Welcome to the Community Vaccine Advisory Committee

Erica Pan, MD, MPH,
State Epidemiologist, Co-Chair

Nadine Burke Harris, MD, MPH,
California Surgeon General, Co-Chair
Meeting Process

• All meetings will be virtual and interactive; cameras on; mute until ready to speak
• Use hand raise icon when you are ready to make comments/ask questions
• Consistent attendance by members; no delegates or substitutes
• Today we will be having ASL Interpreter and closed captioning for members
• Website - https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Community-Vaccine-Advisory-Committee.aspx
• Public listen-in mode via telephone at each meeting in English and Spanish
• Meeting will now be live-streamed on YouTube – https://www.youtube.com/channel/UCkNEUkIwtIc_kPenEZWUIoW
• Public comment via written comments COVID19VaccineOutreach@cdph.ca.gov; will be discussed with Committee at subsequent meetings; all public comments received will be posted weekly on the CDPH website
• Technical issues with Zoom – put questions in chat
Summary of Public Comments Since Meeting #8
Opening Comments

Nadine Burke Harris, MD, MPH,
California Surgeon General, Co-Chair

Erica Pan, MD, MPH,
State Epidemiologist, Co-Chair
Update on Vaccine Supply and Distribution

Erica Pan, MD, MPH, State Epidemiologist, CDPH, Co-Chair

Marta Green, California Government Operations Agency

Paul Markovich, President and CEO, Blue Shield of California
CDC Pharmacy Partnership for Long-Term Care (LTC) Program
CDC-LTC-Pharmacy vaccination clinics

- CVS and Walgreens are conducting 3 vaccination clinics on-site
  - Skilled Nursing Facilities (SNFs) started first 12/28/2020
  - Assisted Living Facilities (ALFs) and other facilities started 1/11/2021
  - Over 16,000 LTCFs (98% of total signed up) have clinic schedules
CDC-LTC-Pharmacy doses

- As of 2/2/21 CDC data
  - 348,346 doses administered thus far
    - 297,504 first doses and 50,842 second doses
    - 188,515 resident doses and 159,831 staff doses
Accelerating Vaccine Distribution and Administration

February 2021
Accelerating Vaccine Distribution and Administration in California

A public-private partnership

February 3, 2021
Blue Shield is deeply committed to the health and well-being of Californians

- Mission driven, tax paying, not-for-profit company founded in California in 1939
- Serving 4.4 million members in commercial and Medi-Cal lines of business
- A network of more than 63,000 physicians and more than 370 hospitals
- More than $500 million contributed to the Blue Shield of California Foundation since 2002
- Substantial relief to our members and providers during the COVID-19 pandemic
We have a track record of partnering to achieve shared goals

- Co-Chaired the COVID-19 Testing Task force; increased tests from 2,000 per day to more than 100,000 per day
- Commitment to jointly operate 14 community resource centers with L.A. Care Health Plan and our Blue Shield of California Promise Health Plan
- Partnered with IHA to fund and develop the statewide provider directory called Symphony
- Partnering with the California Department of Education to address youth mental illness through our BlueSky initiative
We are recognized for our commitment to equity

- #1 Regional Company Diversity, Inc.
- Best Companies for Women to Advance
- Top 100 Bay Area Corporate Philanthropists
- 100% rating on the Disability Equality Index
- Deloitte Best Managed Company
- 100% on the Human Rights Campaign’s Corporate Equality Index
- Best Place to Work for LGBTQ+ Equality
We are designing a statewide network to accelerate equitable vaccine distribution...

- Develop a rigorous, reliable, performance management system with the ability to:
  - Track all vaccines from order to injection
  - Understand who is getting vaccinated to ensure equity
  - Receive comprehensive, accurate, same-day data
  - Report performance in a detailed, transparent way

Source: CA COVID-19 Vaccine Task Force
and partnering with stakeholders to deliver results on the ground

- Blue Shield will build a network and operation that can achieve all of the state’s goals
- And we need people to use it to achieve those goals, e.g., equity
- Strategy will include innovative ways to reach vulnerable communities and those disproportionately affected by COVID-19

Source: CA COVID-19 Vaccine Task Force
What now?

Optimize current state

- Enhance communication, education and data to ensure equity in distribution of vaccine
- Support current providers and network to fully utilize their vaccine distribution in a fast and equitable manner
- Track vaccine distribution and administration consistently for accuracy and transparency
What’s next?

Accelerate the rate of vaccinations

• Ongoing meetings with key stakeholders, e.g., local health jurisdictions, to develop the best approach in each community

• A phased approach for the new network beginning later this month

• Regular cadence of communication for transparency
Questions?
Updated Recommendations from Drafting Guidelines Workgroup

Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Rob Schechter, MD, CDPH, Co-Chair, Drafting Guidelines Workgroup
Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup
Erica Pan, MD, MPH, State Epidemiologist, CDPH, Co-Chair
## Proposed Phase 1 & 2 allocation, December 2020

<table>
<thead>
<tr>
<th>Phase</th>
<th>Groups recommended for vaccination</th>
<th>Number of persons in each group (millions)</th>
<th>Number of unique* persons in each group (millions)</th>
<th>Total* (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Health care personnel</td>
<td>21</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Long-term care facility residents</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td>Frontline essential workers</td>
<td>30</td>
<td>30</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Persons aged 75 years and older</td>
<td>21</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>1c</td>
<td>Persons aged 65-74 years</td>
<td>32</td>
<td>28</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>Persons aged 16-64 years with high-risk conditions</td>
<td>110</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Essential workers not recommended in Phase 1b</td>
<td>57</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>All people aged 16 years and older not in Phase 1, who are recommended for vaccination</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Accounts for persons recommended in prior phases or overlap within a phase*
COVID-19 mortality rates are highest in older adults

National Estimate of COVID-19 Deaths per 100,000 Population, by Age Group – Data through Nov 13, 2020

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Death Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>80+</td>
<td>648.8</td>
</tr>
<tr>
<td>65 - 79</td>
<td>149</td>
</tr>
<tr>
<td>55 - 64</td>
<td>51.5</td>
</tr>
<tr>
<td>35 - 54</td>
<td>15.2</td>
</tr>
<tr>
<td>25 - 34</td>
<td>3.3</td>
</tr>
<tr>
<td>18 - 24</td>
<td>1.3</td>
</tr>
<tr>
<td>14 - 17</td>
<td>0.2</td>
</tr>
<tr>
<td>6 - 13</td>
<td>0.1</td>
</tr>
<tr>
<td>0 - 5</td>
<td>0.2</td>
</tr>
</tbody>
</table>

*Data sources: CDC COVID-19 case reports from jurisdictions. Population estimates from 2019 US Census Bureau. Data provisional, subject to change, incomplete for some jurisdictions. Age missing for 21% of deaths. No deaths have been reported since 11/13/2020.
## COVID-19 Hospitalization and Death by Age

### Factors that Increase Community Spread and Individual Risk

<table>
<thead>
<tr>
<th>Rate ratios compared to 18-29 year olds</th>
<th>0-4 years</th>
<th>5-17 years</th>
<th>18-29 years</th>
<th>30-39 years</th>
<th>40-49 years</th>
<th>50-64 years</th>
<th>65-74 years</th>
<th>75-84 years</th>
<th>85+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalization</strong>¹</td>
<td>4x lower</td>
<td>9x lower</td>
<td>Comparison Group</td>
<td>2x higher</td>
<td>3x higher</td>
<td>4x higher</td>
<td>5x higher</td>
<td>8x higher</td>
<td>13x higher</td>
</tr>
<tr>
<td><strong>Death</strong>²</td>
<td>9x lower</td>
<td>16x lower</td>
<td>Comparison Group</td>
<td>4x higher</td>
<td>10x higher</td>
<td>30x higher</td>
<td>90x higher</td>
<td>220x higher</td>
<td>630x higher</td>
</tr>
</tbody>
</table>

### Actions to Reduce Risk of COVID-19

- Wearing a mask
- Social distancing (6 ft goal)
- Hand hygiene
- Cleaning and disinfection

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### COVID-19 CASES, HOSPITALIZATION, AND DEATH BY RACE/ETHNICITY

#### Factors that increase community spread and individual risk

<table>
<thead>
<tr>
<th>Rate ratios compared to White, Non-Hispanic Persons</th>
<th>American Indian or Alaska Native, Non-Hispanic persons</th>
<th>Asian, Non-Hispanic persons</th>
<th>Black or African American, Non-Hispanic persons</th>
<th>Hispanic or Latino persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASES¹</td>
<td>2.8x higher</td>
<td>1.1x higher</td>
<td>2.6x higher</td>
<td>2.8x higher</td>
</tr>
<tr>
<td>HOSPITALIZATION²</td>
<td>5.3x higher</td>
<td>1.3x higher</td>
<td>4.7x higher</td>
<td>4.6x higher</td>
</tr>
<tr>
<td>DEATH³</td>
<td>1.4x higher</td>
<td>No Increase</td>
<td>2.1x higher</td>
<td>1.1x higher</td>
</tr>
</tbody>
</table>

Race and ethnicity are risk markers for other underlying conditions that impact health — including socioeconomic status, access to health care, and increased exposure to the virus due to occupation (e.g., frontline, essential, and critical infrastructure workers).

#### Actions to reduce risk of COVID-19

- Wearing a mask
- Social distancing (6 ft goal)
- Hand hygiene
- Cleaning and disinfection

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¹ Data source: COVID-19 case-level data reported by state and territorial jurisdictions. Case-level data include about 80% of total reported cases. Numbers are unadjusted rate ratios.


<table>
<thead>
<tr>
<th>Condition</th>
<th>Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>2.8 (2.3-3.4)</td>
</tr>
<tr>
<td>CAD</td>
<td>1.3 (1.0-1.8)</td>
</tr>
<tr>
<td>History of Stroke</td>
<td>0.9 (0.6-1.4)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.2 (2.5-4.1)</td>
</tr>
<tr>
<td>Obesity</td>
<td>2.9 (3.4-5.7)</td>
</tr>
<tr>
<td>Severe obesity</td>
<td>4.4 (3.4-5.7)</td>
</tr>
<tr>
<td>CKD</td>
<td>4.0 (3.0-5.2)</td>
</tr>
<tr>
<td>Asthma</td>
<td>1.4 (1.1-1.7)</td>
</tr>
<tr>
<td>COPD</td>
<td>0.9 (0.7-1.4)</td>
</tr>
<tr>
<td>Any condition</td>
<td>3.2 (2.7-3.8)</td>
</tr>
</tbody>
</table>
Risk of in-hospital death among persons hospitalized for COVID-19 increased with age

Risk of in-hospital death among patients with COVID-19 associated hospitalization, COVID-NET March 1 - May 2, 2020

85+ years vs 18–39 years: 10.98
75–84 years vs 18–39 years: 7.67
65–74 years vs 18–39 years: 5.77
50–64 years vs 18–39 years: 3.11

Male: +1.3
Immunosuppression: +1.39
Renal disease: +1.33
Chronic Lung Disease: +1.31
Cardiovascular Disease: +1.28
Neurologic disorder: +1.25
Diabetes: +1.19

Adjusted Rate Ratios and 95% Confidence Intervals

Underlying Medical Conditions

**COVID-NET**: Of hospitalized adults that died, nearly 80% had 3 or more underlying medical conditions*

![Bar chart showing weighted percent of hospitalized persons with specified conditions.](https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-08/COVID-05-McLung.pdf)

*Defined as one or more of hypertension, obesity, diabetes, cardiovascular disease, neurologic disease, chronic lung disease, renal disease, asthma, immune suppression, gastrointestinal/liver disease, and autoimmune disease. **Unadjusted for age or other demographic variables. Each severe outcome adds up to 100 percent. COVID-19 associated hospitalizations reported to Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET) surveillance system from March 1-August 15, 2020. The denominator is restricted to cases with a discharge disposition and for which chart review was completed. COVID-NET is a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations among children and adults through a network of over 250 acute-care hospitals in 16 states.*
<table>
<thead>
<tr>
<th>Californians not receiving IDD services</th>
<th>Population</th>
<th>Percent of population</th>
<th>Cases</th>
<th>Deaths</th>
<th>Case rate per 100,000 (95% CI)</th>
<th>Case-fatality rate (95% CI)</th>
<th>Mortality rate per 100,000 (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Califoritans</td>
<td>39,157,583</td>
<td>100%</td>
<td>816,488</td>
<td>15,912</td>
<td>2085 (2081–2090)</td>
<td>.019 (.019–.020)</td>
<td>41 (40–41)</td>
</tr>
<tr>
<td>Californians receiving IDD services</td>
<td>354,640</td>
<td>100%</td>
<td>2948</td>
<td>162</td>
<td>831 (802–862)</td>
<td>.055 (.047–.064)</td>
<td>46 (39–53)</td>
</tr>
<tr>
<td>Californians receiving IDD services by type of residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home or family home</td>
<td>315,650</td>
<td>89.0%</td>
<td>1651</td>
<td>47</td>
<td>523 (498–549)</td>
<td>.028 (.021–.038)</td>
<td>15 (11–20)</td>
</tr>
<tr>
<td>Community Care Facility (CCF)</td>
<td>23,722</td>
<td>6.7%</td>
<td>538</td>
<td>23</td>
<td>2268 (2086–2465)</td>
<td>.043 (.029–.063)</td>
<td>97 (64–145)</td>
</tr>
<tr>
<td>ICF/DD-Habilitative (ICF/DD-H)</td>
<td>3739</td>
<td>1.1%</td>
<td>209</td>
<td>13</td>
<td>5590 (4898–6373)</td>
<td>.062 (.037–.103)</td>
<td>348 (203–594)</td>
</tr>
<tr>
<td>ICF/DD-Nursing (ICF/DD-N)</td>
<td>2163</td>
<td>0.6%</td>
<td>95</td>
<td>15</td>
<td>4392 (3606–5339)</td>
<td>.158 (.098–.244)</td>
<td>693 (421–1141)</td>
</tr>
<tr>
<td>ICF for the Developmentally Disabled (ICF-DD)</td>
<td>557</td>
<td>0.2%</td>
<td>106</td>
<td>5</td>
<td>19,031 (15,987–22,498)</td>
<td>.047 (.020–.106)</td>
<td>898 (384–2084)</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>1031</td>
<td>0.3%</td>
<td>284</td>
<td>58</td>
<td>27,546 (24,906–30,353)</td>
<td>.204 (.161–.255)</td>
<td>5626 (4377–7204)</td>
</tr>
<tr>
<td>Other</td>
<td>7778</td>
<td>2.2%</td>
<td>65</td>
<td>1</td>
<td>836 (656–1064)</td>
<td>.015 (.003–.082)</td>
<td>13 (2–73)</td>
</tr>
</tbody>
</table>
Additional Studies

- US claims (FAIR, Makarty) and UK studies: 2-3 fold risk of mortality from COVID in persons with disabilities
  - ~90% of mortality in UK in persons with disabilities 65+ years of age
  - No data on which disabilities or additional underlying conditions in fatal cases
- Unable to assess the residual risk in those currently excluded in Phase 1a and 1b guidance
  - <65 years of age
  - Outside of congregate care
- Data from California study suggest a decreased than average risk ("protection") to those residing outside of congregate settings
- How much of the observed risk to persons with disabilities reflects additional underlying medical conditions?
The Workgroup reaffirmed prior recommendations from CDPH

1. **Phase 1a**: Complete immunization of the healthcare workforce and long-term care facilities.

2. **Phase 1b Tier 1**: Immunize individuals age 65 years and older or working in the essential sectors of agriculture and food, education and childcare, or emergency services.

3. The Drafting Guidelines Workgroup continues to strongly emphasize equity in its recommendations and in the implementation of immunization against COVID-19.
In response to the updated proposal, the Drafting Guidelines Workgroup recommends:

The next group includes but is not limited to:

- Individuals 16 -64 years with underlying serious medical conditions or disabilities that increase their risk of developing severe COVID-19.
  - Applies only to settings, such as health systems or other clinics (but not mass clinics or other local health department clinics) where underlying conditions or disabilities can be verified through access to medical records.
  - The qualifying health conditions and disabilities need to be defined with sufficient specificity that eligibility for the Phase can be determined when patients request an appointment for the vaccine.
- Implementation plans should include outreach and assistance to individuals who have barriers to making appointments for the vaccine or access to vaccine.
- These groups are prioritized after Phase 1b, Tier 1 due to their large numbers and comparative aggregate risk of severe outcomes.
- An alternative proposal limiting eligibility to individuals with multiple (e.g., more than 3) underlying medical conditions was also raised for discussion.
- Local health departments emphasized their crucial role in immunizing residents in local correctional facilities and homeless shelters.
Using Equity Moving Forward

Nadine Burke Harris, MD, MPH,
California Surgeon General, Co-Chair
Categorized Priority System

- A Categorized Priority System (CPS) is a data-based tool to calculate how to distribute a scarce resource equitably

- Using a CPS addresses the need for both simplicity AND equity

- Currently being used by Massachusetts, Tennessee, New Hampshire, and Rhode Island

- Example shared at last meeting: 80% of future vaccine supply could be allocated according to the current methodology, and 20% of the vaccine supply could be allocated to counties or regions based on the lowest HPI quartile ZIP codes.

• EXACT NUMBERS TBD
Categorized Priority System

100% of vaccine doses

80% allocated on evolving methodology (‘E.M. doses’) → County X
→ E.M. doses

20% allocated on HPI → County X
→ HPI doses

County X total

Total doses
Categorized Priority System

100% of vaccine doses to County or Region

80%

20%

20% - Quartile 1
20% - Quartile 2
20% - Quartile 3
20% - Quartile 4

Aggregate distribution to lowest Q – 40%
Tools To Address Equity

• Allocation using a Categorized Priority System

• Outreach to targeted populations

• Earned and paid media powered by research

• Partnering with Community Based Organizations

• Incentives, support and accountability
  • Pay for performance, incentivizing partners to provide:
    • vaccine administration in low HPI
    • vaccine administration to vulnerable communities
    • pop-up clinics
    • transportation services
    • in-home services
# How do we ensure equity in our vaccine delivery?

## What does equitable delivery of vaccines look like?

All Californians - especially those disproportionately impacted by COVID-19 - have **equitable access** to the COVID-19 vaccine

Ensuring that all communities, **urban and rural**, receive equitable **allocations** of the COVID-19 vaccine

Engaging in state and community outreach **education efforts** focused on awareness

Achieving **high vaccination rates** in all communities

## How will California track and achieve equitable vaccine delivery?

California has stated a strong commitment to equity.

COVID-19 has highlighted the importance of focusing resources to address these goals. Such resources may include:

- **Pay for performance (P4P) payments** for vaccinating individuals living in the lowest HPI quartile census tracts

- Payments to providers for bringing **vaccines to communities of color**

- Payments for **targeted outreach and engagement efforts**

- **Enhanced payments** to facilitate evening accessibility, translation/physical services, etc.

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As of **FEB. 1, 2021**
Break
Next Steps on Community Engagement, Equity, and Vaccine Acceptability: *Continuing Discussion*

Nadine Burke Harris, MD, MPH, California Surgeon General
Maricela Rodriguez, Office of Governor
Marcela Ruiz, CDSS
Martha Dominguez, Ph.D., MPH, CDPH
Arleen Brown, MD, UCLA and Olive View-UCLA Medical Center
Office of Governor Newsom

Maricela Rodriguez

Director of Civic Engagement & Strategic Partnerships
Vaccinate All 58 - Campaign Highlights

Digital Overview (Programmatic + Paid Social)

- 49,059,155 Total impressions
- 92,704 Clicks
- Languages: English, Spanish and Traditional Chinese

Programmatic Vaccine Messages Highlights:

- 37,166,179 Impressions
  - Video: 16,606,824
  - Display: 17,427,039
- 57,155 Clicks
  - Display: 42,605 (0.22 CTR) / Industry benchmark: 0.13
  - Video Completion Rate (83.98% VCR) / Industry benchmark: 70%

Paid Social Vaccine Messages Highlights:

- 35,549 Clicks
  - Most clicks are coming on Facebook/IG (18,806) and Snapchat (12,810)
Earned Media Highlights

Statewide Media Briefings
A total of 79 outlets attended the following virtual ethnic media briefings held on January 21 – 22, 2021. The briefings garnered over 90 pieces of coverage across the state.

Asian American Pacific Islander - January 21, 2021
- Kaying Hang, Senior Vice President of Programs and Partnerships, Sierra Health Foundation
- Dr. Erica Pan, State Epidemiologist, California Department of Public Health
- Dr. Tan Duong, Private Practice Medical Specialist
- Steve Kang, Director of External Affairs, Koreatown Youth and Community Center in LA

Latino - January 22, 2021
- Luz Gallegos, Executive Director, TODEC Legal Center
- Dr. Tomás Aragón, Director, California Department of Public Health
- Dr. Veronica Ramirez, Hospitalist, Martin Luther King Jr. Community Healthcare
- Dr. Trinidad Solis, Public Health Physician, Fresno County Department of Public Health

Black and African American - January 22, 2021
- Chet Hewitt, President and CEO, Sierra Health Foundation
- Dr. Nadine Burke Harris, Surgeon General, California Office of the Surgeon General
- Dr. Elaine Batchlor, Chief Executive Officer, Martin Luther King Jr. Community Healthcare
- Shantay R. Davies-Balch, Executive Director, BLACK Wellness & Prosperity Center

Upcoming
Mid-February – California Tribal & American Indian/Alaska Native media briefings
Early March – Next round of virtual ethnic media briefings
California Surgeon Gen. Embraces Idea of NBA Partnership for Vaccination Outreach

LA Watts Times
January 28, 2021
Dr. Nadine Burke Harris
When Dr. Nadine Burke Harris heard last week that the National Basketball Association (NBA) was discussing educating the African American community about receiving COVID-19 vaccines, she said partnering with the league could be a game-changer in the state of California.

From “Vaccines to Vaccinations”: Officials Urge Black Community to Take COVID Shot

Sacramento Observer
January 26, 2021
Dr. Nadine Burke Harris
“Our big goal is to turn vaccines into vaccinations,” she said. “So as our state continues to ramp up the rollout of our vaccines, we are continually committed to a fair and equitable allocation and distribution process. Equity has been central to California’s vaccine strategy.”

MLK Jr. Hospital Vaccinations
Rafu Shimpō Los Angeles Japanese Daily News
January 22, 2021
Dr. Erica Pan
Dr. Erica Pan of the California Department of Public Health said the vaccines represent “the light at the end of the tunnel,” but urged the public to remain vigilant and continue to follow safety protocols. “We’re working around the clock to speed up the vaccination process, while emphasizing fair and equitable distribution,” Pan said.
Vaccinate All 58 - New Graphics

Learn more about COVID-19 Vaccines

Infórmate sobre las vacunas contra el COVID-19

Regístrate para recibir una notificación cuando sea tu turno de vacunarte contra el COVID-19.

Para más información, visita MyTurn.ca.gov o llama al (833) 422-4255.
Black History Month - “COVID-19 Heroes” Multimedia Activation

- Recognize Black “COVID-19 Heroes” fighting to end the pandemic including Californians at the local level, such as health care professionals and essential workers.

- Highlights about the heroes will be paired with key vaccine and educational messaging.

- On-air radio talent will highlight individuals and their contributions through vignettes. Stories will be amplified through print, social, and earned media efforts. Each radio station will develop a customizable program to drive authenticity for their station and listeners.
California Department of Social Services

Marcela Ruiz

Director, Office of Equity
Community Engagement

Cohort 1: The Center
- Releases Invitation (12/21)
- Awards announced (2/4)
- On-Boarding (2/14-2/18)
- Outreach (2/18 - 7/31)

Cohort 2: California Foundation
- Releases Invitation (1/30)
- Community Announced (tent. 2/11)
- On-Boarding (TBA)
- Outreach Begins (March)
Community Engagement

- **Statewide**
- **Data driven**: HPI and COVID burden
- **Interactive Engagement (priority)**
  - Training
  - Phone Banking
  - Door-to-Door
  - Canvassing
  - Texts/Emails
- **One Way Outreach**
  - Social Media
  - Traditional Media
## Community Engagement

<table>
<thead>
<tr>
<th>Disproportionately Impacted Populations</th>
<th>Priority Labor Sectors</th>
</tr>
</thead>
<tbody>
<tr>
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<td>● Native Hawaiian/Pacific Islanders</td>
<td>● Manufacturing</td>
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<td>● LGBTQ+</td>
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<td>● People with disabilities and deaf and hard of hearing populations</td>
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<td>● Older adults (65+)</td>
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<td>● LEP</td>
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<td>● People experiencing homelessness</td>
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<td>● Multi-generational households</td>
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Vaccine creative and media project awarded to

Multicultural integrated media agency
Duncan Channon will provide a comprehensive multicultural COVID-19 vaccine communications campaign plan in support of the following priorities:

• Develop a strategic, overarching approach for public health messaging handling the vaccine rollout, including addressing barriers to the vaccine (i.e. hesitancy) as well navigating through continued COVID-19 uncertainty and countering misinformation and disinformation with science-based and evidence-based facts.

• Develop a statewide strategic, media campaign that is cost efficient and maximizes reach to communities disproportionately impacted by COVID-19 including Hispanic/Latinos and African American/Black populations, essential workers, and other target groups determined by CDPH, based on internal and external research.

• Emphasize public health strategies and tactics to ensure users are reached where they consume information in multiple languages, using the Medi-Cal threshold languages as a guide.

To operationalize the framework above, Duncan Channon will execute the following strategic approach:

• Connect - Demonstrate an understanding of lived experiences + values in order to connect emotionally.

• Educate - Give Californians factual information to combat their concerns and help overcome any vaccine hesitancy.

• Normalize - Create the sense that “people like me” and “people I trust” are doing it (i.e. social pressure).

• Activate - Encourage Californians to get vaccinated.
Vaccinate All 58: Research

Goals:
● Develop deeper understanding of barriers, including hesitancy factors
● Determine motivators for adoption
● Examine likelihood among Californians to get the vaccine
● Identify best communications channels to deliver messages

Tactics:
● **Stage I:** Literature Review
● **Stage II:** Stakeholder Interviews
● **Stage III:** Generational, Online Ethnographic Sessions
● **Stage IV:** Online QualBoard, Qualitative Discussions
Qualitative Boards Findings

BARRIERS TO VACCINE HESITANCY

LACK OF INFORMATION
and guidance from government agencies and health experts has created mistrust and fear that government is trying to control them

ANTI-VACCINE SKEPTICISM
and conspiracy theories have led to misconceptions about how mRNA works, DNA mutation, and potential of spreading the virus post-vaccine

HISTORICAL INCIDENTS WITH VACCINES
have influenced African Americans’ and Native Americans’ views on vaccinations (Tuskegee Experiment, downplaying use of traditional & natural remedies, etc.)

LACK OF EFFICACY & SAFETY DATA
and speed of which vaccine was developed have created questions about potential long-term effects

- Lack of information
- Anti-vaccine skepticism
- Historical incidents with vaccines
- Lack of efficacy and safety data
Factors Empowering Communities to Get Vaccine

Alignment Across Stages I-IV

HAVE THE RIGHT MESSENGER
Messages communicated by trusted sources from within each community will resonate best with each segment, someone that people can relate to and who can speak to the subtle nuances of how it is impacting that particular segment.

DISSEMINATE INFORMATION IN LANGUAGE AND IN CULTURE
Messages communicated by trusted sources from within each community will resonate best with each segment, someone that people can relate to and who can speak to the subtle nuances of how it is impacting that particular segment.

HUMANIZE LIVED EXPERIENCES
Testimonials of real people in various population segments who can share their experience with COVID-19 (its effects even after recovery) and the vaccine, why they vaccinated, its importance, how it will impact them and their family, its effect on their quality of life, etc.

USE CHANNELS TO REACH AUDIENCES WHERE THEY ARE
Share messages where people are consuming information, beyond traditional media channels, and based on the population segment tapping into localized CBOs, local news media, and especially ethnic media outlets for the more marginalized communities.
Stakeholder Interviews: Key Findings

**Messaging**
- Highlight the safety and benefits of the vaccine
- Integrate the concept of everyone working together
- Focus on how the vaccine helps family and community
- Address the side effects
- Acknowledge the distrust in government

**Messengers and Influencers**
- Doctors and medical professionals
- Religious leaders
- Promotoras, health navigators, and trusted community members
- Community health workers and cultural centers
- Family members and caregivers
- Legal, health and social community activists
Stakeholder Interviews: Barriers to Vaccine Acceptance

- Concerns about the effects of the vaccine on pregnancy
- Lack of long-term efficacy and safety data
- Concerns with process for how fast the vaccine was developed
- Fear of deportation
- Myths about the vaccine
- General government mistrust
- Not enough information being disseminated about the vaccine
- Lack of data about the vaccine
- Perception that herd immunity is better than the vaccine
- Number of doses and gap time between doses
- Fear of being used as “guinea pigs”
- Timing for vaccine distribution is not clear
- Reliance on traditional medicine and home remedies
- Gaps in how communication flows down to highest risk groups (e.g. farmworkers)

January 2021 Social Quest Stakeholder Interviews of 15 CVAC Members
Consumer (Dyads & Triads) Findings

- COVID-19 vaccine has a tremendous emotion, anxiety, fear, frustration and anger surround this topic.
- Layers of confusion feed hesitancy.
- Decision-making is happening moment-to-moment.
- Fear and confusion of vaccine availability and eligibility.
- Concern that even having taken the vaccine, one can still spread the virus, further influencing hesitancy.
Barriers, Misinformation & Info Gaps That Cause Vaccine Hesitancy

**Key Barriers to Vaccination That Need to Be Addressed**

**Systemic Socio-Cultural & Economic Influences**
- Historical trauma based on legacy of eugenics medical experimentation
- Discrimination & inequities within the healthcare & insurance systems
- Poverty, lack of basic access to food, housing, healthcare
- Exclusion of ethnic/racial groups in studies
- Marginalized communities with less access to information

**Emotional Influences**
- Anger over unrealistic lockdown restrictions
- Distrust of authority and their intentions
- Religious concerns if vaccine ingredients include fetal tissue
- Fear of getting COVID with the vaccination
- Fear of DNA alteration
- Fear of mandatory vaccination, motivated entirely by the unknown
- Numb response to rising death rates

**Behavioral/Cognitive Repercussions**
- Lack of trust in science undermines important scientific data
- Discrediting a pandemic that’s not statistically possible
- Misunderstanding of herd immunity and its imperative
- Distrust of government prime people to be easy prey of falsehoods and conspiracy theories
- Cognitive bias leading to consuming dubious content rather than credible information on safety and benefits
- Overwhelm of conflicting information, Influence of social media, lack of attention span
- Abandonment of reason, instead turning to gut checks
- Politicization of COVID & vaccine
- Empathy gap in caring for the greater good
- Passive impact of misinformation on people’s judgement

**Vaccine Specific Info Gaps**
- Ongoing research on adverse effects, health risks, interaction with other meds
- Rushed development, accelerated FDA approval
- Misunderstanding of mRNA
- Efficacy, length of protection
- Roll out & distribution schedule
- Potential to still be a spreader
- Impact on unborn babies

**Formative Research**
Status Update on Research

- Ongoing monthly online boards & panels
  - Starting February 8

- Focus groups- attitude and beliefs
  - Recruitment and scheduling now

- Focus Groups – creative testing
  - Recruitment and scheduling now

<table>
<thead>
<tr>
<th>Focus Group #1: Latino / Latinx</th>
<th>Unacculturated, Spanish Preferred, Spanish Dominant</th>
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<td>Focus Group #2: Latino / Latinx</td>
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<td>Focus Group #3: African American</td>
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<td>Focus Group #4: Asian/Philippine, Vietnamese, Hmong, Lao, Cambodian</td>
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<td>Focus Group #5: Native Americans</td>
<td>Self-Identified Native Americans</td>
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<td>Focus Group #6: Asian/Chinese</td>
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<td>Moderated in English or Cantonese or Mandarin</td>
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<tr>
<td>Focus Groups #7: Indian/Hindi &amp; Punjabi</td>
<td></td>
<td>Moderated in English</td>
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Share, Trust, Organize, Partner: the COVID-19 California Alliance

STOP COVID-19: Understanding and Reducing Disparities in COVID-19

Arleen F. Brown, MD, PhD
Steve Dubinett, MD
Keith Norris, MD, PhD

NIH CEAL
Community Engagement Alliance
National Institutes of Health
CEAL Objectives

1. To conduct **urgent community-engaged research** and outreach focused on **COVID-19 awareness and education** to address the widespread misinformation about COVID-19 and promote an evidence-based response to the disease;

2. To promote and **facilitate inclusion of diverse racial and ethnic populations in COVID-19 clinical trials** (prevention, vaccine, therapeutics), reflective of the populations disproportionately affected by the pandemic.

**States Awarded:** Alabama, Arizona, **California**, Florida, Georgia, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, Texas
STOP COVID-19 CA
Program Goals

In partnership with community stakeholders:

1. **Identify unique barriers and facilitators to:**
   i) **knowledge** about COVID-19 risk, testing, and prevention,
   ii) **feasibility and acceptability** of COVID-19 vaccine trials, and
   iii) **uptake** of an approved vaccine across high-risk communities in California
   • Examine variation by geography and risk group (race/ethnicity, language, occupation, etc.)

2. **Co-develop, and examine the effectiveness of, culturally/linguistically tailored strategies**
   for reducing multilevel barriers to:
   i) knowledge, ii) trial participation, and iii) intent to receive vaccin

3. **Identify best practices for training and deploying academic community-partnered teams**
   that include “trusted messengers” who will bring culturally tailored, community-relevant
   information to communities and sectors at high-risk for COVID-19.
   • Examine their impact on i) knowledge, ii) trial participation, and iii) intent to receive vaccine
Sites and over 70 Community Partners

State Population: 39M
COVID Cases: 3.35M cases*
COVID Mortality: 42K deaths*
## STOP COVID-19 CA: Community Partners

### 71 Active Community Partners Across California

| University of California, Los Angeles CTSA | Los Angeles Community Consultant Panel for the COVID-19 Vaccine Clinical Trials; South Central Prevention Coalition; Recreation & Family Services, Watts Rising, Housing Authority of the City of LA; Bienestar Health Centers, Healthy San Gabriel Valley; Esperanza Community Housing Corporation; Healthy African American Families; Office of Samoan Affairs; AltaMed Institute for Health Equity, Filipino American Service Group, Inc., City of LA Department of Aging; Los Angeles Unified School District; Worksite Wellness LA, Watts Labor Community Action Coalition; and Los Angeles County Departments of Health Services and Public Health. |
| San Diego State University RCMI | Family Health Centers of San Diego, Clinicas de Salud del Pueblo, Inc., The San Diego County Promotores Coalition, Vision y Compromiso, County of San Diego Health and Human Services Agency |
| Stanford CTSA | SOMOS Mayfair, NextDoor Solutions, Catholic Charities of Santa Clara County, The Latino Cancer Institute |
| University of California, Davis CTSA | Central California Environmental Justice Network; Líderes Campesinas; California Rural Legal Assistance Foundation; Radio Bilingüe; West Modesto Community Collaborative; Centro Binacional para el Desarrollo Indígena Oaxaqueño; Building Healthy Communities-Fresno; RISE, Inc.; Health Education Council & Mexican Consulate in Sacramento; Madera Coalition for Community Justice & Central California Asthma Collaborative |
| University of California, Irvine CTSA | Orange County (OC) Healthcare Agency, MOMS OC, OC Asian, and Pacific Islander Community Alliance, Vietnamese American Cancer Foundation, Pacific Islander Health Partnership, Coalition of OC Community Health Centers, Institute for Healthcare Advancement, Children’s Hospital of OC, Memorial Care Hospital, Madison Park Neighborhood Association, Fountain Valley Hospital |
| University of California, Merced | Cultiva la Salud (United Way Merced County), Healthy House within a Match Coalition, California Health Collaborative, Rural HEAL, Golden Valley Health Centers, Mariposa and Madera County Health and Human Services Agencies, Merced County Public Health Department |
| University of California, Riverside RCMI | HARC (Health Assessment and Research for Communities), Borrego Health, HIV and Aging Research Project, Riverside/San Bernardino Indian Health Inc., Raíces Culturas, NAAACP Riverside |
| University of California, San Diego CTSA | The Global Action Research Center (ARC), San Ysidro Health, Family Health Centers of San Diego and San Ysidro Health, County of San Diego Health and Human Services Agency |
| University of California, San Francisco CTSA | Chicano/Latino/Indígena Health Equity Coalition; African American Community Health Equity Council; Asian and Pacific Islander Health Equity Coalition |
| University of Southern California (USC) CTSA | Vision y Compromiso, Altamed, Clinicas Monsenor Oscar Romero, Proyecto Pastoral, Weingart YMCA, Children’s Hospital Los Angeles, LA LGBT Center, Bienestar Human Services, APLA Health, The LGBTQ Center of Long Beach, APAIT |
| Key Health/Education System Partners | Veterans Administration Medical Centers across California; County Departments of Health Services and Public Health; Federally Qualified Health Centers or Community Clinics linked to all sites; Primary and Secondary Schools |
STOP COVID-19 CA: Site Projects

Information Needs | Trial Participation | Vaccine Hesitancy

**Trusted Education/Outreach**
- CHWs
- Community Organizations
- Local Media (Spanish radio, Ethnic newspapers)
- Health Fairs, town halls, listening sessions
- Visual Arts

**Qualitative Research**
- Focus groups in multiethnic communities
- Deliberative community engagement

**Capacity Building**
- Training (CHWs, Media)
- Education tailored for population

**Community surveys / needs assessments**
- Surveys
- CHIS (CA. Health Interview Survey)
- Educational assessment

**Clinical Trial Community Engagement**
- Studios
- Community advisory boards
- Recruitment / outreach

**Populations / Communities**
- Latinx – including monolingual Spanish
- Black/African American
- Pacific Islander
- American Indian / Indigenous
- Asian – Filipino, Chinese, South Asian
- Essential Workers, e.g., farmworkers
- Immigrant
- LGBTQ
- Low-income
STOP COVID-19 CA: Statewide Activities

• California Health Interview Survey (CHIS)
  • Conducted in English, Spanish, Cantonese, Mandarin, Korean, Tagalog and Vietnamese
  • COVID-19 Survey March to September 2020
  • CEAL Activities:
    • Dashboard with estimates for high-risk counties (e.g., Riverside, Merced)
    • Include new indicators related to discrimination in A/NH/PI populations

• Ethnic Media Outreach
  • Training and resources for varied ethnic media statewide to raise awareness about COVID-19 risk, attitudes/beliefs, clinical trials, and vaccines.

• Community/Academic co-development, tailoring, sharing of interventions
  • CEAL Activities: Develop, conduct, and evaluate the effectiveness of trainings in i) knowledge, ii) vaccine trial participation, and iii) uptake of an approved vaccine
Community Engagement

• Locally informed approaches, leveraging unique partnership networks and insights in each community while coordinating with the national network.

• Investing in trusted leader outreach, education, and messaging

• To date:
  • **119** COVID-19 related webinars, town halls and community meetings, reaching over **10,000** participants
  • In Los Angeles, CERP and STOP COVID-19 CA collaborated with three COVID-19 vaccine clinical trials, yielding minority participation rates of **69%-74%**, far higher than the national average.
  • Disseminated real-time results from active and ongoing vaccine hesitancy projects to community members; clinical and social agencies; local, regional and state policy makers; public health departments; and health plans.
Community Engagement

COVID-19 Vaccine Clinical Trials Open for Enrollment in Los Angeles: Understanding the Importance of Diversity

By Dr. Arleen F. Brown, Keith Norris, MD, PhD and D'Ann Morris, MFA
Published November 19, 2020

COVID-19 does not see color but America does. America puts fewer resources into communities of color. As a result, the COVID-19 pandemic is much worse for communities of color in Los Angeles and across the nation. Higher positivity rates, higher hospitalization rates, and higher death rates have hit local communities of color hard. Dr. Anthony Fauci recently said “Good Morning America”: “Help is really on the way.” Dr. Fauci was talking about earlier COVID-19 vaccines. This time around, vaccines will be free and we hope they will be produced in large enough numbers to inoculate millions of us. Now it’s up to all of us to get vaccinated as soon as possible.”
Community Friendly Materials:
Communicating the Science

Vaccine Effectiveness: Race/Ethnicity Data

Weighing the Risks:
Infection vs. Vaccination

Every million COVID-19 vaccinations

~2-3 serious reactions
~1-2 hospitalizations

~15,000 deaths
~70,000 hospitalizations

Timeline of mRNA technology and key figures in vaccine development

Modern and Pfizer vaccine each reported 16 serious allergic reactions out of 4 million doses (as of 1/25/21)
## Preliminary Themes in COVID-19 Vaccine Acceptability/Hesitancy

<table>
<thead>
<tr>
<th>Questions, Information, &amp; Concerns</th>
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<tr>
<td>Social Determinants of Health, Accessibility, Affordability</td>
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<tr>
<td>Population-Specific Considerations</td>
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<tr>
<td>Additional Requests/Hope in Vaccine Delivery</td>
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Community-friendly COVID19 vaccine information based on vaccine hesitancy focus groups

COVID-19 Vaccine Information: Answers to Important Questions!

January 2021

Pfizer & Moderna

Why should I get vaccinated?
- Vaccination protects you, your family, and your community from any asymptomatic COVID-19.
- Reduces the chance of hospitalization and death.
- Being unvaccinated may increase your risk of COVID-19 and serious long-term complications.

Is the vaccine safe for someone like me?
Over 70,000 people participated in Pfizer and Moderna trials and were equally safe for all:
- Adults, all ages (65+, over 85% effective).
- Race/ethnicities (Black, Latino, other communities of color, over 95% effective).
- Chronic conditions (about 90% effective).

Even if you had COVID-19 already, the vaccine is safe and can prolong your immunity.

How many people from racial and ethnic groups were part of the clinical trials?
Moderna and Pfizer clinical trials included a broad range of diverse participants: American Indian (0.8%, 0.6%), Asian (4.7%, 4.4%), Black (9.7%, 9.8%), Hispanic/Latino (20.5%, 26.2%), Multiracial (2.1%, 2.5%) and Pacific Islander (0.2%, 0.3%), respectively.

How does the vaccine work?
The vaccine teaches your body how to recognize and respond to COVID-19.

Side effects
- Mild fever, fatigue, headache, chills.
- Nausea, vomiting, diarrhea.
- Muscle aches.
- Itching, redness, or tenderness at the injection site.

Is there a risk of allergic reactions?
Yes, allergic reactions are common. If you have a history of severe allergic reactions, consult with your healthcare provider before vaccination.

What is the vaccine made of?
Four ingredients: Protein (mRNA), fats (called lipids), salt, and sugar (preservatives). No animal products (hormones, serum). No foreign parts used to make the vaccine. These vaccines do not contain any parts of the coronavirus and cannot cause COVID-19.

How was the vaccine tested? Was it rushed?
Quickly but carefully. There were multiple testing steps and production oversight to ensure safety. These vaccines were tested in clinical trials before being approved for emergency use.

Which vaccine is better? Do I have a choice?
- Both Pfizer and Moderna vaccines are about 95% effective.
- At this point, due to limited supply, you cannot choose.

Is the vaccine required?
Not currently, but you are strongly encouraged to get the vaccine. Postponing vaccination can increase your risk of COVID-19 and long-term complications.

Should you get the vaccine if you had COVID-19?
Yes. Protection from the vaccine is safe and can prolong your immunity. You can wait up to 90 days after infection for vaccination but can receive it as soon as local regulations allow.

Do I still need to wear a mask after getting the vaccine?
Yes. The vaccine protects YOU from getting sick due to COVID-19, but it is unclear whether you may still get mild or symptom-free cases that transmit COVID-19 to others. Continue to follow public health guidelines, such as wearing a mask, social distancing, and avoiding indoor crowds.

How do I find out where to get the vaccine? Is it free?
Visit your local county department of public health website or talk to your provider for information on eligibility and where to get the vaccine. The vaccine is free. In some cases, you may provide insurance or a facility fee.

Why are some communities, such as Black, Latino, American Indian, Pacific Islanders, or Asian Americans, being encouraged to get the vaccine?
Some communities may have been offered vaccines earlier than others because their infection, hospitalization, and death rates have been disproportionately high due to occupational risk as essential workers, insufficient medical access, etc.

Other questions or concerns?
Your questions are important and deserve to be answered by knowledgeable and trusted individuals. Contact your physician or local public health department for more questions.

Updated versions of this document will be published on stopcovid.19ca.org.

NIH CEAL Community Engagement Alliance

Stop COVID-19 CA
2021

Published by UCLA Health

For more information, visit www.stopcovid.19ca.org

The science is based on data shared by the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) in the United States, as well as by other health organizations across the world.

www.stopcovid19.ca
www.cdc.gov/vaccines.html
www.fda.gov/vaccines

Nature of the collaboration: This project is supported by the National Institute of Allergy and Infectious Diseases (NIAID) of the National Institutes of Health (NIH), under Award Number U01AI117075. The content is the responsibility of the investigators and does not necessarily reflect the views of the NIH or the U.S. Department of Health and Human Services.
Key Questions Going Forward

Nadine Burke Harris, MD, MPH,
California Surgeon General, Co-Chair

Erica Pan, MD, MPH,
State Epidemiologist, CDPH, Co-Chair
Closing Comments

• Next Meetings
  • February 17, 2021 from 3:00 – 6:00pm
  • March 3, 2021 and/or March 17, 2021 from 3:00 – 6:00pm

• Agenda for Next Meeting

• How to Make Public Comment: COVID19VaccineOutreach@cdph.ca.gov

• Adjourn