccines. And I do urge the public to come visit VaccinateYourFamily.org, learn about our Don't Skip Vaccines and our Good Health WINs collaborations, and for educational materials on all diseases.

And for Congress, we have a special report that we write for you every year called the State of the ImmUnion, which is on our website.

Thank you so much for the opportunity to testify. I look forward to answering questions.

[The prepared statement of Ms. Pisani follows:]

AMY PISANI, M.S., EXECUTIVE DIRECTOR, VACCINATE YOUR FAMILY
TESTIMONY BEFORE THE HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
A SHOT AT NORMALCY: BUILDING COVID-19 VACCINE CONFIDENCE

MAY 26, 2021

Vaccinate Your Family: The Next Generation of Every Child by Two (VYF) builds on the important legacy of Former First Lady Rosalynn Carter and Betty Bumpers, Former First Lady of Arkansas/wife of Senator Dale Bumpers. Together, these pioneers worked to advance a national focus on protecting all people in the United States from vaccine-preventable diseases. Their work began in the 1970s as First Ladies of Georgia and Arkansas, respectively, and continued during the Carter Administration, resulting in incfederal support for vaccine programs nationwide and the passage of state laws requiring evidence of vaccinations for school entry.

Thirty years ago, in response to a U.S. measles epidemic, which sickened more than 55,000 people, hospitalized over 11,000, and killed more than 120, many of whom were young children, Mrs. Carter and Mrs. Bumpers founded our organization as *Every Child by Two* (ECBT). Prominent epidemiologist, Dr. William Foege, former CDC Director and Chief of the Smallpox Eradication Program, Dr. Walt Orenstein, Director of the CDC's National Immunization Program, and other esteemed board members offered their expertise in immunizations and health care, helping to guide our mission and implementation plans.

Within two years of the establishment of ECBT, Carter and Bumpers traveled to more than a dozen states, and ultimately to all 50 states to foster vaccination efforts and build immunization coalitions, consisting of local policymakers, grassroot organizations and concerned citizens. Today, these coalitions continue to work along with state and local immunization programs across the U.S. and are doing their part to ensure access to COVID-19 vaccines.

During the Clinton, Obama and both Bush Administrations, ECBT successfully secured support to make vaccinations a national priority, institutionalized immunization screening for the seven million pregnant women and children served annually by the USDA's Women, Infants and Children (WIC) program and helped to facilitate the Vaccines For Children program (VFC), which provides free vaccines to eligible children.

Our work has saved lives. Among children born over the last twenty-five years, the CDC estimates that access to the VFC program will prevent 419 million illnesses, 936,000 early deaths, and 24.5 million hospitalizations, resulting in a savings of nearly \$1.9 trillion in societal costs and \$360 billion in direct costs.

Today, thanks to our founders enduring legacy, our organization's impact is beyond measure as vaccinations have saved millions of lives and significant costs. Today, we are led by a committed board of directors, scientific advisory board and staff comprised of renowned medical, public health and policy experts. Building on ECBT's successes in raising childhood vaccination rates and reducing immunization disparities, the organization decided to broaden its mission to include people of all ages. To reflect our expanded focus, Every Child By Two was renamed Vaccinate Your Family in 2018.

It has been an unbelievably challenging year for everyone, both here in the U.S. and around the world. On the heels of a major measles epidemic in the U.S., we were leveled by a pandemic the likes of which we have not seen since 1918. Nearly everyone knows someone who has died or been hospitalized from COVID-19 and too many businesses have collapsed. Many people who were already struggling to make ends meet found themselves in greater economic and emotional despair. The greatest toll in both deaths and economic disruption occurred among communities of color and for those with comorbid health conditions.

I want to take this moment to thank the Members of Congress for the work you have done to keep economic ruin at bay for many people and businesses while we awaited a vaccine. I, and many others in the immunization and public health space, also acknowledge the immense effort policymakers and both Administrations made to keep the public safe and shore up our public health infrastructure in the lead up to, and roll out of, lifesaving COVID-19 vaccines.

As you know, everyone 12 years of age and older are now eligible for at least one COVID vaccine authorized by the Food and Drug Administration (FDA) for emergency use. This extended age range is a critical development as nearly 14,000 children have been hospitalized due to COVID since the start of the pandemic. Babies under 1 year old and children with certain underlying health conditions may be more likely to have severe illness from COVID-19, and children may develop a very rare, yet very serious condition called MIS-C, or Multisystem Inflammatory Syndrome. Even if a child is asymptomatic, they can still pass the virus on to more vulnerable individuals. There are ongoing clinical trials for children younger than 12, and we expect the results to be available later this year.

In my 26 years at Vaccinate Your Family, we have consistently tackled three important issues: access, public education, and hesitancy. It is important not to view these issues in isolation. If vaccines are difficult to access, and evidence-based information is not readily available, people will be more likely to lean into vaccine hesitancy rather than deal with some rather extraordinary financial and geographical access hurdles. Similarly, if people are hesitant about vaccines, they will not support policies that would make it easier for people who *want* them, to have access to them.

Vaccine confidence is built on trust. Trust takes time that we do not currently have to end this pandemic. However, Vaccinate Your Family has been working to build confidence in routine vaccines since our inception thirty years ago. We have learned that the two key tenets to building confidence, other than time, are: transparency and respect.

Transparency: Since the beginning of the pandemic, we have focused not on encouraging people to blindly accept an eventual vaccine, but to learn about the safety systems in place to ensure the ongoing safety of all vaccines. We encouraged the public to watch the vaccine development and authorization processes carefully. And VYF called for companies developing vaccines to meet all the usual milestones in vaccine development and research, keeping in mind that some steps could be conducted simultaneously to speed up the process without compromising safety or efficacy.

We also called for the FDA to adhere to normal review procedures, ensuring that each vaccine would be vetted as it would for any other product seeking an Emergency Use Authorization and eventual full approval. As a result of this work, VYF hosted a series of webinars and live Facebook events on which FDA's Dr. Hahn, Dr. Woodcock, Dr. Marks and CDC leadership have spoken to broad groups of stakeholders and answered their questions about the COVID-19 vaccines.

Respect: Our work to ensure transparency is an ongoing part of our efforts to respect the ability of each person to decide whether a vaccine is right for themselves and their loved ones. We invite people to ask questions about vaccines and point them to science-based information, without judgment.

I know that having access to science-based information is essential to building confidence, because I personally experienced hesitancy while I was pregnant with my first child, twenty years ago. In the year 2000 after just two years in my role as the Executive Director of ECBT, I attended the House Committee on Oversight & Government Reform hearings where Andrew Wakefield (who has since been stripped of his medical license) was given the opportunity to share his (now retracted) Lancet study that proclaimed that MMR vaccines caused autism. As a pregnant person who was still learning the science of vaccines, I too became susceptible to the gravitas of Wakefield and bewildered by the data he was presenting to members of the Committee. Fortunately, I was able to reach out to VYF's Board members including Dr. Walter Orenstein and Dr. Paul Offit, renowned vaccine experts. They answered each of my questions with patience and compassion, helping me move from hesitancy to confidence by the time my child's vaccines were due. Later that year, as anti-vaccine celebrity Jenny McCarthy began to gain traction in her efforts to sow doubt about vaccine safety, Danielle Romaguera, a mother who lost her infant to whooping cough came to our organization to share her story and become an advocate to stop the disinformation that was becoming increasingly prevalent via the media and Internet. It was at that moment when we realized that if everyone had access to experts and the science, they too could move from hesitancy to confidence. And that is how our Vaccinate Your Baby (now called Vaccinate Your Family) campaign was born. The campaign grew and became our focal point and has evolved into becoming one of the nation's largest social media programs aimed at educating the public on vaccines and their safety and to counter vaccine disinformation. We built a WHO Vaccine Safety Net certified website www.vaccinateyourfamily.org and filled it with the facts on vaccines, global safety studies, and personal stories of families devastated by the loss of loved ones to vaccine preventable diseases. We have made an impact by bringing the

information to the public so that they can make informed decisions about their family's vaccinations.

We also understand that a variety of trusted sources must be engaged in order to impact the public's confidence in the vaccines. That is why we are partnering with stakeholders in much of our outreach around COVID-19 vaccines. We recently launched the Good Health WINs (Women's Immunization Networks) program with the National Council of Negro Women (NCNW) to reach their 2 million members and affiliates as they sort through COVID-19 information and find new ways to educate and vaccinate their families, friends, and neighbors. We've also begun work with Dia De La Mujer to not just translate materials into Spanish, but to create culturally relevant resources that engage and motivate people who are more comfortable communicating in Spanish. Finally, we are working with immunization coalitions in the Midwest and South to develop new campaigns to raise vaccination rates in both rural and conservative areas, enlisting new partners such as agricultural extensions and Evangelical leaders.

Vaccinate Your Family stands ready to continue these programs into the future, until we have proven through our actions that vaccines are of critical importance to *everyone*. Congress can help us on the path to vaccine confidence by supporting policies to one, improve access and two, ensure the flow of information.

First is access. Data shows that children in rural areas as well as those on Medicaid are up to 33.8% less likely to receive some immunizations. The difference is startling: over 4% of uninsured children receive no vaccines, compared to less than 1% of privately insured children. For adults the disparities are startling. According to a report published in 2016y, only 16% of African Americans were vaccinated against shingles, compared to 38% of white individuals. In fact, the US spends nearly \$27 billion treating four adult vaccine-preventable diseases (flu, pneumococcal disease, shingles, and whooping cough), including costs of medical visits, hospitalizations, and prescription costs.

For seniors, first dollar coverage is critical in getting necessary vaccines. Without it, we can expect more adults to be required to pay out-of-pocket expenses for vaccines. Expanding first dollar coverage of vaccines to Medicare Part D and encouraging Medicare Advantage and stand-alone Medicare Prescription Drug Plans to include immunizations in the zero-cost sharing tier is also critical to reducing the barriers to access for all adults. Influenza and pneumococcal vaccines, which are both covered by Part B, have been received by 71.5% and 61.3% of seniors over the age of 65, respectively. This same population must spend between \$14 and \$102, on average to receive either the shingles or the Tdap vaccine. These two vaccines that protect against four diseases have only been received by 27.9% and 14% of seniors, respectively. The cost savings of vaccinating all adults for our economy, coupled with increased workplace productivity, are well worth the investment.

The second focus area is information. Public health officials need good, timely data to evaluate vaccination efforts, direct appropriate resources to under-vaccinated communities and remind individuals when they or their children are due for a vaccine. To that end, based on our experience, we ask that Congress support timely access to appropriate vaccines and improved

public health information systems to better measure immunization rates. This Committee can help achieve this goal by doing three things:

First, strengthen the Vaccines For Children Program. As part of CDC's Immunization Programs, VFC buys vaccines in bulk, distributes them to state and local health agencies, who distribute them to providers who then administer them to eligible children. VFC has made tremendous strides in closing vaccine disparities, but this gap seems to be widening in the past few years. In that vein, we ask that Congress support HR 2347, introduced by Dr. Schrier, a member of this Subcommittee and cosponsored by other members. The bill would improve VFC by expanding eligibility, incentivizing more providers to participate in the program and better tracking vaccine administration to understand these disparities.

Second, focus on adult populations that are at risk of going unvaccinated. To that end, we ask support for HR 959, Representative Underwood's "omnibus" bill, that would encourage the inclusion of pregnant and nursing women in COVID vaccine clinical trials, so that we can ensure these vaccines are safe for these women and create a campaign to educate and encourage vaccination among pregnant women, particularly those in underserved communities. In addition to a COVID vaccine, pregnant women need to be immunized in each pregnancy against influenza and pertussis (also known as whooping cough) to protect both mom during pregnancy and their infant until they are old enough to receive their own vaccines. Sadly, women of color are much less likely to receive vaccines in pregnancy than their white counterparts, and this bill will help to address this disparity.

We also request support for HR 8725, the Helping Adults Protect Immunity, or HAPI, Act. Introduced by Representative Soto, the bill would ensure that Medicaid recipients can receive necessary vaccines, without having to pay out of pocket. No one should go without life-saving vaccines because they cannot afford them, especially in a public health emergency.

Finally, we ask that Congress support HR 550, introduced by Subcommittee Member Anne Kuster and Dr. Buschon. This bill would strengthen the Immunization Information Systems to allow for better information sharing among health agencies, all while protecting patient privacy.

It is important to remember that people also still need other life-saving immunizations. In fact, recent data show that during the pandemic significant numbers of children, adolescents and adults have fallen behind on routine vaccines recommended by the Centers for Disease Control and Prevention (CDC). While providers, health systems and patients have adapted to telehealth visits, you cannot administer immunizations virtually. As COVID restrictions lift, we must ensure children and adults are up to date on their vaccines to ensure that we do not end a pandemic with another vaccine preventable disease epidemic. I urge you to visit www.vaccinateyourfamily.org to learn about our *Don't Skip Vaccines* and *Good Health Wins* collaborations and for educational information on all vaccine preventable diseases.

Thank you for your time and your commitment to our nation's health.

Ms. DEGETTE. Thank you so much. And I urge all the Members to read your report, because it is an excellent snapshot of where we are. And now the Chair is very pleased to recognize Dr. Shelton. You are recognized for 5 minutes for an opening statement.

STATEMENT OF KAREN SHELTON, M.D.

Dr. SHELTON. Good morning, Chairwoman DeGette, Congressman Griffith, and members of the committee. My name is Dr. Karen Shelton, and since 2016 I have been the director of the Mount Rogers Health District with the Virginia Department of Health. I am also acting director for a Lenowisco and Cumberland Plateau Health Districts. I am honored to be with you today to discuss the importance of vaccines and vaccine education, as well as the role that local health departments like mine play in improving vaccines, access, and acceptance.

We are very proud of our work in the far southwest region of Virginia, in Mr. Griffith's district. I serve a geographic area with 16 localities that is larger than Connecticut. End to end, it takes me about 4 hours to drive across our jurisdiction, with many communities that lack access to broadband internet or even cell service. Situated in the heart of Appalachia, practicing public health in southwest Virginia might look different from public health in other parts of the country. But what all local health departments have in common is the shared goal of protecting and promoting the health of our communities.

The response to COVID-19 pandemic has been the epitome of what public health does for our community. We know our communities well, including the assets and barriers to care, distinct local culture, the industries and living situations that might pose challenges, as well as the community-level partners and organizations that must be included to be successful. We live in our community and serve our neighbors.

In the fall of 2020, prior to the authorization of COVID-19 vaccines, our region experienced a surge of cases, hospitalizations, and deaths. Our area already was experiencing disproportionately poor health outcomes and is at increased risk from COVID-19 due to chronic disease and elderly population and limited healthcare access. In the winter, district daily caseloads spiked, and we could no longer conduct full case investigation or contact tracing. We advised schools to go fully virtual, and our local hospital capacity teetered on the brink of being overrun.

At the peak of our disease burden, vaccines became available, and the ability to vaccinate our healthcare workers and first responders, followed by our most vulnerable elderly population, brought inexpressible joy. When vaccines began to roll out late December 2020, the Far Southwest Health District—had the advantage of a long history of partnerships, providing vaccines in our communities, and being service-oriented health departments with large staff, allowed us to begin giving vaccines rapidly.

With these partnerships, we led the State in percentages of population vaccinated from the onset of the vaccine campaign through March. We vaccinated our high-risk essential workers and prioritized teachers, because they had been teaching in person

since the fall. We watched as our case rates fell and healthcare capacity was restored.

We realized early on that the vaccination rollout heavily favored the tech savvy, those with internet, cell service, smartphones, and computers. As vaccine supply increased and demand decreased, we transitioned to our mobile units in May to reach the areas of the community that were more remote and had less broadband access.

We are working with county administrators, emergency coordinators, schools, faith communities, and local businesses to increase vaccine uptake. We are scheduling outreach and mobile clinics at farmers markets, festivals large and small, high traffic areas such as convenience stores, and places people are already gathering: restaurants, breweries, wineries, churches, hiking trails, sporting events, food banks, parks, music events. We are partnering to give tickets as incentives for vaccines and creating messaging with trusted local voices.

Some of our challenges have been in data acquisition. Currently, vaccines given out of State do not show up in our counts. And as we border North Carolina, Tennessee, Kentucky, and West Virginia, this makes it challenging to discern our true vaccine numbers. Virginia is working to access this data.

Another challenge is technology needs. Our existing network is so poor that we cannot reliably participate in Zoom or Google Meet.

We know there is some vaccine hesitancy in our community. However, many labeled as hesitant have simply not had access to vaccine or opportunity to have their questions answered. We feel it is important not to label our population, in order to avoid creating resistance where it may not truly exist. We know there are multiple reasons why people choose not to be vaccinated: medical, religious, political. We feel our role is to provide education and opportunity for vaccination by meeting people where they are in their own community and being champions for the vaccine.

We are grateful to Congress, emergency funding, and attention to the needs of public health response of COVID-19. This response would benefit from single-dose vaccine packaging, streamlined national vaccine data, coordinated messaging that speaks to many different populations, and continued resources for local public health outreach.

We know that some of the most important components of a successful vaccination campaign are access, education, opportunity, and respect. We appreciate the support of the Federal Government to create access to vaccine, and we will continue to work respectfully with our communities for education and opportunity. We will continue to seek to learn from others' successful vaccination strategies.

Thank you again for inviting me to testify today, and I look forward to your questions.

[The prepared statement of Dr. Shelton follows:]

Written Testimony
House Energy and Commerce Oversight and Investigations Subcommittee
A Shot at Normalcy: Building COVID-19 Vaccine Confidence
May 26, 2021

Statement of Karen Shelton, MD
Director, Mount Rogers Health District
Acting Director, Lenowisco and Cumberland Plateau Health Districts
Virginia Department of Health

Good Morning Chairwoman DeGette, Congressman Griffith, and members of the Committee. My name is Dr. Karen Shelton and I am the director of the Mount Rogers Health District with the Virginia Department of Health. I am also acting director of Lenowisco and Cumberland Plateau Health Districts. I have been with Mount Rogers Health District since 2016.

I am honored to be with you today to discuss the importance of vaccines and vaccine education, as well as the role that local health departments like mine play in improving vaccine access and acceptance. We are very proud of our work in the far southwest region of Virginia, in Mr. Griffith's district.

The Role of Local Health Departments in Responding to the Pandemic

I serve a geographic area with 16 localities that is larger than Connecticut, with 381,647 residents. The health districts I lead have almost 350 employees, which includes those contracted to help with COVID-19. End to end, it takes me about 4 hours to drive across our jurisdiction, with many communities that lack access to broadband internet or even cell service.

Situated in the heart of Appalachia, practicing public health in southwest Virginia might look different from public health in other parts of the country, but what all local health departments have in common is the shared goal of protecting and promoting the health of our communities. Our mission is to build healthy communities through disease prevention and control, health promotion and education, protection of environmental resources, and preparedness for emergency response. The response to the COVID-19 pandemic has been the epitome of what public health does for our communities. We provide quality, customer-focused health services in our local health departments, schools, worksites, homes and other community locations. We know our communities well, including the assets and barriers to care in our communities, distinct local culture, the industries and living situations that may pose challenges, as well as the community-level partners and organizations that must be included to be successful. Our population health efforts help us identify needs and barriers in our localities, and we work with residents and stakeholders to collectively improve health outcomes, taking a broad and holistic view of health. We live in our community and serve our neighbors.

During the COVID-19 pandemic, my staff and I have worked closely with the entirety of the federal-state-local governmental public health partnership. This continues to be critical during the largest mass vaccination campaign in our nation's history. In the fall of 2020, prior to the authorization of COVID-19 vaccines, our region experienced a surge of cases, hospitalizations and deaths. Our area that already experiences disproportionately poor health outcomes and is at increased risk from COVID-19 due to chronic disease, an elderly population, and limited health care access. In the winter, district daily caseloads spiked at rate of over 100 cases (106 cases per 100,000 people). We could no longer conduct full case investigation and contact tracing. We advised schools to go fully virtual because of our subsequent inability to prevent community transmission from breaching into the schools. Our local hospital capacity teetered on the brink of being overrun.

At the peak of our disease burden, vaccines became available, and the ability to vaccinate our healthcare workers and first responders, followed by our most vulnerable elderly population, brought inexpressible joy. We watched as our cases fell and healthcare capacity was restored.

A steady supply of vaccines is a necessary part of this ongoing effort. Equally important is communication and education through trusted voices and health care providers, the opportunity for residents to ask questions and receive accurate answers, and the ability to deploy targeted outreach efforts to remote and underserved communities. We need resources and staff to make these opportunities happen.

Vaccine Hesitancy Prior to COVID-19

In considering how current vaccine hesitancy and access barriers impact the pace of our national recovery from COVID-19, it is important to acknowledge how these challenges existed for us, at local health departments, prior to this pandemic.

Immunization is one of the most successful and safest public health interventions available. In the United States, vaccines have led to the near-elimination of several diseases, significant reductions in mortality, and improvements in daily life. Despite this, vaccine hesitancy is a persistent public health concern that has led to outbreaks of vaccine-preventable diseases, particularly among under-/un-immunized individuals and communities.¹

¹ Zucker et al (2020). Consequences of Undervaccination – Measles Outbreak, New York City, 2018-2019. *New England Journal of Medicine*, 382, 1009-1017. <https://www.nejm.org/doi/full/10.1056/NEJMoa1912514>; Hall et al (2017). Measles Outbreak – Minnesota April – May 2017. *Morbidity and Mortality Weekly Report*, 66(27), 713-717, <https://www.cdc.gov/mmwr/volumes/66/wr/mm6627a1.htm>. Centers for Disease Control and Prevention (2019). Counseling Guide for Outreach Workers to Address Vaccine Hesitancy Among At-Risk Adults during Outbreaks of Hepatitis A. https://www.mass.gov/doc/guide-for-addressing-vaccine-hesitancy-among-clients/download?_ga=2.10619444.1449527047.1621878523-1510906861.1621878523

Local health departments successfully provide clinical immunization services, conduct surveillance, provide education to health care providers and the public, and develop communication campaigns to bolster immunization rates. However, local health departments have long faced numerous challenges to this work. In 2017, the National Association of County and City Health Officials (NACCHO) conducted an assessment of local health department immunization programs.² Fifty-six percent of respondents indicated vaccine hesitancy was one of the top barriers to their local immunization program. Along with this, respondents indicated insufficient staffing (44%), lack of vaccine education and confidence (37%), and lack of funding (27%) as other barriers their local immunization programs encountered.

The challenge of vaccine hesitancy is not new to COVID-19, but the devastating loss of life and threat of new variants highlights the critical importance of a successful mass vaccination effort. While important federal, state, and local efforts were underway before the pandemic to strengthen vaccine confidence through implementing the [Centers for Disease Control and Prevention's \(CDC's\) Vaccinate with Confidence framework](#), we are still facing substantial needs and work ahead to adequately strengthen vaccine confidence.

Local Health Department Roles and Actions to Address Vaccine Access

When vaccines began to roll out late December 2020, the far Southwest Virginia health districts had the advantage of a long history of partnerships providing vaccines in our communities, and being service oriented health departments which allowed us to begin giving vaccines rapidly. Early on, we had the ability to maximize our throughput for vaccine administration and were able to vaccinate healthcare workers and first responders quickly. We then moved to our highest risk citizens, the elderly, who have the poorest outcomes from COVID-19 disease. We also vaccinated our high-risk essential workers and prioritized teachers since they had been teaching in-person since the fall. Because of limited vaccine allocation, in late January the state went to a population-based allocation for vaccine. The 16 localities of southwest Virginia represent 4% of the population and received 4,000 doses of vaccine weekly for all partners to give – hospital, pharmacy, healthcare providers, and health departments.

In March, the Federal Retail Pharmacy Partnership started and doubled the number of vaccines in our community, allowing us to expand our phase further to include those 16 and older with medical conditions. As vaccines slowly increased, we were able to continue working through the highest risk populations.

By early to mid-April we were ready to open vaccination fully in accordance with the President's and Governor's Directives. We found that as we opened, there was less demand for vaccine. Surrounding states, including Tennessee, had opened several weeks before, and those who

² Rodgers, K. (2018). Local Health Department Immunization Programs: Findings from a 2017 NACCHO Assessment. <https://www.naccho.org/blog/articles/local-health-department-immunization-programs-findings-from-a-2017-naccho-assessment>

really wanted the vaccine found ways to get it. With this drop in demand for vaccine at higher volume clinics, we made plans to transition to our mobile units and go out into the community.

We realized early on that the vaccination rollout heavily favored the tech savvy – those with internet, cell service, smart phones, and computers. To help with equity, all senior clinics were scheduled by phones. We encouraged families, friends, and neighbors to help their loved ones pre-register online for a vaccine. People were able to call the local health department to sign up on the registration list.

We transitioned to our mobile units in May to reach areas of the community that were more remote. Much of our region does not have cell service or internet access, and many people do not have smart phones or computer access. In one of our localities, only 48% of households have a broadband subscription, and the locality with the highest number of households with broadband in any of our 16 localities is 77%.

Some communities have fewer providers offering COVID-19 vaccines, making finding an appointment more challenging. Some of our residents have gone out of state for vaccine, as we border four other states, and many receive their primary healthcare in the surrounding states of North Carolina, Tennessee, Kentucky, and West Virginia. Currently, the vaccines given out of state do not show up in our counts in Virginia and therefore the numbers may not truly reflect a border county's vaccination rate. Virginia is working to access this data.

We know there is some vaccine hesitancy in our community; however many labeled as hesitant have simply not had access to vaccine or opportunity to have their questions answered. Some of our residents live in geographically isolated areas, and do not often leave their community, including for medical care or vaccinations. Others are busy working and raising families, and have not yet had the time to make an appointment. We feel it is important not to label our population, in order to avoid creating resistance where it does not truly exist. While we wish everyone would rush to get the vaccine at their earliest opportunity, we know that some people just need more time before they are ready.

We are working with county administrators, emergency coordinators, schools, faith communities, and local businesses to target areas such as low-income communities, remote communities, and communities without internet access. We are scheduling outreach and mobile clinics at farmers markets, festivals (large and small), high traffic areas such as convenience stores, and places people are already gathering (restaurants, breweries, wineries, churches, hiking trails, sporting events, food banks, parks, music events). We are partnering to give tickets as an incentive for vaccines, and we are creating messaging with trusted local voices.

We know there are multiple reasons why people choose not to be vaccinated – medical, religious, political. We feel our role is to educate our community, answer their questions, and provide opportunity for vaccination by meeting people where they are in their own community.

Local health departments, as chief health strategists within their communities, are actively working to support equitable COVID-19 vaccine administration and uptake across all communities, all races, ethnicities, demographics and geographies. In southwest Virginia, we cover a large rural area. In rural areas, it is critical to build cross-sector partnerships to effectively meet the needs of the community. Through our prior community vaccination and population health efforts, we have strong relationships with other agencies and stakeholders. This was a critical benefit in our COVID-19 response – we knew we had partners to help with containment, mitigation, and vaccination efforts. The force multipliers through National Guard units and Medical Reserve Corps volunteers have been a critical component of our response efforts.

With the recent expanded authorization of the Pfizer vaccine for 12 and older, we have been busy vaccinating our middle and high school students at in-school clinics. We are committed to making it as convenient as possible for people to be vaccinated, no matter where they live in our geographic area.

These challenges and innovative approaches are not unique to my area of southwest Virginia. There are stories, shared by NACCHO, from across the nation of how our public health colleagues are meeting the challenges of vaccine access. For example, the Erie County Health Department in New York worked with local businesses to provide free giveaways and graduation party supply coupons to high school students who got vaccinated. They also used a prom theme for vaccine clinics, knowing that students have missed out on traditional events like proms and dances this past year. Health departments wanted to create a fun and welcoming atmosphere at clinics to celebrate students taking care of their health and protecting the community and people around them.

Similar to the jurisdictions I serve, Coconino County in Arizona is scheduling pop-up vaccination events in collaboration with community partners at convenient, high traffic locations. They are also using creative social media to help educate the community, and providing information in the Spanish on their website. These examples show how local health departments across the nation are using innovative approaches to make sure no one is left behind who wants to be vaccinated and to provide accurate, timely information to combat myths and misinformation.

We need to convene further forums to share our experiences of successes and challenges we have encountered to help increase vaccination coverage.

Challenges to Ensuring Equitable Vaccine Uptake

Making vaccines accessible to the population is the most important part of this effort, and this requires staff and resources. Public health infrastructure has been chronically underfunded, making quick response during times of crisis challenging, and requiring innovative and flexible local staff. Local health departments need long-term workforce and infrastructure investments in order to be able to successfully and nimbly respond to the next pandemic.

Inclusion in Strategy and Planning

As local health departments, our role in the community gives us keen insight into what is needed to be successful, and our public health expertise gives us the tools to do so. This ground level expertise is critical to ensure that national and state plans and policies to fight the pandemic can be successful. Nationally, there has been varied engagement of local health department expertise in the state and federal planning. We must strengthen this partnership to ensure that federal and state response and vaccination planning is informed by local health department expertise.

Workforce

Unfortunately, the work of governmental public health—and local public health in particular—has long been under-resourced which has a direct impact on workforce. Local health departments were hit particularly hard by the 2008 recession. In many communities, they never recovered, and when COVID-19 emerged, workforce capacity was down 21% in local health departments nationally.

We have fewer staff serving larger populations with increasingly complex public health challenges to tackle. With these circumstances, local health departments are forced to shift resources from other public health activities to adapt to the demands of emergencies. The pandemic has been no exception. Since the start of the pandemic, local health department staff have been pulled away from other essential areas like food safety, HIV prevention, overdose prevention and response, and immunization. When NACCHO asked last spring how COVID-19 had impacted regular local health department immunization programs and services, most who responded (88%) indicated that they had to reassign their immunization staff to support the response. A number of local health departments (17%) also indicated that they needed to shift money from their regular immunization program budgets to support the response.³ While much has changed since last spring, this context is important as the same local health department staff who are responsible for vaccinations and protecting our communities from outbreaks of vaccine-preventable diseases like measles and influenza, were the same staff who were pulled away from those duties to support activities like COVID-19 contact tracing and supporting people who needed to isolate or quarantine. We are now relying on these same

³ Sharpe-Scott, K. (2020). Report from the Field: The Impact of COVID-19 on Local Health Department Immunization Programs. <https://www.naccho.org/blog/articles/report-from-the-field-the-impact-of-covid-19-on-local-health-department-immunization-programs>

people to vaccinate us against COVID-19. We need a strong focus and investment in restoring jobs in local public health, but also in recruiting top talent and retaining them in the field.

Data

Local health departments also need data. While local health departments have firsthand knowledge of their communities, we need timely, comprehensive and granular data to track where vaccines have been allocated and which populations have been vaccinated, identify which populations are and are not receiving vaccine, and what areas need to be targeted. In southwest Virginia, many people go to bordering states to be vaccinated, but we lack access to that information, making it challenging to see the full picture of who is and is not vaccinated in the region. All health departments need comprehensive data so we have a national picture of vaccination rates. This data is critical to doing our work.

Similarly, local health department technology systems need to be upgraded. Our existing network is so poor that often we cannot fully participate in a Zoom or Google Meet at our office, and some of our phone systems are so antiquated that they do not even have voicemail. Internet speed lags, taking a substantial time to load email or COVID-19 data dashboards. In the midst of the pandemic, a network cable was cut and we literally had no access to any state system for several workdays, statewide. It is difficult to overstate how challenging this abysmal infrastructure makes it to do our regular health department work, let alone keep pace during a technology-dependent pandemic response.

Funding

We are very grateful for Congress' emergency funding and attention to the needs of the public health response to COVID-19. The health districts I serve are part of a centralized state health department and we have seen the benefit of those investments in a timely way. NACCHO has related that in some other states, local health departments have had great variability in receiving federal funds in a timely manner. We are hopeful that local health departments across the country will get consistent access to the resources they need in a timely manner to continue the vaccine rollout.

The public health response to COVID-19 would benefit from single-dose vaccine packaging, streamlined national vaccine data, coordinated messaging that speaks to many different populations, and continued resources for local public outreach.

Long-term investments

While today's hearing is about COVID-19 vaccine access and hesitancy, it cannot be overstated that this is an issue that was a challenge for public health long before the pandemic and it will outlast the pandemic without investment and attention. Our efforts to build confidence in vaccines are ongoing, but every person vaccinated brings us closer to ending this pandemic. Focus and investment in building vaccine confidence must last long after the COVID-19

pandemic has ended. We can and must learn from these earlier long-term failures to invest in public health as we continue to work through the pandemic and prepare for the next crisis.

Closing

I am proud to serve southwest Virginia, and to work with dedicated colleagues each day to address all aspects of the pandemic response. The opportunity that COVID-19 vaccines provide is incredible, but we can and must do more to address barriers to acceptance and access to achieve our goals in an equitable way. Local health departments across the country work directly with individuals in our communities and are ideally situated to address vaccine hesitancy, combat vaccine misinformation, and increase vaccine confidence. The efforts and lessons learned from local health departments and their community partners in supporting equitable COVID-19 vaccine uptake have the potential to also address vaccine hesitancy, build broad confidence in routine vaccination, and better protect our nation against future vaccine-preventable disease outbreaks.

We know that some of the most important components of a successful vaccination campaign are access, education, opportunity, and respect. We appreciate the support of the federal government to create access to vaccine, and we will continue to work respectfully with our communities for education and opportunity.

Thank you again for inviting me to testify today and I look forward to your questions.

Ms. DEGETTE. Thank you so much, and thanks to all of our witnesses for their testimony.

It is now time for Members to ask questions, and the Chair will recognize herself for 5 minutes.

We know that COVID-19 vaccines are safe, effective, and our shot at a return to normalcy. And, as the panel has been discussing today, the main issue is, are Americans choosing not to get vaccinated, or do they simply not have the opportunity, and how can we help them?

Dr. Omer, you testified that there is a large group of “fence sitters” who have questions about the vaccine, that—but can be provided with the right interventions. Can you very briefly tell us what some of those interventions that the data shows us might work are?

Dr. OMER. Yes—no, so this is a group that—which doesn’t actively think about vaccine but can be persuaded, or—either their beliefs are—

Ms. DEGETTE. Yes, can you tell us some of those methods that can work?

Dr. OMER. Yes. So one of them, one of the approaches, is to provide basic information about the immunization process itself. So that is number one.

The second thing is making—bringing the vaccines closest to them, but also informing them that it is there.

The third is these community outreach efforts—sorry, can you hear me?

Ms. DEGETTE. Yes.

Dr. OMER. Yes, so I will—

Ms. DEGETTE. We can hear you.

Dr. OMER. I will continue, yes. So—

Ms. DEGETTE. Yes, please.

Dr. OMER [continuing]. Then community outreach efforts that are—so the administration has announced, in terms of investing in community health workers and individuals going door to door, there are existing programs there, as well, that are coordinated by community-based organizations. Empowering them with evidence-based messaging, but also the ability to schedule there and then.

So these are some of these approaches—

Ms. DEGETTE. Right.

Dr. OMER [continuing]. That can bridge the gap between demand and supply.

Ms. DEGETTE. Thank you very much.

And Dr. Shelton, you talked about some of the unique needs of rural individuals. I am wondering if you could tell us some of the strategies that you think work with rural Americans.

Dr. SHELTON. Thank you. Yes, we have been working—like I said, one of our greatest problems is access, and—to the vaccine, as far as going out to populations where they have not been able to take advantage of registration and sign-ups online. So going out into the communities where there is not—where they don’t have the broadband access or cell service or computer service. So we have been taking our mobile units out into the community to try to reach them.

We would benefit from greater education opportunities with these. We do have some community health workers beginning to come online. But again, training them, and getting them up and rolling to be able to actually answer those questions on the spot with people who were there to give vaccines would be very helpful in our ongoing strategy there.

Again, taking opportunities also where there is——

Ms. DEGETTE. Great, thanks. OK, thank you.

Ms. Pisani, you have been working on these vaccine issues for years, as you said. And one of the greatest pockets of vaccine hesitancy is, obviously, with children, which you have been working on. My home State of Colorado has one of the largest groups of these parents.

Very briefly, what would you say to the parent of a child who is eligible for a shot, who isn't sure about the benefits?

Ms. PISANI. Congresswoman DeGette, were you calling on me? It broke up for a second.

Ms. DEGETTE. Yes, I was calling on you. What would you say to the parent of a child who is reluctant to get a shot for that child about what the benefit would be?

Ms. PISANI. Yes, and I think that that is a big decision that families need to make. And everyone should be asking about any medical product. And that is something that Vaccinate Your Family, we feel really strongly we want to be the sort of no-judgment zone.

So really, what you need to think about are, first of all, we know that millions and millions of children have now been vaccinated safely. But also, really thinking about what are the risk-benefit ratios, I don't think that some parents are really recognizing that. Even though we haven't had a huge number of children who have died from COVID, we know that they can have multisystem inflammatory disorder. We don't know what the long-term consequences will be of COVID. We know that people who got polio decades ago are back in their wheelchairs today. We know that, if you get chickenpox, you can get shingles later in life, which I got last year and, let me tell you, it is no picnic.

So we don't know what the future will be. And it is—you know, that is why I vaccinate my own kids. I want to make sure that they don't end up suffering something in the future.

Ms. DEGETTE. Thank you so much.

OK, I am going to finish with you, Mr. Offerman, because I think one of the reasons you have chosen to be a spokesperson urging people to get the vaccine is because you are well known for playing the TV character Ron Swanson, who has a [audio malfunction] government programs, even though he worked for the government. And so I want to ask you, what is your message to Americans out there who are wondering if they should get the vaccine, or if they should have their family members get the vaccine?

Mr. OFFERMAN. Sorry, can you repeat the—just the last part of your question?

Ms. DEGETTE. Sure.

Mr. OFFERMAN. Wondering if they should get a vaccine, or——

Ms. DEGETTE. What is your best—or tell their family members why they should get a vaccine.

Mr. OFFERMAN. Well, to me, it really just comes down to, as Ms. Pisani just pointed out, the risk-benefit ratio, the—what is likely to occur at the hands of COVID-19 is much more catastrophic than what has now been proven to be a harmless vaccine.

And so it is not a sensibility of deciding for oneself and saying, “Oh, my immune system will take care of me.” Instead, act as a member of a community, or as a good neighbor or a good citizen and say, “Ah, the experts have made it clear that, for the health of all, we absolutely have to achieve this herd immunity. So let’s all get our shots.”

Ms. DEGETTE. Thank you so much.

And now, Mr. Griffith, I am very pleased to recognize you for 5 minutes.

Mr. GRIFFITH. Thank you, Madam Chair. I took my headset off because, apparently, I was the cause of the previous—my headset was causing the previous buzz. Hopefully this is better—

Ms. DEGETTE. We are not judging, though. Don’t worry.

Mr. GRIFFITH. All right, I appreciate it. And I do appreciate this hearing being held today.

In recent months we have seen a variety of efforts by the State, local, and Federal Government to educate and inform the public about vaccines. We have also seen efforts by the private sector, such as public service announcements from our cable providers and other TV and radio providers, and website tools that seek to bring awareness. It is important that we continue to find creative ways to communicate this information, as there are still many pockets of unvaccinated individuals.

And Dr. Shelton, I was wondering if I could speak with you about that. You mentioned the proximity of the States and—that are near us, and the committee has heard me talk about that many times, how you could actually be in five States in a single day down in our corner of southwest Virginia.

That being said, you are getting the information from the States, but I read an article—or you are hoping to get that information from the States. You haven’t yet. I also read an article last week that the Federal Government was starting to share that information with localities. And I was just wondering if the VA was sharing that information, because both Mountain Home there in Johnson City and the VA center in Salem have vaccinated a lot of 9th District constituents. And I am just wondering if that is showing up in your records of people in our district that have been vaccinated.

Dr. SHELTON. No, sir, not yet. We don’t have the Federal doses calculated—in one instance, but we did talk with one of the local penitentiaries about the number of vaccines given. It actually raised our percentage points 3 points in that county, just—but that was—access to—at this time.

Mr. GRIFFITH. And that was the—was that the Grayson facility or the Lee facility? Was it Federal or State?

Dr. SHELTON. Federal facility.

Mr. GRIFFITH. A Federal facility, OK.

Dr. SHELTON. In Lee.

Mr. GRIFFITH. Yes, ma’am. And you have talked somewhat about it, but—I know you are learning about the pockets of unvaccinated

people, and I am glad to hear you have mobile units out there. Do we need to do more to get the mobile units out, and maybe not just units that do the vaccinations but, as you have indicated, educate the public about the history of the vaccines and the safeness of them?

Are there other things that we should be doing or encouraging Virginia to do in that regard?

Dr. SHELTON. Well, we have a messaging campaign, and we are looking to kind of adapt this messaging and work toward our localities in things that speak to them. As Dr. Omer said, message about liberty and freedom along a lot of our constituents who may not be wanting to get vaccinated, but also to answer their questions. A lot of people have concerns. Concerns about—is huge in our area, and there are other—some of these more distinct cultural, rural areas, messaging would be very helpful.

Also, we do have health education that we are beginning to send out in advance—to answer these questions one on one. And so we are—and how to really—and to be the boots on the ground, and to answer those questions—and more people out doing this would be helpful.

Mr. GRIFFITH. And I appreciate that, and I also appreciated in your comments that you talked about not labeling people or pressuring them, because the people in our area are very proud people. And you want to turn folks off, come in and say, “We are from Richmond” or “We are from Northern Virginia, and we are going to tell you how to do it.” That doesn’t work in our area, as you know, and I appreciated you making those comments. Do you want to amplify that at all?

Dr. SHELTON. Well, the health department in southwest Virginia provides a lot of—for our community, and we are a trusted source of information to them. So we do respect all the viewpoints that we do hear, and we try to work with people in their own community and to address their concerns, specifically—again [audio malfunction] people without a lot of—they ought to have all their questions answered.

Mr. GRIFFITH. Yes, I appreciate that, and I think it is very helpful that you are a native of the area and have long served both patients and the community, and I think that helps you get that message out. If there is anything that we can do to help get that message out, not only in our part of southwest Virginia but in east Tennessee or rural parts of North Carolina, West Virginia, all of which border our territory, and—we are more than happy to do it.

And as you can see, as as the chairwoman pointed out, this is not a Democrat or Republican issue. This is about all of us working together. And we have had some counties that have been hit pretty hard, even over the border in West Virginia. I had a county over there, not in my district, but one that was really hit pretty hard. So we are trying to do it, and we appreciate what you are trying to do and what all the witnesses are doing here today. Thank you.

I yield back—

Ms. DEGETTE. I thank the gentleman. The Chair now recognizes the chair of the full committee, Mr. Pallone, for 5 minutes.

I don’t see Mr. Pallone.

Mr. Pallone?

We may have lost him briefly. And so, Ms. Kuster, are you ready to go? Why don't I recognize you for 5 minutes?

Ms. KUSTER. Thank you, and I apologize, I am just trying to pull up my remarks. Thank you so much, Chairwoman DeGette—

Ms. DEGETTE. Take your time.

Ms. KUSTER. Can you hear me? Chairwoman DeGette, can you hear me?

Ms. DEGETTE. Yes, yes.

Ms. KUSTER. Great. Thank you for holding this important hearing today, and thanks so much for our witnesses, for your testimony and preparation.

The progress we have seen these past few months in beating back COVID-19 has been nothing short of remarkable. In just over 1 year, we have undertaken an incredible effort to manufacture multiple highly effective and safe vaccines. And we have undertaken, literally, a warlike vaccination campaign to get shots into the arms of the American people.

On January 20th, when President Biden took the oath of office, only 1 percent of adults were fully vaccinated. But today over 50 percent of American adults are fully vaccinated. And not to brag on New Hampshire, but over 70 percent of adults in my State have at least 1 dose.

While these statistics are encouraging, more must be done as we begin to see the signs of vaccine hesitancy among certain populations. A key component to our continued vaccination efforts is ensuring that we have hard data collected to ensure that we can improve access in rural communities, including my district. And that is why earlier this year I introduced the Immunization Infrastructure Modernization Act, bipartisan legislation that would improve and expand information sharing between State and Federal governments, as well as public and private healthcare providers, to ensure that vaccines are being administered effectively, efficiently, and fairly across all States and territories.

Immunization information systems, IIS, are secure, multifaceted systems that allow for the sharing of crucial information and the maintenance of records. My bipartisan legislation aims to bolster these systems and support real-time immunization record data exchange and reporting.

Dr. Gracia, you identified in your testimony deficiencies in our immunization information systems, many of which could be improved by advancing my bipartisan legislation with Congressman Bucshon. Can you discuss why it is so important for immunization information systems to be consistent in the type of data collected and reported?

Dr. GRACIA. Yes, thank you for that question and for your leadership with regards to addressing the importance of a strong and robust immunization infrastructure. That is, indeed, really, a core part of what we need with regards to our public health system and our public health infrastructure.

What we have seen, for example, has been—over the years that, actually, the immunization information systems have not kept up to pace with regards to the need for funding to ensure that we have really robust, comprehensive immunization systems that can do the type of surveillance, whether it is in the detection of outbreaks,

being able to tailor interventions—because you identify that there are certain populations in communities that, either for hesitancy or for access, have not been immunized—and then being able to ensure that there is interoperability of these systems, as well as ensuring that the programs themselves—and that the immunization program itself has the ability to do the type of vaccine education and outreach.

And so, as we think about, certainly, within the context of the COVID-19 pandemic, how critical that is for the local communities, as well as States, to be able to tailor interventions to be able to get resources to those communities that are undervaccinated, it is also important in the longer term, as we think about shoring up our immunization infrastructure to be able to detect and assess and address the next emergency.

Ms. KUSTER. Great. And Mr. Offerman, thank you for joining us and using your platform to encourage Americans to get the COVID vaccine. You speak to the effects the pandemic has had on your work in the entertainment industry and how, by listening to doctors and trusting each other, you and your colleagues were able to safely get back to work last year.

Since this was a successful strategy, how do you think this can help our national vaccination effort, particularly in rural areas like the one you grew up in?

Mr. OFFERMAN. Well, you know, I think it is just a matter of extending the leadership that the—our other witnesses are talking to, and getting this clear messaging to all of our citizens who are confused by the information they are getting. That comes from a variety of reasons: misinformation, conspiracy theories, mistrust, et cetera. And I think we just need to turn up the volume on the clear information that it is safe, everyone should do it.

It is your duty, as a family member. You know, if you love yourself, your family, your community, it is beholden on all of us to step up and be a good neighbor and a good family member and just shout that to the hills.

Ms. KUSTER. Great. Well, thank you for helping us shout that to the hills. And with that, I yield back.

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

Mrs. RODGERS. Thank you, Chair DeGette and Morgan Griffith. As ranking member, I really appreciate the approach of today's oversight hearing, and thank you to all our witnesses. I, too, just have some followup questions.

Dr. Omer, I wanted to ask the simple question: Do you have confidence in the three COVID-19 vaccines that are available today in the United States and the ways in which they were developed, reviewed, and authorized?

Dr. OMER. Absolutely. And as an independent academic, I would have said so if I did have any lack of confidence in them.

Mrs. RODGERS. Thank you.

Ms. Pisani, I wanted to ask, do you believe it is important for people to get the best and most accurate information?

And you stated that, that you believe it is important. How do you believe that they can, and allow them to make the best decisions for that—themselves?

Because right now, some of the most common questions we have from people are that they are concerned about getting—you know, they want to make sure that they have the best and most accurate information when it comes to getting the COVID-19 vaccine, and just any insights you have, as far as addressing those concerns.

Ms. PISANI. Well, I mean, I think there's a combination of issues, obviously. And maybe we'll talk a little bit more about social media disinformation, and that is a really important issue that we have to deal with.

But we do know that people do trust their providers. And so they are the most important source of information right now, no matter where you live.

But, you know, hearing from some folks in rural and urban, the challenges are so different, depending on where you live. And I literally traveled the Nation with Mrs. Carter and Mrs. Bumpers. And if you're in Wyoming, and you are an hour and a half away from your medical care, that type of message that you need to get is a little bit different than a person who could just go down the road and go to any clinic and get vaccinated.

So that trusted messenger issue, I mean, we are getting a little tired of hearing it, but it is so essential. Like, if you trust your evangelical leader, that is the person who needs to encourage your vaccinations. If you trust your local football coach, if you are from Penn State, those are the folks that you want to encourage to talk about vaccines. So I think it is different, no matter—depending on where you live.

Mrs. RODGERS. Thank you.

Dr. Omer, I wanted to ask you to address the issue of people being concerned about side effects, because the fear of the fever, the fatigue, especially following the second vaccine, is one of the leading reasons why people are choosing not to get the COVID-19 vaccine. Would you just address what you think is the best way to approach someone who is concerned about the side effects and the potential of losing a day of work or two?

Dr. OMER. Yes. I think that is a really good question. So there are two things that should be emphasized for the individual.

First of all, that this is the transient side effect. We get fatigue, pain, sometimes fever. They are expected. They were seen in the trials, and they are not connected to the serious adverse events, et cetera. So if you are getting that, it is just that, it is inconvenience. It is hard, in its own right, to be down with fever or fatigue, but it is not a sign of something more—sort of ominous, it's not an ominous sign for a more severe and long-term side effect. That is number one.

The reason why it is happening is that, when your body is trying to mount a strong immune response, for some people—not for everyone, I did not get these side effects. That did not mean that I did not mount an adequate immune response. But for some people, that means that that inflammation, that immune response, leads to these transient side effects. And so those are the things we need to communicate.

Mrs. RODGERS. Thank you.

And my final question, Dr. Shelton, in your written testimony you note that in the rural areas it is especially important to build the cross-sector partnerships in order to meet the needs of the community. And I just wanted to ask if you could share any examples of those partnerships and why you believe it is critical in the rural communities, in particular.

Dr. SHELTON. Yes, we have built these relationships over time. It is very important, the relationships we have with our hospitals, as well as our pharmacies and healthcare providers with the roll-out of the vaccine. But we also have long-term partnerships with our county administrators, emergency coordinators, and schools. When it came time to go out and give the vaccine to the students, for those who were 16-plus and then 12-plus, we, you know—begin to provide vaccines within the schools.

Also, working in our larger—emergency coordinators, just having the whole community pitch in and help with these efforts went a long way toward increasing—and the number of people we were able to vaccinate.

Mrs. RODGERS. Super. Thanks for your work.

Madam Chair, I yield back the remainder of my time. Thank you.

Ms. DEGETTE. I thank the gentlelady. The Chair now is pleased to recognize the chairman of the full committee, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Chairwoman DeGette. My questions, a lot of them are the same ones that Ranking Member Rodgers asked, so I guess we think alike, Cathy. But let me try to ask those that maybe you didn't cover. I wanted to ask Dr. Omer about these, you know, misconceptions.

You know, we hear fears from Americans about vaccine safety, that they were developed too quickly, or the process—review process wasn't rigorous enough, and there is also this thing about the side effects with—that vaccines can cause fertility problems.

Just, you know, set the record straight for us. Why should we not be worried about this type of misinformation that is swirling, particularly online?

Dr. OMER. Yes. So this is a misconception that is out there that we—the corners were cut. The corners weren't—you know, nobody took a shortcut. It is just that we built a highway. And that is why the—streamlining the process, cutting the—some of the bureaucratic process but also increasing efficiency by how we recruited in trials.

If I may take the liberty of giving you one example. So if you need 30,000 people in a trial, which were an average size, 30 to 40,000 people, you can have 30 sites with 1,000 people, or you can have 60 sites with 500 people, or 120 sites for recruitment for 250 people. So that is why—that is one example of how efficiently we expanded the number of sites, because resources were available, et cetera, so that we did these trials quickly, rather than doing it—you know, waiting for each site to enroll, let's say, 1,000 people, or 3,000, if you were going with 10 sites. So that is important.

The processes that were used to ensure safety and efficacy are time tested. This was—these were the processes, the data collection, the evaluation. And just to remind everyone that all—with all

of these trials, by regulation they have to have an independent data and safety monitoring board. So, even beyond the outside committee independent review that FDA performed while these trials were going on, there was weekly, ongoing safety review and effectiveness review after the data became available was happening.

And then now, the—there is an unprecedented effort to ensure that there is robust vaccine safety surveillance. And that is why you hear about certain signals. You know, if you look for—you do robust surveillance, you hear about these signals. And FDA and the CDC has done—taken a rational—conservative, in a sense—to protect the safety—to protect the general public against any uncertainty, as well. That path, by leveraging those data and having a short timeframe from signal emergence to signal evaluation, and then a recommendation. So this has enabled us to trust the process, and to trust the outcome of this development and deployment process.

Mr. PALLONE. Well, thank you. Another [audio malfunction].

Ms. DEGETTE. OK, Mr. Chairman, can you start your question again?

Mr. PALLONE. Yes. [Audio malfunction] come down today to meet with the vice president on broadband. So I had to get on the road.

But this is about whether people who previously had COVID-19 should still get vaccinated.

Dr. OMER. So I don't know if—

Mr. PALLONE [continuing]. Understanding around that.

Dr. OMER. Sorry, I—

Ms. DEGETTE. Go ahead, Doctor.

Dr. OMER. Yes, so—OK, I was unclear if the question was for me, but I would answer it.

Mr. PALLONE. Yes, it is OK. Well, I guess it—actually if Dr. Gracia wants to answer it, about whether people who previously had COVID-19 [audio malfunction].

Dr. GRACIA. Yes, the recommendation is that people who have had COVID-19 should still get the COVID-19 vaccine. You know, there is natural immunity and antibodies that are developed through infection with COVID-19. However, that is not as robust as what we know from—with regards to vaccination. And so—and we don't know how long that natural immunity can last. And so the recommendation is, indeed, for those who have COVID-19 to also get the COVID-19 vaccination.

Mr. PALLONE. All right, thank you so much.

Thank you, Chairwoman DeGette, I appreciate it. I yield back.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

The Chair is now pleased to recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. I thank the chair, and I thank all of our witnesses for being here today. This is such an important panel that we have put together.

And I—you know, the—one of the things that leads to hesitancy, of course, is not being consistent in the information that is delivered. And I think Mr. Offerman, actually, said it at the beginning of his testimony. He is—“Here I am, just a regular guy, and we have to defer to all the scientists.”

But let me just tell you, Mr. Offerman, this is a novel disease. And the scientists were sometimes embarrassed, because what they

had said at the beginning wasn't what they ended up saying several weeks or months later. And I can think of no area where that has been less pronounced—or where it would be more pronounced—as where did this virus originate. And the stories that we were told early on are now not comporting with the stories that we are hearing now.

And Chairwoman DeGette, I think it would be incumbent upon this committee, being the primarily investigative committee of the subcommittee of the Committee on Energy and Commerce, to ask those questions, and ask them thoroughly. I realize——

Ms. DEGETTE. Will the gentleman yield?

Mr. BURGESS. Yes, I would be happy——

Ms. DEGETTE. Will the gentleman yield?

So I agree. I think it is very important that we find a—that we investigate where—particularly, if the virus escaped from some lab, because that, of course, has implications for international health.

Mr. BURGESS. Yes——

Ms. DEGETTE. And I have already spoken to the ranking member. Whatever we can do—I don't think China is going to produce any documents to this committee.

Mr. BURGESS. No——

Ms. DEGETTE. But we are going to do whatever investigation is appropriate. And Mr. Griffith and I are on the same page.

Mr. BURGESS. So reclaiming my time, because it is——

Ms. DEGETTE. I will give you a little extra time, too.

Mr. BURGESS. All right.

Ms. DEGETTE. I will give you a little extra.

Mr. BURGESS. I have got more than I can get through, anyway, and I, obviously, will be submitting questions for the record, as is my habit.

But that is—if we can reestablish some credibility, even after the fact, I think that is going to be so critically important, because not only do we have a once-in-a-lifetime pandemic, we had it on top of a once-in-a-lifetime political year, and it left people, in many cases, confused. And now the challenge for all of us is to—how do we get to people and help them understand what is—what I believe would be in their best interest.

Chairman Pallone, I guess we have lost you to the ether somewhere, but I have asked for your help in interceding with the Speaker. All of us, or most of us, took the vaccine in December. The Speaker told us we were—it was necessary for the continuity of government, and so—fully vaccinated, to be sure.

And yet we behave as if we are still frightened of the disease. And that does not send—in my opinion, that does not send the right message. So, in conjunction with other doctors in the Doctors Caucus, we have asked the Speaker for clarification. We have to vote in these odd ways. We are doing this hearing in a virtual format. This should be in our main hearing room.

This should be—if we are, indeed, all vaccinated, and we—or those of us who are vaccinated believe that we can no longer transmit the illness or contract the illness, we should behave that way. And if there is someone who says, well, for whatever reason, I don't feel comfortable being in that setting, sure, let's have special arrangements. But we shouldn't be doing hearings remotely. We

shouldn't be doing voting on this intractable schedule that just seems to never end. It doesn't allow us the opportunity to amend bills and have the appropriate legislative input. So I just make that plea. It is time. It is time for us to get back to normal.

Now, I do have to ask Mr. Offerman a question, because this is absolutely critical, and I need to know the answer to it. With your vast experience as a wood worker, do you find that English walnut has no sense of humor?

Mr. OFFERMAN. Thank you for your question. I want to hit one point you just mentioned, and that is I believe, once you are vaccinated, you can still transmit the virus. It doesn't eradicate that possibility. The vaccination is simply a protection. But the reason that we are—I believe we are still trying to be safe, is because you can still catch it and pass it to others.

Mr. BURGESS. Yes, well, the—reclaiming my time again, the CDC guidelines that came out a week ago Thursday seemed to have—seemed in a different place than that. And I recognize that there is new information coming all the time, and we have—many of us have been—have issued pronouncements that turned out then to be inoperative later on. That is part of dealing with an novel virus that is of this severity.

But it does appear that those who have been vaccinated are—if the virus is recoverable from their nasopharynx, it is no longer infective. And we need to know the answer to that, to be sure. But you just look at the broad graphs of the prevalence of disease in the United States of America, and, clearly, something is different now than it was in January. And do we need to be behaving the same way we were in January?

And if we believe that the vaccine is what has brought us to that point, why don't we model that behavior?

Thank you, Madam Chair. I will yield back, and I have got a ton of questions I will submit for the record.

Ms. DEGETTE. I thank the gentleman. The Chair now recognizes Miss Rice for 5 minutes.

Miss RICE. Thank you, Madam Chair.

And Dr. Burgess, I couldn't agree with you more. I would love to get—for all of us to get back to our prepandemic life. And I would encourage you to speak to your colleagues on your side of the aisle as to why they are preventing us from doing that, and because they are not getting vaccinated.

Mr. Offerman, if I could ask you, if you had every unvaccinated Member of Congress before you, what would you say to them? How would you convince them? What would you say to convince them to get the vaccine?

Mr. OFFERMAN. Well, thank you for your question.

And just to answer Dr. Burgess quickly, English walnut is indeed humorous.

If I had the unvaccinated Members of Congress before me, I would simply try to appeal to their common sense and say, "Look, as our conversation just now pointed out, we are humans, which means we are always learning more information. Sometimes we think we have got it figured out, but then things continue to evolve. Even if we have a solution, the variants show up. We will

always have to be vigilant. There will be more, you know, there will be more, ostensibly, SARS viruses coming in our future.”

And so I would just say, “Look, all we—with the information that we have, the decent thing to do to—is to pitch in for the common good, regardless of any other misinformation, and get the shot.”

And if you guys—you know, if you need a cookie, or a lottery ticket, or I will take you down the street for a glass of single malt, if that is what it will take, then I will be happy to pick up that bar tab.

Miss RICE. You might have some Members take you up on that, Mr. Offerman.

The daily average vaccine administration in the U.S. reached a peak of 3.4 million doses in April of 2021. Unfortunately, that average has declined to approximately 1.8 million daily doses in recent weeks. So this is the issue that we are talking about.

Mr. Offerman, you mentioned you had some family members back home in Illinois who are told—look, we are not going to be able to get—I have someone in my own family who is —knows—you know, has family members who knows the science of this, that were experts in infectious disease. Do you know—and I am not asking you to out any of your relatives by name, but is the reason—is it mis- and disinformation?

Because there is so much of that on social media. We can’t control where people are getting their information from, but we know that there are, you know, a handful of people, Robert Kennedy Jr. being one of whom, who posts mis- and disinformation regarding this vaccine every day on social media.

So have you been able to figure out the source of the hesitancy in people in your family, and how do you address that, specifically?

Mr. OFFERMAN. Well, I mean, yes, the—one of the family members in question actually used to work as a phlebotomist. And so they feel they have, you know, a sense of authority. And their information streams are, you know, both news channels, or “news channels,” and social media platforms that turn this issue somehow into a political football and say, you know, “Is this administration telling you the truth? Should we listen more to this administration?”

And this—you know, I understand that that is, you know, the state of affairs in modern-day America. But this—what we say to this family member is, “Your children, two—arguably, the cutest children in the family—haven’t gotten to see their grandparents for over a year because of the danger of”—you know, it is a perfect storm. We have a couple of immunocompromised kids, as well. So we have to be incredibly vigilant. “Can’t you just do this for the good of the family?”

And, you know, because of their incredible will and their wonderful Midwestern stubbornness, they so far refused. So we just try not to pull our hair out, and keep taking a deep breath and say, “Hopefully, we can all get together soon.”

Miss RICE. Mr. Offerman, I just want to thank you so much, because, you know, you say that you are not one of the smart people here and not one of the scientists, but you—your ability to reach millions of people is unmet by anyone on this Zoom. And so I really appreciate you being—and willing to talk about this, and to do it

in a way that, you know, can reach regular people. You are talking specifically to people who don't have medical backgrounds, and many of whom admire the work that you do. So thank you so much.

And thank you to all of the other smart witnesses who testified here today, and I yield back.

Thank you, Madam Chair.

Ms. DEGETTE. I thank the gentlelady. The Chair now recognizes Mr. McKinley for 5 minutes.

Mr. MCKINLEY. And I thank you, Madam Chairman, and thank you for getting this panel together, because this is going to be an interesting discussion.

But before I raise further questions, I would like to go to Dr. Omer because, based on his written testimony, there were some—he revealed he had quite a knowledge of the process of the vaccination.

So I am asking you if—without Operation Warp Speed, would we have a vaccine today in just 8 months?

Dr. OMER. I think it is correct to say that the efforts that happened over the last year have really helped develop and sort of evaluate these vaccines.

But I also point out—

Mr. MCKINLEY. If I could, if—let me just—that is what I wanted to point—I think back on the other, as to why we are not getting—I think we are sending mixed signals. We elected officials, public statements, public—I think we are sending confusing and mixed signals out to the public. No wonder they are—look back on just last year, just—not even 7 months ago, 8 months ago, we had the then-Senator Harris saying that she would not take a vaccine if it were approved by the Trump administration. Now, think about that.

And then we have—for decades all of us were taught, once we get a vaccine, we are protected against a disease. But then—and then, on May 13th is a—a couple of weeks ago, the CDC announced that vaccinated people no longer need to wear masks. That sets the tone. But now, follow through with that.

The next statement, just a few days later, a week later, the President was at the Ford Rouge plant in Michigan, wearing a mask after he had been vaccinated, after the CDC had already come out. Dr. Fauci was wearing a double mask, and he was asked about that, the issue, again, challenged on that.

So, Dr. Omer, again, do you think the actions of our political officials and—their statements and their actions, are they impacting us on the vaccine hesitancy?

Dr. OMER. So, unfortunately, I wouldn't be able to track back, you know, sort of—since I wasn't following exact specific day or time where everyone was—anyone was wearing a mask, but I can do—I can speak broadly, because we tested this in our messaging trials, as well, that bipartisan support and endorsement of vaccines are extremely important. And so I agree with a clear, bipartisan message on this issue is helpful.

Mr. MCKINLEY. OK. So let me say—build off a little bit what Dr. Burgess was saying, because I think we are all frustrated about this, because Speaker Pelosi has said she is not going to let us go

back into session until all the Members are vaccinated. But unlike the Senate—they are back, and they are not wearing masks. They are back on the floor. They are working in committees. But we are still—like this hearing today—still being done virtually.

Now, this is contradictory towards what the Attending Physician has said and what the CDC's guidelines are saying. So, Dr. Omer, do you think that Nancy Pelosi is following the science in continuing to keep the House shut down and extending proxy voting? What is the end game?

Dr. OMER. So Congressman, unfortunately, I am not in the position of evaluating specific House policies because I haven't looked at it.

But I will say that, when these trials were done, they did not include end points for transmission. So when the data came out, it was very appropriate to say that, to prevent transmission to others, we should wear masks even if you are vaccinated. Since then, the state of evidence has evolved. And for several weeks, or actually, you know, a couple of months, we had—we started seeing studies that say that even transmission is drastically reduced.

But there is a nuance to this. The nuance is that if you know—if you can verify that everyone is vaccinated, then it is perfectly safe. And CDC has said that, for people to interact like, you know, pretty much normal, with the exception if you are in a healthcare facility, et cetera.

Mr. MCKINLEY. Then, if I could, just in—

Dr. OMER. We could—

Mr. MCKINLEY [continuing]. Go back, if I could—reclaiming my time, but are we ever going to get—it is not realistic to get 435 Members of the House to get vaccinated before we go back into session again. Are we going to continue this nonsense?

I think it—let me hear from you.

Dr. OMER. So I would—again, without commenting on specific policies, because I am not sort of that knowledgeable about the details, but I would say that, even if you cannot verify, a lot of activities can happen indoors. CDC has said that, with masking and—but then it depends on what the compliance is for masking, et cetera, if you don't know who is vaccinated and who is not.

So that—there is a nuance there. I do think that we have evidence of high protection and decreased transmission.

Mr. MCKINLEY. Thank you.

Madam Chairman, I yield back the balance of my time.

Ms. DEGETTE. Thank you.

The Chair now recognizes Congresswoman Schakowsky, the birthday girl, for 5 minutes.

Ms. SCHAKOWSKY. I thank the chair and all our witnesses. It is so great to celebrate with you today.

In March the Center for Countering Digital Hate and Anti-Vax Watch found that 65 percent of antivaccine social media content stemmed from just 12 individuals called the Disinformation Dozen. Despite being brought to the attention of the social media companies, a review one month later found that at least nine of those individuals still maintained active accounts on Facebook and Instagram and Twitter.

More alarming, a sample review of Facebook posts over the last week showed that online—that only 19 posts had fact-checking labels applied to them. The posts that are left say things like “asymptomatic people can’t spread the virus” and that the “COVID-19 vaccine is a genetic mutation.” One post alone reached approximately 62,500 people.

Ms. Pisani, although vaccine myths continue to be accessible on social media, we understand that your organization had a challenging time getting factual vaccine information posted on social media. Can you briefly tell us about your experience, and how long did it take to be resolved?

Ms. PISANI. That is a really great question. It happened—it has happened to us on several occasions. And so at Vaccinate Your Family we started Facebook—I believe it was almost the year it began. We jumped right into social media. We felt like it was a really important place to be.

And what happened was, years ago, we ended up being drowned out by these larger organizations that have a lot of money. And they were sharing disinformation. And it was a—just a few people, but with the most amount of money. While the rest of us were starting to realize that we had to provide information in order to be allowed to post, we hadn’t realized it yet. And so they had beat the algorithms. We didn’t know about them yet, so we hadn’t fixed our problem.

Most recently, during the COVID year, we were no longer able to get comments on our Facebook page for almost 7 months. We never were able to speak to a single person at Facebook. That is a really big deal, because we are the largest social media group on vaccines in the nation, and we have people from around the world. So when we can’t—when our posts don’t get boosted because we don’t have a lot of movement on our pages, that makes a really big difference.

So the companies can fix our algorithms. They—there is a lot that they can do. They can stop feeding people disinformation based on their search terms, on the information that they are already reading. They could whitelist groups like Vaccinate Your Family, Voices for Vaccines, the Academy of Pediatrics, and other groups that share fact-based information. There is so much that could be done to fix the problem.

Ms. SCHAKOWSKY. Well, thank you for that. That is very disturbing, and I want to work with you to see if we can make that better, so that factual information doesn’t have barriers to getting out.

Dr. Gracia, unfortunately, as you mentioned in your testimony, misinformation campaigns have targeted people of color and low-income communities, often without accessibility to antivaccine—to—without accountability. The antivaccine movement has been able to exploit justifiable, historic distrust, and the media companies have helped to further their antivaccine goals.

Can you talk to us a little bit about that? I am almost out of time, but I would love to hear that.

Dr. GRACIA. Yes, thank you for that question. It is important, because when we talk about why certain communities may not be

getting vaccinated, this issue of misinformation is so critically important, and it is important as it relates to communities of color.

There are efforts underway. One of the efforts that we have, for example, at Trust for America's Health, is through our Public Health Communications Collaborative, in which—it is a collaborative between Trust for America's Health and a partnership with the CDC Foundation and the de Beaumont Foundation, where we actually do tracking on misinformation and provide guidance, in particular, for public health officials at the local and State levels to be able to address misinformation.

And then there are also other efforts. For example, the campaigns Between Us, About Us, where you have, for example, a campaign specifically for the Latino community that was recently launched through UnidosUS and the Kaiser Family Foundation, creating PSAs and other tools featuring Latino healthcare providers and other Latino health workers that can be used in the community to be able to combat some of that misinformation that is happening.

And there is, likewise, a campaign specifically featuring Black healthcare providers that the Black Coalition Against COVID and others are engaged in. And that way they have the tools and the resources to be able to address some of the many myths about the COVID-19 vaccine.

Ms. SCHAKOWSKY. Thank you so much. And trusted messengers, I think, are so important. So thank you for your important work. I yield back, and I appreciate—

Ms. DEGETTE. I thank the gentlelady. And the Chair now recognizes Mr. Palmer for 5 minutes.

Mr. PALMER. Thank you, Madam Chair, and happy birthday, Jan. And following up on your last question, I think that there is a role for faith-based organizations in increasing the confidence in the vaccines and maybe even serving as a familiar distribution site.

And what I would like to ask Dr. Gracia is, has anyone looked into reaching out and partnering with the faith-based organizations for vaccine distribution or for public service announcements as a communication vehicle to raise the confidence among people, particularly in minority communities, which we know have an aversion to certain vaccinations?

Dr. GRACIA. Yes, absolutely. The faith community, faith leaders are such important partners as it relates to being trusted messengers and trusted institutions, as far as places of worship in communities. And in certain communities of color, it is actually one of the entities we highlighted in our policy brief as a core and trusted messenger. There are, indeed, many messengers.

The administration has certainly been engaging with the faith community but also seeing, you know, local health departments, State health departments that have worked with faith leaders, where it is either to be able to get messages out to communities or to serve as potential vaccination centers, utilizing, for example, a church parking lot, doing virtual town halls to be able to deliver messages that they trust from their faith leaders.

Mr. PALMER. Dr. Shelton, along the same lines, there are certain—there are unique issues that rural communities face when it comes to vaccine distribution. And I think that working through

the faith community in rural areas could be helpful. But can you comment on how State and local governments could increase access to and confidence in the vaccines in rural communities?

Dr. SHELTON. Yes, thank you. Certainly—has been a great asset to our vaccine distribution—we had—

Mr. PALMER. Madam Chairman, I can't hear her answer. I—suspend my time for a moment.

Ms. DEGETTE. Yes, yes, we are having difficulty hearing you.

Dr. SHELTON. OK, can you hear me now?

Ms. DEGETTE. Yes. Perfect, thank you.

Mr. PALMER. OK.

Dr. SHELTON. OK, yes, certainly, our faith communities have been a huge asset—sites that we had—

Mr. PALMER. Madam Chairman, suspend again, if I may.

Ms. DEGETTE. Yes, yes. This is the other issue this committee needs to work on, is our broadband access in rural areas.

Mr. PALMER. Yes.

Ms. DEGETTE. So let's try it again.

Mr. PALMER. If she can't—if we can't understand her, can she just answer the question in writing, submitted to the committee?

We will try it one more time, but if we can't hear her, we will just ask for her to submit it in writing.

Dr. SHELTON. OK. Can you hear me now?

Mr. PALMER. Oh, yes.

Ms. DEGETTE. Yes.

Dr. SHELTON. OK. Certainly, our faith-based communities have been a very important part of—many of our large—that we have had over the last several months have been in faith—we do this for our—also for local outreach to our neighborhoods, actually some of our—communities, including our Black and Hispanic communities. So that's a very important thing.

As far as our State and local governments, I think working with our faith communities—there.

Mr. PALMER. OK. I couldn't understand all of it. So, if you don't mind, submit it in writing.

I would also like you to respond to—I have had some people speak to me about people having excess to vaccine and not knowing what to do with it, and concerned about it expiring.

So, if there are some things going on in your State and local governments in that regard, I would like to know about that.

And I would also like to point out that we are all focused on injectable vaccines, and there is research being done right now—there are clinical trials being done on another intranasal vaccine that not only has shown promise in mucosal immunity, but it will protect against infection, but it also protects against transmission. And I—Doctor, I just hope that we will continue to focus on the development of new vaccines that there might not be as much opposition to.

And the last thing I would like to say, Madam Chairman, I don't know how many of you have had a chance to look at Mr. Offerman's website for his wood working, but the canoe that he made out of cedar is absolutely, stunningly beautiful. And I don't know if he built it, or someone in his shop built it. They built a dresser out of walnut, apparently, a solid piece of walnut. It is

amazing. I don't know if any of us could afford a canoe or a dresser like that. But they are really beautiful pieces.

And I want to commend you for your outreach to the homeless. I think one of the great tragedies of the welfare state and homelessness is the loss of incredible talent and ingenuity and imagination among those people. And the fact that you are bringing them in, giving them a chance to demonstrate their artistic ability is amazing. And I want to congratulate you on that.

And I yield back.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes the chairman of the Environment and Climate Change Subcommittee, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you, Chairwoman DeGette. Can you hear me?

Ms. DEGETTE. Yes, we can hear you.

Mr. TONKO. OK, thank you. And I thank you and Ranking Member Griffith for hosting this wonderful meeting.

We have heard today that there is no one-size-fits-all solution to—for increasing COVID-19 vaccination rates. While we have made tremendous strides in just a few short months to increase vaccine supply, we know that availability does not equal access. And the reality is that many Americans remain unvaccinated due to access barriers to getting vaccinated.

Dr. Gracia, you emphasized in your testimony, and I quote, “lack of culturally and linguistically appropriate information and services, less access to technology required to sign up, less access to transportation, and a lack of paid sick leave may be hindering vaccine access for some populations.” So how are these barriers preventing unvaccinated Americans from accessing COVID-19 vaccines, especially those who make up the movable middle?

What populations are most likely to face these challenges?

Dr. GRACIA. Certainly. Thank you for that question. So if we think about, for example, low-income communities, many communities of color, with regards to being disproportionately, actually, those that work in some of the frontline jobs, some of the jobs that were deemed as essential jobs in the COVID-19 pandemic, that actually—many workers of color did not have access to paid sick leave.

And so the challenge of, for example, being able to take time off or being worried about—and losing income, or losing their job, being able to get the vaccine, and worrying about the side—potential side effects and having to take time off can be a barrier. And so addressing those types of issues, such as sick leave, as well as access to child care that families may need in order to get the vaccination, are addressing some of the issues of equitable access.

As it relates to providing information that is culturally and linguistically appropriate, that is ensuring that, for the diversity of communities that we are serving, that information is available, that it is respectful and responsive to the needs of the communities that are being served. And so that is where partnership with trusted community organizations is so critically important.

It is one—certainly, if it is a community that has limited English proficiency, ensuring that communications materials are translated into the languages that the community speaks, to ensure that they have access to information to make those informed decisions. But

it is also understanding what might be some of the concerns and how to message that most appropriately.

So it is, as many have said, it is the message and the messenger, and that is where it gets to understanding the cultural appropriateness of the messages that are being shared, and not doing so in a judgmental way that is a concern of why people aren't being vaccinated, but really getting to the causes of understanding why there may be limits in vaccination.

You also look at other barriers. For example, access with regards to the sites. Are the sites open and accessible during hours that they can actually go to, if they have to work one or more jobs?

And so these are the types of things that we are seeing, certainly now with these investments, and the—or these strategies with regard to pop-up clinics and mobile clinics, and extending clinic hours or the vaccination site hours. These are critically important ways to ensure that access is not a barrier to actual vaccination.

Mr. TONKO. Thank you.

And Mr. Offerman, as an owner and operator of a small business, you have the opportunity to work with the nonprofit Would Works to provide training opportunities to people experiencing homelessness or living in poverty, individuals likely to face access barriers. Like many others, we understand that operations of both the woodshop and Would Works were affected by COVID-19. Has vaccine uptake allowed normal operations to resume for you?

Mr. OFFERMAN. At the woodshop we are just about, you know, back up on our feet. Everybody's vaccinated. And so we still are employing masks, just erring on the side of safety. I don't see why we wouldn't do that.

And at Would Works we have just announced today, coincidentally, we are opening the program back up. That is a much more vulnerable population, so we are taking extra precautions. But it's a wonderful organization. We are very happy to support it. So many of the people who are without homes just need an opportunity. They all want to go to work. They just need a chance. So I love—I wish we would—Would Works nationwide.

Mr. TONKO. Well, thank you. And alleviating access concerns among unvaccinated Americans is, clearly, just as important as addressing other reasons why some people have yet to get the COVID-19 vaccine. So I am encouraged by the strategies being deployed across the country and certainly hope we can amplify these efforts.

And with that, Madam Chair, I yield back. And again, thank you.

Ms. DEGETTE. Thank you. And I am now pleased to yield to Dr. Joyce 5 minutes.

Mr. JOYCE. Thank you for yielding, Madam Chair, and to this panel for testifying on this important subject today.

Dr. Omer, some clinicians had concerns that the U.S. Food and Drug Administration's recommended pause on the Johnson & Johnson vaccine might increase vaccine hesitancy and reduce public confidence in the overall approval process for the other vaccines, as well. Dr. Omer, do you feel that the FDA's actions instill a higher degree of confidence in the safety of the COVID-19 vaccines that have received the emergency use authorizations from the FDA?

Dr. OMER. Yes. I think that was the right thing to do. As they were evaluating they had a temporary pause, communicated the reason for that pause. They—you know, whenever you have an emerging event, there are several difficult options. But they chose the best—the most appropriate, in my perspective—of those difficult options. So, yes, in the long run, it will instill confidence in our vaccine safety and regulatory system.

Mr. JOYCE. Dr. Omer, can you comment on how common the severe blood clotting, combined with low levels of platelets, that resulted in the FDA's recommending a pause of the J&J vaccine—would you say this is a rare, a very rare event? Could you comment additionally, please?

Dr. OMER. So, depending on the group, it is a rare to very rare event. And looking at the risk versus benefit, it heavily favors benefit.

But then it was appropriate to evaluate that, take a pause, evaluate that risk-benefit ratio, and then resume that—the vaccination drive with this vaccine.

Mr. JOYCE. Dr. Omer, how does the rate of severe events for the J&J COVID-19 vaccine compare to other vaccines that we more commonly see people get, the chicken pox vaccine, the MMR that has been discussed previously in today's hearing, which have been proven to be safe and effective?

So what is the rate of severe events comparing J&J's COVID-19 vaccine with other, more commonly administered vaccines?

Dr. OMER. Well, it depends on the event. But overall, it is at par or favorable compared to other commonly used vaccines. So, you know, I would be happy to provide specific details between—based on the risk group and age group, et cetera. But I think it is reasonable to say that, qualitatively speaking, or sort of broadly speaking, that this vaccine is—has similar safety profile or, in certain cases, certain groups, better safety profile than some of the—our other commonly used vaccines, as well.

Mr. JOYCE. Yes, I would like to see that additional data, if you could, please.

And then finally, Dr. Omer, on another subject, how common is it for someone to have an allergic reaction after receiving one of the COVID-19 vaccines?

And is the risk the same among the—all three vaccines that have received the emergency use authorizations from the FDA?

Dr. OMER. So there are different databases that were used. It is also considered within the rare side effect range. And it is one of the ways this is mitigated, because right now we are in a situation where it is mitigated by having people wait an extra 30 minutes if—extra 15 minutes, a total of 30 minutes, who have, you know, a predisposing situation, have a history of allergy, et cetera. So it is more, in the context of mRNA vaccines, if you look at the absolute numbers. But even for mRNA vaccines, it is in the territory of rare events.

So it ranges from, you know—so there are a few ranges around that. But, you know, it is in the rare category for—even for mRNA vaccines.

Mr. JOYCE. And Dr. Omer, could you please comment for us, Dr. Omer, on the safety, from your perch, for the use of these new vaccines in adolescents and children?

Dr. OMER. That is a really good question. So, based on the current data and the data that the Advisory Committee on Immunization Practices has evaluated, in the groups for which it is currently recommended, 12 and up, the benefits substantially outweigh risks. We continue to monitor events.

There was a—there is a signal that various public health agencies, as you know, you may have seen in the news that they are evaluating proactively, just to remind everyone it is a self-limiting event in certain teams. And so—and I have confidence that we will get clarity on this event, as well, in the coming weeks, fairly soon.

Mr. JOYCE. And I thank you for that answer. My colleague, Dr. Schrier, the pediatrician on this panel today, I am sure will also have questions regarding immunization and children.

Thank you, Madam Chair, and I yield the remainder of my time.

Ms. DEGETTE. I thank the gentleman. The Chair now is pleased to recognize the vice chair of the subcommittee, Mr. Peters, for 5 minutes.

Mr. PETERS. Thank you, Madam Chair. I just want to start by saying I certainly share the frustration of Dr. Burgess that we are not all together in person, unmasked, which I believe we could be, if we were all vaccinated. And I know that—I think the—every Democrat is vaccinated. I am sad to say that every Republican is not. So if there is anything we can do to encourage that, I would certainly jump in.

And, as the daily—number of daily vaccinations has declined since April, State and local governments are thinking about that issue, too, with respect to incentive programs to motivate unvaccinated Americans to get shots. In New Jersey there is a shot-and-a-beer program. In Ohio there is a vaccine lottery that offers you a million bucks. I don't know if that indicates that there is higher self-regard among Ohioans than New Jerseyites—I say that as a former New Jerseyite. Major League Baseball teams are offering free tickets to those who get vaccinated at the ballpark.

And the question I have, I guess, for Dr. Omer is whether these programs work. I mean, even before the pandemic hit, you have been researching ways to incentivize vaccine uptake. So do these vaccine incentive programs work?

And what types of incentive programs would be most effective?

Dr. OMER. So there are two things. We know, as a concept, incentives have a role in increasing vaccine coverage. So there has been evidence for several years. We have done some experiments, others have done some experiments, but incentives are useful.

In this pandemic, although the uncertainty is that the—what kind of incentives are better suited. So with our 50-State laboratory, people like us, like myself, are watching and learning from it. And I think it is—but then, you know, within certain limits, it is worth trying different models. So that is the short answer.

Mr. PETERS. And Dr. Gracia, what is your view on the effectiveness of these types of vaccine incentives, and particularly—do you have any evidence that they can increase vaccine uptake in communities of color or Tribal nations?

Dr. GRACIA. Thank you. I think, similarly to Dr. Omer's response, you know, we too, just at our organization, follow the evidence with regards to these policy recommendations.

And with regards to incentives, you know, there can be a place for incentives, and there is just a great deal of innovation that is happening both in the public and private sector regarding that. So I think studying that to see how that is impacting the uptake for various communities, I think, will be important for us, not only now in the pandemic but certainly moving forward.

Mr. PETERS. OK, thank you.

Dr. Shelton, your testimony indicates that you are partnering with stakeholders to give away tickets to incentivize vaccinations. How has the community responded to this incentive?

And more broadly, what kinds of incentives or innovative approaches for encouraging uptake have you seen work in rural communities that can be replicated or expanded on?

Dr. SHELTON. Well, thus far in our mobile units and outreach, the numbers have been very low as we go out. So we are looking to see what incentives might be helpful. And I would love to have some of these incentives to offer to our community as ways to see whether or not these experiments truly do work.

We are just at the beginning of these incentive programs. So, again, we don't have a lot of knowledge yet about what is working, but we look forward to trying these incentives, and seeing what will work, and reporting back on any successes that we do have.

Mr. PETERS. And Dr. Omer, any recommendations for employers who may want to incentivize COVID-19 vaccinations for their employees? Any recommendations you have for us?

Dr. OMER. Yes. First of all, promote it as a social norm. And we know that—we have evidence that promoting even an emerging social norm is helpful.

Ensure that there is safety of everyone involved. So we know that, even though these vaccines are highly effective, people who are immunocompromised, there are certain concerns about them, et cetera. So have those, you know, precautions available for these people.

And sort of look at things like time off for—you know, during vaccination. It is easy to vaccinate, and there will come a time where onsite vaccination will have—pretty soon, for at least some large entities, onsite vaccination may have a role in there.

So I think companies and employers of various sizes have a huge role. Even small businesses. But Mr. Offerman very eloquently spoke on the—on small businesses.

Mr. PETERS. Right. Well, it looks like there is a lot of information to come in on this. And I would certainly invite any of the witnesses who see results from these incentives to reply to the committee and offer us information on that. We would love to get that information.

And Madam Chair, I appreciate you holding this hearing. It is OK to do hearings, virtually. I think it may be in some ways pretty useful, but I really am anxious to get back to work with everybody in person without masks in the committee room. And if there is any way we can incentivize the rest of our colleagues to get vac-

minated, maybe we have learned something from this testimony, as well.

Thank you, I yield back.

Ms. DEGETTE. Thank you, and I agree.

The Chair is now pleased to recognize Mr. Long for 5 minutes.

Mr. LONG. Thank you, Madam Chair, and I appreciate it, and thank all the witnesses for being here today. And I might suggest that, as a first move to get away from these Zoom and committee hearings and things, we might consider doing them over at the White House. Because if you will Google “Pelosi,” “White House,” “no social distancing,” you will see that it is very safe to mingle, mix and mingle there, with people who have been and have not been vaccinated. So just a suggestion for a first move, so we can get back to more normal times.

Dr. Gracia, according to a recent report issued by the Centers for Disease Control, residents in rural communities like I represent a lot of here in southwest Missouri are at increased risk for severe COVID-19-associated morbidity and mortality. Last September, COVID-19 incidents of cases per 100,000 residents in rural communities surpassed those in urban counties. Further, the report found that COVID-19 vaccination coverage was lower in rural communities, at a little under 40 percent, than in urban communities, a little over 45 percent.

The implications of these findings are the disparities in COVID-19 vaccination access and coverage between urban and rural communities can hinder progress toward ending the pandemic. What are the unique challenges found in rural communities of getting available vaccine doses into patients’ arms?

Dr. GRACIA. Thank you for that question, and critically important to address, certainly, these disparities that we are seeing in rural communities. And similarly, we can point to some of the longstanding, as you noted, health disparities that exist in rural communities.

We know, certainly, access to healthcare has been one of the areas that—having access to a healthcare provider and routine, regular care, as far as preventive services, those are issues that can be challenging in rural communities, and that pre-dated the pandemic. But recognizing, certainly, that also, beyond the access to healthcare, are really what we think about the broader social determinants of health.

So, in addition to access to healthcare, is ensuring you actually have transportation to be able to get to those services. Do you have, you know, income, the income to be able to maintain, you know, and have access to healthy, affordable foods and be able to engage in the types of physical activity, et cetera, that is needed for a healthy lifestyle?

I think that we need to really address some of these longstanding issues as it relates to rural health disparities, certainly, as we move forward beyond the pandemic with regards to access to healthcare, whether it is through telehealth and the closure of rural hospitals. We have seen several rural hospitals that have closed during the context of the pandemic, and making access to care more difficult.

But with regards to vaccination, I think some of the promising things that are now happening is the investments, certainly, because of the legislation that has been passed, to do more investments to getting mobile healthcare units out, to be able to fund and support rural health clinics, to be able to do vaccinations in rural communities, and also to be able to educate and do outreach to rural communities through community health workers and other types of health outreach to increase vaccination.

Mr. LONG. OK, thank you. And I, for one, would like to see everyone vaccinated. I appreciate that. And it is discouraging that the rural areas are not able to get the same access.

My next question for Ms. Pisani: The Pfizer vaccine, which is the one that I took back in December, is now available to children 12 to 15. And the Moderna announced this week—or Moderna announced this week that their vaccine is safe and effective for children ages 12 through 17, and they plan to submit their findings to the FDA in early June.

What are the most frequently asked questions that you get from parents that have children in this age range about the COVID vaccine?

Ms. PISANI. We get pretty much the same questions we get with all vaccines, and they want to know what are the long-term side effects of getting a vaccine, which, of course, the answer, again, is what is the long-term side effect of getting the virus. You have to remember to answer it that way.

Parents are hearing the same rumors that are just literally going through wildfire on social media. I have never seen anything like it in my life. You will hear a rumor one day about, you know, questions about infertility here, and then it will go all the way across the globe. And so my friends and my family who have, you know, kids my age and younger—my kids' age and younger—they are asking the same questions: Will they be safe, you know, why do they need them, if they—if the virus isn't as dangerous to the children? And of course, that is all just misinformation that we need to correct.

Mr. LONG. OK. As the father of a pediatrician, I appreciate that very much. And it is—I have said it before on here, but I will say it again, it is very disturbing to me to have someone of such notoriety as Robert Kennedy, Jr., of all people, leading the anti-vaxxer charge.

With that, Madam Chair, I yield back.

Ms. DEGETTE. I thank the gentleman. The Chair now recognizes an actual pediatrician, Dr. Schrier, for 5 minutes.

Ms. SCHRIER. Well, thank you, Chairwoman DeGette, and thank you to our excellent witnesses today.

Vaccine hesitancy is such an important topic. And, as a pediatrician, I spent 20 years reassuring anxious parents about routine childhood vaccinations. And most parents, like you said, that are considered vaccine hesitant have heard something from a friend, online, that gives them pause, and they just want to be sure that they are making the right decision for their child. And we know that conversations with a trusted primary care provider makes all the difference in the world.

However, we are seeing a higher degree of reluctance when it comes to the COVID vaccine for all the reasons you pointed out. So at this point, most parents who definitely want the COVID vaccine for their kids over 12 have already done it or scheduled it. My 12-year-old got his 10 days ago. More hesitant families will visit their primary care provider to seek answers from their trusted doctor.

So I want to start with Dr. Gracia. One of the main questions that I get from parents is about why they should vaccinate their child, when they have heard that the risk to children from COVID-19 is low, and they are making this risk-benefit calculation. So, as a pediatrician yourself, can you briefly describe how you would answer that question to that hesitant parent?

Dr. GRACIA. Yes, thank you for that question, and thank you—it was a pleasure, certainly, also, to partner with you on the vaccines briefing that we did last year, just ongoing, highlighting the importance of vaccinations, and why this is so critical, not only in emergencies but beyond, in calm times, if you will.

I think, you know, formerly, when I formerly practiced as a pediatrician, I think an important thing is, really, to hear and understand a parent's concerns about the vaccination and be able to articulate, certainly, the safety and effectiveness of the vaccine and to note that, yes, while, you know, children have a much lower risk with regards to severe illness and hospitalizations from COVID-19, that is still important to provide that protection and to also think about it from the standpoint of there may be others in the family, for example, if someone is immunocompromised or they interact with others, that it also can provide that protection with regards to decreasing the risk of transmission.

But I think it is especially important, too, to think about the ability for children then to engage in the activities that they were engaging in prepandemic and recognizing some of the social and emotional needs of children to really be able to re-engage in the things that they did prepandemic, and that vaccination is an important strategy for us to get there.

Ms. SCHRIER. I agree. And the risk of COVID is not zero. Several hundred kids have died. We don't know about long COVID. There are many risks, like you said, and getting back to normalcy is so important.

Now, specifically, can you address the concern that some parents now have about finding a handful of cases of mild myocarditis out of many million vaccinated teens, and perhaps how they should think about that risk compared to, say, the risk of getting myocarditis from any viral infection, or certainly at a much higher risk of getting it from COVID itself?

Dr. GRACIA. Right. And I think that it's important, really, one, to hear—again, hear those questions, to listen to their concerns as parents and to tell them what is known now and, as you noted, that, yes, myocarditis can be caused by other viruses, by other bacteria, for example, as well, and—but to assure them, for example, one, you know, the American Academy of Pediatrics continues to recommend that children 12 and above should be vaccinated and that what is being studied, actually showing that, of the cases that—right now there—that there is not conclusive evidence that

there is an association with the vaccine and also that the cases and the numbers of cases that are being seen is what would also be seen at baseline.

And so, you know, really, it is stressing, too, that, especially for organizations such as the American Academy of Pediatrics, the pediatricians who are themselves vaccine experts, and really take this very seriously, and reading the data, I continue to recommend it, as does the CDC.

And then getting back to Dr. Omer about—that these—

Ms. SCHRIER. And then—

Dr. GRACIA [continuing]. The systems, yes.

Ms. SCHRIER. Right. We are looking for a blip above baseline, and we haven't hit that.

Last quick question. I just wanted touch on the new guidance that the COVID vaccine can be coadministered with other childhood immunizations that have been—that have dropped by about 30 percent during the pandemic. And so can you tell me again, Dr. Gracia, your thoughts about coadministration?

What do you say to a parent who is nervous about getting COVID with, like, HPD and Tdap, and our ability to then track potential rare adverse effects if they are given together.

Dr. GRACIA. So, again, I would emphasize, you know, when—I was going to say practice—so I would emphasize again the importance that—how our safety systems are working to be able to detect if there are any concerns with regards to, you know, something like a coadministration, to know that—you know, that these academies, whether it is the American Academy of Pediatrics and others, certainly are reviewing this, and feeling that there is—safety with regards to being able to do that coadministration, which can also then be a support for parents, especially in the need to be able to come back to the office, to be able to do other administration of vaccinations—

Ms. SCHRIER. Thank you.

Dr. GRACIA [continuing]. And building on the existing infrastructure that—

Ms. SCHRIER. Thank you.

Dr. GRACIA [continuing]. Offices—

Ms. SCHRIER. I am out of time. It is so great to see you again. And then just—that path back to normalcy, to school, to summer camps, everything, is vaccinating our kids. Thank you so much.

Ms. DEGETTE. I thank the gentlelady. And then I apologize to Mr. Long for somehow implying his daughter wasn't a pediatrician. What I meant was he is not a pediatrician, although he assures me he once played a doctor on the radio. So there you go.

Mrs. Trahan, I am now pleased to recognize you for 5 minutes.

Mrs. TRAHAN. Thank you, Chairwoman DeGette. Like so many of my colleagues, I am so pleased that earlier this month FDA expanded the authorization of the Pfizer COVID-19 vaccine for adolescents 12 to 15 years old. And CDC quickly recommended its use among this age group.

And I am also encouraged by yesterday's news that, according to Moderna studies, its COVID-19 vaccine appears to be safe and effective for children as young as 12, as well.

However, just as misinformation is spread across social media about the COVID-19 vaccine for adults, I too am concerned that families are facing a barrage of myths and disinformation about their use among children. So I am glad to have such a robust panel of experts here today to help us get the facts straight.

Ms. Pisani, according to your testimony, the Vaccinate Your Family campaign has grown over the years into “one of the nation’s largest social media programs aimed at educating the public on vaccines and their safety and to counter vaccine disinformation.” Unfortunately, we know that this disinformation is rampant online, with parents and children exposed to a range of myths about the safety of the COVID-19 vaccines.

What lessons can we learn from Vaccinate Your Family’s efforts to combat vaccine disinformation?

Ms. PISANI. Thank you for asking that question. So we have—obviously, we have been around for 30 years, so we didn’t start in social media. We began working directly with parents, and children were our focus for 25 years.

So—but one thing we can learn is that—never repeat the negative, first of all. And also that there’s efforts being made. And I have to say Google is doing an amazing job. They are giving out grants around the world to try to help stop disinformation. And Instagram is doing a great job. I don’t know why Facebook is not following up with that.

But we have to really think about the groups that are targeting people, and they have taken to targeting communities of color to sow doubt. And, you know, after all the work that has been done to help the disparities, and all the work we need to do, we have to really think about what is, you know, the line of freedom of speech. We all hold it sacred, but when there is a group of individuals or companies that are making a cottage industry about spreading disinformation and selling alternative products instead of vaccines, I think something needs to be done. That is endangering the United States and, frankly, the global citizens.

Mrs. TRAHAN. Yes, I couldn’t agree more. We have taken that up on another subcommittee—this one. But, you know, authorizing a vaccine for adolescents 12 years and older is one hurdle, but getting shots in arms of those adolescents is another challenge altogether.

You know, Dr. Shelton, you mention in your testimony that your agency has been vaccinating middle and high school students in school clinics. Has this proven to be successful?

You know, what other activities have you led or have planned to expand vaccination efforts to these younger teens and preteens?

Dr. SHELTON. Yes, we have been very grateful for the partnership with our schools to be able to go in and offer vaccines in the middle and high school levels. To be sure, the uptake has been small. It is a difficult time of year. There are a lot of end-of-year testings and sports events going on, and people are afraid to—of side effects and that they may miss work.

So I think a lot of the messaging that we need to use with focusing in our schools is we know that our schools transmit disease, are kind of like the petri dish of the community, so to speak. In the winter time we routinely combat flu and norovirus in our schools.

And so we know that one of the incentives for parents to talk with—for pediatricians and healthcare providers to discuss with their parents is, if you want your students to have all of the great benefits of being—in-person school, and all the social, mental, and physical well-being that they receive from the school, in addition to just the learning, vaccines really are our path to be able to have our schools go in person for longer amounts of time.

We had with—recently, in April, an increase in our cases throughout the district, because we had five different outbreaks in schools, despite having gone in school since the fall. This is the first time. And so, being able to go in and take those vaccines to the schools, we have seen some successes there. But definitely, the importance of what people can achieve by in-person school and the importance of having those vaccines is very much what needs to be messaged.

Mrs. TRAHAN. Yes, no question.

Finally, Dr. Omer, with my remaining time, your testimony cites a survey experiment in which you found that “a bipartisan endorsement of COVID-19 vaccines would help increase confidence in the vaccines.” That is precisely the goal of this hearing today, to work together to debunk vaccine misinformation and send a clear message of support for the COVID 19 vaccines.

Dr. Omer, if we were—if we are not able to dispel vaccine myths, boost confidence, and increase uptake, what potential consequences do we face?

Dr. OMER. So I think we are at risk of entering a vicious cycle, because if we have—so one way of responding to an outbreak is to get ahead of it. And if we don’t get ahead of it by having high vaccination rates, we increase the probability of variants emerging, and then it becomes a cycle of where we need, for example, boosters and other approaches and some nonpharmaceutical interventions, although not—certainly, not at the level as we saw last year, but other measures that hamper normalcy but are applied to prevent adverse outcomes in the public health, in the sense of public health.

So we absolutely need to invest in our—redouble our efforts to vaccinate as high a proportion of our population as possible.

Mrs. TRAHAN. Thank you, Dr. Omer.

I yield back, Madam Chair.

Ms. DEGETTE. I thank the gentlelady. The Chair now is pleased to recognize Dr. Ruiz for 5 minutes.

Mr. RUIZ. Thank you for holding this very important hearing, Chairwoman.

When vaccine distribution was ramping up, there was concern that Black and Hispanic individuals would have a greater amount of vaccine hesitancy than White individuals. And that narrative continues. But it just has not been my personal experience, as a physician, public health expert working in the community, inoculating some of the hardest-hit, hardest-to-reach constituents of mine, the Hispanic farm workers, which in my district face one of the highest rates of infections and deaths. And I have been going out there, administering the vaccine and educating communities about its importance.

[Audio malfunction] for Blacks and Hispanics, they just don't want the vaccine because of mistrust, et cetera. That narrative is dangerous. It abdicates the responsibility of the healthcare system and us to make sure they have access. And it just blames those that have been left behind for generations. And the data is showing that my experience was actually a more accurate picture of what was occurring.

As it is, the problem is not hesitancy, it is access. As with many aspects of our healthcare system, it is not about whether someone wants to get the vaccine, it is whether there are barriers preventing them from doing so. Despite months of headlines driving a narrative that Black Americans and other people of color would be the primary communities hesitant to get the COVID-19 vaccine due to discrimination and a history of medical experimentation in these communities, Kaiser Family Foundation polling shows Black Americans are just as likely to want to get the COVID-19 vaccine as White Americans. And, in fact, among unvaccinated people, Hispanic adults report being twice as likely as White adults to want to get the vaccine.

So I am concerned that, despite being motivated to get the COVID-19 vaccine, access barriers are preventing people of color from getting vaccinated. And we know that Hispanics, for example, have the lowest vaccination rate, even though they have the highest infection rate and death rate than other communities. As a result, the vaccination rates in these communities are disproportionally—way disproportionately—lower than their White counterparts in the United States.

Dr. Gracia, in referencing the vaccination rate disparities among Hispanic adults compared to White adults, you cautioned that “if we only look at the population as a whole, we may be missing significant barriers to access and information.”

So you have touched on some of those barriers already today. Could you further detail what barriers may specifically be preventing Black and Hispanic adults from getting the COVID-19, and what are some good, successful efforts that allow us to overcome those barriers?

Dr. GRACIA. Thank you, Congressman Ruiz. Yes, these are—it is important, as you noted, with regards to the narrative that is being shared, and understanding that inequitable access can also drive these disparities in vaccination rates.

One of the things that we can see is that, when we prioritize and center equity with regards to the vaccine distribution and allocation and administration and ensuring that the sites and locations are accessible, whether it is from the standpoint of the hours—you know, that you have evening hours and weekend hours that are available, that the sites are trusted, community sites, where communities of color already seek their health services.

And we have seen an impact of that, for example, with regards to the community health centers that receive Federal funding, that of the 10 million doses that they have given, over 60 percent of the vaccine administration has been to people of color. And knowing that—

Mr. RUIZ. Yes. You know, the initial phase of this vaccine really got the low-hanging fruit, and they did a first-come, first-served

basis. That puts—advantages those who have high-speed internet, those that have the educational capacity to navigate a complex system, those that have the flexibility from leaving work and standing in line or waiting on the phone for hours at a time. And it disadvantages rural, underserved communities who don't have those factors to benefit them.

So we need to shift now from that model to a grassroots, community-based model, working with community health promoters, taking the vaccines to the people where they are at, with trusted individuals from the community.

And we also have to think how we can change our healthcare delivery system, because the status quo has resulted in these barriers and failures that have not focused on equity but has promoted health disparities. And because of that, we need to use this new form of outreach into our healthcare delivery model, so we can address health disparities in general, so we don't find ourselves in this situation in the next pandemic.

And I ran out of time. And I appreciate you all being here.

Ms. DEGETTE. Thank you so much. This completes the questioning from members of the subcommittee, but we are always happy to welcome members of the full committee to ask questions in these hearings. And we have two today. And so my first nonsubcommittee member, but a wonderful member of the full committee that I will recognize for 5 minutes, is Mr. Bilirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you very much, Madam Chair. I appreciate it very much. And I want to preface my comments by saying that I did get the vaccine, both doses. I had COVID in early January, but I chose to get the vaccine after the 90 days. And I have had a very positive experience.

However, this is for the panel, whoever would like to ask this question—answer this question. Dr. Jay Carpenter, an internist in my district, has encountered young patients who have been vaccinated, young patients in their early twenties, who have suffered from myocarditis—so, again, let me pronounce it again: myocarditis—and the inflammation of the heart.

So has anyone experienced that, any of the experts? Have they seen this from, again, young adults in their twenties?

So who would like to reply to that?

Maybe we can get the—you know, if it is applicable, the whole panel can apply—reply, quickly.

Has anyone seen this?

Ms. PISANI. I would say that it is such a rare—it is such a rare reaction that there is still research taking place. And here in the U.S. we have amazing systems that oversee our safety, and so we have a vaccine-adverse-event reporting system, where everyone is encouraged, if they have any type of adverse event from a vaccine, they are to report it there. We have the Vaccine Safety Datalink. We have got the Clinical Immunization Safety Assessment System. I mean, there is just—and there's new systems that were put in place just for COVID, V-safe and the FDA's BEST system is working.

So there is a lot of different systems that are out there. And I do feel very confident that we will soon know if there is any type

of need for any type of pause. And it makes me feel comfortable that there was a pause on J&J when it was requested.

Mr. BILIRAKIS. OK, anyone else? Anyone else want to comment? Have they experienced this, or heard about this?

I mean, it is very serious, and I would like to actually have Dr. Carpenter maybe contact you, and maybe elaborate more. Is—was that OK? Would—do you welcome that?

[No response.]

Mr. BILIRAKIS. OK, I—

Dr. GRACIA. Congressman, what I would just add to is, with regards to what we noted earlier, that what has been detected is not above the baseline of what we would detect with regards to cases of myocarditis.

So as Ms. Pisani noted, we are continuing to review that and determine if there is actually any association, but there is—

Mr. BILIRAKIS. Thank you—

Dr. GRACIA [continuing]. At this time.

Mr. BILIRAKIS. No, I appreciate that very much. And I understand. My chief of staff has been in direct contact with this particular physician, an internist, and apparently he has experienced this, his patients have experienced this more than once. So it is definitely worth looking into.

Dr. SHELTON. I would say we have not seen that locally, in our area, but certainly, as has been mentioned, the V-safe programs and other monitoring systems, we will continue to look toward those for any—and report any side effects.

Mr. BILIRAKIS. Thank you very much.

Dr. Omer, again, on this topic, given how much information is available, it can be difficult to know which sources of information you can trust. That is for sure, particularly with the internet. How can one ensure that information they find about COVID-19 vaccines is accurate and comes from critical—credible sources?

Dr. OMER. That is a really good question. So the general public can go to several reliable sources and—such as, for the CDC, so the technical documentation from the CDC has been consistently reliable on this issue and others, as well.

The second thing is professional associations. So we have 20 years of research that shows that in this country there is a high level of trust in professional associations. For example, when it comes to pregnancy vaccination, American Congress—American College of Obstetricians and Gynecologists. For pediatric vaccinations, American Academy of Pediatrics. They are highly—not just trusted but trustworthy entities, because they go through a very careful, deliberate process to evaluate the risk and benefit. So these are some of those sources that folks can go to.

And the third thing is that—I have mentioned this national continued medical education program for physicians and providers, other providers. Just—that is one of the reasons why we are doing this, so that, you know, primary care providers, frontline providers feel empowered to talk about vaccine efficacy and safety, and in a way that is evidence-based.

Mr. BILIRAKIS. OK, let me make a statement. I know, Madam Chair, my time is finished, but I recommend that our Members communicate directly with their constituents. I have had a town

hall meeting, it was very successful, with experts, CDC and NIH, and they directly answered their questions.

I can't go any further, so I will submit the rest of my questions for the record. Thank you.

Ms. DEGETTE. I thank the gentleman. And Mr. Carter, you are recognized for 5 minutes as our cleanup batter.

Mr. CARTER. Thank you, Madam Chair. I appreciate the opportunity to waive on, and I thank all of the witnesses. This is very important, very important for me.

I have a large minority population in my district, and it is very important. And I am very concerned, as a pharmacist and member of the Doctors Caucus, a healthcare professional. I went through the clinical trials myself, with the vaccine, to try to set a good example. And I am very concerned about that.

I want to start with you, Dr. Shelton, because I want to know—you have mentioned in your testimony about the many communities that lack access to broadband internet or even to cell service. And we all know that that is a problem. We all know that they can't get to know—or they don't know how to sign up for an appointment or get their COVID-19 vaccine. How can we address that?

How can we address these challenges that—to make sure that these people that don't have access to Internet or cell service, or other kind of technologies, that it is not a barrier to them getting COVID-19 vaccines?

Dr. SHELTON. Well, certainly, providing broadband access is a long-term goal for many, and for our State, as well. Currently, though, it—this lack of access does hamper their ability to even ask their own questions, to find their own good information, and correct and true information.

So we have addressed this by, you know, a lot of people just call the health department or call the pharmacy or the healthcare provider. We have encouraged people to help their families, friends, neighbors who may not have access to try to access and sign them up, especially our elderly population, not as computer savvy, by taking the vaccines out into the community and using our local radio stations or other media stations to allow people to know that there's, you know, vaccines coming, vaccines available.

But this doesn't help as much to answer the questions one on one. So we value those opportunities to speak with them, and encouraging them. This new move that we have now, where we can redistribute the vaccine in smaller increments to many more local providers, will go a long way with helping people to access their local physicians and having their local healthcare providers give them that one-on-one information.

Unfortunately, a lot of people who are not interested in the vaccine may not go to their healthcare provider regularly, anyway, or even have one. So we do have to continue to look at how we could best message in these areas.

Mr. CARTER. Thank you for mentioning the role of pharmacies, because 95 percent of all Americans live within 5 miles of a pharmacist. They are the most accessible healthcare professionals in America. So thank you for mentioning that, because that is very

important, and certainly a big part of what we are trying to do here.

Dr. Omer, I wanted to ask you, according to the Kaiser Family Foundation, about 6 in 10 African-American adults and two-thirds of Hispanic and White adults now say they have either gotten the vaccine, or at least one shot of the vaccine, or they will get it as soon as they can.

At the same time, African Americans and Hispanic adults remain somewhat more likely than White adults to wait and see, if you will, before getting vaccinated. What are—Dr. Omer, in your experiences, what are the main concerns, the top concerns or questions that you have heard from minority populations about COVID-19 vaccine?

Dr. OMER. That is a really good question. So the concern, the specific concerns, overlap significantly with the rest of the population. But they do, you know, sit on a bed of not-so-pleasant series of interactions with the health system overall, not having sort of a healthcare home in certain situations, and some of the other structural barriers that were described earlier.

So the concerns overlap. For example, the concerns, questions about the process, the questions about—that arise from certain rumors, people talking about risk and benefit in certain subpopulation, et cetera. But that is—but they sit on this baseline of understandable mistrust in a lot of these situations.

Mr. CARTER. Well, thank you. And that is something—and I tell you, that, to me, is difficult to get your arms around and difficult for us to address that situation.

You know, we in the Doctors Caucus, we have done everything we can and certainly done a lot to try to build up the confidence of people in the vaccine and let them know that it is safe and effective. And, you know, yes, it was done quickly, but that is because we cut red tape. We didn't cut corners. And they need to be assured of that.

And I think that—and I am real proud to be a member of the Doctors Caucus and proud of what we have done in the way of trying to encourage everyone and bringing about, you know, the fact that it is safe and effective, and building up that confidence.

One more question, Dr. Gracia, just really quickly, you mentioned in your testimony about the real barriers and perceived barriers. What are—what is the difference there, what are you talking about?

Dr. GRACIA. So, you know, real barriers, for example, if you simply don't have access, right, to a vaccination site, or if you, for example, don't have the internet technology to be able to sign up for vaccine appointments, versus what might be a perceived barrier, for example, believing that there is costs associated with the vaccine or that you might not—or not knowing what the eligibility terms are with regards to the vaccine. It is really helping to clarify what are the barriers that an individual experiences and helping them to address getting access to the vaccine.

Mr. CARTER. Great.

Well, this has been a great panel, Madam Chair, and thank you again for allowing me to waive on. And I will yield back.

Ms. DEGETTE. I thank the gentleman, and I thank all of the Members for an excellent hearing. Everybody's questions were very helpful. And I mostly want to thank our witnesses again, an extraordinarily informative and interesting hearing.

We, this subcommittee, we intend to continue our oversight over the vaccine distribution process. And we stand at the ready for all of you, our witnesses, to help in any way we can. So, as you get data for our researchers and our physicians, if you can let us know. And, Mr. Offerman, if you can, please let us know what we can do to help you in your outreach efforts, as well.

And with that, I remind the Members that, pursuant to committee rules, they have 10 business days to submit additional questions for the record. And I would ask the witnesses, if you do get these questions, to please respond promptly to any of them that you may have.

Thank you again to all of you for appearing today.

And with that, the subcommittee is adjourned.

[Whereupon, at 1:38 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

The Honorable Gus Bilirakis (R-FL)

Question for the record to Nick Offerman:

1. Should the goal of the U.S.'s COVID-19 vaccine efforts be herd immunity – why or why not?

Yes:

Thank you for your question. Yes, I do believe that our goal should be to see enough people vaccinated for COVID-19 so that we eventually reach herd immunity. As our nation's leading scientists and medical professionals have asserted, we need everyone to get vaccinated, so that together we can protect ourselves against this very deadly virus and prevent the spread of variants. [Experts estimate that herd immunity would require around 80-90% of the population to have COVID-19 immunity, either through prior infection or vaccination.](#)

Using our common sense and reason, we have learned as a society that scientific facts are not open to opinion or subjective interpretation. For that reason, I earnestly reiterate: everyone should please get vaccinated.

Saad Omer, M.B.B.S., Ph.D., M.P.H., F.I.D.S.A.
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Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“A Shot at Normalcy: Building COVID-19 Vaccine Confidence”
May 26, 2021**

Saad Omer, M.B.B.S., Ph.D., M.P.H., F.I.D.S.A., Director, Yale Institute for Global Health

The Honorable Diana DeGette (D-CO)

1. As we approach the Biden Administration’s July 4th target date for administering at least one COVID-19 vaccine dose to 70 percent of American adults, what are your top recommendations for ways the federal government can continue encouraging COVID-19 vaccine uptake during the second half of 2021?

I covered some recommendations in my testimony. Here’s a summary:

1. Health care providers are the most trusted source of vaccine information - even among those who are vaccine hesitant. There is a need for a national Continued Medical Education (CME) program that covers evidence-based communication approaches for health care providers.
2. Currently health care providers are compensated if they vaccinate their patient; they don’t get reimbursed if the patient ends up refusing the vaccine. However, doctors do not know the outcome of counseling before the end of the visit. Making vaccine counseling itself reimbursable will facilitate this promising intervention for those most hesitant about vaccines. Many other countries do so. For example, [Australia recently instituted rebates for general practitioners who provide counseling](#) on Covid-19 vaccines.
3. Making it extremely easy to get vaccinated will tip the balance for many who are yet to be vaccinated.
4. Many nascent federal efforts to bring vaccines directly to communities, including programs that work with local civic and religious leaders need to be sustained and scaled up.

The Honorable Michael C. Burgess, M.D. (R-TX)

1. There have been recent reports of employees of federal agencies, specifically the agencies responsible for public health such as the Centers for Disease Control and Prevention and the National Institutes of Health, not receiving the COVID-19 vaccine. Do you have any insight indicating why this is?

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- a. These agencies should be leading as examples of confidence in these vaccines. What can we do to increase the level of vaccination within these agencies?

I agree that public health agencies should be leading as examples of confidence in COVID-19 vaccines. I think some of the communication approaches I outlined in my testimony are applicable to federal employees as well.

2. How has vaccine hesitancy in the United States compared to hesitancy in other countries where a COVID-19 vaccine is widely available?

- a. What have other countries experiencing high levels of hesitation done to address this sentiment?

Many other high-income countries have been facing similar problems with vaccine acceptance. No country has been able to get everything right but there are a few examples of effective initiatives:

- France's national electronic media campaign focusing on return to normalcy as a motivation for vaccination.
- Australia recently instituted rebates for general practitioners who provide counseling on Covid-19 vaccines. This will incentivize vaccine counseling.
- Israel's use of a "green pass" that allows vaccinated people to engage in certain activities that non vaccinated individuals are not permitted to engage in provides an incentive for vaccination.

The Honorable Gus Bilirakis (R-FL)

1. Should the goal of the U.S.'s COVID-19 vaccine efforts be herd immunity – why or why not?

I think the U.S.'s ultimate goal should be an immunization coverage of approximately 80% to obtain sustainable control of the outbreak. This is compatible with the herd immunity threshold for the known variants of concern. However, the country can safely resume a lot of activities short of that target because we have prioritized and have achieved high vaccine coverage among the highest risk groups (e.g. older individuals); resulting in substantial reduction in mortality even at overall vaccination rates short of the nominal herd immunity threshold. On the other hand, high vaccination rates will ensure that there are limited resurgences -even when the weather is more conducive to transmission and as more transmissible variants spread in the U.S.

2. If someone has already had COVID-19 and recovered, do they still need to get vaccinated with a COVID-19 vaccine – why or why not?

They should still get vaccinated as high level of immunity is not consistently achieved after infection. However, there is increasing evidence that even one dose of an mRNA vaccine may be sufficient to induce a high level of immune response among those with prior infection.

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- a. Do people need to wait a certain period of time after getting infected before getting vaccinated?

Those with COVID-19 should wait to get vaccinated until recovery from their illness and have met CDC's criteria for discontinuing isolation.

J. Nadine Gracia, M.D., M.S.C.E.
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Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“A Shot at Normalcy: Building COVID-19 Vaccine Confidence”
May 26, 2021**

J. Nadine Gracia, M.D., M.S.C.E., Executive Vice President and Chief Operating Officer, Trust
for America’s Health

The Honorable Frank Pallone, Jr. (D-NJ)

1. You mentioned in your testimony that more federal resources appear to be increasing access to vaccinations within communities of color. How have these federal resources, including those deployed under the American Rescue Plan, helped to address access gaps and promote the overall COVID-19 vaccination campaign in the United States?

Thank you for this question. Federal funding has made a tremendous difference as it relates to increasing vaccination efforts in all communities throughout the United States, but specifically communities of color. With funding in large part from the American Rescue Plan, the U.S. Department of Health and Human Services (HHS) is investing nearly \$10 billion to expand access to vaccines and better serve communities of color, rural areas, low-income populations, and other underserved communities in the COVID-19 response¹. As a result of this funding, \$6 billion is going to community health centers to expand vaccine access to underserved communities in addition to testing and treatment for COVID-19. This funding is also helping to increase vaccine confidence across the country, especially in communities of color. HHS, through the Centers for Disease Control and Prevention (CDC), is investing \$3 billion to support local efforts to increase vaccine acceptance, uptake, and equity. This funding is going directly to states, territories, and some large cities, enabling them to support local health departments and community-based organizations in launching new programs and initiatives intended to increase vaccine access, acceptance, and uptake. This funding is focused on reaching communities hit hardest by the pandemic, including those with a high social vulnerability index, communities of color, and rural areas.² HHS also just announced the first round of

¹ FACT SHEET: Biden Administration Announces Historic \$10 Billion Investment to Expand Access to COVID-19 Vaccines and Build Vaccine Confidence in Hardest-Hit and Highest-Risk Communities. White House, March 25, 2021. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/25/fact-sheet-biden-administration-announces-historic-10-billion-investment-to-expand-access-to-covid-19-vaccines-and-build-vaccine-confidence-in-hardest-hit-and-highest-risk-communities/>

² *Id.*

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funding from the American Rescue Plan Act to develop and support a community-based workforce that will engage in locally tailored efforts to build vaccine confidence and vaccination in underserved communities.³ As a result of these collective efforts, vaccine confidence in communities of color has already gone up significantly, moving this country closer to post-pandemic life.^{4,5,6}

The Honorable Diana DeGette (D-CO)

1. As we approach the Biden Administration's July 4th target date for administering at least one COVID-19 vaccine dose to 70 percent of American adults, what are your top recommendations for ways the federal government can continue encouraging COVID-19 vaccine uptake during the second half of 2021?

Based on recent polling, vaccine confidence is growing nationwide, but there is still work to be done. As of June 15, CDC data show that roughly over 64 percent of adults have received at least one dose of a COVID-19 vaccine while over 54 percent of adults have been fully vaccinated, but vaccination rates vary widely by location.⁷ We are seeing a tragic bifurcation in the country, where infections and hospitalization rates are significantly higher in states with lower vaccination rates. To continue to strive to achieve the Administration's goal, we recommend the following:

- Continue to provide funding for and outreach to the areas in the country with the lowest vaccination rates. For example, vaccine confidence remains lower in rural counties, while residents of these counties have higher rates of disability, chronic medical conditions, lack of insurance and less access to care. We should not give up on these communities. Research led by the de Beaumont Foundation found that individuals who have concerns about the vaccine, including conservative voters, could change their minds if they received appropriate information from a doctor, pharmacist or other medical professional they knew and trusted. Trusted messengers, such as faith and community leaders must be engaged, informed, and empowered to lead their communities toward vaccination. States need to make sure that vaccination is as easy as possible by enabling vaccination at worksites, schools, pharmacies, mobile clinics, and individual healthcare providers.

³ HRSA, Community-Based Workforce for COVID-19 Vaccine Outreach. June 14, 2021. <https://www.hrsa.gov/coronavirus/community-based-workforce>

⁴ Yahoo Finance, "Vaccine confidence has gone up significantly" in communities of color: Doctor". <https://finance.yahoo.com/news/vaccine-confidence-has-gone-up-significantly-in-communities-of-color-123547038.html>

⁵ Axios/Ipsos Poll, May 2021. [topline-axios-coronavirus-index-W45.pdf \(ipsos.com\)](https://www.axios.com/ipsos-poll-may-2021-topline-axios-coronavirus-index-w45.pdf)

⁶ KFF COVID-19 Vaccine Monitor: May 2021. <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-may-2021/>

⁷ <https://covid.cdc.gov/covid-data-tracker/#vaccinations>

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- Continue to prioritize homebound older adults and individuals with disabilities. These recommendations can be found in Trust for America’s Health’s (TFAH) issue brief,⁸ released in March 2021 providing recommendations to ensure that this population and their caregivers are prioritized in accessing the COVID-19 vaccine. Innovative programs and partnerships are emerging across the country, but these need to be maintained through funding and reimbursement.
- Continue addressing the root causes of hesitancy. The root causes of vaccine hesitancy are numerous, from simple lack of information to the detrimental impact of vaccine misinformation. We applaud Representatives Schrier and Burgess for her leadership on the passage of and funding for the VACCINES Act, which will aid research into vaccine hesitancy and support public education campaigns on vaccines. We must continue to prioritize this research and ongoing public education, communications, and social media efforts to impede misinformation before it has a chance to take hold. Risk communications is also a major challenge during any public health emergency when the science and understanding of the situation are rapidly changing. Last year, TFAH began a collaboration with the CDC Foundation, the de Beaumont Foundation, and public health partners to form the Public Health Communications Collaborative (PHCC).⁹ The PHCC coordinates and amplifies public health messaging on COVID-19 to increase confidence in public health guidance and help public health agencies answer tough questions from their constituents.
- Eliminate real or perceived barriers to vaccination. According to Kaiser Family Foundation’s polling, some steps that could convince those who are “waiting and seeing” to get the vaccine includes full FDA approval of a vaccine; paid time off from work to get vaccinated and recover from side effects; financial incentives; and free transportation to a vaccination site.¹⁰ Congress should guarantee permanent, job-protected paid leave, so that all workers can access a vaccine, quarantine, stay home when sick, or care for a sick loved one without fear of losing their job or paycheck.

The Honorable Gus Bilirakis (R-FL)

1. Should the goal of the U.S.’s COVID-19 vaccine efforts be herd immunity – why or why not?

A primary goal of COVID-19 vaccine immunization efforts is to prevent COVID-19 infection, illness and death in people who receive the vaccine. An additional goal is to limit or stop

⁸ Trust for America’s Health. *Ensuring Access to COVID-19 Vaccines for Older Adults and People with Disabilities Who Are Homebound: Recommendations and Considerations for Federal, State, and Local Agencies and their Partners*. <https://www.tfah.org/report-details/covid19-vaccine-access-older-adults-people-with-disabilities-homebound/>

⁹ Public Health Communications Collaborative (About). <https://publichealthcollaborative.org/about/>

¹⁰ [KFF COVID-19 Vaccine Monitor: May 2021 | KFF](#)

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transmission of infection more broadly in communities through high immunity levels that limit the ability of the virus to spread. The advantage of herd immunity is that it limits risk of illness for everyone, including those for whom the vaccine has not been effective as well as those who are not immunized. In the long term, herd immunity also limits ongoing circulation of the virus and thus the opportunity for the development of additional viral mutations and variants. Since vaccinations offer effective prevention against infection and those who are vaccinated can safely return to schools and workplaces, we should strive to vaccinate the largest number of people. Herd immunity can be a useful marker for estimating when enough people will be vaccinated to greatly reduce the possibility of infection. But the ultimate goal of the vaccine efforts is ending the pandemic.

2. What are the most important messages to send to the public on COVID-19 vaccines?

I believe the most important messages to send to the public about the COVID-19 vaccines is that they are safe, free, effective, and accessible to all who want one. The vaccine is our key to unlocking the country and ensuring a path out of this deadly pandemic.

Vaccinate Your Family's Response to Questions for the Record

Degette: Recs for federal government to increase COVID vax uptake

While individual legislators can be trusted messengers within your home states, it is important to recognize that the federal government may not be considered a trusted messenger by those who continue to avoid getting COVID-19 vaccines.

Those holding out getting vaccinated against COVID may not trust the federal government for any number of reasons, or simply just not see the need for it. Instead, we need to be working with local "boots on the ground" groups to identify trusted leaders within those communities, such as faith leaders, teachers, or coaches, and train them to spread the word. The federal government can help by supporting these organizations, providing easily accessible clear, plain language information about vaccines and where to access them.

Fortunately, the Ad Council Collaborative brought together experts in social science and vaccines (including Vaccinate Your Family) to first, get a pulse of the public's opinions on COVID-19 vaccines and to assess vaccination plans and second, to develop toolkits for advocates like VYF to help us reach the 40% of Americans who are considered the "movable middle."

Burgess: difference in hesitancy with COVID vax, compared to other vaccines

Vaccinate Your Family has a long history of educating the public on vaccines and we allow open discourse on our social media platforms (which reach over 3 million people annually). We are seeing three emerging areas of increased hesitancy around the COVID-19 vaccines. One is the current Emergency Use Authorization. People are nervous about something that has not been fully approved by the FDA. Thankfully, both Pfizer and Moderna have applied for full licensure and we expect the FDA to approve these applications shortly. In meantime we need to do a better job communicating the safety of COVID vaccinations, juxtaposed with the severity of COVID.

The second most frequently expressed concern is the speed in which the vaccines were developed. Finally, people are concerned about the temporary side effects of the vaccines that protect you against COVID-19 and do not seem to recognize that the long term side effects of contracting the disease are quite unknown and may be much more serious.

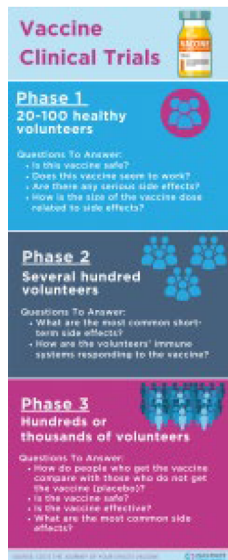
Vaccinate Your Family has compiled a list of Frequently Asked Questions and Answers about COVID in both English and Spanish – we urge Members to take a few minutes to review our content and share with your constituents.

The following example of our work to educate the public about the safety of these vaccines is taken from our website at www.vaccinateyourfamily.org.

Just like all other vaccines in the U.S., COVID-19 vaccine candidates are first tested by vaccine manufacturers/researchers in three phases of clinical trials. The purpose

of these trials is to see if the vaccine candidates are safe and effective. During the Phase 3 clinical trials, researchers compare the health of those who get the vaccine to that of those who didn't. This helps researchers spot common side effects and see if those in the vaccinated group are less likely to get sick than those who got a placebo. (A placebo is a harmless, "fake" vaccine given to half the people in the clinical trial. People in the vaccine clinical trial are not told whether they received the actual vaccine or the placebo), COVID-19 vaccine trials done so far have generally included tens of thousands of people, including people of color.

Researchers follow everyone in the clinical trials who gets the vaccine for at least two months after their last dose to make sure there aren't any lingering issues or side effects that could be caused by the vaccine.



FDA and their Vaccines and Related Biological Products and Advisory Committee (VRBPAC)

Before being authorized for emergency use in the U.S., the FDA's Vaccines and Related Biological Products and Advisory Committee (VRBPAC) [decides](#) if each COVID-19 vaccine meets its safety and effectiveness standard. If the benefits

outweighs the risks of the vaccine, the FDA can make the vaccine(s) available for use in the U.S. by approval or [emergency use authorization \(EUA\)](#).

As of February 28, three COVID-19 vaccines (Pfizer-BioNTech, Moderna and Johnson & Johnson) were authorized by the FDA for emergency use authorization in the U.S.

CDC and their Advisory Committee on Immunization Practices (ACIP)

After each COVID-19 vaccine is authorized for emergency use (EUA) or approved by the FDA, the ACIP meets to carefully review the available scientific research and make recommendations for the use of that particular vaccine. The CDC Director will review ACIP's recommendations and decide whether or not to make them "official".

As of February 28, the CDC has recommended three COVID vaccines for use in the U.S. ([Pfizer-BioNTech](#), [Moderna](#) and [Johnson & Johnson](#))

UPDATE: On April 13, the FDA and CDC recommended a pause in the use of the Johnson & Johnson (J&J) COVID-19 vaccine due to a possible rare side effect called "thrombosis with thrombocytopenia syndrome" or "TTS" (severe blood clot with low blood platelet counts). On April 23, the Advisory Committee on Immunization Practices (ACIP) – the expert committee that advises the CDC – voted to lift the pause on use of the Johnson & Johnson (Janssen) COVID-19 vaccine. **The vaccine is once again recommended for people 18 y.o. and older in the U.S. population. Both the FDA and CDC state that the benefits of the J&J COVID-19 vaccine outweigh the risks.**

Ongoing Vaccine Safety Monitoring Systems in the U.S.

After each COVID-19 vaccine is authorized for emergency use by FDA and recommended by CDC, there are a number of [vaccine safety monitoring systems](#) that are working together to watch for rarer possible side effects that may not have been seen in the vaccine's clinical trials.

Some of the vaccine safety monitoring systems have been around for a long time to monitor vaccine safety after being licensed for use in the U.S. population, including:

- [Vaccine Adverse Events Reporting System \(VAERS\)](#) –U.S. system for reporting adverse events that happen after vaccination. Anyone can report to VAERS. Reports of side effects that are unexpected, appear to happen more often than expected, or have unusual patterns are followed up with specific studies.

- [Vaccine Safety Datalink \(VSD\)](#) – A network of 9 healthcare organizations that conducts vaccine surveillance and research. VSD is also used to figure out if side effects identified using VAERS are actually related to vaccination.
- [Clinical Immunization Safety Assessment \(CISA\) Project](#) – A collaboration between CDC and 7 medical research centers to provide expert consultation on individual cases and conduct clinical research studies about vaccine safety.

There are also systems that were recently developed or expanded to add additional safety monitoring, giving the CDC, FDA, and others the ability to evaluate COVID-19 vaccine safety in real-time in order to make sure the vaccines are as safe as possible, including:

- [V-SAFE](#) – A new smartphone-based, after-vaccination health checker for people who receive COVID-19 vaccines. V-SAFE will use text messaging and web surveys from CDC to check in with vaccine recipients for health problems following COVID-19 vaccination. The system also will provide telephone follow up to anyone who reports medically significant (important) adverse events.
- [National Healthcare Safety Network \(NHSN\)](#) – An acute care and long-term care facility monitoring system with reporting to VAERS.
- [FDA’s Biologics Effectiveness and Safety \(BEST\) System](#) and [FDA’s Sentinel Initiative](#) – Systems that contain administrative and claims-based data for surveillance and research.
- **Centers for Medicare and Medicaid Services (CMS) Database** – FDA and CMS will collaborate to monitor the CMS database (includes approx. 650K nursing home residents).
- **Genesis** – National Institute on Aging awarded a grant to a team of researchers based at Brown University to design a monitoring system to identify and track adverse health impacts after nursing home residents receive COVID-19 vaccinations.

If any serious safety issues are detected, immediate action will be taken to find out if the issue is related to the COVID-19 vaccine and determine the best course of action.

Vaccine Safety for Veterans

- **Department of Veteran Affairs' (VA) Data Warehouse and Electronic Health Records** – A system of electronic health record and administrative data for active surveillance and research
- [VA Adverse Drug Event Reporting System \(VA ADERS\)](#) – A national reporting system for adverse events following receipt of drugs and immunizations

Monitoring Vaccine Safety for Members of the Military

- **Department of Defense (DOD): [DOD VAERS data](#)** – Adverse event reporting to VAERS for the DOD populations
- **DOD's [Vaccine Adverse Event Clinical System \(VAECS\)](#)** – A system for case tracking and evaluation of adverse events following immunization in DOD and DOD-affiliated populations
- **DOD's Electronic Health Record and [Defense Medical Surveillance System](#)** – A system of electronic health record and administrative data for active surveillance and research

Monitoring Vaccine Safety for Tribal Nations

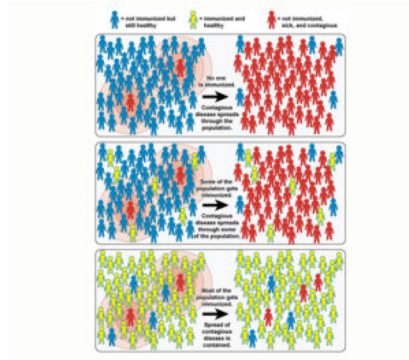
- **Indian Health Service (IHS): [IHS VAERS data](#)** – Spontaneous adverse event reporting to VAERS for populations served by IHS and Tribal facilities

Bilirakis: Is herd immunity the goal?

Herd immunity, or community immunity has thankfully led to the near eradication of polio, and the full eradication of smallpox. And it is crucial to protecting those individuals who cannot be vaccinated against COVID-19 for medical reasons, or are not yet recommended to receive vaccines (children under age 12). Our nation must continue to increase vaccination rates to achieve herd immunity so that we can ensure that the virus has no hosts in which it can continue to spread and mutate. Without a host the virus will no longer be able to develop new strains, which is critical to overcoming the pandemic. We also need to make sure that individuals are caught up on any vaccines they skipped during the pandemic to ensure that we maintain herd immunity for other vaccine preventable diseases like measles. We do not want to end this pandemic with an epidemic. We also discuss this on the VYF website:

Germs can travel quickly through a community and make a lot of people sick. If enough people in your community get a certain disease, it can lead to an outbreak. However, when enough people are vaccinated against a certain disease, the germs can't travel as easily from person to person and the entire community is less likely to get the disease. Even if a person does get sick, there's less chance of an outbreak

because it's harder for the disease to spread if a lot of people are vaccinated and therefore immune. Eventually, the disease becomes rare, and sometimes, it can be wiped out altogether, which is what happened with a very serious disease called smallpox. This is known as community immunity or herd immunity.



Community immunity protects everyone, and it is especially important for people who are vulnerable to diseases, but who can't be vaccinated. This includes children too young to be fully vaccinated, people with serious allergies against certain vaccine ingredients, and people with weakened or failing immune systems (e.g., people with cancer, HIV/AIDS, type 1 diabetes, or other health conditions, and people going through certain medical treatments like chemotherapy.)

Community immunity is also important for the very small group of people who don't have a strong immune response to vaccines. These people who cannot get vaccines or who aren't protected from vaccines depend on a high level of immunization in their schools and/or their communities to help protect them against dangerous, and potentially deadly diseases.

Each vaccine-preventable disease requires a certain percentage of people in a community be vaccinated in order to prevent the disease's spread. The exact percentage depends largely upon how easily a disease can spread from person to person.

Bilirakis: main messages

There are three main messages that need to be communicated about COVID vaccinations:

- First, they are safe.
- Second, they are effective.
- Third, they are necessary. Being vaccinated against COVID does not just protect you, it protects others around you. The only way to get back to normal is through vaccination.

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Attachment—Additional Questions for the Record

**Subcommittee on Oversight and Investigations
Hearing on
“A Shot at Normalcy: Building COVID-19 Vaccine Confidence”
May 26, 2021**

Karen Shelton, M.D., Director, Mount Rogers Health District, Virginia Department of Health

The Honorable Diana DeGette (D-CO)

1. As we approach the Biden Administration’s July 4th target date for administering at least one COVID-19 vaccine dose to 70 percent of American adults, what are your top recommendations for ways the federal government can continue encouraging COVID-19 vaccine uptake during the second half of 2021?

Chairwoman DeGette,

There are several ways the federal government can continue encouraging COVID-19 vaccine uptake during the second half of 2021.

First, the federal government should continue to provide funding for local health departments to hire vaccinators, health educators/community health workers to provide vaccine and education in their community regarding COVID-19, the available vaccines, and the importance of vaccination. It is important to fund not only staff, but also educational and promotional materials for outreach staff to use when they are attending events or speaking with community members. This could include funding for incentives.

Second, the federal government can coordinate and sponsor a national campaign with a diverse assortment of celebrity influencers. Well-known celebrities and influencers can have a substantial impact on someone’s choice to get vaccinated, but the services of these individuals are beyond the reach of local health departments. Creating and sharing PSAs and other marketing materials for use by local health departments would be helpful.

As you heard during the hearing, there is a wide breadth of scientific knowledge about the best ways to combat dis/misinformation and vaccine hesitancy, both from previous vaccine campaigns and new information that is specific to COVID-19 vaccines. The federal government could be of assistance in this area by helping bridge the gap between theory and practice. We would suggest convening conferences or seminars with experts in the field and state, tribal, regional, and local health departments to discuss practical ways to quickly implement best practices and academic knowledge.

Fourth, the federal government can push manufacturers for single-dose vaccine packaging. Many primary care providers are concerned about vaccine wastage, and drawing up the vaccines is a specific process that requires specific training and storage

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capabilities. These barriers may make some providers opt entirely out of providing vaccines to their patients. Having a pre-filled syringe makes it infinitely easier to provide a vaccine at the moment someone is ready and in their doctor's office. This is a very important piece of making COVID-19 vaccines available in all types of health care settings.

Finally, the federal government can assist with streamlining data sharing between states. It is hard to know how many people have truly been vaccinated within a jurisdiction if vaccines are being given across state lines. Given that many goals and restrictions are tied to specific percentages, accurate and timely data is paramount.

The Honorable Michael C. Burgess, M.D. (R-TX)

1. The Doctors Caucus and I have been working to combat vaccine hesitancy. We recorded a PSA video emphasizing the safety and effectiveness, and most recently appealed to the Speaker and Office of the Attending Physicians highlighting the need for Congress to return to some pre-COVID House protocols now that most of us have been vaccinated and the CDC updated its guidelines. What else can Congress do to combat vaccine hesitancy?

Congressman Burgess,

There are several ways Congress can combat vaccine hesitancy. First, Congress can continue to provide funding for local health departments for vaccine, outreach and education efforts. This funding should include money for staffing, but also for educational and promotional materials, and could also include funding for incentives.

It would be very beneficial if Congress could coordinate, alongside other federal stakeholders, a national campaign with a diverse assortment of celebrity influencers. Well-known celebrities and influencers can have a substantial impact on someone's choice to get vaccinated, but the services of these individuals are beyond the reach of local health departments. Outreach specifically by Congressional representatives may be useful in some areas to convince constituents to be vaccinated. Creating and sharing PSAs and other marketing materials for use by local health departments would be helpful.

As you heard during the hearing, there is a wide breadth of scientific knowledge about the best ways to combat dis/misinformation and vaccine hesitancy, both from previous vaccine campaigns and new information that is specific to COVID-19 vaccines. Congress could be of assistance in this area by helping bridge the gap between theory and practice. We would suggest convening conferences or seminars with experts in the field and state, tribal, regional, and local health departments to discuss practical ways to quickly implement best practices and academic knowledge.

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pre-filled syringe makes it infinitely easier to provide a vaccine at the moment someone is ready and in their doctor's office. This is a very important piece of making COVID-19 vaccines available in all types of health care settings.

Finally, Congress can assist with streamlining data sharing between states. It is hard to know how many people have truly been vaccinated within a jurisdiction if vaccines are being given across state lines. Given that many goals and restrictions are tied to specific percentages, accurate and timely data is paramount.

2. Do you believe policies and guidance allowing fully vaccinated individuals to return to pre-pandemic lifestyles serves as an incentive, motivating more people to get vaccinated?
Congressman Burgess,

The intention of these policies and guidance was to serve as an incentive, motivating people to get vaccinated. We have seen an increase in some industries where employer-verified vaccine status is linked with the ability to remove a mask while at work. For the public at large, many unvaccinated people have simply returned to pre-pandemic lifestyles. In order to truly be an incentive, these policies would need to be accompanied by confirmation of vaccination status, which is not part of said guidance or policies.

The Honorable Gus Bilirakis (R-FL)

1. Should the goal of the U.S.'s COVID-19 vaccine efforts be herd immunity – why or why not?

Congressman Bilirakis,

This is a tricky question. We know that cases are dropping locally, nationally, and internationally. We also know that the exact percentage needed to achieve herd immunity for a novel virus is difficult to determine. For different diseases, there are different percentages of vaccination required to achieve herd immunity. The greatest threat comes from variants that can cause a rapid surge in a community with low vaccination coverage.

With a disease that spreads like COVID-19 does, none of us is truly safe until all of us are safe – it is critically important to have high levels of immunity throughout the world. The goal of the U.S.'s COVID-19 vaccine efforts should be to immunize as many people as we can.