TESTIMONY

OF

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BEFORE THE

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THE PATH FORWARD: A FEDERAL PERSPECTIVE ON THE COVID-19 RESPONSE

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Chair Murray, Ranking Member Burr, and distinguished members of the Committee. It is an honor to appear before you again today to discuss the Centers for Disease Control and Prevention's (CDC) ongoing response to the COVID-19 pandemic. It is my privilege to represent CDC, America's health protection agency. We work 24/7 to prevent illness, save lives, and protect America from threats to health, safety, and security. CDC is proud of its key role in preparedness and response to public health concerns here in the United States and abroad.

CDC Efforts to Date

Since we last met, COVID-19 cases have decreased from the spring to summer, and we have made tremendous strides in getting people vaccinated, which has allowed many people to resume their daily activities safely. We are hopeful and have made incredible progress toward controlling this pandemic. However, many states and communities continue to have low vaccination rates, and the threat of variants is growing. We are now witnessing concerning increases in a number of jurisdictions and given the threat of variants, including the increased prevalence of the hyper-transmissible Delta variant, we must remain diligent as we continue to fight this virus.

On June 23rd we officially passed the heart wrenching milestone of over 600,000 deaths from COVID-19 in the United States. This tragic reminder is a powerful motivator for us all to continue to push to achieve higher vaccination rates and prevent the loss of as many more of our loved ones as possible.

As of July 15, about 89% of the U.S. population 65 years and older, 68% of those 18 years and older, 65% of those 12 years and older, and nearly 56% of the total U.S. population received at least one dose of a COVID-19 vaccine. This is good news and demonstrative of continued progress. These gains are thanks to the tireless efforts of professionals from across the public health, medical, business, and multisectoral levels of government who have come together across the country to respond to this pandemic. However, looking state-by-state and county-by-county, it is clear that communities where people remain unvaccinated are communities that remain vulnerable and, in many cases, are experiencing increased numbers of cases. Preliminary data from a collection of states over the last several months suggest the overwhelming majority of deaths from COVID-19 in the United States have occurred in unvaccinated people. Any suffering or death from COVID-19 is tragic. With vaccines available across the country, the suffering and loss are nearly entirely avoidable.

Currently, nearly two-thirds of counties in the United States have vaccination coverage less than 40 percent. We are seeing increasing rates of disease in different areas across the country, primarily in counties with low vaccination coverage. As the Delta variant continues to spread across the country, we expect to see increased transmission in these communities unless we can vaccinate more people. Our authorized vaccines provide protection against the variants circulating in this country – including Delta. Vaccination is the key to protecting these vulnerable individuals, families, and communities and preventing severe disease, hospitalizations, and death from COVID-19. The scale of this unprecedented public health emergency requires unprecedented action — at CDC, 9,300 CDC personnel have been part of our COVID-19 response, both at CDC headquarters and in the field. About 1,700 staff have taken part in over 3,600 deployments to more than 300 locations across the United States and around the world.

As we well know and the world has learned from this pandemic, a public health threat anywhere is a threat everywhere. To support the prevention of international spread, CDC is working around the world with global partners and many low- and middle-income countries to support the planning, implementation, and evaluation of COVID-19 vaccine programs. We will continue working to facilitate lesson sharing across countries to increase vaccine access to all, both here and abroad. CDC is working to ensure that public health decisions are based on the highest-quality scientific information. Since the start of the pandemic, over 300COVID-19 studies have been published in the *Morbidity and Mortality Weekly Report* (MMWR) on topics ranging from health disparities exacerbated during the pandemic, to prevention strategies, including the safety and effectiveness of COVID-19 vaccines, to emergence of new variants. CDC has also produced more than 6,000 documents to provide information and guidance for government agencies, businesses, and the public. CDC is actively studying the epidemiology of post-COVID conditions (often referred to as long COVID), including the prevalence, duration, and severity of symptoms following acute SARS-CoV-2 infection, as well as risk factors for developing post-COVID conditions. This work will help to establish a more complete understanding of the natural history of SARS-CoV-2 infection and post-COVID conditions, which can inform healthcare strategies, clinical decision-making, and the public health response to this virus that will be required over the long term. A recent MMWR article comparing patients who have had COVID-19 with cancer rehabilitation patients and the general adult population

found that post-COVID patients had poorer physical health, more pain, and greater difficulty with physical activities.

CDC has provided new guidance to assist healthcare professionals in evaluating and caring for patients with post-COVID conditions. Recognizing and confirming the impact that post-COVID conditions can have on quality of life is important. The goal of managing post-COVID conditions is to help patients function in the best way possible and improve quality of life.

Now I want to take a moment to give you a more in-depth update on some key areas for the COVID-19 response.

Variants

COVID-19 has brought to the forefront how interconnected we are as a global community and the importance of our international scientific relationships.

In the fall of 2020, several SARS-CoV-2 variants emerged, some of which appear to spread more easily than others. The emergence of variants is, of course, concerning, and it underscores the critical need for genomic surveillance and increased vigilance in the implementation of public health prevention measures.

We are monitoring dozens of variants and conducting ongoing and comprehensive risk assessments through the SARS-CoV-2 Interagency Group comprised of CDC, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Biomedical Advanced Research and Development Authority (BARDA), the United States Department of Agriculture, and the Department of Defense. We are also in consultation with many of our international colleagues. Of the emerging variants, four have captured our attention and have the highest risk to public health: B.1.1.7 (Alpha), B.1.351 (Beta), P.1 (Gamma), and B.1.617.2 (Delta).

The Alpha variant, originally identified in the United Kingdom, was first identified in the United States in December 2020, and quickly became the predominant variant. However, based on CDC's most recent data, the Delta variant is now predicted to be the predominant lineage circulating in the United States. The Delta variant was originally detected in India and the earliest known case in the United States was in February 2021. According to CDC's Nowcast model for the two-week period ending July 3, the national proportion of the Delta variant is projected to be 51.7% of cases, with the Alpha variant being the second-most predominant variant at 28.7%. The third most prevalent variant in the United States is the Gamma variant,

with a projected national proportion of 8.9% for the two-week period ending July 3. The fourth variant of concern, Beta, is projected to be well below 1%.

Available data indicate that antibodies elicited shortly after vaccination with the currently authorized vaccines are able to neutralize the circulating variants, although some have a reduced neutralization against the Beta and Gamma variants in laboratory studies. A recent study from the United Kingdom indicated that the Pfizer vaccine was 93% effective at preventing symptomatic infection with the Alpha variant and 88% effective at preventing symptomatic infection with the Delta variant, and a related study indicated that the Pfizer vaccine was greater than 95% effective at preventing hospitalization when infected with either the Alpha or Delta variants. Based on preliminary data from a Johnson & Johnson vaccine clinical trial in South Africa where the prevalence of the Beta variant was estimated to be 95 percent, the vaccine was 64 percent effective in preventing infection and 81.7 percent effective in preventing severe disease. Additional data from among healthcare workers in South Africa vaccinated with the Johnson & Johnson vaccine demonstrate that 94% of breakthrough infections are mild, in a setting with a high prevalence of the Delta variant. Studies are currently underway to understand the impact on the real-world effectiveness of current vaccines against variants and to better understand the impact of the variants on medical countermeasures.

Since January 2021, CDC has dramatically built up our domestic genomic surveillance platforms to monitor circulating variants. While the decline in SARS-CoV-2 cases compared to the high peak this past winter means that the number of specimens available for sequencing has declined, CDC continues to generate enough sequences to detect emerging variants through the National SARS-CoV-2 Strain Surveillance (NS3) program and contracts with commercial diagnostic laboratories.

With the funding provided by the American Rescue Plan Act, we are further investing in public health infrastructure to strengthen genomic sequencing and bioinformatics capacity. We have issued 29 awards, totaling approximately $37 million, as part of the SARS-CoV-2 Sequencing for Public Health Emergency Response, Epidemiology, and Surveillance (SPHERES) Initiative. These awards are intended to fill knowledge gaps and promote innovation in the U.S. response to the COVID-19 pandemic, and will help integrate next-generation genomic sequencing technologies with bioinformatics and epidemiology expertise across the US public health system.

On July 1, to address low vaccination coverage and increasing cases due to spread of the Delta variant in some communities, CDC, along with other federal partners, intensified our efforts to help states prevent, detect, and respond to hotspots among the unvaccinated by launching COVID-19 Surge Response Teams. With this interagency initiative, CDC will participate in teams at-the-ready to deploy resources and personnel to communities at higher risk for -- or already experiencing -- outbreaks due to the spread of the Delta variant and under-vaccination. In collaboration with state, tribal, local, and territorial health department partners, interagency teams will define the needs on the ground and work to address these gaps. The most important step we can take to prevent these outbreaks is for everyone eligible to get vaccinated, and we continue to work with communities across the country on that goal.

Health Equity

Data continue to show the disproportionate impact of COVID-19 on racial and ethnic minority populations, as well as other population groups such as people living in rural or frontier areas, people experiencing homelessness, essential and frontline workers, people with disabilities, people with substance use disorders, people who are incarcerated, and non-U.S.-born persons.

In June 2021, CDC began providing additional resources to health departments to address COVID-19-related health disparities and advance health equity among populations that are underserved and facing conditions that place them at elevated risk, including racial and ethnic minority groups and people living in rural areas. This funding represents an investment by CDC - $2.25 billion over two years - to support communities affected by COVID-19-related health disparities. CDC's new National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities, is providing grants to local and state public health departments to work in partnerships with members of the affected communities to improve testing and contact tracing capabilities; develop innovative mitigation and prevention resources and services; improve data collection and reporting; build, leverage, and expand infrastructure support; and collaborate with partners to advance health equity and address social determinants of health as they relate to COVID-19.

Community Health Workers (CHW) have a demonstrated impact in the communities they serve yet persistent barriers have left them underutilized in addressing health disparities. In May

2020, CDC announced $332 million dollars in CARES Act funding for a grant program and evaluation to support Community Health Workers for COVID Response and Resilient Communities. The program will support the training and deployment of CHWs to bolster response efforts and strengthen community resilience to fight COVID-19 by addressing existing health disparities. CHWs are well-positioned to reach communities, especially those disproportionately impacted by COVID-19. CHW interventions can improve uptake and access to health care services, improve communication between community members and health providers, reduce the need for emergency and specialty services, and improve adherence to health recommendations.

As of May 2021, CDC has released several publications examining vaccination rates in certain population groups to monitor disparities and track progress towards health equity. The first study, *Demographic and Social Factors Associated with COVID-19 Vaccination Initiation Among Adults Aged ≥65 Years — United States, December 14, 2020–April 10, 2021*, found that after the first 3.5 months of the U.S. COVID-19 vaccination program, 79.1% of adults aged ≥65 years had received ≥1 dose, with higher vaccination initiation among men. Counties with lower vaccination initiation rates had higher percentages of older adults with social vulnerabilities. The second study, *Disparities in COVID-19 Vaccination Coverage Between Urban and Rural Counties — United States, December 14, 2020–April 10, 2021*, found that COVID-19 vaccination coverage was lower in rural counties (38.9%) than in urban counties (45.7%) and that disparities persisted among age groups and by sex. A third study, *Patterns in COVID-19 Vaccination Coverage, by Social Vulnerability and Urbanicity — United States, December 14, 2020–May 1, 2021*, found disparities in county-level vaccination coverage by social vulnerability have increased as vaccine eligibility has expanded, especially in large fringe metropolitan (areas surrounding large cities, e.g., suburban) and nonmetropolitan counties. By May 1, 2021, vaccination coverage among adults was lower among those living in counties with lower socioeconomic status and with higher percentages of households with children, single parents, and persons with disabilities.

Collectively, these findings highlight the need to continue monitoring demographic and social factors affecting COVID-19 vaccine access; to prioritize efforts to ensure equitable access to COVID-19 vaccine; to tailor public health messaging for local populations and counties with high social vulnerability; and the need for public health practitioners to collaborate with health

care providers, pharmacies, employers, faith leaders, and other community partners to identify and address barriers to COVID-19 vaccination in rural areas.

While these data indicate additional work that lies ahead to achieve greater vaccination rates in certain population groups, we know there are communities that have been successful in their vaccination efforts. In June 2021, as part of the National Month of Action, CDC hosted a webinar as a call to action to increase the number of vaccinated people in Black or African American and Hispanic or Latino communities. The webinar highlighted organizations that have conducted successful mass vaccination activities for Black or African American and Hispanic or Latino people. These organizations shared their successes, challenges, and strategies used to increase vaccine education, awareness, and uptake with the nearly 500 participants from public health, healthcare, clinical, and community organization leadership. This effort is part of CDC's ongoing work to share best practices around the country to help all communities achieve the highest rates of vaccination possible.

To assist decision-makers and researchers, CDC also launched a Health Equity page on our COVID Data Tracker. The page catalogs current health equity-related data that align with populations and place-based focus groups identified in CDC's COVID-19 Response Health Equity Strategy.

Vaccines

Vaccination is a critical tool in bringing this unprecedented pandemic to an end. As of May 10, every person aged 12 and over in every state and territory is eligible to get vaccinated. CDC has continued to improve accessibility by increasing distribution of vaccines to medical offices. We have increased the number of medical practices receiving vaccine by nearly 85% since early April and now have over 10,000 medical practices served by primary care doctors, administering vaccine alongside other routine medical care. The country exceeded President Biden's goal of administering 200 million shots in the first 100 days of his Administration. A CDC study[1] reviewing data from two months of early vaccinations among health care personnel found that both Moderna and Pfizer vaccines were 94% effective in preventing symptomatic SARS-CoV-2 infection, seven or more days after the second dose. In addition, another CDC study[2] found these two vaccines were 94% effective against hospitalization among fully

[1] https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e2.htm?s_cid=mm7020e2_w
[2] https://www.cdc.gov/mmwr/volumes/70/wr/mm7018e1.htm?s_cid=mm7018e1_w

vaccinated adults aged 65 years and older. These findings demonstrate the high, real-world effectiveness of these vaccines.

CDC will continue working with partners to monitor how well COVID-19 vaccines work in real-word conditions through multiple studies looking at vaccine effectiveness in various populations, locations, and settings. Through these studies, CDC can obtain more representative, scientifically valid, and complete information about vaccine effectiveness, including factors associated with vaccine breakthrough.

Vaccinations are highly effective against severe disease including hospitalizations and death, thus protecting even the limited number of people who are vaccinated but still get COVID-19. A recent analysis led by CDC published in the New England Journal of Medicine found that mRNA COVID-19 vaccines show secondary benefits of vaccination for people who were fully or partially vaccinated and still got COVID-19. Secondary benefits included having shorter and milder illness and potentially being less likely to spread the virus to others compared to unvaccinated people with COVID-19.

COVID-19 vaccine safety is a top priority for the federal government, and we take all reports of health problems following COVID-19 vaccination seriously. Since April 2021, increased cases of inflammation of the heart muscle, called myocarditis, or outer lining, called pericarditis, —have been reported in the U.S. following mRNA COVID-19 vaccination (Pfizer or Moderna). This is a rare condition and reported cases have occurred predominantly in male adolescents and young adults. Following a thorough safety review and meeting of CDC's Advisory Committee on Immunization Practices, which found the benefits of mRNA vaccination greatly outweighed the risks, CDC continues to recommend COVID-19 vaccination for everyone 12 years of age and older, given the risk of COVID-19 illness and related, possibly severe complications. FDA and CDC also conducted extensive outreach to providers and clinicians to ensure they were made aware of the potential for these adverse events.

CDC and FDA are monitoring reports of Guillain-Barré Syndrome (GBS) after receiving Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 Vaccine. GBS is a neurological disorder in which the body's immune system damages nerve cells, causing muscle weakness or in the most severe cases paralysis. Reports of GBS after receipt of the J&J/Janssen COVID-19 Vaccine in the Vaccine Adverse Event Reporting System (VAERS) are rare, but do likely indicate a small possible risk of this side effect following this vaccine. Around 100 preliminary reports of GBS,

mostly in males, many aged 50 years and older, have been detected in VAERS after 12.8 million doses of J&J/Janssen COVID-19 Vaccine administered. Available data do not show a similar pattern with mRNA vaccines (Pfizer-BioNTech and Moderna). On July 13, the FDA updated the label of the Johnson & Johnson vaccine to add a new warning suggesting an increased risk of Guillain-Barre Syndrome within 42 days following vaccination. This issue will be discussed as part of an upcoming meeting of CDC's Advisory Committee on Immunization Practices (ACIP) later in July. The detection of rare complications, such as myocarditis, thrombosis-thrombocytopenia syndrome (a rare and severe type of blood clot), and GBS, is an important validation of the sensitivity of vaccine safety monitoring systems to be able to pick up even very small numbers of potential vaccine safety concerns.

Building on long-standing relationships with state and local partners, CDC has worked tirelessly to ensure that we are getting vaccines to people as quickly, safely, and equitably as possible. As of July 16, 2021, about 389 million doses have been delivered, and more than 336 million doses of COVID-19 vaccine have been administered. About 79 percent of all Americans age 65 years and older were fully vaccinated by this date, and about 68 percent of adult Americans had received at least one vaccine. This is a whole-of-society effort, and it is inspiring to see people across government, business, and communities coming together to complete this important lifesaving task.

Strong confidence in vaccines within communities leads to more people getting vaccinated, and to fewer COVID-19 illnesses, hospitalizations, and deaths. CDC is working in coordination with national, state, tribal, local, and territorial governmental and non-governmental partners to build trust in the vaccine, the vaccinator, and the vaccination system. We will continue to work with these critical partners to address barriers to vaccinations, including in communities of color and disproportionally affected groups. It is important that we continually deliver the message that vaccines are rigorously studied during clinical trials, and there is a vast network of safety systems that monitor vaccines once they are in use and safety protocols to monitor people when they receive the vaccine. In order to address vaccine hesitancy, it is crucial to provide accurate scientific messaging across all sectors and multiple platforms, using creative communications approaches such as enlisting trusted community members to help address concerns over COVID-19 vaccines. Listening to, and patiently addressing concerns, including on an individual basis, is a vital method that should be used to build confidence in vaccines.

Further supporting efforts to prioritize equity in our vaccine strategy, in early April CDC awarded $3.15 billion directly to states, territories, and some large cities to support local efforts to increase vaccine access, uptake, and equity. The funding focused on reaching communities hit hardest by the pandemic, including those with a high Social Vulnerability Index, minority communities, and rural areas.

In order to enhance vaccine uptake among underserved communities of color and to build trust and confidence in the authorized COVID-19 vaccines, CDC has developed a comprehensive program of approximately 20 national organizations that support hundreds of local and community-based organizations to improve both COVID-19 and influenza vaccination coverage among racial and ethnic groups who have historically had, and continue to experience, health disparities. Jurisdictions are also encouraged to consider factors such as the Social Vulnerability Index and current administration rates in local communities when reaching out to enroll providers. Guidance was disseminated to jurisdictions on increasing the proportion of vaccines allocated to providers who are located in socially vulnerable communities. In July, CDC added a new Vaccination Equity tab to display Social Vulnerability Index and vaccination coverage maps to the COVID Data Tracker. Improving access to underserved communities and populations that have historically experienced greater barriers to healthcare access is another critical component to prioritizing equity in vaccine distribution. Improving access also requires a multi-pronged approach. For example, CDC partners with the Health Resources and Services Administration (HRSA) to provide COVID-19 vaccinations and technical assistance to interested HRSA-funded health centers, with the goal of bringing vaccines to communities and improving access for populations disproportionately impacted by COVID-19. As of June 29, roughly 7 million doses had been distributed to 2,200 HRSA-funded health centers across the nation.

The Federal Retail Pharmacy Program is integral to the work CDC is doing to maximize access to COVID-19 vaccines in all communities, including communities of color and other underserved populations, such as rural communities. CDC partnered with 21 national pharmacy organizations and independent pharmacy networks that represent over 40,000 locations nationwide – to ensure that the public has access to COVID-19 vaccines in a familiar setting. Almost 90 percent of Americans live within five miles of a retail pharmacy. These pharmacies continue to reach out to communities, administering almost 3 million doses at nearly 10,000

mobile pop-up clinics, with 58 percent of people vaccinated by pharmacies in the last two weeks of June being in a minority group.

On May 13th, CDC released new guidance for fully vaccinated people, which said that, anyone who is fully vaccinated can resume activities – indoor or outdoor – safely without a mask or physical distancing, except where required by federal, state, local, tribal, or territorial laws, rules and regulations, including local business and workplace guidance. This decision was based on three major scientific developments: 1) Our vaccines working in the real world, with studies showing them to be >90% effective in the real-world settings in preventing mild and severe disease, hospitalization, and death, 2) Our vaccines proving to be effective against the SARS-CoV-2 variants currently circulating in the country, and 3) Research showing that if you are vaccinated, you are less likely to spread the virus. A growing body of evidence suggests that fully vaccinated people are less likely to have asymptomatic infection and to be able to transmit SARS-CoV-2 to others. While we hope this was encouraging news for the country, we must remain vigilant in our efforts to continue increasing vaccination if we want to continue returning to normal. At this time, CDC sees no need to change our fully vaccinated guidance; however we will continue to monitor all indicators and data closely.

Schools

Since becoming the director of CDC, I have stressed the importance of getting children back to school for in-person learning. The safest way to open schools is to ensure that there is as little disease as possible in the community. With the widespread availability of safe and effective vaccines, we have seen reductions in COVID-19 cases, hospitalizations, and deaths. If vaccination rates continue to increase and community transmission rates decrease, the risk in schools is expected to decrease as well.

CDC began working on guidance, resources, and tools for safe school reopening in March 2020 when the first schools closed. As CDC learned more about COVID-19, we continually updated our guidance, resources, and tools for schools, parents, teachers, and other staff. Earlier this month, CDC released updated guidance to help prevent the spread of COVID-19 and safeguard in-person learning. CDC's *Guidance for COVID-19 Prevention in K-12 Schools* is now updated to reflect the latest science on COVID-19, lessons learned from schools implementing COVID-19 prevention strategies, and the widespread availability of safe and effective COVID-19 vaccines for those aged 12 years and older. Reports suggest that limited in-

person instruction during the pandemic may have had a negative effect on learning for children and on the mental and emotional well-being of both parents and children. In addition, many K-12 schools globally implemented layered COVID-19 prevention strategies during the 2020-2021 academic year. These schools' experiences contributed to our knowledge of the nature of SARS-CoV-2 transmission in schools and informed updates to the K-12 guidance, which emphasizes the importance of offering in-person learning in K-12 schools.

CDC recommends schools implement layered prevention strategies to protect people who are not fully vaccinated, including students, teachers, staff, and other members of their households. These strategies include vaccination for children and adults ages 12 and up, the correct use of masks, physical distancing, handwashing and respiratory etiquette, cleaning and maintaining healthy facilities (including proper ventilation), and contact tracing, in combination with screening testing, isolation, and quarantine for those exposed and not vaccinated. The guidance emphasizes the need for localities to monitor community transmission, vaccination coverage, screening testing, and occurrence of outbreaks to guide decisions on the level of layered prevention strategies.

Mask use and physical distancing are two key prevention strategies for reducing SARS-CoV-2 transmission, but a layered approach that uses several strategies will provide the greatest level of protection. Schools where not everyone is fully vaccinated should implement physical distancing to the extent possible within their structures, in addition to masking and other prevention strategies. If it is not possible to maintain adequate physical distancing, it is especially important that schools layer multiple other prevention strategies, such as masking and screening testing, to help ensure that no students need be excluded from in-person learning .

In April, CDC provided $10 billion to states and jurisdictions to support COVID-19 screening testing for K-12 teachers, staff, and students to assist schools in reopening safely for in-person instruction. In May, CDC also awarded $500 million to jurisdictions to expand the school-based public health workforce, including nurses and other health personnel. Combined, we believe these resources will provide substantial help to schools around the nation as they open in the fall.

SARS-CoV-2 is still a relatively new pathogen, and we are learning more about it and how it impacts different people and communities all the time. CDC's Guidance for COVID-19 Prevention in K-12 Schools presents recommendations based on the best-available evidence at

the time of release. As science and data on SARS-CoV-2 and COVID-19 continue to evolve, we will update our guidance and recommendations to reflect new evidence. CDC stands committed to providing the best, most current data and scientific understanding available to protect the health, safety, and well-being of our communities, including our students, teachers, and school staff.

Conclusion

In closing, I want to emphasize that with increased vaccinations nationwide, we can look forward to seeing more kids in school, more families able to connect with one another safely, and our nation beginning to move forward and heal. But we have to ensure that we are stamping out COVID-19 in all communities, not just some communities. We cannot risk only keeping parts of the U.S. moving forward safely while other parts of the country continue to see tragic numbers of cases and deaths from COVID-19. This will require sustained efforts from all stakeholders and across all levels of government and most importantly individuals making the decision to get vaccinated to protect themselves, their loved ones, and their communities.

We also must address the long-standing vulnerabilities in our public health system and the conditions that led to disproportionate burden of COVID-19 illness and death in some communities. The Fiscal Year 2022 President's Budget Request includes an increase of nearly $1.7 billion for CDC to invest across the public health system. This is an important first step in building back a better public health system that can deliver health security to all Americans.