

California Health and Human Services Agency (CHHS)

California Department of Public Health (CDPH)

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #2 – November 30, 2020 – 3:00pm – 6:00pm

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); **Charles Bacchi**, California Association of Health Plans (CAHP); **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); **Liugalua (Liu) Maffi**, Faith in the Valley; **Christina N. Mills**, California Foundation for Independent Living Centers (CFILC); **Catherine Flores-Martin**, California Immunization Coalition; **Mitch Steiger**, California Labor Federation; **Amanda McAllister-Wallner**, California LGBTQ Health and Human Services Network; **Leza Coleman**, California Long-Term Care Ombudsman Association (CLTCOA); **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); **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 Perdignes**, 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

Vivian Reyes, American College of Emergency Physicians; **Rhonda M. Smith**, California Black Health Network; **Carmella Coyle**, California Hospital Association (CHA); **Pastor J. Edgar Boyd**, First African Methodist Episcopal Church

California State Representatives Attending

Erica Pan, MD, MPH, Interim State Health Officer; **Nadine Burke Harris, MD, MPH**, California Surgeon General

Public Attending

There were 296 members of the public attending by phone.

Committee Co-Chairs

Dr. Erica Pan, Acting State Health Officer

Dr. Nadine Burke Harris, MPH, California Surgeon General

Consultant

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Welcome, Purpose of Today's Meeting, Co-Chairs' Opening Comments and Meeting Logistics

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

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

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Dr. Pan thanked the committee for its time and willingness to participate. She shared some updates from the Governor's press conference today: There has been a very concerning increase in COVID over the past month. We have 10-15,000 cases per day, hospitals are filling up and there are concerns about ICU capacity and staffing in some regions. Over 99% of the state's population is now in the highest/purple tier. Without more intervention, healthcare capacity could become overwhelmed. The state has been modeling scenarios and ICUs could become overwhelmed as soon as December. State leaders are therefore considering interventions to prevent this outcome, including a modified stay-at-home order similar to

March, which could last several weeks. One way to help communities cope is for them to know vaccine(s) are coming soon. CVAC members can help communicate this message.

The goals for today are to give some clear feedback to the Drafting Guidelines Workgroup, given these healthcare workforce concerns and the additional considerations for nursing home residents. The main topic will be starting to discuss Phase 1b – Essential Workers Beyond Healthcare Workers. This will be CVAC’s opportunity to give input on this topic to the Drafting Guidelines Workgroup.

Dr. Burke Harris responded to a question regarding children – whether the vaccine has been tested in children, whether it would be available for children, and where children sit in our priorities. Because the vaccine has not been tested in children, the FDA approval is likely not to include approval for use in children.

The latest information about capacity limitations helps highlight the importance of prioritizing healthcare workers in Phase 1a. Today, CVAC must complete its feedback on Phase 1a and start the conversation about Phase 1b – Essential Workers.

Bobbie Wunsch thanked the group for attending. She shared the following process notes:

- To help mimic an in-person meeting, please keep your camera on and mute on. Please use your hand raise icon if you want to make comments or ask questions.
- Committee Co-Chairs decided they prefer consistent continuity of attendance by members and not delegates, substitutes or proxies. They know this is challenging to accomplish. If you want to change to a different organizational representative who can attend all meetings, please let Bobbie know. Additionally, others from your organizations are always welcome to attend via the public dial-in and streaming of the meeting. Summaries of all meetings will be shared.
- All materials for the public are posted on the CDPH website. The public is in a listen-only mode. Public comments can be submitted at: COVID19VaccineOutreach@cdph.ca.gov.
- Public comments will be discussed at the beginning of the meeting. The committee has reviewed all public comments as of this morning. Public comments are posted on the CDPH website in their entirety. Co-Chairs are working to include public input – e.g., through breakout groups. There will be closed captioning starting at the next meeting.
- Meeting materials will be sent in advance when possible, but the pace is very rapid. Please reserve time on the day of each meeting to review the materials.
- If you have technical issues with your Zoom, please note in chat and Aaron can help you.

Review Public Comments from November 25, 2020 Meeting #1

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Bobbie Wunsch shared information about the public comments received through this morning (Monday, November 30). Members of the CVAC received all 12 comments verbatim that were received by last night (November 29). Three more came in before noon today and more this afternoon before the meeting. All comments, with name and organization, will be distributed to members and posted on the CDPH website. Many comments submitted parallel those by members at the last meeting and many of these will be discussed today.

A summary of the comments:

- 3 requested to be added as members of the workgroup
- 3 commented on the safety of the vaccines
- 1 offered additional data for the Drafting Guidelines Committee to review
- 1 requested that data on Pacific Islanders and Native Hawaiians be included when racial/ethnic breakdowns are offered by CDPH staff
- 1 raised a question about the usefulness of the Vulnerability Index
- 6 raised questions about the inclusion of different populations in the allocation process: people enrolled and staff who serve people enrolled in PACE programs; people with intellectual and developmental disabilities and the organizations serving them; children with special needs; the role of community health centers in vaccine distribution

Continued Discussion/Guidance on Phase 1a DRAFT Guidelines including Feedback from November 27, 2020 Drafting Guidelines Workgroup

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

Robert Schechter, MD, MPH, Chief, Immunizations Branch, CDPH

Dr. Brooks offered context to complete the discussion of Phase 1a. California expects a shipment of 327,000 vaccine doses in the next few weeks. The first and second shipments will be directed toward Phase 1a healthcare workers. Following this, it is expected California will receive one shipment per month, so there will be many future rounds of people vaccinated beyond these targeted groups. Today CVAC needs to complete its discussion of Phase 1a in order to send committee thoughts and recommendations to the Governor's office and the Vaccine Task Force.

Dr. Brooks reminded CVAC members that they represent the diversity of California. Since the Drafting Guidelines Workgroup has not begun discussing Phase 1b, CVAC will have the opportunity to begin this dialogue first.

The World Health Organization definition of equity "implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential." This differs from equality, which implies everyone gets the same thing.

Dr. Schechter provided additional information on Phase 1a. Assuming the vaccines have evidence to show they're safe and effective, California will receive 327,000 first doses in December, with increasing amounts throughout the winter and spring. Ultimately California will have enough vaccine to meet the demand for anyone wanting to be vaccinated, although there is not yet an exact timeline for that end goal. The doses we are considering today are the first 2-3 shipments in December-January, slated as Phase 1a. Vaccine doses will be distributed to local health departments (LHDs) which will determine how to distribute them to healthcare providers in their jurisdictions. A sample allocation spreadsheet was shared to illustrate how LHDs would allocate doses across health care facilities.

The Drafting Guidelines Workgroup reviewed recommendations from the National Academy of Science, Engineering and Medicine (NASEM) and the federal Advisory Committee on Immunization Practices (ACIP). The World Health Organization and academic medical centers have also given their input on how to allocate vaccines for fairness and equity. The principles these groups converge upon are: benefiting people and limiting harm; equity as a core issue; equal concern for all people; transparency, and evidence base. NASEM's goal is to reduce severe disease caused by COVID and also reduce the negative societal impact. Their criteria for allocation include: societal impact, severe disease, spread of disease, and risk of acquiring infection. Equity is a priority in workgroup deliberations and permeates not just allocation but the entire campaign including access, communication, outreach and counseling.

The Workgroup recommendations can be broken into four categories:

Populations for Phase 1a

Draft guidelines mirror national recommendations: the first priority is persons at risk of exposure to COVID through their work in any role in direct health care or long-term care settings. This includes non-clinical workers such as interpreters, transportation and environmental services.

As the ACIP will discuss on December 1, the Workgroup also plans to recommend including residents of Skilled Nursing Facilities, assisted living facilities and other long-term care settings. We are including these residents because they constitute less than 1% of state residents but more than one third of the deaths. There are about 400,000 residents in these settings.

There are about 2.4 million healthcare workers, less those at no risk of direct exposure, so roughly 2 million workers with risk of direct exposure. Healthcare workers are prioritized for many reasons including alignment with recommendations from other national groups (such as ACIP and NASEM), sustaining health services during surges, and their disproportionate exposure risks.

Sub-prioritization

The next set of recommendations are for how the state should sub-prioritize initial doses given that the 327,000 doses will not be enough for the 2.4 million people in these groups. Sub-priorities are by type of facility, location of facility and individual attributes of workers. The workgroup is recommending that the state and LHDs utilize the ranked prioritization construct below to match the doses to priority populations. Assuming vaccines are limited during Phase 1a, doses should be directed to as many tiers and categories as possible to reach the prioritized populations. Those who will be immunizing in each tier should also be immunized.

1. Type of Facility

Tier 1	Tier 2	Tier 3
<ul style="list-style-type: none"> • Acute care, psychiatric and correctional facility hospitals • Skilled nursing facilities, assisted living facilities, and similar settings for older or medically vulnerable individuals <ul style="list-style-type: none"> ○ Include residents in these settings if recommended for Phase 1a by ACIP • Paramedics, EMTs and others providing emergency medical services • Dialysis centers 	<ul style="list-style-type: none"> • Intermediate care, for persons who need non-continuous nursing supervision and supportive care. • Home health care and in-home supportive services • Community health workers, including promotoras • Public health field staff • Primary care clinics including Federally Qualified Health Centers, Rural Health Centers, correctional facility clinics, and urgent care clinics 	<ul style="list-style-type: none"> • Other settings and health care workers, including: <ul style="list-style-type: none"> ○ Specialty clinics ○ Laboratory workers ○ Dental / oral health clinics ○ Pharmacy staff not working in settings at higher tiers

2. Location of Facility

If there are not enough doses to reach all workers in a category (e.g., acute care hospitals), vaccine should be directed to facilities serving the greatest proportion of vulnerable people in their catchment areas using the California Healthy Places Index or other comparable knowledge.

3. Attributes of Individual Healthcare Workers

After these first two levels of sub-prioritization, if vaccine doses are still scarce, health departments or healthcare facilities may prioritize using information about individual workers within the population. Since these attributes are often not known, local facilities should consider offering doses of vaccine to workers using the following risk factors in sequence:

- [Occupational risk of exposure to SARS-CoV-2](#)
- Descending age:

- 65 years and older
- 55-64 years
- Younger than 55 years
- Other attributes supported by evidence, including but not limited to underlying medical conditions, race and ethnicity

The workgroup also wants to ensure that facilities support higher risk workers in these categories by providing extensive information and counseling about the vaccine.

Additional Factors Concerns

If additional factors are needed to prioritize limited doses in local sub-prioritization, the Workgroup suggests LHDs should use: (1) additional evolving information about the COVID-19 vaccine; and (2) ensuring there is minimal waste of limited doses.

1. Evolving information about COVID vaccine

There may be new information about storage and handling requirements, vaccine safety and efficacy in specific populations, and national recommendations and indications for use. The Workgroup's draft guideline states that LHDs may adjust prioritization to reflect or comply with vaccine characteristics. Prompt measures should be taken to revert to the original prioritization criteria and immunize persons delayed by the restrictions as soon as possible.

For example, if the initial supplies of COVID vaccine are limited in quantity and require long-term storage at ultra-low temperatures that limit the ability to redistribute the doses, these supplies may be directed preferentially to settings with appropriate storage capacity (such as hospitals or health departments). Once additional supplies are available, efforts should be made to reach the populations that were missed with these dose shipments.

2. Avoiding unused doses

Another principle is to maximize the number of doses used without compromising the guideline principles. To avoid wastage or disuse, and given that it is uncertain to what extent the population will accept the vaccine, health departments may allocate doses on the assumption that immunization will be accepted by some, but not all, who are offered vaccine, and then adjust later allocations based on the number of doses that are accepted. This will be especially difficult initially since we don't know the acceptance rate.

Facilities and health departments should make intensive and appropriate efforts to reach the groups prioritized at that moment, but also may offer vaccines promptly to persons in lower priority groups when, either demand subsides or is saturated in the current priority groups, or doses are about to expire according to labeling instructions. Health departments may also temporarily adjust prioritization based on other resource constraints while continuing efforts to immunize higher priority groups as soon as feasible.

Closing Concerns Distinct from Prioritization

Dr. Schechter requests the committee's guidance to ensure the campaign proceeds with an equity lens and that as many people are reached and offered vaccine with full information and support as possible. He also mentioned that there are concerns related to vaccine hesitancy, the importance of voluntary receipt, and other operational concerns such as receiving all doses needed for full protection.

Response to CVAC Member Comments from Last Meeting 11/25/20

Dr. Brooks shared another definition of health equity from the U.S. Office of Minority Health:

The attainment of the highest level of health for all people, achieving health equity requires valuing everyone equally with focused and ongoing social efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Dr. Schechter spoke to comments from last week regarding how to communicate what we know and don't know about the vaccine based on current evidence. There will likely be evidence about how the vaccine protects against severe COVID disease and hospitalization. There will not be much known about the effect of the vaccine on transmission, but this will be coming over time. Communications will seek to convey this.

There were many comments and questions about which healthcare workers were included in Phase 1a. The definition is very broad and includes those in non-clinical roles in the home and community, inpatient and outpatient settings. The focus of the exposure is on work-based exposures, not personal ones.

There were many concerns about essential workers not in health care, which will be the theme of the Phase 1b discussion, and will include those in the formal and informal sectors. Questions were also raised about correctional facilities, homeless shelters and other congregate settings. Careful consideration for these vulnerable settings will be given in the next phases.

Member Comments and Questions

Tiers and Phasing

- We don't have enough workforce for critical services during this surge and will likely need to flex. This supports vaccinating as many of our healthcare workers as possible. During the spring lockdown, many non-essential healthcare services like dentistry were curtailed, so should we consider postponing vaccines for some of those in Tier 3 of Phase 1a, allowing us to focus on other essential workers, residents or other vulnerable populations?
 - Even if elective procedures are postponed again, those nurses and other staff that were supporting elective procedures may be deployed to ICUs during the surge.

- Will Tier 1 psychiatric facilities include not only acute psychiatric hospitals but also intermediate and long-term care for those with serious mental illness or substance use disorder? Many healthcare workers and patients there have high rates of co-morbidities.
- Will Tier 2 include outpatient mental health and addiction clinics?
- How did dialysis centers get included in Tier 1?
- Some community health centers are doing mass testing and therefore have greater risks. Could these sites be included in Tier 1?
- What about healthcare workers that have co-morbidities or households with vulnerable members?
 - CDPH: Those individual characteristics are important and can be considered in phasing but aren't currently factored into the prioritization plan in part because of the challenges in trying to gather and screen this information.
- Has there been consideration of which healthcare workers are particularly short-handed during this surge (e.g., respiratory care therapists) as a factor for sub-prioritization?
 - Who will be doing the assessment on healthcare workers' exposure when determining prioritization?
- Will the vaccine be mandatory for healthcare workers in the top tiers?
 - CDPH: At this time it is not expected that vaccines will be mandatory.
- The demographics and risk of patients served by the facility should also be a consideration.
- How do the healthcare worker tiers relate to provision of vaccines to residents of congregate care settings? Do all three tiers of healthcare providers rank higher than residents in congregate care? Do long-term care residents rank higher than Tier 3 healthcare workers?
- Do we have data comparing the categories per tier and infection rate?
- In sub-prioritization within Phase 1a, why did the workgroup prioritize type of facility as the first sub-priority category over the other two measures that center equity - i.e., using an equity index to prioritize location of facility and looking at specific attributes of individuals that make them more vulnerable under category #3? Ranking categories #2 and #3 higher in the sub-prioritization process would better prioritize equity.
- Does sub-prioritization category #2 (location of facility) include an analysis of COVID cases and deaths within counties/census tracts? This would help determine which areas are vulnerable, especially if the data used by the Healthy Places Index is not current.
- I would move community health workers and promotoras up in priority. They are on the frontlines educating and supporting our most vulnerable communities, and they can assist with the demystification and encourage vaccination.
- If type of facility is used as a sub-prioritization factor within Phase 1a, how are home- and community-based healthcare workers not disadvantaged? Utilizing logistical considerations like vaccine storage would also seem to de-prioritize these groups.
- Will the question of people working in a healthcare facility be based on their presence in the facility, or their employment by the facility? I appreciate the inclusion of non-clinical

staff, but does it include the administrator who is working from home? The secretary coming in once a week? The security guard who is contracted by another employer?

- Will we stay in Phase 1a until we are able to vaccinate this population or will we continue to move on before they are given enough?
- California is a national model on data collection and reporting. To date, do we know among the healthcare worker fatalities in what settings they worked?
- If there are insufficient doses in Phase 1a, and the Healthy Places Index is utilized, will there be procedures put in place to ensure there is not a disproportionate allocation of vaccinations based on the index?
- What does Phase 1a mean for home health care workers and specific groups of people with disabilities, both those in congregate living situations and those outside of them who need home and community-based services?

Volume of First Vaccine Shipments

- Have we modeled out how many of the workers in Tier 1 we could reach with the first 327,000 doses?
 - CDPH: It would go a long way toward those first hospital settings (Tier 1).
- Does the 327,000 doses mean that will be enough to serve 163,500 people since the vaccine requires two doses?
 - CDPH: There will be a second release of vaccine about 3 weeks after for the first dose, so we can vaccinate 327,000 unique individuals in the first phase.
- Are we expecting to get 3 million doses by the end of December?
 - CDPH: Based on current information from the federal government we would be able to complete the rest of Tiers 1-3 (completing Phase 1a) by early January.

Implementation and Logistics

- A lot of the first doses will go to those working or living in long-term care settings. When will we talk about how we will get these vaccines on the ground, especially when we get to future phases and need to engage pharmacies? How would a given SNF be notified, how would the vaccine get to them, and which staff would be vaccinated?
 - CDPH: We will come back to these questions in future meetings.
- Do the numbers for Phase 1a include contracted retail pharmacies and are pharmacy supplies determined by each county public health department?
- Vaccine hesitancy amongst nursing home staff (and residents) is critical. How the vaccine is distributed and implemented also matters. We can't expect CNAs or nursing home residents to go to a central location to get vaccinated. We have to account for side effects and the potential for staff to need time off the day after they're vaccinated. We should engage long-term care pharmacies and consulting pharmacists, which are adept in working with nursing homes. Long-term care ombudsmen will be very important in educating staff, residents and families. Nursing home medical directors will also be engaged in this process.

- The success of Phase 1a will trigger the success of the next tiers. Can someone describe how these guidelines will be used at the local level? How will these decisions be made locally, who will make them, and how will eligibility be verified?
 - CDPH: We would like your endorsement of our Phase 1a recommendations, both whether the vaccines should go to healthcare workers and nursing home residents, and whether the prioritization and sub-prioritization are correct. The “how” we will come back to very soon.
- Is a negative COVID test a prerequisite to getting a vaccine?
 - CDPH: It is likely that testing will not be a requirement for receiving a vaccine, although more discussion is pending with ACIP on a national level.
- Is it correct that local health departments will be responsible for distributing and monitoring? How will counties manage the factors, tiers and categories in Phase 1a? Walking through an example would help us understand what this would like.
 - CDPH: Local health departments will have a certain number of doses with each shipment, arriving periodically. They will then take their dose number and the guidelines and, for example, if they had enough doses for most but not all hospitals they would start at the hospital level and take into account the vulnerability index – e.g., directing to a county or other safety net facility before another hospital. They would then proceed to use other characteristics as needed depending on the scarcity of the vaccine.
- Good guidance and oversight for local health authorities is really important since the process will be fast-moving. What is the accountability structure for this complicated role?
- More guidance from Sacramento may help address variations across counties, especially during implementation.
- Who will be making the final decision whether an organization or a facility will be eligible for the vaccine in Tier 1? Unless there are clearly defined eligibility, there will be inconsistent application of the priorities.
- What if healthcare workers have a reaction to the vaccine? Is there a timing issue to not have too much of a workforce of a particular facility out at the same time?
 - CDPH: This and other similar issues will be discussed by the ACIP and there is likely to be national guidance to stagger workers as feasible.

Inclusion of Other Healthcare Workers

- Are home healthcare workers through IHSS and Regional Center in Tier 2 of Phase 1a?
 - CDPH: Yes, these workers are included in Tier 2. Keep in mind that there is no data to show that the vaccine prevents transmission, so decisions are being made based on criticality to societal functioning plus long-term residents because of their disproportionate mortality burden. We therefore can't yet direct vaccine to help prevent further transmissions.

- Have we considered including high-risk unlicensed workers (e.g. home care workers and their families), Medical Assistants (MAs), Licensed Vocational Nurses (LVNs) and Certified Nurse Assistants (CNAs)?
- Are school nurses or school-related health aides considered at-risk healthcare workers?
- Confirming that Phase 1a healthcare workers include all staff in Assisted Living Communities (RCFEs).
- Are community-based home healthcare workers, personal care attendants and other direct support workers considered healthcare workers?
- Are you counting licensing surveyor staff and long-term care ombudsmen that are entering into Residential Care Facilities as facility staff?
- How do community based-organizations fit into the tiers – e.g., CBOs like veteran service organizations that provide housing in congregate settings and supportive services in close contact with at-risk vulnerable populations?
- Are mental health clinicians, counselors/therapists, community based/cultural-based healing practitioners included in Phase 1a?
- Are Certified Nursing Assistants (CNAs) included under registered nurses?
- If equity is our overarching priority, then Phase 1a needs to include the fullness of who we all consider as frontline healthcare workers and we have to figure out how to fairly prioritize healthcare workers. Trying to create boundaries around who is in 1a in a vacuum that doesn't consider the impact of logistics and vaccine hesitancy means that there will be arbitrary limits placed on who is considered in the first place. I'm not sure we agree on who is a "frontline healthcare worker."

Residents in Congregate Care Settings

- What are all the types of congregate settings we're considering – e.g., PACE programs, Medicaid home and community-based services? What does "similar settings" mean?
 - CDPH: We haven't divided up all the congregate settings yet. There may be more specificity in the final recommendation.
- Will ACIP's meeting tomorrow have an impact on our Phase 1a recommendations? If the ACIP decides not to include nursing facility residents, could California make a different decision?
 - CDPH: If the ACIP does not include nursing home residents, we would carefully consider whether they fit in Phase 1a or Phase 1b. We prefer to align with national recommendations wherever possible but would consider alternatives if justified.
- Why might we exclude long-term care residents from Phase 1a?
 - CDPH: After robust discussion, the workgroup included these residents in Phase 1a.
- How will residents with Alzheimer's consent to take the vaccine?
 - CDPH: Informed consent for this population has been discussed and is admittedly very challenging.
- Clients of In-Home Support Services are similar to those in nursing homes. Maybe we should consider them as well.

Outreach and Messaging

- How are "intensive and appropriate efforts" to reach priority groups defined?
- To help address vaccine hesitancy, it is important to have vaccines prioritized for providers who care predominantly for vulnerable communities, both to build upon trust between the providers and community and also to protect providers who will have an essential role for education and outreach.
- Some organizations are working with CDPH to develop educational materials for staff and residents of long-term care facilities, consent forms, etc.
- Promotoras and other cultural health liaisons are important. They can improve the acceptance of the vaccine among immigrant and indigenous communities, especially given the narrow windows given the time and logistical constraints of storing the vaccine. They are overwhelmingly Latina immigrants who have been disproportionately impacted by COVID.
- Vaccinating healthcare workers first will help address vaccine concerns in later phases and may help interrupt an anti-vaccination narrative.

Involving Workers and Labor

- I would encourage us to include a clear collective bargaining process for healthcare employers that are organized.
- We encourage workers to be involved in the way the vaccine gets distributed.

CDPH then took a poll: Do you agree with the Phase 1 prioritization of healthcare workers and residents of long-term care facilities?

- 100% of members voted yes
- Several raised reservations that are largely shared by others. CDPH will continue trying to address and incorporate these concerns, and there will be more opportunities to discuss them soon.

Introduction and Initial Discussion of Phase 1b Framework regarding Essential Workers

Robert Schechter, MD, MPH, Chief, Immunizations Branch, CDPH

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

Ron Chapman, MD, MPH, CDPH

Dr. Burke Harris reflected on our definition of equity. The definition Dr. Brooks shared from the Office of Minority Health was in the NASEM report about equitable vaccine distribution. In addition, staff uncovered another definition from a 2020 NASEM report called *Leading Health Indicators 2030: Advancing Health Equity and Well-Being*. This definition includes a reflection of historical and contemporary injustices and the elimination of health and health care disparities. She thanked the committee for its feedback and encouraging this further exploration.

With Phase 1b - Essential Workers, there is much less to build on. The committee has the opportunity to share community input before the workgroup meets. CVAC voices and the people they represent will be shared with the workgroup as they move into their deliberations. Dr. Chapman shared background on “essential critical infrastructure workforce” as a starting point. There will be additional discussion following the Drafting Guidelines Workgroup meeting.

In March 2020 the federal government and State of California constructed a list of critical infrastructure sectors other than healthcare. This list includes sectors such as communications, critical manufacturing, emergency services, energy, financial services, food and agriculture, government facilities, information technology, transportation systems, waste and wastewater systems.

Including the 1.2 million workers in educational services, the total estimate of non-healthcare critical infrastructure workers in California is 7.4 million. This includes 896,000 in manufacturing, 869,000 in construction, 680,000 in transportation and warehousing, 739,000 in retail trade, 338,000 in agriculture and 153,000 in first responders (police, California Highway Patrol, fire and ambulance), among others. Agriculture workers are concentrated in Central Valley and Central Coast counties with the largest populations in Kern (50,000), Fresno (36,000), Monterey (35,000), Tulare (32,000), Ventura (23,000), and Santa Barbara (17,000).

The UC Berkeley Labor Center found that frontline essential jobs in California are predominantly low wage positions (2/3 of the state median wage - i.e., \$14.68 an hour or less). Members received a link to this publication. The Labor Center defines essential workers as those employed in an industry described as essential critical infrastructure in California’s shelter-in-place order and are employed in a frontline occupation. The positions with the highest percentage of low wage jobs include farmworkers (80% are low-wage), janitors and building cleaners (77%) and cashiers (73%), followed by several others.

Dr. Chapman shared information about the race/ethnicity for the top 15 frontline jobs. For example: 93% of farmworkers are Latinx; 78% of construction workers are Latinx; and 41% of registered nurses are White. He shared the nativity of frontline workers: 81% of farmworkers and 55% of food preparation workers are immigrants, whereas only 23% of secretaries are immigrants. The age distribution of these workers varies widely. Some of the occupations with older workforces are food preparation workers, secretaries, truck drivers and registered nurses.

The Drafting Guidelines Workgroup will be considering NASEM’s national recommendations on December 4, 2020. NASEM put “critical workers in high-risk settings” in Phase 2 (excluding those that can telecommute). For NASEM, Phase 1b is for people of all ages with co-morbid conditions that put them at significantly higher risk. NASEM includes educational workers in their list of critical workers. ACIP is considering essential workers as Phase 1b, ahead of adults

with high-risk medical conditions. This marks a difference between NASEM and ACIP which we need to consider. Given there will not be enough vaccine initially to vaccinate 7.4 million people, potential factors to consider in sub-prioritizing within Phase 1b:

- Societal impact (e.g., functioning, equity concerns)
- Severity of disease
- Potential for transmission

Member Comments and Questions

Farmworkers

- The estimate of agricultural workers seems like an undercount; the policy brief Bobbie shared with CVAC estimates closer to 800,000 if you include fields, packing houses and dairy. A majority of farmworkers are undocumented which leads to employers underreporting them and a large underground economy which adds to their vulnerability.
 - CDPH: There are more essential workers than there are vaccines. Please help us start to think about ways to sub-prioritize within these groups.
- Because farmworkers live in isolated rural regions, I'm concerned about the low number of healthcare workers in rural regions especially given surges in those regions. Can we include rural health care clinics in Tier 1 if there is a critical limitation on healthcare workers in these regions? A mobile strategy may be best to vaccinate these workers, especially those that work 6 and 7 days per week.
- Older farmworkers are especially vulnerable and there are very few protections for them by contractors or anyone else. Rural clinics are critical for education and outreach and need to be part of any campaign to reach these workers. There is also a lot of mistrust, especially among indigenous populations, so ideally community-based organizations would be funded to conduct this outreach.
 - CDPH: Some concepts for prioritizing workers in this category that have been raised so far are: essentiality (importance to society) and vulnerability. We need to come up with some kind of equation to rank all these groups.
- Border communities like Imperial County include farmworkers crossing the border daily and mixing with local residents. This is still busy harvest season. There is a lot of congregating and very little protection due to lack of masks, hand sanitizer or other resources. These groups also have a lot of co-morbidities due to environmental exposures.
- Farmworkers are essential to the farmer and our food. Many promotoras, Community Health Workers and Community-Based Organizations are trusted in these communities. We should go to the community experts.

Teachers, childcare workers and others working with children

- Are child care workers considered part of the educational workforce?
 - CDPH: The Labor Center report includes child day care services as essential, defined as those who provide child care to those in other essential jobs. The Drafting Guidelines Workgroup will consider this.

- Many comments were shared about child care workers and the interconnection to other frontline essential workers being able to do their jobs. Can we reflect this in our criteria? Many are family-based neighborhood care, low-wage women of color, especially those that care for children outside of traditional office hours. Many counties who received CARES Act funding expanded child care services specifically for essential workers.
- Many members also raised the importance of education and the social impact of educators as really important. It was mentioned that NASEM final report's included K-12 teachers and school workers in Phase 1b, a change from their earlier draft. Without vaccinating students, and given the amount of time students and teachers are together in groups each day, and given vulnerable children in those settings, we really need to vaccinate school staff. Also, schools provide more than just education; they're hubs for food, counseling and other essential services. One way to think about overlap is to consider schools in vulnerable and hard hit communities which have large numbers of parents who are essential workers and students living with family members who have co-morbidities and high risk for severe disease. Without schools and child care open, children are spending their days in inappropriate and unsafe conditions. In addition to teachers we should also prioritize teacher aids, school nurses, and other workers in educational settings who are currently serving small groups of "high-need" students in person – e.g., special education, English learner students, foster youth and students experiencing homelessness. One member encouraged the group to consider educators in early childhood and higher education as well.
- Another distinct prioritization within 1b would be special education teachers and para-educators. Students with disabilities are among those groups who have been given priority for in-person instruction, and their teachers are therefore required to teach in person. These students are sometimes less able to follow social distance guidelines, and due to qualified workforce shortages, many of these teachers are older as well.

Other Phase 1b Workforce Priorities and Categories

- No one has been asked to do more during his pandemic than food workers in all settings who have been consistently exposed. We owe them some protection. Public safety and education are also needed for the state to function, so the areas I would prioritize are: health care, food, safety and education.
- Within the state's 96,000 public employees are custodians, those working in the field for Department of Fish and Wildlife, Department of Motor Vehicles, Veteran's Affairs and other public-facing services. They are low-paid workers at high risk of exposure, no ability to telework and often from vulnerable communities. Can we lump all the criteria such as medical conditions, women, BIPOC, etc. to help advance social justice?
- There is variable risk for acquiring infection and more severe disease within many workforces, not just healthcare. Can we consider this same stratification within Phase 1b? What's the maximum reach to the communities most in need?

- We need to be mindful of Child Protective Services (CPS) and Adult Protective Service (APS) workers who are still going into the field and facing risks that have increased during the pandemic.
- Would APS and CPS workers be considered essential workers if teleworking is an option? Who makes that decision?
- We need to prioritize what is having an economic impact. Having ombudsmen in long-term care facilities can help detect staff that are not wearing masks or getting enough Personal Protective Equipment. Deaths in these facilities cause cases to surge and counties to shut down businesses, which causes people to become resentful and angry. Ombudsmen are volunteers, with no worker's compensation coverage.
- Do long-term care surveyors/evaluators and ombudsman count as essential workers? Anyone who is essential to the operations of nursing homes – e.g., surveyors who enter the facilities and ombudsmen who are desperately needed to advocate for isolated residents, are all integral to nursing home operations.
- We may want to define and reconcile who is a COVID essential worker per California vs. federal government directives to minimize confusion.
- Does food include folks working in grocery stores and/or restaurants?
- Is "low wage" only based on the hourly rate and not total income?
- Different state agencies beyond CDPH have slightly different definitions of "essential workers." The Department of Managed Health care uses this definition for the purpose of COVID testing coverage:
<https://www.dmhc.ca.gov/Portals/0/Docs/DO/CovidFactSheetFinal.pdf>
- Does phase 1b include social services, county and city essential employees?
- Transportation workers such as long haul commercial drivers who keep communities supplied often have multiple health conditions, in part because living on the road for long periods does not lead to healthy diet or lifestyle.
- For Phases 1a and 1b the initial priority should be given to workers who encounter multiple people in their day, work in crowded/congregate settings or serve high-risk individuals.
- First responders should be Tier 1 of Phase 1b because of their critical role in keeping the state safe -- using the same logic used to create Phase 1a. The next prioritization could be by age (older workers first), then by race (Native American, Latinx, Black, Asian/Pacific Islander, White per the CDC data shared last meeting), then by location. This could be instead of prioritizing by job category.
- From a public health standpoint, it is more important to vaccinate mobile populations that cannot access testing and therefore it is more difficult to identify if they have a positive test. If we are able to contain and cluster illness because a given population can be easily tested, cases identified and isolated, contacts reached and quarantined, then those groups can be vaccinated at a later time.
- I suggest that we review the more detailed sectors on the state's COVID- 19 webpage that provide more detail on "Essential Critical Infrastructure Workers" from the Governor's Executive Order N-33-20.

- CDPH: <https://files.covid19.ca.gov/pdf/EssentialCriticalInfrastructureWorkers.pdf>
- I'd like to add a criteria regarding interconnectedness - how the work of some essential workers supports and allows the work of other essential workers and health care workers.
 - CDPH: Yes, this is important although possibly harder to assess.

Equity Considerations

- As one way to prioritize in this phase, we should think about workers that can't work from home and are interacting with the public and vulnerable populations. Racial justice is an important lens. These workers include janitors and classified school employees who have been delivering food to families. Let's be as inclusive as possible.
- Logistics are more difficult here because many essential workers don't have traditional employers through whom to channel the vaccine.
- 60% of our healthcare workforce is White. 5% of the healthcare workforce is Latinx as compared to 36% of the California population. By prioritizing this workforce we inadvertently skewed the racial equity allocation. It's important to look back at these "rational" decisions through a racial equity lens. Also, Phases 1a and 1b are interconnected. We've been saying there's a disproportionate effect for Black and Latinx populations so how do we counter the fact that we're starting by disproportionately vaccinating White and Asian American Californians? How can we be accountable to building the trust we talk about?
 - CDPH: We are prioritizing healthcare workers to prevent excess mortality by preserving our healthcare infrastructure to protect vulnerable populations. When we don't have medical capacity, Black and Brown people are more likely to die. So prioritizing healthcare workers helps move us toward our equity goal.
- A majority of long-term care, IHSS and childcare workers are women of color.
- Another criterion to consider for some industries is 'political capture.' In poultry/meat factories, communities have been devastated not just by infection and death but also community trust breakdown as meat and poultry workers were compelled to work in dense, dangerous and infectious situations with impunity protections from political players.
- We know that not everyone will accept the vaccine and that vaccine acceptance has plummeted among African-Americans with growing awareness of racial injustice. So beyond who qualifies for the vaccine, we have to strategize about how we will earn the trust to accept these vaccines. Otherwise we risk perpetuating deep structural inequities, even if our intentions are good.
- We should focus on low-wage workers, as they tend to live in higher density family units which makes isolation more difficult and puts more people at risk. Their jobs often have little sick leave and they typically work in multiple environments. Lower wage workers will be disproportionately people of color so that does help the equity focus.
- Low-wage essential workers who are undocumented may not have regular access to health care so they might not know their underlying health conditions or co-morbidities.

- How can we ensure that private home care workers that work for cash and are often undocumented are included in the list of long-term care workers to receive vaccine?
- I fail to see a focus on communities most at risk.
- Many BIPOC communities have the lived experience, trust and relationships for transformational encounters.
- How do we account for Black and Brown people being more likely to die in healthcare facilities when there isn't a health pandemic? COVID is not exceptional.
 - CDPH: COVID-19 has exposed inequities in our society. Both racism and ageism have been gravely exposed.
- Social isolation is also killing vulnerable older adults, ombudsmen protect them.
- This focus is downstream as opposed to vaccinating our BIPOC communities earning the lowest wages and living in the lowest resourced communities. If we think truly through a population-based perspective, we have the opportunity to center BIPOC communities and shift the focus and the outcome. This has the potential for the greatest societal benefits.
- There could be a third dimension in the definition of equity: essentiality, vulnerability, and addressing long term, historic and contemporary conditions that are producing inequities.
- Our decision making needs to explicitly prioritize communities of color and LGBTQ communities that are disproportionately impacted by COVID-19.
- As we think about prioritizing who receives the vaccine first through a racial equity lens, we have the opportunity to center BIPOC in the decision making process. Our agricultural workers are predominantly Latinx. They are also tripled and quadrupled up in their living quarters.
- Many of the healthcare workers defined may not be the most urgent. We need goodwill that communities most affected are a priority. CBOs need to be part of the determination.
- How will we account for the fact that some high-profile hospitals and health centers serve less at-risk populations and may draw away from our goals of equitable distribution?

Data Considerations

- Are there concerns about saturating the essential worker population with vaccine given that side effects can be quite difficult?
- Will local health departments and providers be required to submit demographic data on who is receiving the vaccine to CDPH? And, will this data be released so we can track progress on equity and other considerations? I hope that data about who is receiving the vaccine and their demographic categories will be public and available to advocates.
- What is the data regarding COVID-19 risk for each category of essential workers? Farmworkers with health risks and co-morbidity should be a high priority. Many farmworkers live in labor camps or housing provided by employers where living spaces are shared. The close proximity of living and working conditions is ripe for spread.
- Some additional sources of relevant data were suggested: (1) Worker's compensation claims data can be used as a proxy for occupational exposure to COVID-19; (2) CalOSHA inspection and complaint data is not exhaustive but illuminates some areas – e.g., there are

a lot of complaints from retail that employers aren't controlling; (3) occupational information collected by CDPH and local health officers – when COVID cases are reported some info on occupation is collected.

- Have you modeled the populations in each priority constituency? How far into the tiers will we get with initial delivery?
 - CDPH: Yes, we will share data for each tier.
- How much vaccine is anticipated for California overall?
 - CDPH: Doses will come at an increasing pace into the spring and summer but we don't know the actual number of doses. It will probably be in the low millions of doses early in 2021 and much larger numbers by the summer.

Implementation Considerations and Logistics

- In bridging Phases 1a and 1b, we need to think about county implementation because it will impact who gets vaccinated. There are structural factors – e.g., how will we determine that someone has co-morbidities without access to their medical records? How will we know if someone is or isn't able to work from home? Our counties and healthcare systems believe some people more than others, which means we can't prioritize in a vacuum. People with disabilities are de-prioritized for treatment in hospitals because of medical rationing and crisis standards of care even if they have co-morbidities, which is not reflected in our framework.
- Practical considerations will have a big impact. For example, if we think it's important to prioritize essential workers with certain co-morbid conditions who cannot get an accommodation to work from home (e.g., some teachers), what is the burden on the individual to "prove" that they fall into this category? And will that burden discourage some from seeking vaccination even if they are eligible?
- Our organization is addressing public charge by leading a protecting immigrant families group and have established best practices for how to educate these groups. The California Primary Care Association has helped come up with communication strategies for how trusted partners can help bridge that chilling effect.
- Who will track, categorize and monitor various worker classifications? This will be a challenge for whoever is administering the vaccine and would be messy for providers and health plans to sort through.
- Some other issues include H2A workers, transfer of virus across borders and responsibility of farmers.
- Cross border workers provide in-home services, nursing and long-term care to many in southern counties; we should ensure their status doesn't impact their access to the vaccine.
- The evolving question about whether the vaccine helps reduce transmission has an impact on 1b prioritization. If we are focused mostly preventing hospitalizations and deaths, then the highest priority is based on age and co-morbidities. If the vaccine does impact transmission, then the question of public interaction and frontline workers becomes much more important.

- The Medi-Cal plans have questions and concerns about workflow and distribution for residents of long-term care.
- Allocation is only a small first step. Implementation matters far more and if we screw that up, the allocation won't matter.
- Several concerns related to pharmacies and their relationships with long-term care:
 - How does the direct vaccine distribution through Walgreens and CVS impact our work, given that it relates to procuring, storing, and administering the vaccine to residents of long-term care facilities?
 - We are concerned about CVS and Walgreen's ability to understand workflow in long-term care facilities. There could be an opportunity more effectively engage long-term care pharmacies and/or nursing facility consultant pharmacists.
- If we continue to require COVID testing of SNF/ALF residents and staff after they are vaccinated, then we will have a natural way of collecting data on whether vaccines prevent transmission or infection. Continued testing will also convey the need for continued social/behavioral interventions post vaccine.
- Were people with disabilities/underlying health conditions a part of the trials?
- Have we considered looking into acceptability rates of the approved vaccines, or cultural health beliefs and perceived social stigma on accepting COVID vaccines? We could present evidence-based messages on vaccines but our communities may still refuse them.
- If an Emergency Use Authorization is issued for a vaccine, is it likely to be cleared for all adults irrespective of their other health conditions?
- Is there any benefit from clustering those who get vaccines to build a herd immunity-like impact, or is it better to spread out the distribution?

General Population

- Do you have an age definition for children?
 - CDPH: Up to age 18.
- Does the same information apply to pregnant women?
 - CDPH: We will reach out to the scientific review committee and get you an answer.
- NASEM's Phase 1b also includes "People of all ages with co-morbid and underlying conditions that put them at significantly higher risk" but I didn't see that group listed in the 1b slides which are focused on essential workers. Since these conditions disproportionately impact BIPOC communities, I think it's important to include this group in the discussion about populations to include in 1b.
- Dialysis patients are another vulnerable population to consider.
- Given the lack of impact information available on the trials related to people with underlying health conditions/people with disabilities it is difficult to suggest how these populations should be prioritized.

Outreach and Messaging

- Members offered to help promote these important messages, educating and coordinating among migrant workers to get their first and second doses even if they move.
- We need to provide local health departments with language to offer vaccines in the most acceptable ways.
- Most nursing home residents don't even know their doctors. Who is going to be educating them about vaccines?
- Many of the patients we serve are also illiterate even in their own language which has been a barrier to education.
- Given the information re: nativity and immigration status, the state should consider how it will message education and outreach regarding the vaccine. Specifically the public charge rule and distrust of government will cause fear that interactions with government could lead to adverse immigration consequences.
- Are we building trust and leveraging relationships with promotoras and other cultural brokers imbedded in the communities we want to reach? They have lived experience and may build trust in more relational ways.
- Vaccinating White healthcare workers may actually help address vaccine hesitancy if Californians believe it indicates they trust the safety and efficacy.

Coordination Across Committees

- Can you share with us how the remaining decisions that may involve the other various task forces around the “how” are decided and how they’ll be communicated with this group?

We will send out the chat and also send you what is being shared with the Drafting Guidelines Workgroup before the next meeting. Several members of the workgroup are listening in today. They will come to our next meeting with their first thoughts about how to organize the prioritization of essential workers. This feedback loop will continue for a few meetings.

Closing Comments

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

Dr. Burke Harris thanked everyone for a great discussion and a challenging task. The goal is to ensure California lives out this commitment and give access to the vaccine based on a framework of safety, equity and transparency. Based on the feedback of this group, the definition of equity has changed and is more reflective of the input. There is good agreement on the “what” but many questions about the “how.”

There is tremendous expertise on this committee about how to reach out to diverse communities, and going forward, there will be a process to capture your best thinking and put it into practice, considering things like public charge, language access and trusted messengers. It is critical to do this well and build trust with our communities. California is the first state in the US to implement an equity metric and may be a tool to consider in sequencing access to the

vaccine. Dr. Burke Harris thanked the committee for a candid, engaged and transparent conversation. The next meeting will focus on Phase 1b.

Next Meetings

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