

California Health and Human Services Agency (CHHS)
California Department of Public Health (CDPH)
COMMUNITY VACCINE ADVISORY COMMITTEE (CVAC)

MEETING #7 – January 12, 2021 – 4:00pm – 6:00pm

MEETING SUMMARY

Committee Members Attending

Fred Buzo, AARP; **Jacob Snow**, American Civil Liberties Union Northern California (ACLU); **Vivian Reyes**, American College of Emergency Physicians; **Susan de Marois**, Alzheimer’s Association; **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); **Michel Feyh**, California Professional Firefighters; **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); **Pamela Kahn**, California School Nurses Organization (CSNO); **Loriann De Martini**, CEO: California Society of Health-System Pharmacists

(CSHP); **Carol Green**, California State Parent Teachers Association (CAPTA); **Lisa Constancio**, California Deputy 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 Imperato**, 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; **Melissa Stafford-Jones**, First Five Association; **Anthony Wright**, Health Access; **Lisa Hershey**, Housing California; **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

Committee Members Absent

Alia Griffing, American Federation of State, County and Municipal Employees (AFSCME); **Andrew Nguyen**, Asian Americans Advancing Justice – Los Angeles; **Pastor J. Edgar Boyd**, First African Methodist Episcopal Church; **Naindeep Singh**, Jakara Movement; **Amber Baur**, Western States Council: United Food and Commercial Workers (UFCW) California

California State Representatives Attending

Tomas Aragon, MD, DrPH, Director, CDPH and State Health Officer; **Nadine Burke Harris, MD, MPH**, California Surgeon General; **Rob Schechter, MD, MPH**, Chief, Immunization Branch, California Department of Public Health

Public Attending

There were 38 members of the public attending by phone, including 1 on the Spanish line, and 653 views of the meeting by YouTube livestream.

Committee Co-Chairs

Dr. Erica Pan, MPH, State Epidemiologist
Dr. Nadine Burke Harris, MPH, California Surgeon General

Consultant

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Opening Comments

*Tomas Aragon, MD, Dr.P.H., Director, CDPH and State Health Officer
Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair*

Dr. Burke Harris welcomed the committee and expressed her gratitude for the group to pause and join today as the state responds to an emerging issue and communicates the latest updates. She expressed her desire to hear from the committee. The purpose of the meeting is to update and respond to some late-breaking information coming from the federal government and the Centers for Disease Control and Prevention (CDC) related to vaccine and vaccine prioritization.

Dr. Aragon welcomed and thanked the group. With hospital surges, infections and deaths, the landscape changes daily. This is a critical time. Vaccine supply is expected to improve with the changes in the federal administration. Today, there was an announcement that the CDC will issue guidelines recommending age as the primary criterion for prioritizing vaccinations. They will recommend: (1) vaccinating people over age 65; and (2) vaccinating people 16-65 with medical conditions. California has not seen the actual guidelines; however, the state was already moving in this direction. This is important because the vast majority of people hospitalized as well as Intensive Care Unit (ICU) admissions/ deaths are among older persons. It is also the case that older adults from highly impacted communities, including Latino, African American and low-income, are most likely to be hospitalized. Therefore, to impact the surge, it is critical to prioritize older age groups. Dr. Aragon also stated that when hospitals are impacted and access reduced, it impacts the whole community.

Dr. Aragon emphasized that the state wants to make this change in a way that honors and respects the work that CVAC and other groups have done in terms of building phases and tiers. He also wants to be sure the system is simple and effective. Quoting Dr. Burke Harris, he stated “Simplicity saves lives.”

Meeting Guidelines

Bobbie Wunsch, Founder and Consultant, Pacific Health Consulting Group

Bobbie Wunsch thanked the group for changing schedules to attend. The hand raised icon has been moved to the Reactions section of the toolbar. She thanked the American Sign Language (ASL) interpreters for joining on short notice. The public is listening in English and Spanish via live call-in line and live streamed YouTube. Public comments are welcome. There will not be a public comment summary today.

Proposal – Tier 1, Phase 1b

Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Robert Schechter, MD, MPH, CDPH and Co-Chair, Drafting Guidelines Workgroup
Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup

Today, the CDC announced its plan to place a greater priority on age as a basis for vaccine access and prioritization. The Drafting Guidelines Workgroup met immediately before this meeting to think about updating California recommendations in light of this pending guidance.

Dr. Burke Harris presented a proposal to modify Tier 1 of Phase 1b. The proposed recommendations are similar to the prior ones but replaces those over age 75 with people ages 65 and older. There would be no change in the prioritized sectors in terms of essential workers in Tier 1 (Food and Agriculture, Education/Child Care, First Responders).

Implementation considerations for vaccinators include:

- If we are moving quickly to vaccinate folks and supply is sufficient then no further sub-prioritization would be needed
- If there are supply shortages, we would recommend prioritizing:
 - those 75 and over
 - vulnerable communities (Healthy Places Index or other Social Vulnerability Index)
 - people with underlying medical conditions that increase risk, as feasible*

*The state is pushing for a ramp-up with larger vaccination events where it may be more challenging to confirm a medical history.

The guidance from the CDC focused on prioritizing older individuals and also those 16-64 year-old with underlying medical conditions that increase risk of severe COVID-19. In our current phase/tier system, 16-64 year-olds with underlying medical conditions are in Phase 1c and at this time the Drafting Guidelines Workgroup agreed that it makes sense to leave that group in Phase 1c because they represent an additional 10-15 million individuals and adding that group would become an implementation challenge. Dr. Burke Harris also re-stated that during the surge those most likely to be hospitalized are those age 65 and older. Dr. Schechter noted that there is no change to those in congregate settings who are included in Phase 1a.

Questions and Comments from Members

People with underlying medical conditions and disabilities living in the community

- Is underlying medical condition solely defined through the CDC list of co-morbidities?
 - CDPH: It is through the CDC list of conditions that increase the risk of severe COVID-19 disease.
- A number of CVAC members wrote to the Drafting Guidelines Workgroup to recommend prioritizing Home and Community-Based Services (HCBS) users who are

high-risk and would be in a nursing facility if they were not in HCBS. This is a known, high-risk population that would be in a nursing home facility if they were not receiving HCBS, and including them would not balloon the figure. This is also an equity issue because they are all low-income people and a great opportunity not to divide people by age, disability or condition but to prioritize a known universe of people based on risk.

- We can operationalize equity and impact for people with disabilities by incorporating people receiving HCBS. This wouldn't require changing anything in the tiers as written, just the way it's clarified and implemented. The total number in this group is much smaller than 1 million since it includes minors under 16.
 - CDPH: We'll take this into consideration, balancing the overall health risks of developing severe COVID-19 disease and these numbers. We need to compare this list to the estimated number of individuals who have a condition listed on the CDC guidelines as significantly increasing the risk for severe COVID. The CDPH team will explore this.
- There is a lot of intersectionality within those 16-64 years old with certain specified conditions receiving HCBS. People working with them through IHSS are often women of color also working in nursing homes and there is risk of spread. Also, parents taking care of adult children with disabilities may be older but not yet 65 and if they get sick their children will not get the care they need. It would extremely helpful for the state to offer help local jurisdictions plan for mobile vaccinations and reaching people in their homes.
- There is a sub-population of 16-64 year-olds in the state who have equity concerns and risk exposure through IHSS and Regional Center workers. These are populations who have historically limited access to quality health care and are at increased risk of severe COVID disease. We don't have great data on their health risks because they are not studied but they shouldn't be punished for that. I urge you to consider this sub-population for Tier 1, Phase 1b. It's especially for IHSS and Regional Center centers because we know who they are, where they live and how to get vaccine to them.
- Is it correct that the age band will be lowered, but disability is not being raised up?
- I don't agree with the decision to leave 16-64 year-olds who have severe risks associated with COVID in Phase 1c. A better approach, in my view, would be to identify easy to reach subpopulations like regional center clients with intellectual and developmental disabilities and IHSS consumers, and move them up to 1b. The disability representatives on this group have made that case in a letter with broad community support.
- We do not agree with this strategy. Not everyone over 65 is as vulnerable to COVID as people with underlying health conditions between the ages of 16 - 65.
- We cannot just "give up" on those in congregate living facilities because of logistical or other difficulties. These are the people who have been dying. Individuals with the same conditions, disabilities, and need for assistance with daily living are in the community with front line healthcare workers coming in to their homes. Their increased

susceptibility to severe illness and death, regardless of their age, is why they should be in Phase 1b. This is not everyone with disabilities.

- Why not include 65-74 year-olds and 16-64 year-olds who are vulnerable and have underlying medical conditions in Phase 1b?
- It is my profound hope that we are not ignoring the vulnerable older adults and disabled who live in assisted living facilities (ALFs) and group homes, however, the present data suggests that we are at risk for ignoring that group. We cannot let that happen!
- It doesn't make sense to have IHSS or Regional Center workers get a vaccine and not the individuals they are providing services for.
- What is the rate of death from COVID-19 in CA of people with significant functional disabilities and co-morbid conditions? If we don't know the answer, how can that be a basis for not prioritizing this specific subgroup of people with disabilities?
- What data do we have on 16 to 64 years old who are in the vulnerable groups?

Age-based criteria and prioritization

- California had already been moving toward age-based approaches. The clarity and simplicity this provides to the public is helpful. However, this is a hard conversation about tradeoffs and adding 65+ category appears to add about 3.5 million people. Is that correct? It's hard to make this decision without a sense of the logistical considerations or the expected vaccine supply. Also, how will older people manage a lot of this process such as online forms?
 - CDPH: The addition of 65-74 year-olds is 4.25 million Californians. With the pace of vaccine right now, we should receive 2 million doses in January and are not precisely sure when the pace will increase (late January/early February) or when new vaccine formulations will become available. Adding those 65-74 years old will require several weeks to months of additional vaccine.
- Does the shift to prioritizing by age group, together with the establishment of mass stadium-style vaccination, represent the beginning of a shift away from priority groups towards a more UK style vaccination model?
- We should focus on how to support seniors living at home and their care providers.
- For 65+ there is typically an established provider relationship.

Congregate Settings

- If we're thinking about high-risk people, we need to make sure that we are exhausting the needs of people in long-term care facilities (LTCFs) before we move to Phase 1b. There are barriers to vaccinations in LTCFs due to the pharmacy partnership and other issues.
- There was a reason nursing homes, assisted living facilities and group homes were listed together – both residents and staff. The data shows that people working in those

settings have had the most dangerous jobs in the country for the past 10 months. The problem now is that we're delayed in getting nursing homes vaccinated and in scheduling vaccinations for those of all ages living in ALFs and group homes – including older adults and the disabled community. These groups are at risk of being left behind in our haste to get to everyone else. If we want to get all the residents and staff in these congregate settings vaccinated, we must immediately engage all the long-term care pharmacies and other pharmacies that can work in collaboration with CVS and Walgreens. All hands on deck are needed.

- CDPH: Although the focus of this meeting is on the emerging CDC guidelines and the notion of adding 65+ to Phase 1b, this does not mean we're abandoning our commitment to thoughtfully and effectively implementing our strategy for Phase 1a. We can do both at the same time and California is still committed to its priority strategy.
- People with Alzheimer's disease don't wear masks, don't physically distance, and can't be kept in their rooms. The only way to protect them is with the vaccine. Many of these people live in ALFs, memory care units, group homes and nursing homes. Many ALFs are not signed up to get the vaccine until March if at all.
- The vast majority of ALFs are still waiting for vaccinations. Marshalling additional resources for these settings would be appreciated. I want to echo the call for clarity since counties are announcing they are moving onto Phase 1b when the ALFs don't have dates for vaccinations yet.
- While I understand the desire to get more shots in arms, I am very alarmed that we are willing to skip to and broaden participants when we haven't yet vaccinated the individuals from the first tier, the 300,000 older adults living in LTC facilities.
- Does this mean there will be more vaccine and vaccinators to get to the majority of seniors and workers in Assisted Living still waiting for vaccination clinic dates?
- Why should the local bar owner care that the neighborhood LTC facility is getting vaccinated ASAP? Because those residents die at a much greater rate, which then keeps that bar owner's county in the purple tier and means the bar must remain shut down. We will hold our economy back by not getting LTC facilities residents vaccinated.
- 6 bed Residential Care Facilities for the Elderly are a disaster right now.
- The long-term care pharmacy partnership is not working.
- Let's open all of the gates, CVS, Walgreens, local County Health, local hospitals, the local pharmacies that already have relationships with LTC facilities.
- The California Association of Long Term Care Medicine's (CALTCM's) Vaccine Delphi group put out the following recommendations last week:
<https://www.caltcm.org/assets/Vaccine%20Delphi%20Recommendations%2001082021.pdf> The realities of the vaccine rollout in long term care has not gone well. Our recommendations provide actionable solutions.

- Can we get an update from CDPH on how many skilled nursing facilities have had their first vaccination clinic in comparison to the number of skilled nursing facilities that have been scheduled to have had their first vaccination clinic? How close are we to being on target with the scheduled vaccination events of skilled nursing facilities?
- 42% of ALF/RCFE residents have Alzheimer's or dementia and many have difficulty complying w distancing, masking and hand washing.
- I've worked in long term care for over three decades. This milieu is poorly understood by those on the outside, including county, state and federal government entities. None of us want to find out in March that we haven't vaccinated the people who are at the greatest risk of dying. Too many of them have already died. Our systems are not set up to do this, except in relation to the long term care pharmacies. Let's commit to actually getting these high risk folks vaccinated immediately.
- I'm very worried about congregate settings potentially being pushed back.
- Pushing congregate living settings down concerns me – I'm very concerned about prisons. Will people who meet age criteria in prisons get vaccinated? We have an aging population in our prisons and this is easy to do. I hope we can prioritize this population.
 - CDPH: Staff in correctional facilities are working with a risk score and are happy to start applying the age criteria.
- I'm very concerned about state prisons, state hospitals, psychiatric facilities, and private detention facilities that the federal government uses.
- I worry about incarcerated people being pushed further back, as well as people experiencing homelessness.
- Does Tier 2 of 1b still include incarcerated and people experiencing homelessness?
- I would be interested in any data on vaccine hesitancy among the prison population including and not limited to staff, as well as people living in homeless shelter/congregate centers.

Ensuring Equity for Vulnerable Communities

- I support the prioritization of vulnerable communities using a place-based index and am glad to see it included in the criteria. Vulnerable communities don't always fit into the tier system so incorporating a place-based index is critical. It's important to keep in mind the longitudinal perspective and that vulnerable and minority communities might not actively seek out vaccinations due to fear and other historical and structural barriers. Proactively using a place-based index will allow us to tailor outreach to these communities. People from these communities may not come to the infrastructure we build and we need to start building trust early and sustain it throughout this process.
- As we move into implementation, it's important to acknowledge that the structure we have in place does not lend to equitable access to care. All of the barriers vulnerable communities face are not going away. Health centers that serve Medi-Cal, Black and Brown communities tend to be under-resourced and do not have systems able to parse

out work sector or status. They do know their populations generally are essential workers and know where the hot spots are. Being flexible and resourcing people in the community doing outreach as trusted messengers, community by community, will reach a broader population faster with an equity lens even if it is not perfect.

- We must not replace vulnerable underserved highly impacted communities and counties with high rates and deaths
- If we are going to expand Phase 1b by 4.25 million people, we should have to make special efforts to ensure some prioritized populations are not left behind (75+, congregate settings, place-based high-risk communities, etc.) while we seek to broaden outreach. It shouldn't be "one line."
- People are getting vaccines while folks in facilities have been skipped or not heard a word in their counties.
- The concern is that with expanding the tier, those more capable of getting vaccinated will get ahead of those less capable, disrupting our efforts at equity.
- The mega pods will not work well for those without cars or transportation. Older people will have a harder time using technology and physically getting to vaccine sites.
 - CDPH: The Drafting Guidelines Workgroup just talked about how to increase scale while holding a very strong equity lens. More will be presented at next week's meeting.
- Our first efforts at mass testing in Sacramento missed a lot of low-income people of color and I don't want to see this repeated.
- Large style vaccination events may exclude many vulnerable community members – those who don't have vehicles, those who are working during times when the vaccination events are being held because they are low-wage workers that are working 6-7 days a week who cannot wait in line during regular hours, those who have digital literacy limitations.
- American Indians and Alaska Natives (AI/AN) have higher mortality at younger ages. They have experienced disproportionate rates of infection and mortality during the COVID-19 pandemic. The excess risk, especially for AI/AN males and persons aged 20–49 years, should be also be considered.
<https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm>
- We should ensure that we are also utilizing mobile strategies with current available vaccines in rural areas. Logistical challenges should not prevent vulnerable rural populations from getting vaccinated. We have to be creative. The UFW Foundation has already been working with the United Farm Workers, agricultural union employers and health professionals willing to collaborate and volunteer to support mobile vaccination that would be accessible to farm workers in their communities and workplaces.
- In our community people are cutting the line, I'm very concerned about making mistakes in a non-transparent system.

- We have said equity is our central priority. I am fearful that going to 65+ will lead us away from equity and inclusion of those most likely to be both impacted by COVID and least likely/able to access care.
- Older adults are not monolith, whether drawing the line at 75 or 65. Not all 75-year-olds are similarly situated or have the same level of risk. A place-based approach like the California Health Places Index (HPI) is so important to delineate sub-priorities to center our allocation framework on equity. For reference, HPI website: <https://healthyplacesindex.org/>
- The distribution problems we have now, focusing on a few million at specific sites is going to be different than a 12 million population mix that engages the general public. We should anticipate problems: there will be lots of interest in this next round, and we should keep appointment slots open for particularly vulnerable, and have outreach efforts to address transportation, technological, cultural, language and other barriers.
- Have there been any case studies of counties or health providers effectively utilizing the HPI to prioritize within age groups?
- Latinos 65+ are more likely to not have access to Medicare or Medi-Cal due to immigration status. Guidance on where they can seek vaccines and partnerships with Community Based Organizations (CBOs) will help us get the word out in the community and is absolutely critical. Otherwise we will not be achieving our equity goals that we collectively agreed to.
- It shouldn't be only first come first serve. For providers and counties that do an appointment based system, we can ensure many appointments go to top priority populations, while we use the broader population to fill the schedule.
- I think we need to find intersectionality between equity for our vulnerable groups, essential workers, 65 year-olds plus, and those 16-64 years old.

Timing, Logistics and Implementation

- Where are we in the phases and tiers right now?
 - CDPH: Every county is in Phase 1a right now. Different counties and facilities have different capacity in terms of their ability to move to Phase 1b. Multiple strategies are being addressed at the same time, including surge, vaccine planning, and others.
- I've read the federal government will now base each state's allocation of vaccines partly on how successful it has been in administering those already provided. Given that we haven't fared well when compared to other states, will this affect California's allocation?
- What happens to the rest of those in Phase 1b, Tier 2--both the sectors and congregate settings with outbreak risk?
- Each county is currently using their own system for people to get vaccine reservations, leading to delays and confusion. Does the state intend to create statewide oversight or a system to streamline the reservation process or are we leaving it up to each county?

- With the increase of 4.25 million people to Phase 1b Tier 1, what is the timeline for vaccine distribution?
- What will be the criteria to trigger Phase 1b?
- Would it be helpful to review the identified challenges and successes with Phase 1a implementation? Our member organizations continue to report inconsistency in messaging and access.
- Can we get a vaccine update? When will they arrive and which counties will they go to?
- Can we get some feedback on how this will impact the other Phase 1b and 1c essential workers? Are we pushing groups back a week, two weeks or are we talking months?
- A well-coordinated, accessible, transparent statewide vaccination rollout program is key to equity and reaching prioritized groups in a timely manner. Information on when, where, and how 1b groups can schedule a vaccine in each county, knowing when each county moves to a new phase/tier, and progress reports with demographic and occupation/industry info will help move us in that direction.

Outreach, Education, Messaging and Community Partnerships

- As of today, 75% of all fatalities in our state have been 65 and older. Age is also the greatest risk for Alzheimer's disease. 94% of all fatalities are among those 50 and older. When we expand to 65+ year-olds, what is the pathway to keep it simple with messaging and communication? People are contacting overwhelmed public health departments. How should we advise people on where they can get started?
 - CDPH: Currently there is a burden for people to do the outreach themselves but this will start to change. The state is building information technology systems to give people access to the information and learn how they can be vaccinated. Health systems will be using their Electronic Health Systems to reach people based on age and medical conditions. To address the equity issues, we know we can't depend on the health systems or the mega pods. For these areas we are seeking partnerships with local health departments and communities. Increasingly through these automated tools at the state and local levels, health plan outreach and online appointment systems, there will be more mechanisms for people to get answers and access over the next several weeks. The goal is to make it as easy as possible for people to get access; therefore there won't be one simple system for everyone. Large health systems are prepared to notify people in Phase 1b based on date of birth. Then there will be the mega pods and more vulnerable communities will have outreach done by public health departments and/or partnerships with CBOs. There will be increasing diversification with the mega pods and routine sources of care. Most people will have choices of where to go.

- When you add 4.2 million people into the next round, with sub-prioritization, the model will start to get complicated. How can we start to expand into the next 11 or 12 million? How are those doses going to come in? Will others be “kicked out”?
 - CDPH: We understand that for some counties and sites, we want to vaccinate as many people as possible, and we’ve established a prioritization system that’s focused on the most vulnerable to hospitalization and death. We also want to allow enough flexibility to ensure that doses aren’t wasted. We’re trying to avoid so much rigidity that we waste doses. For that reason the guidelines are straightforward and they allow vaccinators or decision-makers the option to sub-prioritize if they face supply shortages. This may not be practical in a mega pod, but could be applied in some other circumstances. The health systems are ready to do this once they get more vaccines. The goal is to plan with the assumption there will be much more vaccine soon. Simplicity will save lives and help us prepare for a vaccine supply chain that becomes more and more abundant. Verification is also too complex and therefore it will be an honor system with a focus on age because it’s so easy and relevant. The landscape has changed so at this emergency meeting in this surge with this amount of supply the circumstances point to prioritizing 65 and older.
- What is the communications strategy? There seems to be a big gap between what is needed and what is actually happening.
 - CDPH: The work is happening and will be better communicated to this committee starting at the next meeting.
- Look to promotoras to help particularly older adults and their families to support them.
- How will we reach those who are homebound and can’t drive or otherwise get to a vaccination center?
- One obstacle we are finding in the Central Valley to speeding up Phase 1a completion is vaccine hesitancy. We should use our organizations and networks to convince people to accept the vaccines.
- If health care workers aren't getting it because of hesitancy, then that makes me concerned about our community. Is there any information on the cultural awareness educational grants the Governor's Office talked about during the last meeting?
- I’m curious as to how lessons learned from COVID testing could be applied to getting the vaccines to hard to reach populations. A year into COVID, our indigenous migrant farm worker communities are still having trouble getting a test and a lot of it is rooted in language access. What framework can we transpose in the outreach piece we keep talking about to these hard to reach populations especially as they intersect with some of the newer groups named by the CDC today?
- Nursing homes, assisted living facilities and group homes are intersectional by definition, particularly as they relate to the staff who work in these settings. We need

to make it easier for front line staff to get vaccinated. Many of them don't own cars and use public transportation. We must cater to them, not the other way around. We need a massive educational effort that respects, honors and values the work that they do.

- Critical vaccine transparent messaging and information is needed to counter information about healthcare workers refusing the vaccine.
- My concern is with the cultural outreach to communities of color that have historical hesitancy to vaccinations or lack of connection with their health systems. The census work was over a year's time with mixed results and now we are asking that same process to happen but accelerated and, in a situation, where workplaces are more important. I second so many comments about the need for data to help us with this. I share the fears that we will be inundated with more vaccines coming in. But we can't just say honor system and dispense of concerns when that system has helped create the inequities we see currently in place.
- We need to recognize and resource community clinics and CBOs that have already built trust that larger organizations and health systems have not been able to do as well.
- Going to scale is partnering with community.
- Can this committee get talking points on each phase to inform our conversations with community members and allow us to serve as ambassadors?
- How can CBOs apply for outreach resources?
- Vaccine hesitancy didn't develop overnight. We need to put resources toward trusted messengers to increase vaccine acceptance!

Payers and Health Plans

- Payers need to get answers to logistical questions. We have the information needed to reach people. We know how to find people age 65 and over with co-morbidities. The delivery system does it every day and we're ready and willing. This approach is the right thing to do and very practical, especially since most of this population has Medicare. We can be successful and build credibility. Also, a Medi-Cal lens is an equity lens!
- The age-based approach is doable for health plans. We don't have data on essential workers but we do have this data. As we look at speeding up the distribution of the vaccine through faster channels, it's important to not lose sight of the logistical work needed to reach hard-to-reach populations.

Essential Workers

- I hope in this new plan we don't lose sight of essential workers including teachers, food workers and first responders. When we add a large number of people we may end up with vaccine shortages.
- This is a hard conversation for labor representatives since we represent millions of the people that are getting moved back in line. The arguments in favor of this change are very compelling. We can't support or oppose this proposal overall. We do think that if

this recommendation moves forward, we should couple it with some other things to build confidence: consistency across counties, good information about logistics, clarity and accountability online about doses and distribution, etc. Having these things in place to assure a smoothly functioning system and a willingness to sacrifice for the greater good. Finally, it would be great if we could target those excess doses at risk for being wasted to go to essential workers.

- CDPH: This is a very difficult discussion because it involves who gets life-saving technologies first, second and third. All of us need to be able to represent these decisions to our constituencies. Instead of saying this will move you back in line from the vaccine, ideally we would all say that this decision will move us all closer to an ICU bed if we need it. Communication is critically important and the most powerful tool against this vaccine is our behavior. We can share the *benefits* of this decision for all Californians instead of the downsides.
- Moving faster with vaccinations is critical for nurses and other healthcare workers at the breaking point right now. The county by county process is not effective and not helpful for workers to know when they're going to be in line. We need clear communication from the state because the unknown and lack of transparency is causing additional stress on the shoulders of essential workers.
- Could it be clarified whether the education group listed continues to include child care workers as previously proposed for this phase?
- Does Tier 2 of 1b still include essential workers in transportation/logistics, industrial, residential and commercial sheltering, and critical manufacturing?
- Will demographic and occupation/industry info be added to the CDPH Vaccine Administration report?

Expanding Vaccinators and Vaccine Settings

- 1,000 grocery pharmacies are ready willing and able to help. We can expedite and make this happen.
- The California Fire Service has been working with their local health departments to assist with delivering vaccines in the communities they serve. Is there some way that the state can assist with streamlining the approval process?
- Part of the equitable access to care is access to vaccinators. Would it be possible to mobilize allied medical students (e.g. pharmacy, nursing, dental, etc.) to assist with the vaccination effort? Could counties standardize this mobilization to avoid one county fully mobilizing nursing students while another county is not. This can help prevent burnout and allow students to earn clinical hours. It may also allow counties having issues to access to more vaccinators (i.e. rural and remote areas).
- We need to include independent community pharmacies - there are over 800 in California and they are waiting to enroll and receive allocations to begin vaccinating.

- 78% of farm workers surveyed were uninsured and the majority are undocumented. It is important to support community clinics' capacity and increase the number of vaccinators as CBOs/unions support outreach and education in underserved communities.
- Vendors for people with intellectual and developmental disabilities are ready to be part of the larger army, focused on the solution.
- Local county medical associations are fired up and want to help.
- The access/distribution issue is at the core. There is an army of community members, organizations and volunteers who are ready to be deployed. They are the informal support system ready to be integrated as part of the solution.
- We need to support community health clinics in reaching farmworkers effectively.
- We are working very closely with our local medical society and they have been amazing. They are staffing pods and getting shots in arms right alongside us!

Local Health Jurisdictions

- Each County has a website on COVID vaccination - it varies from health jurisdiction to health jurisdiction. Check out LA County as an example for a great one. <http://publichealth.lacounty.gov/acd/ncorona2019/covidvaccinedistribution/>
- Have we looked into how many vaccines are wasted per county and why they are wasted in Phase 1a? Do we have data from the local public health for presentation?
- Any standardization on deployment will assist Counties in lifting up this huge endeavor.
- From a local public health department perspective, vaccine supplies are still very limited. Many of the strategies that are being discussed are terrific but they depend on vaccine availability. As vaccine availability grows, we will have more flexibility to allocate to other providers - which is exactly what we want to do. Please encourage providers to sign up and be ready to vaccinate - this is "all hands on deck".

Reporting and Accountability

- For transparency knowing where the "line" is would be helpful.

Other

- I want to urge the committee to focus on flexibility. In Phase 1a we collapsed the tiers to allow flexibility for points of distribution and to open up the opportunities for those who want to be vaccinated. This keeps two goals paramount: (1) vaccinating the vaccinators; and (2) not letting any doses go un-used. If we can get these three workforce sectors, older people and their families vaccinated at the same time, I would encourage us to vaccinate family members if they are with their elderly family members and not turn them away (assuming sufficient supply). This will speed up the process.

- We support equity and greater flexibility. We'd also recommend a decision matrix for how providers can most equitably administer the vaccine AND not waste any vaccine and be expedient in the administration.
- Can the state provide counties with concrete procedures and plans for how local public health departments could provide mobile vaccinations, outreach and vaccination to rural areas, and have these logistical frameworks in place particularly if/when a vaccine such as the Johnson & Johnson or AstraZeneca formulation that does not require subzero temperatures is federally and regionally approved?
- We need to balance the need for equity with the concern of wasting vaccinations and insuring that we are getting vaccinations into arms as rapidly as possible!
- For providers, big systems or community clinics, any appointments or clinics set up for vaccinations are outside of the patient care that we need to keep whole at this time. The extra resources needed to provide vaccines in the quantity necessary is a concern.

Closing Comments and Adjourn

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

Dr. Burke Harris thanked the committee for meeting on such short notice and for its input. She reflected a few themes from this vibrant conversation: (1) please don't forget how important it is for us to prioritize equity; (2) don't forget strong implementation for vulnerable seniors and those in long-term care facilities; and (3) don't forget people in congregate settings such as shelters or prisons. Dr. Burke Harris emphasized that the state is not forgetting about those things and won't, and is grateful for the strong reminders about these key priorities.

As California looks and plans forward, responding to the surge and new information about who is most vulnerable and putting the health care system at greatest risk, it is clear that resources need to be in place to ensure that those in Phase 1a are effectively and equitably vaccinated. Dr. Burke Harris acknowledged that this is hard, complicated work and that the state is not losing sight of the logistical complexities in reaching hard-to-reach populations. As California responds to the public health emergency, prioritizing people 65+ in Phase 1b, it is also critical to think about messaging because a key part of maintaining trust is a thoughtful and clear rollout of the plans.

Dr. Burke Harris concluded by asking how to be more specific in looking at 16-64 year-olds who have health conditions that put them at increased risk for severe COVID-19 disease and whether to be more precise in considering a sub-group of these. All these issues will be brought to CVAC for recommendation to the Governor's Office. Dr. Burke Harris thanked the committee for its time, valuable input and responsiveness.

Next Meetings

- ❖ January 20, 2021 from 3:00 – 6:00pm
- ❖ February 3, 2021 from 3:00 – 6:00pm
- ❖ February 17, 2021 from 3:00 – 6:00pm

How to Make Public Comment

Please send public comment by email to COVID19VaccineOutreach@cdph.ca.gov.

DR