

California Health and Human Services Agency (CHHS)

California Department of Public Health (CDPH)

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #1 – November 25, 2020 – 10:00am – 1:00pm

MEETING SUMMARY

Committee Members Attending

Fred Buzo, AARP; **Jacob Snow**, American Civil Liberties Union Northern California (ACLU); **Alia Griffing**, American Federation of State, County and Municipal Employees (AFSCME); **Susan de Marois**, Alzheimer’s Association; **Andrew Nguyen**, Asian Americans Advancing Justice – Los Angeles; **Dr. Chang Rim Na**, Asian and Pacific Islander American Health Forum (APIAHF); **Dr. Ron Williams**, Association of California School Administrators (ACSA); **Michael Dark**, California Advocates for Nursing Home Reform (CANHR); **Lisa Mancini**, California Association of Area Agencies on Aging (C4A); **Carolyn Pumares**, California Area Indian Health Service; **Heather Harrison**, California Assisted Living Association (CALA); **Jeff Luther, MD**, California Academy of Family Physicians (CAFP); **Joe Diaz**, California Association of Health Facilities (CAHF); **Michael Wasserman, MD**, California Association of Long-Term Care Medicine (CALTCM); **David Lown, MD**, California Association of Public Hospitals and Health Systems (CAPH); **Vicky Reilly**, California Association of Rural Health Clinics (CARHC); **Chuck Helget**, California Association of Veteran Service Agencies; **Veronica Kelley**, California Behavioral Health Directors Association (CBHDA); **Preston Young**, California Chamber of Commerce; **Eric Sergienko, MD**, California Conference of Local Health Officers (CCLHO); **Virginia Hedrick**, California Consortium for Urban Indian Health, Inc. (CCUIH); **Carmella Coyle**, California Hospital Association (CHA); **Catherine Flores-Martin**, California Immunization Coalition; **Mitch Steiger**, California Labor Federation; **Amanda McAllister-Wallner**, California LGBTQ Health and Human Services Network; **Lance Hastings**, California Manufacturers & Technology Association (CMTA); **Hendry Ton**, California Medical Association (CMA); **Rocelyn de Leon-Minch**, California Nurses Association (CAN); **Kiran Savage-Sangwan**, California Pan-Ethnic Health Network (CPEHN); **Andie Martinez Patterson**, California Primary Care Association (CPCA); **Thomas J. Kim, MD**, California Rural Indian Health Board; **Jose R. Padilla**, California Rural Legal Assistance, Inc. (CRLA); **Pamela Kahn**, California School Nurses Organization (CSNO); **Carol Green**, California State Parent Teachers Association (CAPTA); **Lisa Constancio**, California Superintendent of Public Instruction; **Laura Kurre**, California Teachers Association (CTA); **Shannon Lahey**, Catholic Charities California; **Esther Bejarano**, Comite Civico del Valle; **Kim Saruwatari**, County Health Executives Association of California (CHEAC); **Andy Imparato**, Disability Rights California; **Silvia Yee**, Disability Rights Education and Defense Fund (DREDF); **Kristin Weivoda**, Emergency Medical Services Administrators of California (EMSAC); **Pastor J. Edgar Boyd**, First African Methodist Episcopal

Church; **Melissa Stafford-Jones**, First Five Association; **Anthony Wright**, Health Access; **Lisa Hershey**, Housing California; **Naindeep Singh**, Jakara Movement; **Denny Chan**, Justice in Aging; **Jeffrey Reynoso**, Latino Coalition for a Healthy California; **Brianna Lierman**, Local Health Plans of California (LHPC); **Genevieve Flores-Haro**, Mixteco Indigena Community Organizing Project (MICOP); **Tia Orr**, Service Employees International Union (SEIU) California State Council; **G Perdigones**, Service Employees International Union Local 1000 (SEIU 1000) (Unit 17-Nurses); **Aaron Carruthers**, State Council on Developmental Disabilities; **Brian Mimura**, The California Endowment; **Gabriella Barbosa**, The Children’s Partnership; **Diana Tellefson-Torres**, UFW Foundation; **Matthew Maldonado**, United Domestic Workers (UDW/AFSCME); **Maria Lemus**, Vision y Compromiso; **Crystal Crawford**, Western Center on Law and Poverty

Committee Members Absent

Charles Bacchi, California Association of Health Plans (CAHP); **Rhonda M. Smith**, California Black Health Network; **Christina N. Mills**, California Foundation for Independent Living Centers (CFILC); **Leza Coleman**, California Long-Term Care Ombudsman Association (CLTCOA); **Liugalua (Liu) Maffi**, Faith in the Valley

California State Representatives Attending

Mark Ghaly, MD, Secretary, Health and Human Services Agency; **Erica Pan, MD**, Acting State Health Officer, Co-Chair; **Nadine Burke Harris, MD**, California Surgeon General, Co-Chair

Public Attending

There were 147 members of the public attending by phone.

Consultant:

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Welcome, Purpose of the Committee, Roll Call of Organizations and Meeting Logistics

Erica Pan, MD, MPH, Acting Public Health Officer, CDPH, Co-Chair

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

Mark Ghaly, MD, Secretary, California Health and Human Services Agency

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

On behalf of the Governor as well as state and local leaders, Drs. Pan, Burke Harris and Ghaly welcomed committee members and thanked them for their time. Dr. Ghaly acknowledged the difficulty of this work given mistrust around vaccines in many California communities, and thanked members for helping communicate to the public about the benefits of the vaccine(s), once their efficacy and safety can be validated. Both Dr. Ghaly and Dr. Burke Harris reflected on health disparities and inequities well beyond COVID. Members were invited because they serve and represent diverse communities across the state.

Dr. Burke Harris presented the principles guiding these efforts and conversations: Safety, Equity and Transparency. She asked members to share their ideas and concerns, and to bring forward these principles when communicating with the communities they represent.

Bobbie Wunsch welcomed public participants on the public listen-only call. She noted that written public comments can be submitted to COVID19vaccineoutreach@cdph.ca.gov. These comments will be posted on the website, sent to committee members and discussed with the committee at subsequent meetings. The website address is:

<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID/Community-Vaccine-Advisory-Committee.aspx>

Role, Timeline and Expectations of Community Vaccine Advisory Committee, Relationship to Scientific Safety Review Workgroup/Drafting Guidelines Workgroup and Challenges Ahead

Erica Pan, MD, MPH, Acting State Health Officer, CDPH

Tricia Blocher, Deputy Director, Office of Emergency Preparedness, CDPH

Dr. Pan reviewed the agenda for the meeting. She referenced the urgency of the timeline and meetings given the current COVID surge. Dr. Pan emphasized the importance of public trust and acceptance in the vaccine and therefore the importance of this group. This committee includes a large and diverse group of organizations to provide different perspectives from across the state; these perspectives will be invaluable to this effort. Member organizations were chosen because of their connections to different populations and are encouraged to reach out to their constituents and bring their input back to the committee. It is especially important to engage populations of disproportionate risk including communities of color and those that reflect California's demographic and geographic diversity.

Dr. Pan introduced the related state workgroups:

- The *Vaccine Task Force* is comprised mainly of state agencies and departments. It is coordinating and addressing logistics and operational needs to receive and distribute the vaccine, and coordinating with local health departments and counties.
- The *Scientific Safety Review Workgroup* was the first to launch and is an independent group of expert physician scientists reviewing vaccine data to reassure Californians that vaccines are safe and effective. This group has met several times and has overlapping membership with the federal CDC Advisory Committee on Immunization Practices (ACIP), Food and Drug Administration (FDA) Vaccine and Related Biologics Products Advisory Committee (VRBPAC), and the Biden transition team for COVID. Without delaying the process for vaccine distribution, the state wants the Scientific Safety Review Workgroup to provide reassurance that vaccines are safe. This will be coordinated closely with the ACIP and VRBAC national approval meetings.

- The *Drafting Guidelines Workgroup* is considering national frameworks for vaccine allocation using the principles of safety, equity and transparency and will be translating these to California. They will bring specific proposals to this committee for input and discussion.

All speakers noted the importance of dialogue between the various workgroups. The Community Vaccine Advisory Committee (CVAC) will review information and learn from the two other statewide advisory groups and advise the state via the California Department of Public Health (CDPH).

Tricia Blocher welcomed and thanked the committee. She acknowledged that there are still many unknowns including which vaccine(s) will be approved by the FDA, their efficacy, when they will be available, how much California will receive, and other factors that dictate how we plan and distribute vaccines throughout the state. There are public concerns about vaccine safety and the speed of development and approval. This process will ensure that California puts its stamp of approval on the vaccines approved by the FDA. Ms. Blocher also reiterated that the state wants CVAC member feedback on issues like who gets the vaccine first from an equity perspective, how it will be distributed, and assistance crafting communications messages to all communities. We look forward to working with you on this and future vaccine allocations.

Dr. Burke Harris reviewed the role of the CVAC to inform the process and represent various communities by sharing ideas that the other groups may not have considered. To be successful in protecting California communities, this will be a bi-directional discussion that includes your input as trusted leaders and messengers in your communities. Dr. Burke Harris acknowledged that all groups have their passions and asked that members respect those of other members.

Dr. Pan shared that this committee will meet frequently, several times over the remaining weeks of 2020. Meetings in 2021 will likely be spaced further apart.

Member Comments and Questions

- If members can't join every meeting can we alternate representation?
 - CDPH: We will get back to you about the possibility for delegates or substitutes. Staff and community members can also listen in on the public line.
- Disability Rights California could help facilitate targeted outreach to specific disability populations such as a sign language Zoom meeting for the deaf community or separate meetings for the autism community.
 - CDPH: This is exactly the input we want from the CVAC. We have a team working on communications and want to reach hard-to-reach populations.
- What is the forum for reviewing the data behind the phasing and distribution chain and priority populations?
 - CDPH: You will see some of the data today that we are considering for initial allocations.

- Are there restrictions on what CVAC members can and cannot share?
 - CDPH: We may present some legal documents to the CVAC at future meetings. Please don't speak to the press without first coordinating with Suzanne Buggy at CDPH. This is a public process and slides are posted on the CDPH website.
- What is the role of the CVAC? How will difficult decisions be made if members of this committee disagree? What is the feedback loop?
 - CDPH: All the workgroups including CVAC are advisory and this is a public meeting. This process is intended to support equity, transparency and public engagement. We will be documenting your feedback; your recommendations are advising CDPH, CHHS and the Administration. Proposals will move between CVAC and the other workgroups. We will share recommendations with these groups and the public. We will engage transparently so everyone knows where there was disagreement and why decisions were made. We are trying to customize federal guidelines to California so local health departments can make decisions and we are trying to encourage consistency in our approaches.
- Are NASEM and federal guidelines the baseline for this process? Is CVAC expected to work from these guidelines or can we deviate?
 - CDPH: We plan to start from the NASEM framework and national recommendations. We would want a strong rationale for California to deviate from these guidelines.
- Does CVAC have the latitude to consider non-medical determinants of health as a factor in prioritizing groups for vaccination? Have other groups considered racism as a public health crisis?
 - CDPH: This information will be presented by the Drafting Guidelines Workgroup and other presentations today.
- Will a uniform process be established for community outreach?
 - CDPH: We are not scripting communications to your members or communities but we do request timely feedback from them and you.
- How much time will we have to translate these materials so they are accessible for our communities?
 - CDPH: We will need some feedback immediately, and between meetings, because we expect vaccine shipments within a few weeks.
- [This](#) article from Harvard Medical School on driving equity in health care includes lessons from COVID that are relevant for our vaccine distribution discussions
- Another [good read](#) authored by NIH Directors

Vaccine Planning Overview

Ron Chapman, MD, MPH, CDPH

Arthur Reingold, MD, Chair, Scientific Safety Review Workgroup

Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup

Robert Schechter, MD, MPH, Chief, Immunizations Branch, CDPH, Co-Chair, Drafting Guidelines Workgroup

Dr. Pan introduced the panel for this section and shared their credentials.

Dr. Chapman reported that CDPH has a long history of vaccinating large numbers of people in California on very short timelines. This includes working with clinics, hospitals, pharmacies and local health departments, and dealing with other pandemics such as H1N1.

Governor's Vaccine Task Force Overview: The Governor's Vaccine Task Force is composed of many state agencies and departments and meets weekly to get vaccine updates and provide input. The CVAC will report to the Governor's Vaccine Task Force.

Scientific Safety Review Workgroup: This is an 18-member workgroup of vaccine experts whose charge is to put the California seal of approval on vaccine safety. They have met twice and are on call to immediately review clinical data when it's available. The 12 members from California are joined by two member scientists from Nevada, Oregon and Washington through the Western States Partnership.

Drafting Guidelines Workgroup: This workgroup's role is to develop allocation guidance for local health departments to determine who will receive vaccine during this initial time period when supply is limited. It is a 16-member workgroup that meets weekly and is currently working on guidelines for the allocation of Phase 1a. Its next meeting is on November 27 and we're looking for your input and feedback for that meeting. We will let you know how your input informed their deliberations when the CVAC meets next on November 30.

Vaccine Task Force Infrastructure: A vast CDPH infrastructure supports this effort and includes communications, information management, logistics, administration, budgets and legal.

Scientific Safety Review Workgroup

Dr. Reingold updated CVAC on the Scientific Safety Review Workgroup and acknowledged the importance of CVAC members and local health departments. He shared a vision that most Californians will equitably receive safe and effective COVID vaccines; that severe COVID illness will be minimized; that transmission will be reduced; and that we can end the pandemic soon.

California annually gives tens of millions of vaccines to millions of people including infants, children, adults and older people. Vaccines are given in an array of clinical settings; local health departments are key in pandemics like this one. There is good evidence that vaccines work. They are one of the top contributors to public health in the 20th century and most people, including providers, have never seen many of the diseases that used to sicken many people just 40-50 years ago. This can lead to more fear of vaccines than diseases, because most of us don't know how serious these diseases can be.

In the US, no vaccine can be used until it is approved by the FDA. Like drugs, vaccines go through a rigorous evaluation process to receive licensure, or Emergency Use Authorization (EUA). We expect COVID vaccines to receive either licensure or EUA. The FDA also monitors efficacy and safety after vaccines are approved. Under Operation Warp Speed, the first phase of search and discovery, plus pre-clinical trials for COVID vaccines, occurred at a very accelerated pace. But clinical studies on humans consider safety carefully, and in Phases II and III effectiveness is reviewed. The COVID vaccine process is not shortcutting those important steps. Once the results of those studies are available, they need to be presented in great detail for review by the FDA and then reviewed by an independent external advisory committee called VRBPAC. After VRBPAC review, the FDA decides whether to issue a license or EUA. After that, the CDC Advisory Committee on Immunization Practices (ACIP) also reviews the information and makes a recommendation to the CDC Director with details about who should receive which vaccines under which circumstances and whether there are any contraindications. Then the FDA and CDC have joint responsibility to monitor the effectiveness of the vaccine in the real world by monitoring safety and other studies. Any time there is a concern regarding adverse events after immunization, they conduct thorough assessments to determine whether there is a cause-effect relationship.

Dr. Reingold shared the various COVID vaccine candidates worldwide. The messenger RNA (mRNA) from Pfizer and Moderna uses a novel approach. Many vaccines are under development and there will be clinical trials and likely licensure for a range of vaccines over the next 6-12 months. Of the many vaccines in Phase III trials, there are promising reports from three candidates: Pfizer, Moderna and Oxford AstraZeneca. Both Moderna and Pfizer vaccines are in Phase III clinical trials, each of which include tens of thousands of people, and show high efficacy around 95% in US trials. Both these vaccines require a 2-dose schedule. The Pfizer vaccine requires ultra-cold storage which poses a challenge for storage and distribution. The 2-dose schedule also requires careful tracking and follow-up to ensure proper dosage.

Neither the Pfizer nor Moderna vaccine has shown any serious safety concerns or adverse events, although both vaccines produce mild side effects like fatigue, similar to other vaccines. Concerns about more rare adverse outcomes cannot be studied easily in Phase III clinical trials and the FDA will be monitoring outcomes once widespread vaccination begins. There is good evidence that these vaccines prevent severe COVID disease and the trials will tell us whether they prevent milder disease. We probably won't know if they prevent COVID-related mortality or much about their effects on transmission of the virus. Children have not been included in the trials so we won't know anything about safety and efficacy in children, and we won't know about the duration of protection.

Pfizer has already submitted its data package to the FDA for review and approval; Moderna is expected to submit its package any day; and timing for Oxford AstraZeneca is unclear. Typically, after the manufacturers submit trial data to the FDA, the FDA reviews it for 2-3 weeks and then schedules a VRBPAC meeting to develop a recommendation to the FDA. In this case, ACIP has

committed to meeting within 24 hours of FDA review. The process of states like California having their own review process is unusual. Dr. Reingold shared that California has many leading experts on vaccines participating both in national and state workgroups. Our expert group has committed to meet immediately following action by ACIP and FDA. If the ACIP approves the vaccine, the federal government will be shipping vaccines to states immediately.

Dr. Chapman reported on the unique challenges related to the Pfizer vaccine. The two doses are to be given 21 days apart. It must be stored at ultra-low temperatures (-93 degrees F), which has never been managed before. The vaccine will be shipped directly from Pfizer and will arrive in December if approved. It will be shipped in special “pizza boxes” with a minimum number of 975 doses per shipment. All doses must be used before they expire (difficult for small sites). They can be stored in a refrigerator for up to 5 days but then cannot be used or re-frozen. Shippers come filled with dry ice and require special Personal Protective Equipment (PPE) like eye protection, special gloves and a metal scoop.

To overcome these challenges, CDPH is working closely with clinics, hospitals and health departments to ensure freezers are available across the state. It has ordered 16 storage freezers and is developing a contract with dry ice makers. The initial shipment will come with one dry ice re-supply from the federal government. The state is assessing provider ability to manage the storage issues and is encouraging partnerships, especially in rural counties.

The Moderna vaccine may be 2-3 weeks behind Pfizer in the approval process. It is also a 2-dose vaccine and has more normal storage requirements. Orders will be shipped with a minimum of 100 doses.

Drafting Guidelines Workgroup Update

Dr. Brooks shared a sample allocation spreadsheet that local health departments will complete to request their allocation of vaccine doses across local providers. We want to ensure equity by defining the target groups within healthcare workers and essential workers based on risk factors and other characteristics. Dr. Brooks reviewed the vaccine allocation equity principles established by the Drafting Guidelines Workgroup in its first three meetings. The foundational principles are benefiting people and limiting harm while prioritizing equity. The two procedural principles are transparency and evidence-based decisions.

Dr. Brooks then shared the NASEM framework, the goal of which is to reduce severe morbidity and mortality and negative societal impact due to the transmission of COVID. NASEM’s allocation methodology is based on the following four criteria: (1) risk of acquiring infection; (2) risk of severe sickness or death; (3) negative societal impact from that person being sick for a prolonged time; and (4) the risk of spreading disease. Since we don’t have much data on whether the vaccines prevent transmission, we are focusing on the first three criteria.

NASEM is recommending the following groups for Phase 1a:

- High-risk healthcare workers who will have a negative impact if they are unable to work
- Healthcare workers with a high risk of exposure to COVID
- Health care workers with a high risk of severe disease
- First responders (see below)

NASEM is recommending the following groups for Phase 1b:

- People of all ages who have underlying conditions
- Older adults living in congregate or other crowded settings

NASEM defines healthcare workers as “health professionals who are involved in **direct patient care**, as well as those working in transport, environmental services, or other health care facility services—**who risk exposure to bodily fluids or aerosols.**”

The ACIP defines first responders for Phase 1a as: (1) healthcare workers such as EMTs and paramedics; and (2) other essential workers including law enforcement and fire who are not EMTs or paramedics. We can choose to follow this framework or not.

Member Comments and Questions

Comments and Questions on Specific Populations:

- What about populations we don’t have information about – e.g., children and pregnant women? How and where will these populations be addressed, and will that be raised with this committee? Many essential workers are pregnant women.
 - CDPH: There is no current recommendation or plan to give the vaccine to children, especially young children. It is likely that ACIP will recommend that pregnant women consult with their providers to weigh the balance of risk and benefit. Although there are no known risks, we are always reluctant to vaccinate pregnant women unless we know the benefits outweigh the risks. There is no known contraindication for women who are lactating/breastfeeding.
- What is the race/ethnic diversity of the clinical trial populations?
 - CDPH: 30-40% of those in clinical trials in the US are Latinx or African American. We aren’t aware of any differences in safety or efficacy by race/ethnicity for this or any other vaccine.
- The NASEM framework recommends that household members of Phase 1a healthcare workers be vaccinated. Should we consider and discuss this?
- Skilled Nursing Facilities (SNF) and residential treatment also include non-elders- like those with a serious mental illness and those in treatment for a substance use disorder.
- Our efforts in memory care settings will be limited by the nature of dementia and cognitive impairment. The focus must be on vaccines, PPE, testing and infection control.

- Patients in psychiatric hospitals and inpatient facilities with mental health problems often have physical disabilities and co-morbid conditions. They may not be able to adhere to social distancing, mask, and hand washing guidelines.
- Californians with a serious mental illness (SMI) and substance use disorder (SUD) are often disengaged from their home culture/ethnic group, overlooked and discriminated against. These groups are often treated primarily in County Behavioral Health, which would be a good place to vaccinate.
- We should include people with developmental and other disabilities living in congregate settings as part of Phase 1a since they are three times more likely to die from COVID.
- There are many vulnerable populations hidden by the data as presented - e.g., case fatality rates in Californian Asians are significantly higher than national Asian rates; Pacific Islanders have much higher COVID risks than Asian/Pacific Islanders as a whole; and indigenous migrants from Central America are grouped with the Latinx population.
- Intersectional risks are important to consider in the roll out of the vaccine plan such as race and age, e.g. older Latinx adults.
- Farm workers should be prioritized in the first phase because they have a very high risk of exposure and tend to live/work in isolated regions with few healthcare facilities.
- Will vaccine recipients need to reside in the US? This would exclude migrant farmworkers in border communities, among others.
- Will Medi-Cal cover health care for undocumented immigrants (and others) who may have adverse reactions to the vaccination?
- Has California chosen not to include children, even if they have two or more co-morbidities, as part of Phase 1b?
- Will vaccination be recommended for people who are HIV-positive? Were people with HIV included in the trials?
- California is home to the highest population of American Indians and Alaska Natives, most of who live in urban areas. Historical injustice should be considered as part of the equity considerations in this process. There is also a political relationship between tribes and the State of California to be considered in the vaccine distribution.
- Given the lack of data on efficacy in older adults, and the fact that older adults in congregate settings are being currently prioritized in Phase 1b, how will the state balance the interests of risk vs. safety?
 - CDPH: We will need to carefully observe how they perform with respect to effectiveness and safety. We anticipate having some data from the trials about 65 year olds and older, including variation within this age group.
- Will assisted living facilities for Alzheimer's patients be considered congregate living or is this only skilled nursing facilities?
 - CDPH: These settings are being considered similar to SNFs as very high risk.
- One member encouraged the state to think about intersectionality across the various factors and focus on older adults of color.

- CDPH: The CDC ACIP recommendations includes intersectionality across risks. Local facilities and health departments will use their own granular data to implement the guidelines.
- CDPH: NASEM included workers in senior settings in Phase 1a to reduce the risk they bring to seniors as they come and go from those settings.
- Older adults have been isolated for 9 months; essential caregivers for this population need to be vaccinated before they die of heartbreak and loneliness.
- Other at-risk populations not mentioned yet today include those who are incarcerated, homeless or unsheltered, living in domestic violence shelters, and other congregate living facilities beyond skilled nursing facilities (SNFs).
 - CDPH: Correctional facilities are considered congregate living and therefore very high priority. Staffing in correctional facilities, healthcare and otherwise, are being carefully considered given very high COVID rates.
- Have we considered inmates and healthcare in our prison systems, factoring in overcrowding and health beliefs about vaccination that may affect participation rate? Black women and men and people of color are overrepresented in the prison system with pre-existing medical conditions and most of the essential workers like nurses and custodians, among others, are people of color in the prison system with comorbidities.
- Those in the underground economy are not likely to have healthcare through their jobs and continue to work – e.g., the undocumented, sex workers. We need to think about how we will reach these groups.
 - CDPH: These other populations are currently considered outside Phase 1a for healthcare workers but will be evaluated in Phase 1b. We are starting with creating a fair process as we move to that phase. There are national definitions of critical workers but the pandemic has highlighted many other workers that are vulnerable and have been overlooked and underemphasized.
- Even within rural areas, there are more isolated and hidden communities and populations. We will need to consider mobile access for these; rural health centers will be critical. Within the farmworkers community, one quarter of workers are indigenous and speak indigenous languages like Mixteca, not Spanish. This means working with CBOs and understanding the importance of trust.
 - CDPH: There is representation from Mixteca Indigenous Community Organizing Project (MICOP) on the CVAC.
- How will veteran housing and the caregiver staff fit into the prioritization chart? For example, our project includes 20 residents, 80% of whom are 60 years of age and older, many with health, mental health and substance abuse issues.
- The Alzheimer's Association is interested in assurance that SNFs and RCFEs are both considered health care/congregate settings for purposes of both residents and staff. SNFs will need support to administer vaccines on site instead of sending residents to a hospital or clinic and risking community exposure.

- Food and Agriculture are in Phase 1b, Essential Workforce. Because this is a Latinx, low-income, immigrant workforce, it is an equity issue as well as a health issue. What special consideration is being given to this community, if any?

Comments and Questions on the Vaccine:

- Why did the Pfizer vaccine efficacy rate increase from 90 to 95% within a few days?
 - CDPH: The difference reflected several dozen new cases as disease incidence rose quickly among the placebo group because of the COVID surge.
- How can we message the difference between these vaccines preventing disease severity vs. disease transmission, and how this impacts behavioral interventions such as mask usage? There appears to be no information on this topic - i.e., the Pfizer trials did not test for virus in patients unless they were symptomatic.
 - CDPH: This is correct regarding the clinical trials although it may be possible with serologic studies to see whether vaccines prevented infection. It is clear that the transmission of the virus will continue for months after we begin vaccination, so we need to message that mask usage will continue to be very important. Some of the vaccine candidates still undergoing trial are looking at asymptomatic infection and the amount of virus shed, but this seems unlikely to be addressed with the Pfizer and Moderna information going to the FDA.
- The vaccines are being reported to be 95% effective against symptomatic disease, not necessarily effective against infection and/or transmission. This will be important to consider in public messaging.
 - CDPH: The federal government has a way to systematically collect information on vaccine adverse events - the Vaccine Adverse Events Reporting System <https://vaers.hhs.gov/>
- There are multiple types of vaccines: does this complicate our strategy?
 - CDPH: Yes, the Pfizer vaccine requires ultra-low temperature storage and comes in 975 dose units that need to be handled with care. We may have different options with future vaccines. The state will be considering this in supporting local health departments.
- Will it be OK for there to be variations in who receives which vaccines?
 - CDPH: If you get an initial dose of one vaccine, you'll need to get a second dose of the same one, but it won't matter if co-workers or family members received different vaccines.
- Has there been any evidence that shows the efficacy and safety of the vaccine for those that have been exposed to COVID before? Should healthcare and essential workers who have been exposed to COVID get the vaccine?

Comments and Questions on Committee Role, Process and Other Workgroups:

- ACIP meetings are open to the public (on-line). Their past meetings are archived and available; future ones are announced as soon as they are scheduled.

- Should this committee be considering transmission or only vaccine-related questions?
 - CDPH: Vaccines may help stop spread but we won't know that early on. We won't necessarily know to what degree the vaccines are helping essential sectors continue to operate (e.g., healthcare, agriculture) vs. keeping people from getting sick vs. preventing spread. Preventing severe disease will be the priority but preventing transmission is an important secondary one.
- What discretion do counties and local health departments have to differ from state guidance/recommendations?
 - CDPH: The state does not have enforcement powers, but local health departments have representation in the workgroups and continue to meet between meetings. There is every reason to think they will follow them.

Comments and Questions on Vaccine Logistics:

- It would be useful for workers and their unions to have access to these allocation forms and to have the opportunity for input since employers might not always have clarity regarding employees' risk of exposure.
 - CDPH: We will discuss these questions at our next meetings. This is exactly where we want CVAC input.
- Please discuss the distribution plan through the Pharmacy Partnership for LTC (Long-Term Care) Program and its relationship to the state distribution plan.
- Should we be considering the logistics of getting vaccines to different settings or this happening in other groups?
 - CDPH: The goal of this group is to recommend prioritization and allow the state to manage the logistics.
- The distinction between logistics and prioritization is helpful but also overlapping. For example, some nursing home residents will lack the ability to give consent or have access to public education about the benefits of vaccines.
 - CDPH: This committee can help by thinking about ways to reach the audiences they know.

Comments and Questions on Messages, Outreach, and Distribution:

- Will there be funding to allow community organizations to explain to the communities about the vaccine and combat vaccine hesitancy/misinformation?
- Would it be possible for CDPH to develop guidance for medical facilities receiving the vaccine to distribute the vaccine at trusted non-clinical sites: schools, places of worship, supermarkets, sports stadiums, etc.?
- Historical racism is a significant barrier. If we don't improve upon the history it will have implications on the trustworthiness of our public health efforts by BIPOC communities.
- Non-traditional vaccine campaigns would be very useful in reaching groups such as immigrants working in the marijuana black market during later phases of distribution

- My main concern is misinformation about the vaccines, the delivery process and knowing who will be trusted and effective messengers in all of our communities.
- We need to infuse the wisdom, leadership and expert voices of community residents in this process.
- Is the State reaching out to tech companies to try to combat misinformation about vaccines over social media platforms?
- Communications strategies with Latinx indigenous communities can build off the foundation of the Listos California campaign:
<https://www.listoscalifornia.org/community-projects/farmworkers-initiative/>
- The promotora model has proven to reach inaccessible communities in urban and rural communities.
- Can we build on the communications efforts started with the census to reach diverse communities in California?
- Community-based contact tracer programs are examples of the role trusted messengers can play in providing information, outreach and education to the most vulnerable communities. Initiatives like this can play a critical role in vaccine outreach and education to indigenous communities, African-American, Southeast Asian, Punjabi, LatinX, and more.
- Food distribution sites statewide can provide outreach and education, and also act as vaccine sites.
- Plain language explanations of exactly how the vaccines work in the body will be key.
- It will be important to convey that these vaccines have not been proven to reduce transmission or infection, and to be mindful that our prioritization does not undermine this message. If we vaccinate residents or workers in congregate care settings we may be going outside our framework and risk undermining mask usage, etc.

Introduction of Data Related to Phase 1a and Review of Phase 1a Recommendations by Drafting Guidelines Workgroup and Questions by Members

Robert Schechter, MD, MPH, Chief, Immunizations Branch, CDPH, Co-Chair, Drafting Guidelines Workgroup

Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup

Ron Chapman, MD, MPH, CDPH

Dr. Brooks presented data and recommendations from the Drafting Guidelines Workgroup. He underscored that this process is necessary because the quantity of vaccine will be very limited initially and we want to ensure it is fairly distributed. Phase 1a will target high risk health workers and medical first responders. Dr. Brooks reviewed the definition of the priority healthcare workforce that are targeted for initial vaccine allocation: *Health professionals who are involved in **direct patient care**, as well as those working in transport, environmental services, or other health care facility services—**who risk exposure to bodily fluids or aerosols.***”

To address the limited allocation, the workgroup is proposing three categories of criteria for how the vaccine is sub-prioritized within the Phase 1a priority: Type of Facility, Location of Facility, and Attributes of Individual Healthcare Workers. There is a tiered approach being considered in Phase 1a, with the first tier to include hospitals, congregate care settings and EMS personnel; the second tier to include primary care clinics, home health, community health workers and public health staff; and the third tier to include all other facilities.

Type of Facility: There are 2.4 million healthcare workers in California: 43% of these work in acute care hospitals, 8% in DSS residential settings for the elderly, 7% in skilled nursing facilities, 5% psychiatric hospitals and 39% in other settings. Some settings such as hospitals have more workers whereas others are smaller but face high risks.

Location of Facility: California has a Healthy Places Index (HPI) to help determine where to geographically prioritize the vaccine. The HPI offers a Community Vulnerability Index with 25 variables across 8 themes such as environment, housing, education and health care access. It is being used in the *Blueprint for A Safer Economy* and the COVID health equity playbook. Dr. Brooks shared an example of using the HPI at the city level, demonstrating how various communities in Sacramento are more vulnerable or stable. This might be especially important in future phases of allocation beyond healthcare workers.

Individual Characteristics of Healthcare Workforce: The workgroup is considering characteristics of the workforce, including occupation, age, sex, race/ethnicity, and co-morbid conditions. The workgroup is also mindful that some of this information will not be available to the vaccinators. Occupation and age are most readily available, whereas co-morbid conditions may not be. Dr. Brooks shared the distribution of healthcare workers by license type. Available data does not include many essential healthcare workers at high risk; however it is useful to review the overall numbers. For example, 19% of healthcare workers are nurses and 12% are physicians. Only 7% are EMTs or paramedics, so this is a smaller sub-population to prioritize.

Dr. Brooks reviewed the data on co-morbidities and the links to adverse health outcomes from COVID. Unfortunately, we may not have this information for healthcare workers when making allocation decisions. He also reported data on COVID by race/ethnicity illustrating the disparate impact of the disease. For example, American Indians and Alaska Natives are 2.8 times more likely to contract COVID than non-Hispanic Whites, 5.3 times more likely to be hospitalized, and 1.4 times more likely to die. Risks are also higher for African-Americans, Latinx and Asian Americans, some of which reflects their status as essential workers, living in impacted housing and/or co-morbid conditions. On age, he reported that currently there is no recommendation for the vaccine for children. After adulthood, the risk progression is linear and then becomes exponential. Those of advanced age are at much higher risk for hospitalization and death. The workgroup is considering how the age of various healthcare workers will impact their risk.

Next Steps: The CVAC will meet again on Monday November 30. The Drafting Guidelines Workgroup will be meeting the next several Fridays. Dr. Brooks invited members to ask

questions and offer input about how we can determine allocations to make this a fair process for California. He noted that their input will go to the Drafting Guidelines Workgroup on November 27 and feedback from that will be shared at the next CVAC meeting November 30.

Member Comments and Questions

- Some healthcare facilities have already started receiving kits for facility patients and residents from pharmacies under a separate allocation process. It would be helpful to have the HPI data in local areas ASAP as these processes begin.
- Many visitors to congregate settings have been giving care because of understaffing (e.g., eating, bathing); can they be considered healthcare workers in Phase 1a in some circumstances?
- We want to be sure that especially with the vaccine storage issues staff at Skilled Nursing Facilities and other residential facilities for the elderly are considered essential healthcare workers.
 - CDPH: We are looking at workers in long-term care facilities and SNFs as high risk. We will address the complex logistics in ensuring the various vaccines reach the targeted workforce.
- Would In-Home Supportive Services workers be included in Phase 1a?
 - CDPH: Yes, the Drafting Guidelines Workgroup considers them a healthcare workforce.
- Many IHSS staff work in more than one setting, the home and licensed facilities.
- Regional center in-home care providers are essential workers and in similar working conditions as IHSS workers
- How will various essential workers be prioritized beyond health care and first responders? For example, essential infrastructure workers include waste industry collection and recycling workers that insure garbage collection, processing and disposal protects public health and safety. How will you prioritize within that fairly large group of workers that offer different levels of service, exposure and benefit to society?
- Key groups to consider are child welfare workers and home visitors. Also important is ensuring we reach the full range of child care workers; family-based care and family, friend and neighbor child care providers, center-based child care and preschools.
- Will school nurses be considered as nurses in Health Care Workers? We are in close and sometimes prolonged contact with ill staff and students. Please consider the aides in the school setting who work with our most vulnerable, medically fragile students.
- Where do school nurses and teachers fit in? I'm thinking about the importance of having students in school.
- Would an attribute of a health care worker include family/household structure: those with multigenerational living conditions, or in contact with elderly in their families, etc.?
- Social workers on the frontline providing safety net services should have high priority.

- Community Health Workers have been providing education and prevention in underserved communities, delivering masks and other services out in the community in high risk populations, boots on the ground coalitions members and promotoras de salud
- Behavioral health workers are healthcare workers- including alcohol & drug counselors who are not licensed but certified - are not listed, although they are the providers of addiction treatment and peers with lived experience, so by definition have SUD or SMI.
- I appreciate and support the need for equity in the distribution of the vaccine. For the allocation to healthcare workers in the hospital, it is critical that we target and outreach to healthcare workers who are unlicensed and have similar risk as doctors or nurses.

Closing Comments and Adjourn

Next Meetings

Bobbie Wunsch, Pacific Health Consulting Group

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

Dr. Burke Harris thanked members for sharing their questions and comments and reiterated the commitment to review emails and chat. All input will be communicated to the Drafting Guidelines Workgroup and then members will hear back as to how that input was incorporated.

The next meeting on November 30 will include a review of public comments from the CDPH website, a review of Phase 1a recommendations from the Drafting Guidelines Workgroup, and introduce the topic of Phase 1b essential workers for discussion over several meetings.

We recognize there is an incredibly huge amount of work to do in a very short period of time. Today we heard from you about considerations, planning, outreach and communications for vulnerable populations based on various characteristics, and we are grateful for that input. We will meet weekly through December, every other week in January and then monthly.

Members should receive invites for the following Zoom meetings:

- November 30, 2020 from 3:00 – 6:00pm
- December 9, 2020 from 3:00 – 6:00pm
- December 16, 2020 from 3:00 – 6:00pm
- December 21, 2020 from 3:00 – 6:00pm

How to Make Public Comment

Please send public comments to: COVID19vaccineoutreach@cdph.ca.gov. All public comments will be posted on the website and discussed at the beginning of the November 30 meeting. The call-in number for the public will be posted on the morning of November 30.

Have a safe, quiet and happy Thanksgiving!