

California Health and Human Services Agency (CHHS)

California Department of Public Health (CDPH)

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #3 – December 9, 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); **Jeff Luther, MD**, California Academy of Family Physicians (CAFP); **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); **Dean Chalios**, California Association for Health Services at Home (CAHSAH); **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); **Rhonda M. Smith**, California Black Health Network; **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); **Mary McCune**, California Dental Association (CDA); **Christina N. Mills**, California Foundation for Independent Living Centers (CFILC); **Jackie Garman**, California Hospital Association (CHA); **Orville Thomas**, California Immigrant Policy Center (CIPC); **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 (CNA); **Kiran Savage-Sangwan**, California Pan-Ethnic Health Network (CPEHN); **Susan Bonilla**, California Pharmacists Association (CPHA); **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); **Debra Schade**, California School Boards Association (CSBA); **Lorian DeMartini**, CEO: California Society of Health-System Pharmacists (CSHP); **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; **Vivian Reyes**, American College of Emergency Physicians; **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); **Liugalua (Liu) Maffi**, Faith in the Valley; **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); **Jodi Hicks**, Planned Parenthood Affiliates of California (PPAC); **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; **Amber Baur**, Western States Council: United Food and Commercial Workers (UFCW) California

Committee Members Absent

Pamela Kahn, California School Nurses Organization (CSNO)

California State Representatives Attending

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

Public Attending

There were 167 members of the public attending by phone: 163 in English and 4 in Spanish. 439 members of the public viewed the meeting by YouTube livestream.

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. Burke Harris welcomed the committee and expressed her gratitude for their engaged participation in the community input process. She then reminded them of the core values of safety, equity and transparency that are grounding and guiding the community vaccine input process.

Dr. Burke Harris welcomed co-chair Dr. Erica Pan who also expressed her appreciation for the committee's time and advice. Dr. Pan shared some state updates: record numbers of cases and positive test results with a large volume of test results still being processed. The trajectory is concerning with the state's hospitals and healthcare workers overwhelmed. More facilities are requesting waivers to reduce the ratios of healthcare workers to patients and receive help from other states and countries. Unfortunately, the peak of this surge is still ahead in the next 2-3 weeks. The state launched a regional stay-at-home order last week for Southern California, San Joaquin Valley and the Greater Sacramento area as all have regional Intensive Care Unit capacity of less than 15%. Hospitals are trying to increase capacity or discharge/reduce non-essential care to accommodate the pending demand. CDPH will share its communications toolkit so the committee can help share messages around limiting non-essential activities with non-household members.

Dr. Burke Harris emphasized the importance of collectively highlighting the vaccine as the light at the end of the tunnel. The CVAC can help as strong and trusted messengers. She then shared the agenda for today's meeting: an update on timing of vaccine approval, definition of equity, the plan for distribution and logistics, and Phase 1b criteria related to essential workers.

Bobbie Wunsch reviewed the meeting process with a few new additions:

- Please keep your camera on and microphone on mute
- Please use the "raise hand" icon if you want to speak or ask a question
- Attendance has been amazing; thank you for your commitment to this important topic
- From now on, meetings will have American Sign Language interpretation. Please welcome our two ASL interpreters who you can spotlight on your own screen
- Closed captioning will appear at the bottom of the screen for this and future meetings
- The public is listening in in English or Spanish; we are livestreaming the meeting on a YouTube channel
- The public is encouraged to make public comment in writing through the mailbox COVID19VaccineOutreach@cdph.ca.gov
- At every meeting, public comments will be reviewed and sent to committee members
- If members have technical issues they can chat them and Aaron Matlin will try to help

Review Public Comments since November 30, 2020 Meeting #2

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Public comments sent to members were collected November 29 through December 7 at 10 pm. There were 55 public comments submitted and CVAC members received these on Tuesday December 8. Here is a summary of those comments:

- 5 comments offered their organizations as a site to distribute vaccines
- 3 comments were about the importance of vaccine safety and informed consent
- 1 suggested CDPH website improvements
- 37 comments recommended groups that should have access to the vaccine first or very early in the process. These included: meat and poultry workers, optometrists, school personnel including bus drivers, law enforcement and first responders, long-term care facilities, people with intellectual and developmental disabilities and staff who work with them, metal can industry, RN case managers, California Dental Association, child care workers, critical infrastructure (gas, electric, water industry), medical device industry, lab workers, public defenders and clients, death care industry, blood centers, assistive technology providers, news media, farmworkers and people in residential treatment centers).
- 2 comments requested additional data on race/ethnicity characteristics (disaggregating Native Hawaiians and Pacific Islanders, updating farmworker data)
- 7 comments requested participation as members of the CVAC (airline pilots, health center partners, Pacific Islander representative, San Bernardino County, California Life Sciences Association, adult day health centers, people with intellectual disabilities)

Update on Timing of Vaccine Approval by FDA and CDC

Robert Schechter, MD, MPH, Chief, Immunizations Branch, CDPH and Member, Scientific Safety Review Workgroup

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

Dr. Schechter reported on the status and timeline for vaccine approvals. The data submitted by Pfizer and Moderna about their candidate vaccines has been under review and tomorrow, December 10, the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) will meet to make a recommendation decision on whether FDA should authorize the Pfizer candidate vaccine. On Friday December 11 and Sunday December 13, the CDC's Advisory Committee on Immunization Practices (ACIP) will review the data and consider an authorization decision. The Western States Scientific Safety Review Workgroup (representing California, Nevada, Oregon and Washington) is reviewing data and preparing to make a thorough, prompt evaluation. Meanwhile, doses are poised for shipment nationwide.

The VRBPAC meeting tomorrow is being livestreamed on YouTube and other media.

Some information about the vaccine studies has been posted on the FDA website. Dr. Schechter shared a slide showing the overall efficacy data of the Pfizer vaccine, including in persons 55 years and older. The data is very detailed by age group, race/ethnic groups and health/disease categories, for vaccine vs. placebo groups. There are also extensive safety data on adverse vaccine effects. This data has been reviewed in-depth and will be discussed tomorrow.

The meetings of the ACIP are public and will be available in a number of media including YouTube, with links available on the ACIP website.

Dr. Schechter shared a calendar highlighting the various meetings and decision points. If all of these groups conclude that the vaccines are sufficiently safe and effective, then California will receive the Pfizer vaccine next week. The calendar shows both the Pfizer and Moderna vaccines with the Moderna vaccine becoming available as soon as December 22 if all goes smoothly.

Questions and Comments from Members

Vaccine Questions and Comments

- ACIP recommends that healthcare workers with COVID infection within the past 90 days may choose to delay vaccination. Nurses have been denied testing despite exposure to a suspected or confirmed COVID patient. How would a nurse know if or when they have been infected without adequate testing? Where did this recommendation come from?
 - CDPH: Testing is not needed before offering the vaccine. The ACIP recommendation is based on scarce vaccine supplies and that a person could choose to defer their own vaccination to make the dose available to another healthcare worker without any known immunity. This recommendation is also based on current expert information about proven re-infections. It gives the power to the vaccine recipient.
- Will the adverse effects data regarding the Pfizer vaccine be reported by demographic groups? There is concern that folks will be less likely to get the second vaccine if they have adverse effects with the first dose. This is an important opportunity for advocacy.
 - CDPH: There was limited information on this in the briefing packages but stay tuned for information from tomorrow's meeting. Dr. Schechter agreed that everyone needs to provide accurate information about what to expect, how the vaccine works, and to anticipate and answer questions about safety.
- Can we make conclusions as to whether the vaccine is safe for people with complex medical needs?
 - CDPH: There is not information about medical interactions. The FDA Briefing Document for Pfizer's Emergency Use Authorization is [here](#) and page 22 shows co-morbidity characteristics of trial participants.
- How are the allocation and scientific advisory workgroups understanding whether these vaccines prevent infection or transmission? This will affect which groups we prioritize.

- CDPH: In Phase 1a, we assumed the vaccines mainly prevent disease and not transmission. This may change moving ahead.
- When might we know more about transmission? It seems to be misinterpreted in the media, often with comments about community immunity.
- When might we know about vaccine safety for children and would we start to vaccinate adolescents?
- Do we have a sense of doses pending from Moderna if/when it's approved?
- Please post the FDA-Pfizer and FDA-Moderna meeting links on the CDPH website.
- What are the current timeline estimates for completion of Phase 1a in California and start of Phase 1b, and how many doses are expected to be in California at that time?
 - CDPH: We believe Phase 1b may begin during January.

Pharmacy Partnership

- The federal partnership with CVS and Walgreen's is contingent upon a state activation. Do you know when California intends to activate it?
 - CDPH: Dr. Schechter reported that the state is likely to make an activation decision quickly after careful consideration of the urgency and also the implications for directing doses to the program and the timing. It's important to balance making doses available while not keeping them away from other high risk populations. Another consideration is that pharmacies need staff to provide vaccinations and may not be ready.
- Members are getting conflicting information at the county level about state doses. Long-term care residents and staff are included in Phase 1a. At the county level, we are hearing that the CVS/Walgreen's allocation is separate from the first 327,000 doses.
 - CDPH: The first 327,000 doses will be followed by another 2 million by the end of the month. This means that Phase 1a healthcare workers and long-term care residents can be reached with a first dose by the end of December. Most long-term care facilities are signed up for the pharmacy partnership and will be served outside of the 327,000 doses through California doses provided directly to that partnership. There may be supplemental efforts in some counties to reach facilities outside the partnership. The 327,000 will likely go largely to hospital settings, followed closely by the pharmacy partnership for Skilled Nursing and other long-term care facilities, and supplemental local efforts to reach some of those facilities as well.
- Do we have access to a copy of the CVS/Walgreen's agreement?
- What information will the state get about who is vaccinated under the federal partnership program in long-term care facilities? Will that information include demographic data and be available to the public? We want to make sure the facilities that have been hardest hit are prioritized.

- All long-term care facilities are currently served by pharmacies and local pharmacists who know the residents and routinely attend to their needs. Is it possible for the state to encourage CVS/Walgreen's to contract with these pharmacies?
- How will the pharmacy event approach work? Will long-term care staff and residents be vaccinated during the same event? This could result in staff being off due to side effects at the same time frail residents may experience unexpected side effects and require greater amounts of care.

Outreach and Messaging

- Understanding the perceived reluctance of some African-Americans to receive immunizations based on past medical experiments and other structural racism, how can leaders in low-income communities of color address this issue with comfort and confidence, encouraging those communities disproportionately affected by COVID to participate early?
 - CDPH: It's important to acknowledge this country's terrible history and also acknowledge that those damaging practices created the foundation for many of the modern safeguards we have today in biomedical research and medical care. Laws about informed consent were created after the Tuskegee experiments in the 1970s. It is important for CVAC members to communicate that there are now protections such as informed consent and legal regulations. Also, California has a foundational grounding in equity and Governor Newsom has been clear about the importance of California For All as demonstrated in the diversity of the scientific review panel as well as the diversity and openness of this community review process. Dr. Burke Harris shared that the state wants all Californians to have trust and confidence in this process. Dr. Pan added that the state will be developing messages around this and share with this committee for feedback. Between CDC, state and local efforts, there will be outreach and information to address various community concerns.
- The California Association of Long-Term Medicine has a group working on educational support to reduce vaccine hesitancy and tools available on their website: <https://www.caltcm.org/covid-19>. There are presentations available for medical directors and clinical leaders to train them to educate staff and a presentation for training staff which they will make available.
- Front line nursing home staff and other essential workers of color must be honored and valued. We should not require them to be vaccinated but instead develop educational materials to help everyone learn the value of getting vaccinated.
- We need to make sure that we do pre-education now via trusted community messengers, cultural brokers and community leaders to build trust and prepare our communities for vaccinations.
- Some suggested messengers: church leaders and other thought leaders in the African American community; promotoras and Community Health Workers, who have been shown

to be effective in outreach and education in diverse communities; and successful community testing sites that have developed trust in their communities.

- We could utilize the robust infrastructure and process used for Census outreach and engagement in hard-to-count communities.
- CVAC should have a more focused conversation on the outreach and education strategies that grapples with the diversity of our state.
- With multiple vaccines imminent, families are asking which is best, which has side effects, which is safest and whether they should wait for a better one. Talking points about the safety of all vaccines would be helpful.
- Is there an effort from CDPH's programs in WIC, chronic illness, Champions for Change or Office of Health Equity to develop materials? Has the Office of Health Equity worked with the Department of Health Care Services on how to reach out to undocumented immigrants who utilize Medi-Cal for children and young adults?
- Will there be funding available for partner groups to develop and deliver vaccine messaging materials and/or campaigns for the populations they know?
- We need to fully disclose the potential adverse effects. Excluding or minimizing information will worsen vaccine hesitancy and foster negativity and fear, especially in populations prone to skepticism.
- Tribal and Urban sites also serve undocumented immigrants so reaching out to these groups is an interest of the Indian Health Service.
- Messages should include stories and narratives of individuals who have been vaccinated and what they may experience as far as side effects.
- Some more information about the Stop COVID-19 CA Collaboration and its work to address vaccine acceptability can be found [here](#).
- Unions and employers need to work together to ensure equitable distribution to the workers and instill trust in the vaccine through data driven messaging.
- How will outreach to the undocumented community address reporting safeguards?
- Messaging should utilize a socio-cultural lens and address health beliefs on vaccination and vaccine acceptability. We need to create multilingual, multi-ethnic and multi-dialect messages through posters, flyers, websites and social media on approved vaccines and participation in vaccination.
- It is particularly impactful for farmworkers and indigenous migrants to hear directly from healthcare workers and be able to ask questions. Perhaps the messaging can include doctors and nurses who have been vaccinated speaking on the importance and safety, either on the ground or via call-in radio shows.
- Can CDPH work with the Department of Social Services' immigrant integration program and the Complete Count office to identify where cultural competency components might be needed on a geographic basis and how best to get in touch?
- How does the distribution plan envision getting vulnerable communities to come in for their second dose? Maybe patient navigators and promotores can provide outreach.

- We need to keep messaging the need for social distance, masks and increased testing.

Accountability

- With health equity in local distribution and allocation, how do you ensure accountability at the local level? We have to ensure transparency and accountability across the board.
- We have concerns about the amount of local discretion given to both local health departments and provider entities over who gets the vaccine, without appropriate consultation with healthcare and essential workers. While we can approve guidance at the state level, there is so far limited control to direct counties and providers to follow that guidance. Can the state help by providing transparency, like a dashboard?
- How will counties ensure these priorities are followed by employers and others? How will we ensure vaccine actually reaches the most affected groups, especially groups with untraditional employer models?
 - CDPH: CVAC can help suggest a list for Phase 1b and our next conversation will be focused on communication, outreach and education. The Governor's office is focused on sharing information about legal protections like paid time off and legal advocacy groups to ensure workers' rights. This is part of the implementation process beyond the guidelines that will help the most vulnerable be informed, aware and have access to resources if there are challenges.
- Are the criteria recommendations for local health departments or enforceable mandates? What level of autonomy will health departments and providers have?

Definition of Equity

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

Dr. Burke Harris heard from the committee that having a shared definition is important. The role of this committee as an advisory body is to give input to the Drafting Guidelines Workgroup and to give voice to the public and various constituents members represent.

On November 30, CVAC co-chairs suggested the World Health Organization definition. Based on member feedback, the co-chairs decided to offer another definition from the U.S. Health and Human Services' Office of Minority Health:

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

This definition was shared at the last meeting and now is an opportunity for CVAC discussion. Ultimately CVAC will recommend a definition to the Drafting Guidelines Workgroup for their process.

Member Questions and Comments

- Disability is a natural part of the human experience and not inherently negative. This definition implies a medical view in which “the highest level of health” as defined might differ from the viewpoint of an individual with disabilities, mental illness or substance use disorder. Disability rights advocates would like to see an inclusion of well-being and equal access. "Health" is not an absolute state that involves the absence of disability.
- There are 1,400 facilities in addition to long-term care for people with intellectual disabilities. These individuals are frail and need representatives that are willing to take the time to discuss the challenges as we deploy the vaccine.
- The NASEM report has a prescriptive component that includes what is required to attain health equity. It's not just about avoiding inequalities but also about resource allocation. Can we include something in our definition about resource allocation? Achieving equity includes intentional efforts to address barriers to getting needed care.
- The NASEM definition is good but what health means is very nuanced and depends on the individual, culture and community. I would propose including the notion to attain health equity we need to have strong and trusted partners with communities and stakeholders.
- We cannot address health equity by just defining it. We need to address health inequity which refers to preventable, avoidable, unfair, and unjust differences, resulting from poor governance, corruption, or cultural exclusion and disparity, inaccessibility to healthcare and other services so that the disadvantaged group has more difficulty accessing than the other coexisting social group. The systemic or organizational disadvantages one social group receives in comparison to the other coexisting group, as a result of government policies, procedures, existing culture and laws is known as structural or organizational inequity.
- I hope our definition of equity can incorporate the notion of intersectionality or intersecting identities and how those intersections can magnify to create unique barriers for individuals based on their identity or perceived identity. We recommend that the Drafting Guidelines Committee think about scaffolding or layering the different considerations because they have a multiplier effect. (For example front-line, low wage, folks that live in over-crowded conditions should have greater access to vaccines first.)
- There will be a barrier to informed consent for many communities including people with developmental disabilities. The cornerstone of informed consent is knowing the vaccine is safe for the person receiving it.
- Our state doesn't have to ration health care or discriminate against people with disabilities. We need to make vaccines as accessible as possible. The disabled community has had outstanding challenges getting information and accessible COVID testing.
- Members liked the mention of historic and contemporary injustice.

- Ageism is often ignored when discussing inequities. This pandemic has highlighted the combination of ageism and racism.
- It's important to review disaggregated data when looking within a diverse group like Asian/Pacific Islanders. Native Hawaiians and Pacific Islanders in particular have been significantly hurt by COVID.

Dr. Burke Harris thanked the group for its thoughtful input which will be communicated to the Drafting Guidelines Workgroup.

A poll was held to determine if the committee wanted to adopt the NASEM/Office of Minority Health definition of equity. Of 78 members attending, two thirds voted to adopt the definition with a number of additional reservations noted here:

- Several members commented that a definition of equity should also include targeted resources to remove barriers that prevent the full inclusion and participation of all groups, with an intentional focus on communities that have been historically oppressed and disproportionately impacted by the COVID pandemic.
- Members also suggested that a missing aspect of this definition is the intentional incorporation of patient voice in defining and determining equity, and including or centering impacted people in the design of health interventions .
- Several members wanted to ensure the definition addresses the state's most vulnerable residents, including the homeless and undocumented, and to acknowledge inequities and systemic racism that exist within the conditions that shape health (i.e., social determinants of health).
- Additional language should be more explicit about not just equal treatment but the need to meet specific needs and obstacles for the full diversity of our communities.
- Addressing healthcare access could address geographic disparities in rural areas.

Initial Discussion of CDPH Plans for Distribution and Logistics

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

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

Dr. Schechter shared some information about what usually happens each Fall in California. In a state of 40 million Californians, about half the population gets a dose of flu vaccine over a 3-month period. Tens of millions of other routine vaccine doses are also given each year, most but not all, to children. Most of these are given in clinics and hospitals, increasingly in pharmacies. Local public health departments are the safety net, providing less than 10% of overall vaccines during routine times and doubling that capacity during pandemics. Local health departments allocate most of the supplies for pandemic vaccines.

The state expects about 2.3 million doses of vaccine by the end of December and an additional 4 million doses by the end of January. This assumes 600-700,000 doses of Moderna vaccines at the end of December.

Dr. Schechter reviewed the following steps for the overall process:

1. Local Health Departments (LHDs) will receive allocations from the state and review enrolled providers in their regions in conjunction with CDPH prioritization guidance. They will allocate vaccine doses to enrolled providers and residents of long-term care facilities, approving orders and forwarding them to CDPH for processing.
2. CDPH will review LHD orders and pass them on to a national system that includes CDC and the manufacturers.
3. CDC will review these orders and pass on to the authorized manufacturers
4. Manufacturers will fulfill orders and ship across the country. The timeframe for this whole process can take just a few days.
5. When utilized, intermediary distributors like UPS or FedEx will follow the appropriate cold chain requirements.
6. When they receive vaccines, California providers will store them according to protocols and begin to offer vaccines according to state guidance.

Vaccines will be available in a local mix of settings based on local circumstances. Initially, there will be few settings, including public health clinics and local health departments. As more vaccine becomes more available, distribution will become more similar to seasonal flu vaccine available in an increasing variety of settings.

There were several questions from members about an article in the New York Times regarding the state sharing data with the CDC. Dr. Schechter emphasized that California only shares de-identified data with the federal government.

Member Comments and Questions

Long-Term Care Facilities

- Since we don't have enough vaccines to vaccinate the first group, and since long-term care facilities are facing huge spikes and rising death rates, can we focus on community prevalence in long-term care facilities, since a certain level predicts widespread exposure? Both staff and residents need vaccine – staff because they can bring the virus in, and because their jobs are so dangerous, and residents because their mortality risks are so high.
 - CDPH: The workgroup shares the concerns about these vulnerable settings. The initial California prioritizations mirror national recommendations to emphasize congregate settings as high priority for early scarce doses and the state is looking closely at the CDC Pharmacy Partnership and its potential for serving those settings. Additional measures may be needed to protect workers and residents.

- I hope that in the allocation of the scarce initial vaccines the workgroup will keep in mind a report the California Healthcare Foundation released showing that the more Black and Brown residents a long-term care facility has, the higher are risks of outbreak. I hope counties will consider this in their allocations.
- Will residents of long-term care facilities under Phase 1a include incarcerated people who reside in long-term-care settings?
- Several members commented on whether it would be appropriate to vaccinate staff in various congregate settings given that the data does not yet confirm that vaccinating staff will prevent transmission to residents.
- Health plans have a lot of questions about the doses coming to long-term care facilities and how that process will work.
 - CDPH: Immunization teams from the pharmacies will be going to long-term care settings. Most facilities have signed up to participate in these programs, with two large chain pharmacies acting as immunization teams. Once the program starts, some of California's allocation will be set aside for that program.
- Payers are anxious to know the details because they don't want to slow things down once the vaccine is available. The vast majority of individuals in long-term care facilities are covered by Medi-Cal, and the CDC guidance says CVS and Walgreens should bill the payers. Payers want to help ensure this process is smooth for members and patients. It will help to learn this now and build on it for Phase 1b and future phases.
- There are a great range of long-term care facilities. Will counties decide which facilities fall into this category and therefore Phase 1a?
 - CDPH: The guidance does not specify all variations on congregate living so this would require some discretion at the local level. We can try to clarify this for local health departments if needed. Hopefully lower risk settings would fall after those with the most frail or vulnerable patients.
- Are nursing homes and assisted living treated equally or is there a priority between the two? Not every Residential Care Facility for the Elderly (RCFE) has a pharmacy partnership.
- Walgreen's and CVS are using informed consent forms in nursing homes that make little sense. A more appropriate consent form for long-term care can be found [here](#).
- Staggering the vaccine distribution in long-term could include: No more than one third of facility residents per vaccination event; no more than 50% of facility staff per shift per vaccination event; no more than 50% of facilities that utilize the same hospital per region per vaccination event; and vaccination events held at least four days apart to ensure previously vaccinated staff and residents have recovered from side effects.
- Will long-term care staff and residents be given a choice of vaccine?

Data Privacy and Information-Sharing

- How will the privacy of patient data be addressed while ensuring that health plans, providers and related healthcare entities can communicate and prepare for adverse reactions?
 - CDPH: One of the contractual agreements that providers will sign to receive vaccine is agreeing to enter data into the California Immunization Registry (CAIR), either directly or through their Electronic Health Record/other export. They will also be required to issue proof of immunization and reminder notes into the registry which should be accessible and searchable for all providers.
- Is there an opportunity to understand more about the de-identification approach and what will be shared with the federal government? Just knowing gender, birthdate and zip code is enough to identify 85% of the population even without name or address. What will be collected, kept, de-identified and shared with the federal government? What can public health agencies do with this information?
 - CDPH: Dr. Schechter does not have a list of the data fields that are being collected but this has been closely reviewed to modify the Data Use Agreement. This can be added to future agendas.
- How can we be sure that privacy of priority worker lists is protected once they are shared with vaccinators?

Vaccination Locations

- For Phase 1a, will vaccines be distributed at worksites or will workers/patients have to go offsite for both rounds? Is the approach centralized or not? It might be more efficient to bring vaccine to the healthcare facilities and long-term care facilities. Distributing vaccines in certain worksites like state buildings and 24-hour facilities will help ensure essential workers who have limited flexibility are vaccinated. It was acknowledged that centralized vaccinating might be complicated from a financing/coverage standpoint but would have benefits for expedience and healthcare capacity.
 - CDPH: Local health departments (LHDs) are planning to utilize a combination of field and central immunizations. CDPH is trying to provide LHDs with additional immunization resources, staff, Medical Reserve Corps, etc.
- Utilizing workplace distribution of vaccines will help ensure that workers who are uninsured and/or have transportation or logistical issues, especially for two doses, will be reached. It may also help identify those who need the vaccine and may be missed – e.g., security guards, janitors or lab techs that are front-line and at risk for exposure but not employed directly by the healthcare facility.
- We should try to ensure minimal congregating during vaccine delivery. Can we consider home delivery or giving vaccines at worksites for high-risk groups rather a central location?
- The vaccine distribution process is a huge concern. Farmworkers don't necessarily engage with the traditional health system. We recommend that mobile clinics deliver vaccines on-

site at workplaces when possible. Additionally, we suggest that vaccine allocations be prioritized to community health centers (FQHCs, migrant health centers) who are trusted institutions that are more likely to have multi-lingual and multi-cultural staff.

Other Vaccination Logistics

- What will state review of the local health department orders include? Since the whole process will take a few days, I can't imagine the state review is anything too rigorous.
- Will providers be responsible for notification and identification of those prioritized for early doses? Will they verify that individuals presenting for vaccine are eligible in that phase? How can these lists be checked for accuracy? What happens when workers aren't on the list? What sort of training will workers administering the vaccine receive? Who is making these decisions and how do we contact them?
 - CDPH: This will vary. Sometimes there will be worker or patient lists; other times the immunizing clinic or provider will have to verify qualifications following prioritization guidelines per the contractual agreement.
- How do we ensure we're not burdening one facility with side effects at the same time?
 - CDPH: The ACIP advises staggering immunization efforts for this reason. This is an important consideration that may be challenging to implement.
- Will providers listed in Phase 1a, Tier 3, that work in Tier 2 settings be vaccinated with their Tier 2 colleagues (e.g., dentists working in community clinics)?
- Can we save the one-dose vaccines for homeless and other especially vulnerable populations?
- What level of discretion is held, and by whom, for doses remaining in the Pfizer shipments? How will leftover vaccines be re-allocated if vaccine uptake is lower than expected in the first priority populations? How can we ensure these quickly get to people with co-morbidities and other risks?
 - CDPH: If a healthcare facility is giving and storing the vaccines they will have some flexibility and discretion in terms of matching doses per vial and preventing wasted doses. If doses are being brought to the field like a long-term facility there will be coordination between the immunizing team and facility ahead of time and an effort to match doses for that site in advance.
- How are we going to get vaccine doses to workers based on occupation? There may be ways to keep privacy safe and be orderly, but with 8 million workers, many of whom are paid under the table, verifying eligibility will be nearly impossible. We urge workers and their representatives, particularly unions, be part of the discussion.
- Many sectors have workers with risks in all the criteria. I would recommend systems be immunized – e.g., not just teachers at a school but bus drivers, clerks and custodians.
- What are the criteria for "enrolled providers"?
- This process makes sense to get vaccine to healthcare workers but doesn't address the issue of distributing to the general population which will be much harder to scale.

- How does the distribution plan envision immunizing home health and hospice providers who provide care in private homes rather than facilities?

Financing and Coverage

- What is the process for individuals who have prepaid health plans/health insurance coverage by California employers across the border?
- If members present at the pharmacy for a vaccine, the pharmacists won't have their full health records to verify eligibility. Payers could be helpful here.

Discussion of Phase 1b New Data and Criteria regarding Essential Workers

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

Ron Chapman, MD, MPH, CDPH

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

Background and Updated Phase 1b Data

Dr. Burke Harris thanked the committee for its excellent questions. She informed the committee that its comments were taken to the Drafting Guidelines Workgroup last Friday November 30. The discussion today will inform their next meeting on Friday December 11, and then at the next CVAC meeting they will provide guidance about the prioritization of sectors. Dr. Burke Harris reminded the committee that this Phase 1b conversation is focused on specific sectors as outlined by the Governor in March 2020, not specific occupations. Members received this list of essential worker sectors.

Dr. Chapman presented data on a profile of essential workers in California to inform committee thinking and decision-making. Some data is new and /or refreshed since the last meeting.

Per the Governor's order in March, essential sectors beyond health and public health include: Emergency Services, Food and Agriculture, Energy, Water and Wastewater, Transportation and Logistics, Communication and Information Technology, Education and Child Care, Government Operations and other Community-Based Essential Functions, Critical Manufacturing, Financial Services, Chemical and Hazardous Materials, Defense Industrial Base, and Industrial, Commercial, Residential and Sheltering Facilities and Services. Education and Child Care was originally included in Government and Community-Based Operations but has been pulled out because of committee interest.

We are differentiating between industries vs. occupation. Each sector includes dozens of occupations. This can be confusing but we are prioritizing the industry sectors. For example, both a truck driver and an accountant working for a logging company would be included in the sector of Forestry. Many members believe our prior agriculture numbers were too low so the revised estimate is 989,500. This is based on a UC Davis study from 2016 and seems more

accurate. Agriculture workers can be full-time, seasonal, or migratory workers. Most workers employed in agriculture do not work year-round and many are undocumented so it's hard to know exact numbers. Many will need outreach to access the vaccine that is linguistically and culturally appropriate. Geographically, the majority are based in the Southern San Joaquin Valley, followed by the Central Coast and then Northern San Joaquin Valley. The top five counties are Kern, Fresno, Tulare and Ventura.

The total revised estimate for California essential workers beyond healthcare is 8.2 million.

Educational services (1.3 million) are broken down into several categories, with the largest being elementary and secondary school employees at 912,000. Again, this includes many occupations within the sector.

The UC Berkeley Labor Center identifies 15 frontline occupations that are essential and low-wage. Farmworkers represent the group with the highest proportion of low-wage workers at 80% (compared to 32% for all California occupations). Slides addressing race/ethnicity, nativity and age were shared. For example, 93% of farmworkers are Latinx and 81% are immigrants.

The workgroup also wants to look at occupational hazard based on risk of infection. As of August 2020, 26,399 healthcare workers have tested positive for COVID-19. A report from the state of Washington suggests that sectors with the highest infection risk include: Health Care and Social Assistance (25%); Agriculture, Forestry, Fishing and Hunting (11%); Retail Trade (10%); Manufacturing (9%); Accommodation and Food Services (7%); and Construction (7%).

Dr. Chapman reminded the group how important race/ethnicity and age are in terms of risk for COVID infection. Latinx and other populations of color face much higher risk than White Californians, and with increasing age there is increasing risk of hospitalization and death with COVID. Additional data can be made available upon request; CDPH has a very strong data team available to support this project.

Member Comments and Questions

Worker Protections

- Worker protections for those in Phase 1a and Phase 1b are important given possible adverse events after vaccine. Some of the expanded sick leave protections California passed are expiring in December and hopefully will be extended.
- Essential workers should have access to paid time off for both doses of the vaccine and to recover if they experience adverse effects from the vaccine.
- It is imperative that we have strong health and safety measures in place to mitigate the risk of COVID exposure at the worksite even with vaccine priority.

- I recommend offering additional paid sick time for everyone taking a vaccine. Can we recommend the state require employers to pay for additional sick days?
- Employers do not comply with sick leave policies; farmworkers may not know their rights.

Worker Requirements

- Will it be communicated that employers can't legally require/mandate staff be tested or vaccinated?
- Would we feel comfortable saying staff working with medically vulnerable COVID-negative people can choose to not get vaccinated?
- The impact of allowing employers to require vaccination of a new COVID vaccine as a condition of employment will have a chilling effect on the populations most subject to historic inequity and mistreatment. If we require health staff to be vaccinated, we may see critical staff shortages on the day of the vaccination event.

Child Care Workers

- There are a number of industries and occupations not captured in the UC Berkeley data presented today. For example, child care workers are mostly low-wage women of color but they have not been represented. There is little data for the informal caregivers who are caring for children. It would be helpful to see racial, ethnic, and pay breakdowns.
 - CDPH: The data team will look for information on this group.
- There are rising numbers of COVID-19 cases in child care facilities. Could we review the most recent data on this?
- Are child care workers, and informal caregivers of young children 0-5, included in the data on Educational Services?

Other High-Risk Individuals

- Will Phase 1b only be essential workers? Previous guidance indicated it would also include high-risk individuals. Several members recommended including people with disabilities and comorbidities living in home or community-based settings in Phase 1b, including those with heart and pulmonary disease, diabetes, on dialysis, and people with intellectual or developmental disabilities who are three times more likely to die from COVID.
 - CDPH: Both the nation and the state are planning to start with essential workers but we are open to considering other high-risk groups.
- Will essential workers be addressed first before moving on to other possible groups for inclusion? If so we may lose thousands more people before they are considered. We have data on these people.
- The early eviction data is demonstrating a dramatic uptick in COVID cases and deaths. This is having a disproportionate impact on BIPOC communities, with highest risk and trauma for women and children.

Agricultural Workers

- Many farmworkers still work in the winter in industries such as citrus, mushrooms, dairy, vegetables, nurseries and livestock. Throughout the year, farmworkers move from one crop or region to another. Most undocumented agricultural workers don't have a choice but to continue working because they don't qualify for unemployment insurance.
- Some issues are specific to migrant workers or H-2A agricultural guestworkers who qualify for different types of benefits. The H-2A program raises jurisdictional issues. During the last spike in cases there were multiple COVID outbreaks with H-2A workers across California
- It's important to keep in mind both on-the-job and potential community spread when workers return home.
- This week 14,000 agricultural workers in California responded to a text survey responding that: 13% have never been to a doctor for a general health check (outside of the emergency room); 17% have not been to a doctor in over three years. Many are uninsured and 35% have been diagnosed with illnesses that put them at increased risk for COVID disease.
- Farmworkers are critical essential workers that lack access to handwashing stations, masks and must carpool or take buses to reach their worksites.

Other Worker Groups Not Represented

- What about the newly unemployed who are looking for jobs?

Phase 1b Criteria for Consideration

Dr. Schechter presented the preliminary criteria suggested by the Drafting Guidelines Workgroup based on feedback suggested by the CVAC:

1. Societal impact of sector/occupation
2. Impact on economy of sector/occupation
3. Equity concerns
4. Occupational exposure (exposure on the job/severity of disease)

Based on a survey with two thirds of CVAC members responding, 96% of members agreed to use these four criteria to evaluate vaccine allocation to essential workers. Ten people responding to a question what criteria would you add suggested:

- Death/adverse outcomes risk/severity of disease (10)
- Geography to prioritize regions most impacted by COVID (5)
- Equity lens – e.g., low-income workers from vulnerable populations (3)
- Risk of community spread based on job/sector (2)

A majority, 83% of members, felt that we should rank the criteria, and suggested ranking in this order: (1) occupational exposure; (2) equity; (3) societal impact of job; and (4) impact on

economy. There seems to be consensus around using these criteria and ranking them, so therefore the Drafting Guidelines Workgroup will plan to use these as it sorts through various occupations and industries.

Member Comments and Questions

Ranking and Order for Essential Workers

- Will there be a potential for distinguishing between frontline essential workers who have close contact with members of the public or who have work conditions that require them to be in close contact with large numbers of co-workers?
- Essential workers, especially low-wage essential workers, live in overcrowded conditions which can make them super-spreaders. Some of these workers live in congregate settings like homeless shelters. Can we prioritize people in crowded housing situations or multi-generational households? There would need to be guidance for how to ask questions about personal housing situations or health status without violating privacy issues. Would the Healthy Places Index score help identify these households?
 - CDPH: This information can be used to drive planning and outreach at the local level to reach some of those shelters and locations. It could represent another geographic approach to vaccination.
- Within food and agricultural workers, the poultry and meat industries are set up structurally to create problems. There have been outbreaks in the Central Valley. Workers are unreachable at their job locations, and these jobs have been politicized and almost compelled to work in very dangerous conditions.
- Truck drivers are another risk group crossing state and national borders.
- How will workers provide the same service in different geographic areas be treated – for example, private sector EMS "first responders" not listed in Phase 1a?
- Essential healthcare workers that are often overlooked include alcohol and drug counselors and peers in behavioral health, many of whom have co-morbidities.
- Are social workers providing safety net services to California's most vulnerable populations included in Phase 1b? There needs are increasing across the state.
- Can we break down the industries more? Those with the most power and decision-making authority will also have the most protection (e.g., Superintendent vs. special education teacher). There will also likely be links to race/ethnicity and class equity.
 - CDPH: One criterion suggested is those unable to work from home.
- The decisions we make in Phase 1b will impact Phase 2 and beyond. The intersections between people who get the vaccine in Phases 1a and 1b will impact others in the community. Many adults, especially immigrants, learn about health from their children, so as we consider prioritizing communities in 1b we should also think about pathways of communication and trust-building, which many community-based organizations understand. Much of this happens through schools and education systems.

- CDPH: We should really think about this. We might want to prioritize other trusted populations to get vaccinated first if this will build trust among other communities.
- How will this prioritization work in practice? Will people have to prove that they're a certain type of worker or suffer from multiple co-morbidities? Will they have to sign something attesting to this fact? Who will enforce this? Will the individuals administering the vaccine be expected to turn people away?
- Can we look at excess mortality and morbidity data from this year?
- There were a number of survey responses to separate out death and risk of death/adverse effects from the other four criteria. I hope there is follow up on that at the next meeting.
- Could we look at the industry data using the equity metric framework (the HPI data or something similar)? Could we prioritize those who live or work in the most vulnerable areas identified instead of prioritizing between sectors?
- Another factor under "exposure" would include how workplaces will change under the new public health orders before vaccine distribution.
- One consideration of societal benefit is workers who can work from home, such as teachers, but for whom returning to their workplace would benefit society.
- I would like to suggest an added criterion of "political capture" - groups that are compelled to work based on political reasons.
- The 13 critical infrastructure sectors also have a multitude of sub-sections This more detailed listing can be found [here](#).

An Intersectionality Approach

- As we build consensus around the four criteria, how will we use them? Is there a way to layer the criteria to recognize the intersectionality and cumulative risk across these criteria in various industries?
 - CDPH: Dr. Burke Harris reminded the committee that its recommendations will go to the Drafting Guidelines Workgroup so CVAC can recommend how it thinks the criteria should be utilized.
- We're looking not just at the person or their job, as reflected in the additional criteria we're recommending. Can the Drafting Guidelines Workgroup consider the ecosphere people are in?
- I think it's also important to note the intersection between essential workers and co-morbid conditions such as diabetes, obesity and age. These are some of the intersections that arise because of low income and how disability is both a cause and a consequence of poverty.

Education Sector

- The vaccine adds another layer of protection for safe, equitable in-person education since public education is vital to our state's recovery.
- Having a vision from the state for Phase 1b rollout will help give local health departments and education agencies a jump start for an implementation approach that is easy,

accessible, transparent and efficient. How can school communities include staff, students, families and household members who are essential workers be vaccinated together to give greater wrap around protection for a whole school, with special consideration for Black, Latinx, indigenous and other communities that have been disproportionately affected?

- We can use the Health Equity Index to consider the burden of infection and disease.
- K-12 education impacts childcare for other essential and healthcare workers. There are also differences in exposure and infection by age group. Different occupations within education face different risks – e.g., central office staff may be able to work remotely whereas special education teachers and aides might need to be hands-on.

Dr. Burke Harris summarized the conversation so far. The role of the CVAC is to discuss criteria and advise the Drafting Guidelines Workgroup on the use of these or other criteria in doing rank order assessment of Phase 1b essential workers. Today the concept of intersectionality has emerged, recognizing that occupational exposure may intersect with issues of equity since certain groups are more likely to be frontline workers. The group also wants to keep in mind the strong impact on the economy and societal functioning and recognizing some of these groups represent important pathways of communication and trust-building we should strengthen. One question is whether the allocation strategy is based on preventing disease, and the groups are reviewing the data to be sure our criteria and ranking reflect the latest evidence.

Dr. Schechter said that the workgroup would take this discussion, criteria, intersectionality, the data presented by Dr. Chapman and any additional data on occupational risks and disease, to its meeting December 11 as it evaluates sectors and occupations.

Dr. Brooks added that the Drafting Guidelines Workgroup would integrate this additional information as it deepens to the next level of tiered rankings. This has been a great partnership and the workgroup appreciates the additional novel thinking the CVAC generates.

Closing Comments & Adjourn

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

Dr. Burke Harris thanked the group for a robust discussion. Bobbie Wunsch thanked the ASL interpreters. There will be a short evaluation for members over the next several days; please give your candid feedback. The team will respond to chat questions not addressed today.

Next Meetings

- December 16, 2020 from 3:00 – 6:00pm
- December 21, 2020 from 3:00 – 6:00pm
- January 6, 2021 from 3:00 – 6:00pm
- January 20, 2021 from 3:00 – 6:00pm

- February 3, 2021 from 3:00 – 6:00pm
- February 17, 2021 from 3:00 – 6:00pm

Agenda for Next Meeting – December 16, 2020

The next meeting will focus on public information, trusted messengers, vaccine acceptability and communicating to vulnerable and hard-to-reach communities.

How to Make Public Comment

Send an email to COVID19VaccineOutreach@cdph.ca.gov