

**California Health and Human Services Agency (CHHS)
California Department of Public Health (CDPH)**

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #9 – February 3, 2021 – 3:00pm – 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; **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); **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 Superintendent of Public Instruction; **Laura Kurre**, California Teachers Association (CTA); **Shannon Lahey**, Catholic Charities California; **Esther Bejarano**, Comite Civico del Valle; **Kim Saruwatari**, County Health Executives Association of California (CHEAC); **Andy Imparato**, Disability Rights California; **Silvia Yee**, Disability Rights Education and Defense Fund (DREDF); **Kristin Weivoda**, Emergency Medical Services Administrators of California (EMSAC); **Melissa Stafford-Jones**, First Five Association; **Anthony Wright**, Health Access; **Lisa Hershey**, Housing California; **Naindeep Singh**, Jakara Movement; **Denny Chan**, Justice in Aging; **Jeffrey Reynoso**, Latino Coalition for a Healthy California; **Brianna Lierman**, Local Health Plans of California (LHPC); **Genevieve Flores-Haro**, Mixteco Indigena Community Organizing Project (MICOP); **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

Liugalua (Liu) Maffi, Faith in the Valley; **Pastor J. Edgar Boyd**, First African Methodist Episcopal Church

California State Representatives Attending

Nadine Burke Harris, MD, MPH, California Surgeon General; **Erica Pan, MD, MPH**, State Epidemiologist; **Rob Schechter, MD, MPH**, Chief, Immunization Branch; **Maricela Rodriguez**, Office of Governor Gavin Newsom; **Marcela Ruiz**, California Department of Social Services; **Marta Green**, California Government Operations Agency; **Martha Dominguez, CDPH**; **Kim McCoy Wade**, California Department on Aging

Public Attending

There were 48 members of the public attending by phone, one on the Spanish line, and 710 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

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

Erica Pan, MD, MPH, State Epidemiologist, 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 to the committee and the general public for their comments, concerns, advice and data. All of the submissions are reviewed and incorporated to the extent possible. Bobbie Wunsch also welcomed the committee and briefly reviewed the meeting process.

Dr. Burke Harris anchored the meeting in the values of safety, equity and transparency. In the face of a limited vaccine supply, the process of determining how vaccines are allocated is: 1) ensuring safety through the Western States Scientific Safety Review Workgroup; 2) receiving input from the CVAC advisory body and public comment to help address concerns, pose questions and make recommendations; 3) sharing CVAC comments and recommendations with the Drafting Guidelines Workgroup which uses the input to make difficult decisions about recommendations to the administration. This framework and the three groups were based on recommendations from the National Academies of Sciences, Engineering and Medicine (NASEM) which sought to create a framework where public and community voice could be heard and incorporated into the process, while charging medical and public health experts with ultimately making the difficult decisions. Dr. Burke Harris re-stated explicitly that equity includes equity for people with disabilities, in addition to race, ethnicity and socioeconomics.

Dr. Burke Harris noted that there have been many questions raised during and between meetings and the state is trying hard to get answers. The agenda today was constructed to offer answers, such as the federal pharmacy partnership, where certain populations fall in the transition to an age-based approach, how vaccine hesitancy will be addressed, how employers will participate in age-based vaccine distribution, and how notification about eligibility and vaccinations will work. Some topics will be addressed at the next February meeting.

Dr. Pan reflected that this is the 1-year anniversary of the first US cases of COVID-19. She shared encouraging trends around cases and test positivity, as well as hospitalizations and ICU admissions. It appears the surge is ending although restrictions, mask-wearing and social distancing remain. She acknowledged that although everyone has sacrificed there have been disproportionate impacts for some people and communities. She acknowledged how difficult the scarcity of the vaccine is for everyone and thanked this committee for its partnership.

Review Public Comments since January 20, 2021 Meeting #8

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Bobbie Wunsch summarized public comments received between January 19 and February 1. There were 269 individual or organizational submissions of public comment. Highlights include:

- UC Berkeley School of Public Health suggested using an anti-racist approach to vaccine distribution
- 11 people suggested simplifying the system to get a vaccine including public announcements
- 2 individuals requested improving the accessibility of vaccination facilities Including location, parking and signage
- Several any comments were about vaccines for healthcare workers including suggesting optometrists and veterinarians as vaccinators, and the California Behavioral Health Directors Association requesting behavioral health workers be identified as part of Phase 1a
- Many requests to prioritize specific occupations and communities to receive vaccine sooner: people who are homeless and working with the homeless (1); farmworkers, including one from the Santa Cruz Board of Supervisors (3); school staff and teachers (6); childcare workers/Head Start (2); people over 65 (4); people over 60 (2); people 50-64 (1); IHSS workers and participants (4); people under 65 with physical disabilities (32); people under 65 with underlying medical conditions including diabetes, cancer, HIV/AIDS, Hepatitis C, autoimmune conditions, lung disease, chronic kidney disease and blood diseases (54); adults with intellectual and developmental disabilities (24); a Superior Court Judge, Presiding Judge, Alameda County Bar Association and Association of Public Defenders on behalf of all court-related employees (13); cannabis industry (1); water, utility, power, energy workers (1); dockworkers (1); airline industry (1); public transit workers (13); food industry and USDA inspectors (3); bedridden and homebound elderly (5); people in waiver programs (1); biotech industry (2); family caregivers (3); independent living facilities/retirement communities (2); general contractors and construction workers (2); semiconductor industry (1); port authorities (1); laundromat workers (1); communications infrastructure contractors (1); code enforcement officers (1); research and testing labs (7); global communications (2); office building maintenance personnel (1); immigrants in detention facilities (3); and residential camps for children and youth (2).
- 4 individuals offered their help in vaccinating and making their families available (1 finds screening for volunteers is onerous, 1 suggests we teach non-health care workers to administer vaccines, 1 suggests using the National Guard to help with distribution and 1 offers private clubs as facilities for vaccination sites)
- 1 suggests using age as an equity factor and 2 suggest maintaining the age-based approach
- 1 suggests we not vaccinate prisoners or teachers working at home

- UCLA California Health Interview Survey provided detailed data on Native Hawaiians and Asian Pacific Islanders concerned that Healthy Places Index misses the impact of COVID on these communities
- 1 person wanted data on why the Moderna vaccine adverse events caused a pause in San Diego County
- 1 request to add someone from the cancer community to CVAC

Update on Vaccine Supply and Distribution

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

Marta Green, California Government Operations Agency

Paul Markovich, President and CEO, Blue Shield of California

Vaccine Supply Moving Forward

Dr. Pan highlighted some data and updates:

- 6.3 million doses have been delivered to California
- 3.8 million doses have been given
- Over 600,000 people have received two doses
- About two thirds of the supply has been administered
- Many are holding on to second doses without knowing how many doses are coming
- California is now 29th among states and doing well relative to other large states
- There have been big increases in capacity and now vaccines are the limiting factor
- For the next several weeks, California should receive: 1 million doses (week 1), 1 million doses (week 2), and 1.2 million doses (week 3). Some are committed as second doses.

California should soon begin to get 3-week projections from the federal government, an improvement over 1-week projections. Some of this depends on new vaccine approval and supply. The state will keep CVAC and the public up to date as information evolves.

Federal Long-Term Care Partnership

There is a CDC pharmacy partnership for skilled nursing facilities and long-term care facilities. CVS and Walgreens partnered nationally with CDC and plan to conduct 3 vaccine clinics at each site. They started with Skilled Nursing Facilities (SNFs) on December 28 and Assisted Living Facilities and others on January 11. Over 16,000 LTCFs (98% of the total) have clinics scheduled. As of February 2, there have been 348,346 doses administered: 297,504 first doses and 50,842 second doses. This includes 188,515 resident doses and 159,831 staff doses. The logistics have been challenging. There are 17,000 Long Term Care Facilities (LTCFs) in California and the vaccine was first received during the state's worst surge. Data reporting involves many systems, including new federal and state ones. There is ongoing work to improve the data flow and many of the early communication problems between partners have improved. All facilities should be completed by mid-March and SNFs by the end of February. Vaccine uptake among residents has

been good at 78% but less than 40% of staff have received more than one dose. There is a need to work on outreach and vaccine hesitancy in these settings.

Accelerating Vaccine Distribution and Administration/Third Party Administrator (TPA) Role

Marta Green introduced her role in establishing a TPA program to administer vaccines through a statewide vaccine network to ensure the equitable delivery of current and future vaccine supply. This is different in that the state will allocate vaccines directly to providers to maximize efficiency and have real-time transparency into where the vaccines are, who receives vaccinations and ensure they reach communities disproportionately impacted by COVID-19. The state will enter into a cost-basis, no-profit contract with Blue Shield of California to serve as the TPA for the statewide vaccine network. This network will include providers who meet program requirements, such as data integration, equity, and volume capacity. There will be a wide variety of provider types including health systems, hospitals, clinics, pharmacies, mass vaccination sites, mobile clinics and home-based vaccinations.

A TPA is an entity that selects and manages a network responsible for the delivery of health care or other services on behalf of a group of people. Blue Shield of California was selected to be the TPA for this project and is tasked with creating and managing an equitable and efficient statewide vaccine provider network. Ms. Green shared information about Blue Shield of California and its experience with similar projects. It's a California-based non-profit health plan with a provider network that covers all 58 counties and has experience as a TPA.

The key functions of the TPA will be to:

- Develop and manage contracts with providers in the state vaccine network, including start-up costs and incentive payments to reward equity and other metrics
- Communicate real-time information with providers about state expectations, tiers, policies and procedures, etc.
- Monitor and oversee the network to ensure it's performing to expectations
- Implement vaccine distribution with consideration of hot spots and equity measures
- Feed provider data to MyTurn.CA.Gov and the statewide dashboard for real-time transparency on the performance of the network and the penetration of vaccines

Ms. Green shared that the TPA will streamline multiple systems for vaccine reporting and data lags and gaps. The goal is to consolidate systems, ensure real-time availability of data, provide a user-friendly tool for the public to register for vaccinations, and ensure consistent tracking of follow-up doses. The state will ensure transparency by approving all distribution and administration criteria. The state will report vaccine administration statistics such as volume, geographic distribution and equity metrics through a public online dashboard. The guiding principles for distributing the vaccine are: saving lives by equitably distributing vaccines; distributing doses efficiently with minimal waste; being strategic and data-driven; and a highly coordinated and transparent process. The distribution framework will be developed by the

state working with partners and local health jurisdictions on the network development and distribution framework. Ms. Green shared that equitable distribution of vaccines will look like:

- All Californians - especially those disproportionately impacted by COVID-19 – will have equitable access to the vaccine
- All communities, urban and rural, receive equitable allocations of the vaccine
- Significant state and community outreach education efforts are focused on awareness
- California achieves high vaccination rates in all communities

California has stated a strong commitment to equity and will do the following to achieve it:

- Offering pay for performance (P4P) payments for vaccinating individuals living in the lowest HPI quartile census tracts
- Payments to providers for vaccinating communities of color
- Payments for targeted outreach and engagement efforts
- Enhanced payments to facilitate evening accessibility, translation/physical services, etc.

Paul Markovich, President and CEO of Blue Shield of California, spoke about Blue Shield's commitment to the project and shared that he believes the elements are in place for a gradual return to normalcy. There is a steady and increasing supply of vaccines and groups of people in government, health care and communities committed to success. What has been lacking is a systematic process to optimize all these pieces. Blue Shield has been asked to put this process together and manage it on behalf of the state. Mr. Markovich stated his intent for this process to happen quickly, effectively and collaboratively with CVAC and many other stakeholders. Mr. Markovich shared background about Blue Shield. Mr. Markovich volunteered to co-chair the Governor's COVID-19 Testing Task Force and was successful in increasing testing volume 50-fold; Blue Shield is active in Los Angeles establishing community resource centers for the low-income Medi-Cal population; and is partnering with the California Department of Education to address youth mental illness through its BlueSky initiative. Blue Shield has been recognized for its commitment to diversity, equity and inclusion. For example, there is no pay gap between minorities and non-minorities or between men and women in the organization.

Blue Shield plans to design a statewide network to accelerate equitable vaccine distribution. It will develop a rigorous, reliable and timely performance management system to:

- Track all vaccines from order to injection
- Understand who is getting vaccinated to ensure equity
- Receive comprehensive, accurate, same-day data
- Report performance in a detailed, transparent way

It will also partner with key stakeholders to build a high-performing network that can achieve the state's goals including equity. This strategy will include innovative ways to reach vulnerable communities and those disproportionately affected by COVID. It will consider its efforts successful only when vulnerable communities have been fully vaccinated. The goal of the

current phase is to continue vaccinating high-priority groups as quickly as possible, coordinate data and support vaccinators. The next phase is to accelerate the rate of vaccinations with minimal waste and phase in the new network later this month.

Comments and Questions from Members

Data and State Dashboard

- Why is there no state dashboard?
 - CDPH: There is a state dashboard that is continuing to be updated and improved. We can present it next time.
- Will the dashboard report race and ethnicity data?
 - CDPH: Yes, there is a plan to report this. Other state registries have this field but there is missing data and this will be improved soon as part of data accountability. The TPA will incentivize reporting of complete demographic details for the vaccinated population so it can be reported with granularity. Nationally only half of vaccinations are reporting on race/ethnicity. Patients have to agree to share it and this is where trust is needed.
- When capturing demographic data, people should self-identify if they have a disability or chronic health condition, even if the data is imperfect.
- Comments flagged additional elements to include in the dashboard: counties, cities, and zip codes; occupation; and, additional elements to include in data collection: housing status (e.g., stability, instability, homelessness), sexual orientation and gender identity.
- Consumers/families should be able to see vaccination rates of residents and staff by facility.
- Data collection needs to be voluntary. Post vaccination monitoring for an allergic reaction is an excellent time to explain why the data is important and being collected (in the person's primary language) and could be done by a volunteer.
- Some very basic and crucial communication is still not happening: exactly who is getting the vaccine and hesitancy rates. Transparency engenders trust.

Proposed P4P Incentives

- Can we give a differential payment with an equity goal for those that are proactively trying to vaccinate people with high-risk disabilities? Serious health conditions in all ages?
 - Staff: We will bring this back as we develop P4P payments. We may share our preliminary thinking for feedback electronically.
- Will the Blue Shield TPA network/approach be in *addition to* or *instead of* the current approaches to vaccine distribution?
 - Staff: The state is centralizing distribution but will credential the existing providers in the county-based systems. There will be a transition to a state-decided network that will build on the existing network and can deliver the vaccine to various communities. Every provider may not continue but the

state is working with county health providers to ensure the right providers to reach these key populations as quickly as possible.

- What are the dollar amounts for the incentives? Are these incentives state dollars not reimbursable from the Federal Emergency Management Agency (FEMA or other federal funds)?
- What are the incentive payments for? Cost of setting up in an underserved community?
- Can the state provide data on successful P4P programs in healthcare? Instead of providing incentives and “hoping” that those incentives work, we need to make sure that the vaccinations occur. A few articles on P4P in healthcare.
<https://www.acpjournals.org/doi/full/10.7326/M16-1881>
<https://www.acpjournals.org/doi/abs/10.7326/M17-3005?journalCode=aim>
<https://link.springer.com/article/10.1007/s11606-017-4243-3>
- Speed and equity may not be inherently at odds, but for the groups that have historically suffered disproportionate healthcare and systemic barriers, including abuse of their trust, it will take time to trust in vaccination. This is partly a matter of "performance" from vaccination providers AND a matter of gaining trust. What will actually happen with incentive payments if the provider doesn't manage to "earn" them?
- “Accountability” is relative during a pandemic. Who is “accountable” for the 8,664 nursing home deaths? I can explain why P4P is problematic in healthcare.
- P4P will keep vaccinators accountable. It is common contracting to reward meeting goals.

Congregate Settings

- What is the total number of California LTCF residents and LTCF staff?
- Are the 78% and 40% vaccine uptake rates in LTCFs national or state figures?
 - CDPH: These are state figures.
- Is there similar data on age that looks at case rates and mortality rates for age bands who reside in different settings: own home, Intermediate Care Facilities(ICFs), nursing homes, etc.?
 - CDPH: Vaccine Dashboard includes LTC Facility Pharmacy
<https://covid19.ca.gov/vaccines/#California-vaccines-dashboard>
- Granular vaccination uptake data for healthcare workers at nursing homes and assisted living facilities would give useful insight into vaccine hesitancy issues for the communities that disproportionately work in these roles— especially women of color.
- Can you clarify correctional facilities? Immigration detention facilities? We need to prioritize prisons, immigration detention, homeless shelters and similar facilities regardless of age.
 - CDPH: We are working on how to address high risk congregate settings including incarcerated settings, homeless shelters, U.S. Immigration & Customs Enforcement (ICE) detention facilities and mental health/behavioral health (BH)/Substance Use Disorder (SUD) residential facilities. As noted by the Drafting Guidelines Workgroup, local health departments are poised to

do this and we will be working with Blue Shield on assuring allocation to these settings in the context of an overall equity framework.

- The jail and homeless populations are transitory -we had initially discussed perhaps having Johnson & Johnson 1-dose be an option for these folks.
 - CDPH: The Drafting Guidelines Workgroup will also be discussing this recommendation at their meeting this Friday.
- We cannot find 38% of vaccinated long term care staff to be acceptable. When the federal pharmacy partnership is over, who will do the work to get them vaccinated?

Provider Network

- The "provider requirements" outlined could be difficult for entities that have the best ability to reach communities of color. Can we learn more about the provider network and criteria and what "volume capacity" means?
- It is important to include our over 800 independent neighborhood pharmacies. They are located in underserved communities, urban and rural. They may not have large volume capacity but ensure equity and access to those with transportation and language barriers.
- Is it true that if a county contracts with the TPA they cannot issue vaccines to other providers, like community health centers? Does this mean that every single provider that wants to vaccinate must have a contract with the TPA? California Primary Care Association (CPCA) is concerned about this.
- Do providers at the county have to re-apply to be a provider to the state TPA? How will the transition work? How do we get the benefits of centralization without new barriers?
- CVAC has discussed "trusted messengers" and clearly that must include "trusted vaccination agents." Especially if we want people to let someone into their home.
- How is the TPA going to contract quickly with the thousands of providers that are needed?
- If there are problems, do we have mechanisms for complaints to quickly identify and fix issues? Where would people call if there's an issue?

Community Health Centers

- Will Blue Shield engage with Community Health Centers (CHCs) as the trusted source of care for low-income and uninsured people?
 - Blue Shield: There is a tension point here. Vaccines are highly perishable and have to be stored at extremely cold temperatures. We need to work with networks that can manage this and administer all the doses to prevent waste. We need some flexibility and local reach. Blue Shield needs the most help with identifying where the sites should be – including mobile, at-home, pop-up sites – and work with people who know each community to make sure there's a supply chain without waste getting to communities.
 - CDPH: It is often perceived that equity and volume are at odds with one another. California has heard from the federal government that states will be

allocated vaccines based on their rates of actual administration. The faster we get vaccines out, the faster we will get them in. This is central and the state is utilizing accountability, P4P incentives and contractual language to ensure vulnerable communities are vaccinated.

- We have concerns about not utilizing Federally Qualified Health Center (FQHC) capacity. Health centers say they receive very few or zero doses from their county health departments. These are the providers focused on vulnerable farmworker, rural and uninsured communities. Some have been reprimanded for using the doses for farmworkers despite following guidance. We need a structured, centralized way to reach farmworkers through mobile strategies and smaller FQHCs.
 - State: CHCs and FQHCs are key partners. We want to get them in the network especially in strategic areas that can help meet equity goals.
 - Blue Shield: Our ability to move quickly and ensure efficacy may mean we place a separately managed vaccine facility near the CHCs and FQHCs rather than expecting them to do it all. There are multiple options.
- Health centers were created and put into underserved locations to build relationships for equity reasons. They have built a legacy of trust and have refrigerators; they know how to vaccinate populations. The Biden team has a plan for FQHCs as partners and yet they haven't been leveraged in California. Volume and equity are not equal things. Equity is slow and messy. Every single CHC should contract with the TPA and receive an allocation even if it's slow. They have systems in place but need resources and to be in the conversation.
- We cannot forsake equity for volume. Many clinics are small but are in the places serving the people no one else can get to and those folks trust the clinics. We would like to see every CHC secure vaccines no matter their volume capabilities.
- We agree with the state on equity but are dismayed that large systems appear to be getting all the vaccines. We would like to see providers like community health centers that serve 7.4M people- nearly all of whom are under 200% of the federal poverty level (FPL) and over 2/3 of whom are black, indigenous, and people of color (BIPOC) secure vaccines . How is the TPA going to balance this?
- The network of physician groups are often those groups serving the insured. Community Health Centers are the ones serving under and uninsured. They need to be included and resourced if we are really achieving equity versus equality.
- Many CHC's have spent their limited resources on freezers and infrastructure needed to provide vaccines. Resources are better spent to support these efforts than recreating an infrastructure with different messengers.
- FQHCs serve many persons with disabilities, insured and uninsured.
- Local plans fully support CHCs on looking to our clinic partners in this.
- I would encourage communication with CHC's, invite you all to speak with our patient educators and promotores about what is needed to reach vulnerable communities.

Traditional systems that may seem efficient for patients that can navigate the system are inefficient if not working with folks that know how to provide care to those patients.

- FQHCs are critical to Equity. Blue Shield should work closely with FQHCs, especially in rural areas.

Vaccine Implementation

- How does the TPA intend to deliver the vaccine to individuals who are homebound, particularly in rural areas, given the refrigeration requirements?
- A large percentage of home health patients are non-ambulatory and our home care agency nurses are happy to vaccinate their homebound patients if they receive vaccines directly.
- How can someone receive a second dose if they received their first dose before January 10th? The system to auto-schedule second doses was not built until after that date. Some are past the recommended time interval and are told they cannot make appointments.
- The allocation has been consistently sound. It's the provision and individual ability to access provision which has been the problem.

Rural Communities

- We ALSO NEED TO NOT FORGET OUR SMALL RURAL COMMUNITIES, who are often poorly resourced but don't "fit" the rubric for "high risk communities based on numbers.
- There remains a deep and profound need in rural communities, like Imperial County. They are hit hard by the vaccine and aren't able to get vaccines. We have a Councilmember in Blythe, CA in Riverside County and residents there need to drive 2 hours each way for a vaccine.

Coordinating with Stakeholders

- Working with trusted messengers will involve more than input from CVAC. Legitimate distrust exists in communities with managed care. What are the details of that component?
- Key stakeholders should expand beyond local health jurisdictions (LHJs) to integrate community voices.
- "Stakeholder" models for planning and program implementation have proven problematic during this pandemic. The highest risk of death is coming from older adults and the disabled in congregate and home settings, especially older adults of color in multigenerational households. How will subject matter experts in geriatrics, long term care medicine and complex chronic care be fully engaged in developing and adjusting the plan? The key weakness of the FPP was that it was pharmacy-centric, rather than person-centric. How will this program be person-centric for those who have the greatest challenges accessing the vaccine? P4P approaches in healthcare are controversial and can run counter to a person-centric model. Why not just focus on getting this done?
- It is critical for Blue Shield to recognize they need subject matter experts like the FQHCs and those of us with expertise in long term care and the care of the disabled. Overlaying a

statewide approach that doesn't actively engage the experts in the planning and operations risks repeating the failures that we've already had.

Other Blue Shield/TPA Questions and Comments

- How was Blue Shield of California selected? What factors were considered by the Governor's office?
- It is my hope that Blue Shield will include community agencies as part of the outreach and education component and local clinics and partners to reach our most vulnerable.
- I hope the TPA can build out a system that captures intersectional data along age, disability, race, and the other factors already identified. It is not as helpful to report out data by silos given the diversity within communities and the way intersectional discrimination works.
- Will this be outside of the ordinary /routine Medi-Cal point of service or integrated within?
- How will the TPA coordinate with the Biden's Administration plan to ship millions of doses of vaccine directly to pharmacies?
- I want to know what we are doing to ramp up capacity to administer vaccines. Our current infrastructure gets flu shots to 19 million Californians--just less than half of the population. (Kaiser and Blue Shield do a little better but not significantly more). To get herd immunity of two doses, we need to do 60M. So wouldn't we need more providers and infrastructure?
- How will the Blue Shield TPA interface with existing health plans/systems /providers? Do they schedule an appointment with their provider, or with this statewide system? Depending on the answer, that leads to follow-up questions of determining pre-existing conditions: a current plan/provider may have that ability to target, more than Dodger Stadium, so appreciate the logistical issue but trying to understand how it would work. Another follow-up question is about strategies for those who are uninsured/without usual course of care.

Updated Recommendations from Drafting Guidelines Workgroup

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

Rob Schechter, MD, CDPH, Co-Chair, Drafting Guidelines Workgroup

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

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

Dr. Schechter and Dr. Brooks presented on the transition from an age- and sector-based approach to an age-focused approach to vaccine prioritization. Dr. Schechter recapped national recommendations and shared data on the risk for older adults: there is a very large increase of severe/fatal disease starting as early as 55 and a tremendous increase in risk after 80 years old. CDC data on risk by race and ethnicity generally shows a two- to five-fold risk of hospitalization and death in Native American, Latinx and African American populations. Overall, it appears that people with underlying conditions have about a three times higher risk of being hospitalized or

dying from COVID-19 than those with no underlying conditions. Of hospitalized adults that died from COVID, nearly 80% had three or more underlying medical conditions.

The workgroup reviewed a few studies regarding people with disabilities. Dr. Schechter shared one study found that people with intellectual and developmental disabilities (IDDs) living in SNFs have the highest case rates and death rates, those in other congregate settings had lower rates but still elevated, but those residing in their own or a family home were at lower risk than the general population. Claims data nationwide and some UK studies find two to threefold rates of mortality in persons with disabilities compared to those without, although many of these studies included older adults and did not differentiate between who also had multiple underlying conditions. It is therefore challenging to assess the risk associated with those currently excluded by the immunization prioritization guidelines – i.e., those under 65 and residing outside congregate settings.

Dr. Brooks then presented that the Drafting Guidelines Workgroup met and re-affirmed the prior recommendations:

1. Phase 1a: Complete immunization of the healthcare workforce and residents of long-term care facilities.
2. Phase 1b Tier 1: Immunize individuals age 65 years and older and/or working in the essential sectors of agriculture and food; education and childcare; or emergency responders . The Drafting Guidelines Workgroup continues to strongly emphasize equity in its recommendations and in COVID vaccinations.

Dr. Brooks shared that the Drafting Guidelines Workgroup is recommending that the next phase or tier should include, at a minimum, Individuals 16 -64 years with underlying serious medical conditions or disabilities that increase their risk of developing severe COVID-19. The workgroup understands that this group is more challenging to identify and verify in large vaccination sites; therefore, this recommendation:

- applies only to settings, such as health systems or other clinics (but not mass clinics or other local health department clinics) where underlying conditions or disabilities can be verified through access to medical records.
- requires that the qualifying health conditions and disabilities are defined with sufficient specificity that eligibility for the phase can be determined when patients request an appointment for the vaccine.
- suggests that implementation plans include outreach and assistance to individuals who have barriers to making appointments or receiving the vaccine.
- Prioritizes these groups after Phase 1b, Tier 1 due to their large numbers and comparative aggregate risk of severe outcomes.

Dr. Brooks mentioned that an alternative proposal limiting eligibility to individuals with multiple (e.g., more than three) underlying medical conditions was also discussed. He acknowledged

that local health departments have emphasized their crucial role in immunizing residents in local correctional facilities, homeless shelters and detention facilities, and this will be the plan and intent for these settings and populations. Dr. Brooks voiced that he is encouraged by the Blue Shield plan: to ship vaccines directly to vaccinators, to work on equity, to document race and ethnicity data, and to have real-time data about who is being vaccinated.

Dr. Pan shared that the state takes very seriously concerns about people with disabilities and underlying medical conditions and affirmed this will be the next priority group. She indicated that the conditions need further definition and methods to do this in an equitable way, including those for whom COVID may prevent someone with a disability from receiving services they need for well-being or survival. The Drafting Guidelines Workgroup will take a closer look at things like what level of kidney disease to prioritize and how to define severe diabetes. Secretaries Ghaly and Richardson directed the state to form a vaccine implementation group to address concerns about how to operationalize this. The group will be co-led by Kim McCoy Wade, the Director of the Department of Aging, Director Dr. Tomas Aragon, State Public Health Officer and Director of the Department of Public Health (CDPH) and Nancy Bargmann, Director of the Department of Developmental Services. Director Wade thanked the representatives from the disability community, the aging community and other stakeholders from the medical community and labor who will be joining the group. The group will address recommendations on the when, the how and the where, addressing details on how to operationalize equity. Dr. Pan indicated that there still is an intent to move to an age-based framework and that as the state learns about forthcoming supplies, it will map out the next phases and tiers. Dr. Brooks reminded the group that the Drafting Guidelines Workgroup is listening to the CVAC for its input toward final recommendations to the Governor.

Comments and Questions from Members

People with Disabilities and Underlying Health Conditions

- Thank you for your progress on this issue and responsiveness and for explicitly stating that disability is a component of the state's equity framework. The proposal that was presented is the best attempt to thread the needle based on the science. One suggestion is to name developmental disabilities in the list. I look forward to the workgroup.
- As a person with a disability and multiple underlying health conditions, I don't feel confident that doctors would be able to give me the documentation I need to qualify for a vaccine.
- We've been pushing for Regional Center and Home & Community-Based Services (HCBS) clients, why was the IDD population researched but these others weren't? These populations have similar high risk factors.
- I want to emphasize choice for people with disabilities. We should have a choice to go to the site that is easiest to access which may not be my doctor's office.
- Is there consideration of the Journal of the American Medical Association (JAMA) research on those with psychotic disorders, specifically schizophrenia spectrum disorders, who have

shown to have rates of COVID mortality – second only to age? While a small population, it is still a high risk group.

- We should allow all In-Home Support Services (IHSS) providers and clients get the vaccine at the same time. Many times IHSS Providers are the people who will be taking their clients to the appointment.
- I fear that this approach to Phase 1b, Tier 2 places the burden on individuals to "prove" their disability and does not feel appropriate, especially considering the state knows many of these individuals and has information about them.
- Medical racism results in people of color with high-risk disabilities getting un-diagnosed/under-diagnosed. The approach proposed under Phase 1b, Tier 1 exacerbates those disparities by keeping people out who may still be high-risk.
- I do worry about the most vulnerable patients who do not have routine healthcare and hence, may have many comorbidities but are not aware of them.
- One of the reasons that we think it is important to include people with disabilities who are IHSS, Regional Center, Medi-Cal waiver (and so forth) consumers is because this is a group that highly intersects with people of color, low income, LGBTQ+, and so forth, as well as multiple comorbidities. Finding ways to easily verify these specific groups will be important.
- Thank you for including people with disabilities, including those who are deaf.

Essential Workers

- Please consider worksite-based distribution (vaccinations in worksites/work areas).
- MyTurn.gov only allows healthcare workers and individuals 65+ to book appointments immediately. Why aren't the other 1b tier 1 populations of essential workers (child care workers/ farm workers, etc.) also being prioritized to receive appointments now? Were those groups pushed to a lower tier priority once 65+ was included in the 1b group?
- Imperial County has yet to put vaccines in the arms of most vulnerable essential farmworkers. Imperial County needs more vaccines and is one of the counties hardest hit.
- Adding to the data presented regarding COVID-19 morbidity rates: A recent University of California, San Francisco (UCSF) study showed agricultural workers are at an extremely high risk. Based on death certificates from the state Department of Public Health, the study estimates additional mortality among 18-to-65-year old Californians based on occupation, with other breakouts according to race and ethnicity. "Working age adults experienced a 22 percent increase in mortality compared to historical periods" during the pandemic, according to the abstract. However, "relative excess mortality was highest in food/agriculture workers (39 percent increase)." And while "Latino Californians experienced a 36 percent increase in mortality," there was "a 59 percent increase among Latino food/agriculture workers." Most counties are not prioritizing agricultural workers despite evidence that we should vaccinate agricultural workers now.

- What is the plan for Phase 1c essential workers in public transit, water/wastewater workers, and sanitation workers? It's important to maintain an adequate workforce for critical services.
- I still find essential workers (other than the three groups in 1b, 1) conspicuously absent as we're discussing new iterations of Phase 1b, Tier 2.
- Based on the slide - it is a 65+ AND/OR Essential Workers. Teachers need the vaccine to open schools this school year.
- How are In-home caregivers to vulnerable older adults, paid and unpaid, accounted for? Are they healthcare workers? Will they need "proof" of being a caregiver to be vaccinated?
- If I'm understanding this proposal, we will further significantly delay vaccinations for essential workers not in Tier 1/Phase 1B. For example, bus drivers, social workers, utility workers will wait additional months for vaccination. These workers cannot quarantine and face employer intransigence with respect to personal protective equipment (PPE), social distancing, etc.
- We see that child care workers are not a focus of this phase. The First 5 Association of California is developing a set of messages and communications outreach to target childcare workers. We'd welcome partnering and coordinating efforts with the state.
- Several of the "priority labor sectors" named by the California Department of Social Services (CDSS) are not in Phase 1b, Tier 1. It seems harmful and almost cruel to convince them of the need for immediate vaccination while pushing them so far back in line. They should be placed back in Phase 1b, Tier 1.

County Implementation of Phase 1b, Tier 1

- There is some confusion as to where 65 and over lie, and this conversation re-affirmed that within the tier, 65 and over is not prioritized over essential workers. However, we are seeing counties like Sacramento, Solano and Placer that are prioritizing 65 and over above essential workers, and also prioritizing within the essential workers. Can counties do this?
 - CDPH: We are in a transition phase. There are about 3 million people eligible in Phase 1a and 8.5 million in Phase 1b, Tier 1, so we need 23 million doses for these populations and we've received 6 million doses. We've said these groups are equal in Phase 1b, Tier 1 but counties had plans in place before we pivoted and it is very difficult to operationalize this efficiently. It will take time to get through the 8.5 million people in this tier especially given concerns with hesitancy and uptake. Going forward we are thinking about rolling eligibility so we will not get through each phase before we move on to the next group but we want to make a good dent. There is variability and we are planning more centralization and equivalency across the state.
- Sacramento County has said their priority for 1b is seniors and public safety. My concern is that occupations like food and ag that don't have the PPE and ability to social distance will be last in 1B and continue to be overrepresented in COVID deaths and exposure.

Comments and Questions about Phases and Tiers

- The recommendations posed are not in line with what we've been suggesting as a group.
- Combining everyone over 65 also overlooks higher or lower risks within that group.
- Is this recommendation in place of the age-based tiers under 65 that were announced last week? Or alongside with the age tiers and other essential/exposed workers as was originally planned for Phase 1b, Tier 2?
 - CDPH: This is not in place of an age-based framework. The state is still moving to an age-based framework.
- PLEASE provide clear direction to counties regarding Phase 1b, Tier 1.
- I'm still unclear about the actual prioritization after Phase 1b, Tier 1: Is the recommendation by the Drafting Guidelines Workgroup to create a Phase 1b, Tier 1.5? Or how does it relate to age bands or the workers/congregate care settings in the former Tier 2? Do providers have the ability to prioritize for those with pre-existing conditions within Phase 1b, Tier 1?
 - CDPH: After Phase 1b, Tier 1, the focus will be on high-risk conditions, then become age-based. Yes, providers can sub-prioritize and many are doing this.

Promotoras

- There exists an army of promotoras across hundreds of community-based organizations (CBOs) throughout all of California ready to assist with outreach education and partnering with providers, CHCs and plans to reach our more vulnerable and in need before and after they receive the vaccine.
- Has there been clarification to counties that promotoras are eligible under 1a designation?

Using Equity Moving Forward

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

Dr. Burke Harris reminded the committee of the previous presentation on a Categorized Priority System (CPS), including a database tool to calculate how to distribute the vaccine equitably. She acknowledged it is critically important to address both equity and simplicity. A CPS tool is one way to do this and is currently being used in other states. For example, she presented an example of a possible equity model in which 80% of vaccine supply is allocated according to the current methodology and 20% allocated to counties or regions based on the lowest HPI quartile zip codes (or census tracts). Dr. Burke Harris presented a simplified diagram clarifying that the lowest HPI quartile would receive double the number of doses that it would in the current, population-based methodology. The goal of this strategy would be to use this equity framework to bring a proportionate number of doses to communities experiencing the greatest impact of COVID-19. The final determination of how equity will be applied will be finalized very soon.

Dr. Burke Harris commented that allocation of vaccines through a CPS is only one tool to address equity. Other strategies include outreach to targeted populations; earned and paid media powered by research and targeted to vulnerable communities; addressing low vaccine confidence; partnering with CBOs in outreach, communication and vaccine implementation; Incentives, support, accountability, and P4P for transportation, mobile and in-home services.

Addressing a question of why the state should incentivize providers to vaccinate vulnerable communities, Dr. Burke Harris shared that California acknowledges that addressing equity requires recognizing the historic and structural barriers that make it more difficult for these communities to have the same access to vaccines. This means the state does need to create incentives to achieve equivalent outcomes in vulnerable communities. The state looked to the HPI because it looks at the resources communities need to stay healthy – transportation, education, health centers, etc. The history of racism and discrimination means that community resources are not evenly allocated, which gives rise to the differences we see in health outcomes, vaccination rates and other outcomes. To address these structural barriers the state needs to provide support for health care providers in vulnerable communities and compensate for under-investment. It also has to require data and accountability. Dr. Burke Harris highlighted that P4P is common in many sectors and industries and reiterated strategies Marta Green shared earlier that will center equity in vaccine delivery.

Comments and Questions from Members

- Will the HPI be calculated by census tract or zip code?
 - CDPH: This is still being operationalized.
- Can you help me understand how the Phase 1b, Tier 1, with insufficient vaccine supply, will have equity incorporated and operationalized in decision-making and rollout at the local level – e.g., with farmworkers and childcare workers?
 - CDPH: The Drafting Guidelines Workgroup first developed a framework based in part on age and in part on sector as one way to operationalize equity. As the state recognized the need to move to an age-focused framework, the determination was to complete Tier 1 of Phase 1b and then make the transition. Part of the consideration of completing this tier included the consideration of equity and recognition that many counties had already begun implementing Tier 1. As we were moving to a more age-based system we recognized that the allocation of vaccines to vulnerable communities would be important to prioritizing equity within an age-based framework.
- At the local level as this is rolling out, the vaccine limitations mean we're not seeing the path to the groups we agreed from an equity perspective are important to vaccinate early.
 - CDPH: This is also why we're moving to a TPA – to use contractual tools to more quickly and unambiguously operationalize equity.

- Can you clarify why we are moving from a minimum allocation of doses to lowest quartile zip codes to a P4P system and what will be different? Why are we going to P4P instead of having a set number of doses to underserved areas? How do CPS and P4P compare?
 - CDPH: There are multiple tools at play. The state will allocate where the doses go through the TPA using data will be used to direct doses to lowest quartile zip codes. The TPA will use the CPS to allocate disproportionate doses to the lowest quartile regions and then – additionally – utilize financial incentives and P4P to promote equity. The TPA will be paid at cost for its efforts, and the P4P is for vaccine administrators on the ground, not for the TPA. All these are ANDs, not ORs. Achieving equity is hard and needs all these tools to address entrenched barriers over centuries. California’s commitment to equity means we will use all the tools in the toolbox to get there.
- I appreciate the notation of the highest affected and at risk. In practice, not all counties are not following those priorities. I look forward to the Blue Shield plan which stresses the importance of reaching the hard to reach, vulnerable communities with less access.
- Will vaccines allocated to a particular quartile be allocated to people who establish that they live or work in that zip code, or just to vaccines administered in those zip codes?
 - CDPH: Allocation may be based on communities the provider serves to try to get at , but accountability will be based on where the persons reside.
- I want to encourage the state and all of us to consider equity in those 65 and older trying to get the vaccine now in Phase 1b, Tier 1. Most of these people getting the shots now are White, building on train tracks that have long fueled disparities. I fear that as we transfer to the TPA we will continue an open system that rewards privilege, access and capacity, putting older adults of color harmed by COVID in a disadvantaged position. I fear we’re not drilling down on strategies to reach these populations now.

Next Steps on Community Engagement, Equity and Vaccine Acceptability: *Continuing Discussion*

Nadine Burke Harris, MD, MPH, California Surgeon General

Maricela Rodriguez, Office of Governor

Marcela Ruiz, JD, Director, Office of Equity, CDSS

Martha Dominguez, Ph.D., MPH, CDPH

Arleen Brown, MD, UCLA and Olive View-UCLA Medical Center

Dr. Burke Harris re-introduced Maricela Rodriguez, Marcela Ruiz, Dr. Martha Dominguez and Dr. Arleen Brown. Ms. Rodriguez shared highlights from the campaign so far. The digital content in three languages is performing above industry standards. There is programmatic and paid social media that includes pre-rolls on websites and other tactics. There are PSAs running in English and Spanish, plus live reads through ethnic media reaching 40 media outlets in 18

different languages. The approach is nimble to reach a maximum audience with key messages on safety, effectiveness, data privacy and free vaccines. Earned media included three media briefings this week in partnership with Ethnic Media Services and California Black Media with 79 outlets attending and generating over 90 pieces of coverage statewide. There are new graphics on the partner toolkit site in English and Spanish, including one with My Turn that includes the call center number. New content and translations continue to be added. Ms. Rodriquez shared a sample related to Black History Month, highlighting COVID-19 heroes on the frontlines of mitigating spread and sharing key vaccine information. This is a partnership with radio, amplified through print, social media and earned media efforts, leveraging Black History Month to reach the Black/African American community.

Ms. Ruiz updated the group on the community outreach campaign and community engagement efforts. CDSS and the Labor Workforce Development Agency are jointly administering money to support outreach to disproportionately impacted communities and people working in high-risk industries. They will be contracting with 150 organizations to conduct outreach administered through the Center at Sierra Health Foundation (“The Center”) and the California Community Foundation (CCF) that builds on the strong networks from census outreach.

Outreach priorities will be driven by data on COVID burden, HPI and other equity indices. Partners will have access to data maps and tools to help target their research. The state is prioritizing high-quality interactive engagements such as training, phone banking and canvassing since the purpose is to ensure these populations have a chance to ask questions in their language. One-way outreach will be supported but is not the priority for this project. Ultimately the goal is to direct people toward the vaccine and processes available to help them enforce their labor rights and other economic supports. Ms. Ruiz highlighted the populations and sectors of focus, including worker rights with a focus on industries in which workers may experience greater risk of contracting COVID – i.e., farmworkers, food service, janitorial, warehouse/logistics and manufacturing. Other disproportionately impacted populations of focus include Asian Americans, Black/African Americans, Native Americans, Latinx, Middle Eastern and North African, Native Hawaiian/Pacific Islanders, LGBTQ+, people with disabilities, deaf and hard of hearing populations, older adults (65+), Limited English Proficiency, people experiencing homelessness, and multi-generational households.

Ms. Dominguez shared that the state has selected a multicultural integrated media agency called Duncan Channon, with specialized capacities and experience to ensure a multicultural campaign to reach all Californians. Their focus will be ensuring a strategic overarching approach for public health messaging and developing a statewide strategic media campaign that is cost-efficient and designed to reach communities disproportionately impacted by COVID. Their approach will be sequential; connecting, educating, normalizing and activating Californians with creative messaging and tactics. She shared an overview as follows:

- Develop a strategic, overarching approach for public health messaging handling the vaccine rollout, including addressing barriers to the vaccine (i.e. hesitancy) as well navigating through continued COVID-19 uncertainty and countering misinformation and disinformation with science-based and evidence-based facts.
- Develop a statewide strategic, media campaign that is cost efficient and maximizes reach to communities disproportionately impacted by COVID-19 including Hispanic/Latinos and African American/Black populations, essential workers, and other target groups determined by CDPH, based on internal and external research.
- Emphasize public health strategies and tactics to ensure users are reached where they consume information in multiple languages, guided by Medi-Cal threshold languages.

The state has robust research informing this approach and are determining the motivators for adoption through a comprehensive literature review, stakeholder interviews, generational online ethnographic sessions and online qualitative discussions. Four barriers to vaccine adoption the state continues to examine are:

- Lack of information and guidance, creating fear of government control
- Anti-vaccine skepticism, conspiracy theories related to mRNA, etc.
- Historical incidents with vaccines, especially in African American and Native American communities
- Lack of efficacy and safety data given speed of development and concerns about long-term effects

Some factors that seem to empower communities to get vaccinated include:

- The right messengers that are trusted and resonate in each community
- Disseminating information in language and in culture
- Humanizing lived experiences – testimonials from real people who can share their experiences
- Using channels to reach audiences where they are including local CBOs, news media and ethnic media outlets

Key findings from stakeholder interviews in which CVAC members participated include:

Highlights the safety and benefits of the vaccine

- Integrates the concept of everyone working together
- Focuses on how the vaccine helps family and community
- Addresses vaccine side effects
- Acknowledges distrust in government

These interviews suggested that messengers and influencers should include doctors/medical professionals; religious leaders; promotoras, health navigators and other trusted community members; community health workers and cultural centers; family members and caregivers; and legal, health and social community activists.

Stakeholder interviews shared the following barriers to vaccine acceptance:

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

Finally, in consumer interviews with family dyads and triads across the state, the state learned:

- The COVID-19 vaccine invokes tremendous emotion, anxiety, fear, frustration and anger
- Layers of confusion feed hesitancy
- Decision-making is happening moment-to-moment
- Fear and confusion are surrounding vaccine availability and eligibility
- Concern that even after being vaccinated, one can still spread the virus

Dr. Arleen Brown shared information about the project STOP COVID-19, Share, Trust, Organize and Partner: the COVID-19 California Alliance. STOP COVID-19 was funded by the National Institutes of Health to:

- conduct urgent community-engaged research and outreach focused on COVID-19 awareness and education to address the widespread misinformation about COVID-19 and promote an evidence-based response to the disease; and
- promote and facilitate inclusion of diverse racial and ethnic populations in COVID-19 clinical trials (prevention, vaccine, therapeutics), reflective of the populations disproportionately affected by the pandemic.

As one of 11 states funded, the California Alliance includes 11 academic health centers and 70 community partners. The goal of the project is to:

- 1) Understand barriers and facilitators to knowledge about COVID-19 risk, testing, and prevention; feasibility and acceptability of COVID-19 vaccine trials; and uptake of an approved vaccine across high-risk communities in California, as well as examining variation by geography and risk group (race/ethnicity, language, occupation, etc.).

- 2) Co-develop and examine the effectiveness of culturally/linguistically tailored strategies for reducing barriers to knowledge, trial participation, and intent to receive vaccines
- 3) Identify best practices for training and deploying academic community-partnered teams that include “trusted messengers” who will bring culturally tailored, community-relevant information to communities and sectors at high-risk for COVID-19. Examine their impact on knowledge, trial participation, and intent to receive vaccines.

Community partners include diverse groups and each site is working collaboratively on relevant projects in their community, including trusted education and outreach from CBOs and Community Health Workers; local media; health fairs; and visual arts. There is qualitative research such as focus groups and deliberative community engagement; capacity building and bi-directional training; surveys; needs assessments; and clinical trial community engagement. The project works with different populations and communities and in conjunction with the California Health Interview Survey (CHIS) and a dashboard of COVID questionnaires. To date there have been about 120 webinars, town halls and community meetings reaching over 10,000 people. In Los Angeles they have worked collaboratively with the clinical trials because they keep hearing that people in the trials “don’t look like us.” In fact minority participation in the California vaccine trials is 70-75%, which is far higher than the national average. They have also developed community friendly materials that communicate the science in a visually clear way that resonates with many audiences. Many of these materials are designed to counter hesitancy, fear and misunderstanding about the vaccine.

Some of the preliminary themes raised through these methods and settings include:

- Questions, concerns and need for information about specific things such as whether fetal tissue was used in the development of the vaccine and diversity of vaccine trials
- Social determinants of health, accessibility, affordability, transportation, childcare, elder care
- Population-specific concerns such as legal status for self, family and community
- A lot of diffused positivity and altruism despite hesitancy – e.g., “If someone would sit down and talk to me and answer my questions, there’s a much greater chance I’ll take the vaccine.” This suggests that providers should ask why when people say no to the vaccine.

Finally, the project has consolidated FAQs into electronic fact sheets in English and Spanish for Community Health Workers and others doing outreach. Dr. Brown emphasized the need to make sure people on the frontlines get their questions answered and their concerns addressed. Sometimes they are reluctant to talk openly about their own concerns about medical research.

Comments and Questions from Members

Culture and Language Access

- Given rates in Pacific Islander (PI) communities, there should be a PI media workgroup.

- CDPH: Great idea. We have been doing outreach to Native Hawaiian and Pacific Islander groups and are intending to do more.
- Our statewide information doesn't account for unique localized communities with low-income, high Limited English Proficiency communities engaged in 'essential work' and least connected with health resources. Punjabi and Hmong communities in Central California (and of course our Latinx communities) are engaged in meat/poultry factory work - an occupation and employers with conditions that increase the chance of contracting the virus.
- Please include post-vaccination literature, instructions and follow-up vaccination in different languages to increase participation rate for the second vaccine shot.

Barriers to Vaccine Access

- A lot of outreach is how to activate people, but the second part is navigation. If we activate people and then they hit barriers, it can be demoralizing and confirm that the system is not made for them. Some solutions: promotoras/health navigators; place-based approaches that coordinate the activation with navigation and access to vaccine clinics in a local setting.
- Even as a White older adult advocate I still haven't been successful in getting my own mother vaccinated. This is just too challenging a system.
- Access is near impossible if you are poor, don't have a computer, understand how to go online or have time to wait hours to get a response.
- We've heard that some sites have asked for social security numbers as part of the registration process (for example, the PetCo Park website in San Diego asks for SSN as a requirement to register and we've heard about a site in Fresno that had forms that people were asked to fill out with SSN information). SSNs should not be collected. This is sending a message that undocumented individuals are not welcome.
- At a recent mass vaccination site, Spanish-speaking people with appointments were turned away due to language and other things. The behavioral health staff onsite for emotional support were bilingual and able to intervene.

Vaccine Hesitancy and Confidence

- Getting granular data as soon as possible is key to learn from hesitancy among those within Phase 1a. We can learn from focus groups, etc.
- CBOs providing mental health services that have access to the vaccine are finding a significant proportion of staff are hesitant. We need to better understand what is underlying this to develop interventions to provide targeted information and motivation.
- This is important research. Some of the vaccine hesitancy is similar to what we experience with other vaccines, but this suggests that there's a lot that is specific to COVID-19.
- As we've learned in the long term care setting, increasing vaccine confidence takes work, and must be combined with patience. This undertaking is not in the wheelhouse of the healthcare industry and will take a village and a collaborative approach. We must start by

respecting, honoring and valuing those who we need to educate. It won't happen overnight and takes a tremendous amount of work. Incentives for providers is not the solution.

Communication and Outreach

- The "outreach to targeted populations" by "partnering with CBO's" is essential to equity success for all the reasons we know and that have been shared here.
- It would be helpful to have an email/number for Deaf folks to text to get information.
- Please include visually impaired as well.
- I would also suggest that CBOs of all kinds receive technical assistance to ensure our messages are broadly inclusive to specific subgroups with multiple personal characteristics (e.g., Latinx LGBTQ+ individuals of high weight). All messaging can make assumptions.
- Will anyone be vetting the vaccine information shared by the organizations? Will there be any standardized materials that will be used to ensure accuracy of information and avoid duplication of effort? It's important to lead people to reliable consistent sources.
- Could you share if there are call centers where people can find out more about vaccines? I'm certain healthcare workers would love to volunteer for such efforts.
- Thank you for including people experiencing homelessness. Would like to continue to explore community engagement in partnership with affordable housing developers, their low-income, predominately BIPOC residents and staff.
- The timing of messages seems challenging if we are encouraging people and they get the vaccine when they receive the messages.
- Bilingual Radio Network like Radio Bilingue and Radio Campesina need to be critical partners to reach rural Latinz populations. Also Radio J ornalera , Radio Indígena(Mixteco).
- How will Blue Shield incorporate this information into their program? The vaccination effort must be driven by this knowledge and expertise.
- The communications campaign should be explicit that legal status is not required. Commercials, PSAs with elected/health officials need to provide this messaging. Messaging should include environmental cues that it is safe for undocumented individuals.
- We need to identify factors that impact "credibility"; trusted messengers, existing networks and CBOs, culturally informed messaging, effective scheduling and delivery systems.

Suggestions/Requests for Future CVAC Meetings

- It would be helpful to have a one page overview of the prioritizations and Blue Sheld's role.
- It is difficult for blind individuals to actively engage with a presentation and monitor the chat. Everything has to be screen read. And the charts need to have clear visual description. The many charts summarizing COVID rates have left people with disabilities out.
- Beyond prioritization, it would be good at the next meeting to get further into the specific logistics of the last mile of distribution--where equity ultimately lives or doesn't.

Closing Comments and Adjourn

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

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

Dr. Burke Harris acknowledged that this meeting had a lot of content in the interest of addressing CVAC questions. She thanked everyone for their robust participation and discussion. All questions that could not be answered will go back to teams to bring forward answers/solutions. Dr. Burke Harris emphasized that the engagement of CVAC and the public is making the process better and the state is incorporating as much as it can of the excellent recommendations and suggestions that are shared.

Next Meetings

- ❖ February 17, 2021 from 3:00 – 6:00pm
- ❖ March 3, 2021 *and/or* March 17, 2021 from 3:00 – 6:00pm