



Written Statement of Dr. J. Nadine Gracia

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

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

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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)

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.