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House Energy and Commerce Oversight and Investigations Subcommittee
A Shot at Normalcy: Building COVID-19 Vaccine Confidence
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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]

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[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.