California Health and Human Services Agency (CHHS)

California Department of Public Health (CDPH)

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #5 – December 23, 2020 – 2:00pm – 4:00pm

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); **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; **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 As

sociation (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); **Liugalua (Liu) Maffi,** Faith in the Valley; **Pastor J. Edgar Boyd,** First African Methodist Episcopal Church; **Melissa Stafford-Jones,** First Five Association; **Anthony Wright,** Health Access; **Lisa Hershey,** Housing California; **Naindeep Singh**, Jakara Movement; **Denny Chan,** Justice in Aging; **Jeffrey Reynoso**, Latino Coalition for a Healthy California: **Brianna Lierman,** Local Health Plans of California (LHPC); **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
Charles Bacchi, California Association of Health Plans (CAHP); **Leza Coleman,** California Long-Term Care Ombudsman Association (CLTCOA); **Genevieve Flores-Haro,** Mixteco Indigena Community Organizing Project (MICOP)

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

Public Attending
There were 117 members of the public attending by phone, including 2 on the Spanish line, and 1,930 views of the meeting by YouTube livestream.

Committee Co-Chairs
Dr. Erica Pan, MD, MPH, Acting State Health Officer
Dr. Nadine Burke Harris, MD, MPH, California Surgeon General

Consultant
Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

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

Erica Pan, MD, MPH, Acting Public Health Officer, CDPH, Co-Chair
Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Dr. Burke Harris and Dr. Pan welcomed the committee and thanked them for meeting during the busy holiday season. She reiterated her appreciation for the committee's engagement, participation, knowledge, and insights.

Bobbie Wunsch welcomed the group and echoed Dr. Burke Harris' appreciations. She reminded everyone of the process agreements – please keep cameras on, audio muted, use hand raise icon to speak or ask a question, and use the Chat feature to comment or ask questions. There are two ASL interpreters and closed captioning. The public is participating through English and Spanish call-in lines, and the meeting is being livestreamed on YouTube. Public comments can be sent to Covid19VaccineOutreach@cdph.ca.gov. Public comments are posted verbatim on the website two days before the CVAC meeting and then summarized at each meeting.

Dr. Burke Harris thanked the committee for making time for the important conversation about vaccine distribution in California. She reminded the group that the principles guiding the process are safety, equity, and transparency. Many excellent questions have been raised and the state is committed to responding to these questions. For example, given many questions about communications, especially with vulnerable members of the community, last week's meeting included staff from CDPH and the Governor's Office who are leading those efforts, and a group conversation to solicit your ideas and suggestions. Dr. Burke Harris also commented that some questions take longer for research and response. Dr. Burke Harris highlighted that those in state government, and especially CDPH, are working hard during this surge, and that the state is attempting to give accurate, up-to-date responses in a rapidly moving landscape. Today's agenda is a response to some of these questions and includes an update from Dr. Pan on the surge, the state's partnership for vaccinating long-term care settings, and Phase 1b draft recommendations from the Drafting Guidelines Workgroup. Finally, to address the many questions about vaccine and vaccination logistics, today's meeting will include two local health officers to share information about the process.

Dr. Pan welcomed and offered updates to the group. California is in the midst of a surge, with COVID-19 test positivity rates as high as 13%. There are signs that this surge is leveling off. This week many hospitals are in contingency care and working to avoid crisis care standards by sharing resources across regions and hospitals.

The U.S.Food and Drug Administration (FDA), the FDA's Vaccines & Related Biological Products Advisory Committee (VRBPAC) and the Advisory Committee on Immunization Practices (ACIP) have all approved the Moderna vaccine for use in the U.S., and the Western States Scientific Safety Review Workgroup met and agreed the Moderna vaccine is safe and effective. Some shipments of this vaccine have started to arrive. Over 120,000 vaccinations have been given to California residents with many more given every day.

The pharmacy partnership targets skilled nursing facilities (SNFs). Local health departments (LHDs) are trying to control outbreaks in SNFs and other settings while also continuing to give non-COVID-19 vaccines and deliver other services. Many LHDs welcome the pharmacies' rapid help with vaccinations. The state will be monitoring all of this very closely. Part B of this partnership for Assisted Living Facilities will be the next phase and may be activated shortly. The state is balancing resources and risks to augment the different resources and capacities across regions and LHDs, based on values of safety, equity, and transparency.

Review Public Comments since December 16, 2020 Meeting #4

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Bobbie Wunsch shared a summary of 358 public comments (171 pages) submitted between December 15 and December 21:

- 2 members asked to be added to the CVAC
- 26 people asked how they could be vaccinated
- 3 organizations offered to provide or deliver vaccines or house traveling medical staff
- 1 question about the data sources used by the Western States Scientific Safety Workgroup
- 1 request to post all public outreach materials and communications toolkits
- 8 organizations commented that outreach and education should start immediately
- 345 comments requested certain classes of workers be included in Tier 1 of Phase 1b, including one petition on behalf of workers and inmates in correctional facilities and one petition on behalf school personnel including community colleges)
- 48 comments requested to prioritize elderly and other at-risk individuals early in Phase 1b, Tier 1

Discussion of Phase 1b Recommendation Regarding Tier 1, 2 and Tier 3 of Essential Workers from Drafting Guidelines Workgroup; Update from ACIP and Phase 1b

Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup
Robert Schechter, MD, MPH, CDPH and Co-Chair, Drafting Guidelines Workgroup

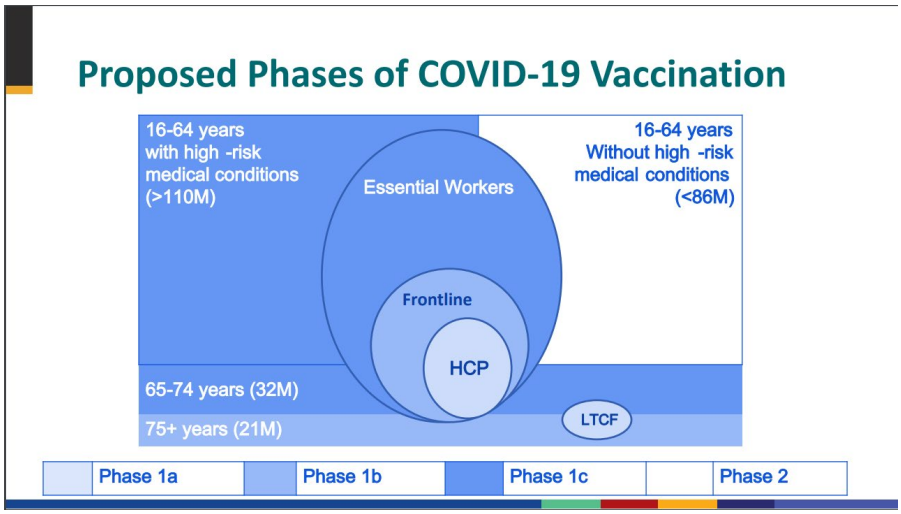
Dr. Burke Harris thanked the Drafting Guidelines Workgroup for their tireless work and for considering the feedback of the CVAC. Dr. Brooks and Dr. Schechter will present the latest recommendations from the Drafting Guidelines Workgroup and members of the Workgroup are on the call today. A summary of the CVAC comments will be sent to the Drafting Guidelines Workgroup for consideration before Phase 1b recommendations are sent to the Administration.

Recap of December 16 Meeting

Dr. Brooks recapped December 16 CVAC meeting input. The CVAC suggested that the Drafting Guidelines Workgroup consider four criteria as it prioritizes vaccine for Phase 1a healthcare workers (and possibly other future groups as well): risk of acquiring infection, risk of severe sickness and death, negative societal impact, and risk of spreading disease (lower priority because the impact of the vaccine on transmission is still unknown). For Phase 1b essential workers, CVAC suggested assessing worker sectors by occupational exposure, equity, societal impact and economic impact. The Drafting Guidelines Workgroup used existing data and studies to assess various sectors using these criteria. Dr. Brooks shared examples of criteria in each of these four categories. For example, under societal impact, a sector would be ranked higher if it is necessary for society's daily survival. Based on the analysis, the leading candidates for Tier 1 are Education and Child Care (1.4 million workers), Emergency Services (1.1 million workers), and Food and Agriculture (3.4 million workers).

Advisory Committee on Immunization Practices (ACIP) Meeting December 20

Dr. Schechter shared that on Saturday December 19, the Advisory Committee on Immunization Practices (ACIP) met to approve the use of the Moderna vaccine and again on Sunday December 20 to discuss vaccine prioritization recommendations for phases after Phase 1a. For Phase 1b, the ACIP voted to include persons age 75 and over and frontline essential workers. For Phase 1c, they voted to include people 65-74 years old, 16-64 year-olds with high-risk medical conditions that put them at increased risk of COVID-19, and other essential workers not included in Phase 1b. ACIP conclusions were informed by balancing goals of: (1) reducing severe illness for those most at risk; and (2) vaccinating workers necessary to maintain societal functioning, with each phase including groups based on each of these goals. California's preliminary decisions also balance these goals and acknowledge overlap between some of these broad goals – e.g., healthcare workers who have underlying conditions. This allows the state to address health, equity, and disparity as well as economic and social impact. The graphic below illustrates the ACIP preliminary recommendations:



There is a great deal of overlap between the ACIP proposal and the thinking thus far by the Drafting Guidelines Workgroup. One difference is that ACIP is recommending additional frontline workers that California initially did not include: Manufacturing, Postal Service and Public Transit, as well as persons 75 years and older. California's Drafting Guidelines Workgroup has been considering other high-risk groups not been proposed by the ACIP.

Dr. Schechter shared data documenting the importance of vaccinating older Californians in Phase 1b. Those over 75 have substantially higher death rates from COVID-19 than younger adults, up to 500 times higher in those over 85. The mortality risk is higher in both congregate care and non-congregate settings.

The Drafting Guidelines Workgroup is proposing the following populations for Phase 1b:

- Persons at risk of exposure to COVID-19 through:
    - their work in any role in specified California Essential Critical Infrastructure Sectors OR
    - residence in selected settings
- Persons 75 years of age and older
- Persons aged 65–74 years with medical conditions or disabilities that place them at high risk of severe COVID-19

The workgroup is differentiating between those who are able to work without risk of exposure vs. those that do have a risk of exposure. For example, there is specific concern about education – while many can work from home, there is a substantial impact of distance learning.

The Workgroup also proposes for Phase 1c:

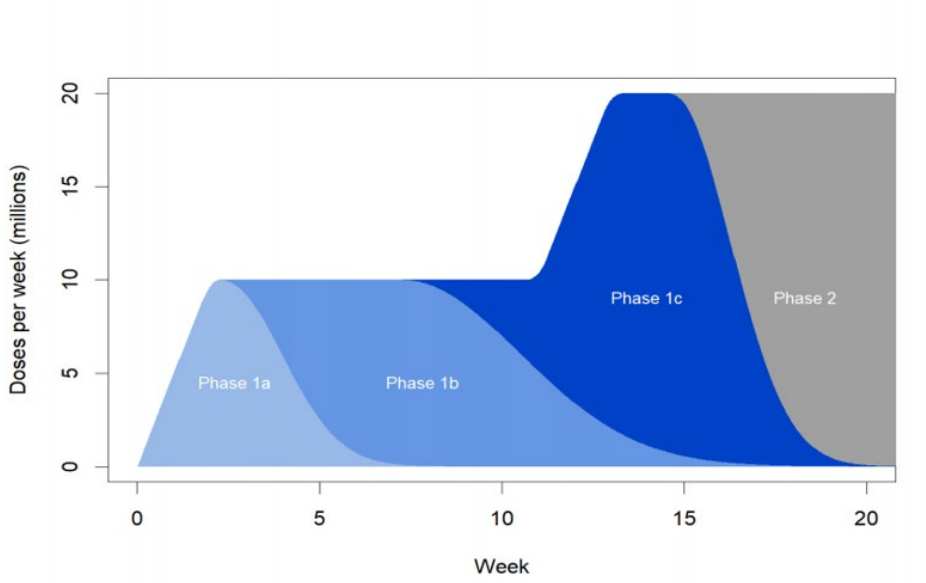
- Persons at risk of exposure to COVID-19 through their work in any role in California Essential Critical Infrastructure Sectors not included in Phase 1b

- Persons 65-74 years of age not included in Phase 1b
- Persons aged 16–64 years with medical conditions or disabilities that place them at high risk of severe COVID-19

Dr. Schechter shared estimates of the number of people in the various phases; however, he noted that these sector sizes over-estimate the number or workers who would be at unavoidable occupational risk. Tier 1 of Phase 1b, which includes Education and Child Care, Emergency Services, and Food and Agriculture, and those over age 75, includes 8.5 million people. Tier 2 of Phase 1b, which includes Critical Manufacturing; Industrial, Commercial and Other Facilities and Services; Transportation and Logistics; 65-74 year-olds with high risk; and congregate settings that face high risk, including those incarcerated and facing homelessness, includes 6.5 million people. Phase 1c, would include just over 12 million people, most of them in the category of 16-64 year-olds with high-risk conditions. Based on the latest federal estimate, this suggests that California will have sufficient doses for Phase 1a by the end of December; Phase 1b by February; and Phase 1c to start as early as February and completing in the spring or summer, as demonstrated by the table below.

Month	New 1st Doses (people)	Cumulative	Sufficient Doses for …
December	≤2.5 M	≤2.5 M	Phase 1a
January	3.75 M	6.25 M	Phase 1b
February	6.25 M	12.5 M	Phase 1b (some Phase 1c?)
Spring, Summer	?	?	Phase 1C and some Phase 2

The workgroup will continue to consider criteria for sub-prioritization given the timeline of doses. These might include the considerations used for healthcare workers – e.g., occupational exposure, risk of severe disease or death within occupation (could include age, underlying medical conditions, including working in vulnerable communities), likelihood of spreading disease to coworkers and the public, and potentially other factors. There will be transitions between phases as well as overlap between the phases. Decisions about when to transition and introduce a new phase will be made at the state and local levels. Dr. Schechter shared this conceptual graphic from the CDC about a possible sequence of events:



Local health departments (LHDs) will need partnerships with immunizers across the state to deliver on these priorities and goals.

Dr. Burke Harris reminded the committee that the recommendations presented today reflect consideration of CVAC's input combined with public health data and national guidelines. For example, the Drafting Guidelines Workgroup took intersectionality of risk heavily into account based on CVAC input. Dr. Burke Harris commented that Local Health Officers will address logistical questions shortly. Dr. Pan will bring responses to questions about the long-term care pharmacy partnership to the next meeting and questions from the chat will be answered in future meetings.

<u>Member Questions and Comments</u>

Phase 1a – Healthcare Workers

- Where do mental health workers fit in this schema?
    - CDPH: Mental health workers are considered healthcare workers in Phase 1a.
- Can we get in writing that healthcare includes behavioral health to ensure Local Health Departments follow this?
- Should we prioritize mental health workers in direct contact or cannot be effective via telehealth?
- Are personal care assistants who help people with activities of daily living considered healthcare worker or frontline essential workers?
- We should consider "occupational exposure" for mental health workers (e.g., residential treatment centers, staff providing in-person services in schools, community-based programs, etc.).

Pharmacy Partnership for Long-Term Care Facilities (LTCF)

- Will CVS/Walgreen's decide which SNFs get how many vaccines? Are they bound by the allocation framework that the CVAC provided feedback on? I hope they emphasize equity by prioritizing facilities that are more likely to experience outbreaks (e.g., ones with more Black and Latinx residents).
- Are CVS/Walgreen's responsible for all vaccines in LTCF, or are some set aside for facilities not participating in the partnership?
- When will the pharmacy partnership for Part B, Assisted Living Facilities and Residential Care Facilities for the Elderly (RCFEs), be activated? What criteria must be met first? There are 1,745 resident deaths to date in RCFEs/board and care/assisted living plus the loss of staff lives. We need to know what to tell residents, family and staff.
- How does Tier B of the LTCFs reconcile with the state's overall prioritization? Are LTCFs supposed to be reaching out to congregate living facilities where they don't already have contracts, or does that fall into the authority of another vaccinating entity?
- Is it known how many doses of the vaccine have been received and administered to nursing home residents?
- Will CVS and Walgreens assist in vaccinating different tiers when LTCFs are completed?

Other Congregate Care Settings

- Does the inclusion of incarcerated people in Tier 2, Phase 1b include federal prisons?
    - CDPH: The vaccine supply for federal prisons comes from federal allotment, not the state or local allocation. On Sunday the ACIP concluded that both staff and inmates at correctional facilities could be immunized at the same time on a case-by-case basis. Therefore, the state needs to coordinate with the federal government. For now, this tier applies to state prisons and local jails.
- Do long-term care facilities include congregate living facilities such as jails/prisons and immigration facilities, or at least, long-term care facilities located within jails/prisons?
- Does this include clinicians and other staff and residents at Short-Term Residential Treatment Programs (STRTPs – formerly group homes) for youth up to age 21, many of whom have multiple co-morbidities including mental health and addiction?
- Does the congregate living category include people in immigration detention centers? Does California have the ability to access these facilities to provide vaccinations? I believe California has the authority to inspect and oversee conditions in the facilities and that they have to comply with public health orders.
- Can we consider vaccinating patients/inmates, healthcare workers and other essential workers who are in the same (overcrowded) building or institution?
- Part of the messaging should be that it is in all Californians' interest to reduce outbreaks everywhere to maintain ICU capacity and ensure health access for all of us.
- Including incarcerated individuals is essential from an equity perspective.

Prioritization of Elderly and Other At-Risk Populations

- In the tiers of Phase 1b we are using age as a proxy. Why aren't we including people at a higher level of risk into those same categories?
    - CDPH: The risk of an individual may not be the same as the risk of the population group they belong to. The federal and state groups considered this but ultimately looked at the extreme mortality risk associated with older age. With respect to intersectionality, the risk associated with age (>75) is far greater than the risk seen in any other category. No other group demographics or co-morbidity exhibit this much risk statewide or nationally. Because age is the greatest risk factor of death from COVID-19 it is the first category for inclusion. Many of the other adults at high risk will be vaccinated by the end of February.
- It is hard to operationalize equity if we are requiring people to know about or prove a high-risk medical condition. Many people of color have high risks that they may not know about or be able to document. A place-based approach using a tool like the Healthy Places Index that aggregates various types of risk would be a good alternate strategy. How will this figure in?
    - CDPH: This suggestion is under consideration currently. Expect to hear more about this soon. Also, many of these communities have a high number of frontline essential workers that will be vaccinated early.
- Can you clarify the differences between these recommendations and those of ACIP? Do California recommendations mirror ACIP but add 75+ year-olds and 65-74 year-olds with co-morbidities? Is it true that the state has added tiers within Phase 1b? Things that are logistically simple and have equity – like age and place – are compelling. Given this, why include only 65-74 year-olds with co-morbidities rather than all 65+ year-olds?
    - CDPH: The data clearly show that 75+ year-olds are an outlier, whereas 65-74 year-olds have a lower risk. Approximately 50% of those 65-74 will be in Phase 1b, Tier 2 rather than Phase 1c because of a co-morbidity or risk factor. Vaccine scarcity requires us to come up with ways to sub-prioritize.
- I encourage the Drafting Guidelines Workgroup to expand Phase 1b to include people 65+ without the "high risk medical conditions" caveat. The death rates for older adults in CA is about the same from 65-69 (10.1) as 70-74 (11.2).
- Data for California shows that COVID-19 mortality rates for those in the 70-74 year-old range are similar to those 75-79 years old. These age groups are split up in different tiers, probably to align more with CDC age range recommendations. However, California is much more diverse compared to other areas of the country and maybe California data on age ranges is more relevant. Do these age-group trends hold when you break down by race/ethnicity and other equity factors? Mortality rates are disparately higher for Black, Latinx and Native Hawaiian/Pacific Islander older adults: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx
- Why not include those under 65 with medical conditions or disabilities that place them at high risk of severe COVID-19 in the third category as well?

- What are the obstacles/drawbacks to going outside national recommendations to include 65-74 year-olds with high-risk conditions? How would they be identified?
- One additional group that should be considered for Phase 1b is those who have a nursing home level of care and receive Home and Community Based-Services (HCBS), including people on SNF Medicaid waivers. Their need to receive personal care assistance and healthcare means they cannot fully isolate in their homes. Because they are not specifically identified, some will be left in Phase 1c or even Phase 2 although some of their workers, such as IHSS workers, will receive vaccines in Phase 1a. HCBS users may avoid services because of virus risk and this accelerates a SNF admission. It may not make sense to include HCBS workers in Phase 1a but not HCBS users.
- Do we have data on the age of COVID-19 patients in hospitals, emergency departments and ICUs to add to the statewide CDPH data on case rates and fatalities?
- Are the high risk specific conditions named? Alzheimer's isn't an underlying health condition but CDC reports troubling mortality rates nationwide for Alzheimer's patients.
- People with disabilities in a range of ages are at risk because they have a specific, worsening condition or medical need that is urgent, and they have been unable to get treatment due to medical rationing. This is "provable" through a provider's medical necessity evaluation. Some of this also intersects with how people of color may have received delayed diagnoses or needed care because they lack insurance or funding.
- Are we recommending an intersectional approach to the application of the criteria for sub-prioritization? We have used this word and discussed the importance of intersectional analyses, but it is not clear to me how we are putting it into practice. It is essential to an equity grounded approach.
- Current systems often underestimate illness severity in communities of color.
- Can we include a "safety valve" where an individual who can show severe risk is moved up into a higher tier based on that individualized risk?
- Other populations have striking mortality rates due to underlying medical conditions, 3x for people with developmental disabilities, 10x for people with Down Syndrome.
- There is a particularly bad confluence of age, disability, congregate living, long-standing infection control problems in nursing facilities, and existing data requirements. We know the impact of COVID-19 on older persons, but we do not necessarily "know" the impact of COVID-19 on all potential co-morbid conditions because the research is farther behind, and we don't collect disability data by functional data. We collect data by "diagnosis" which is not the same thing and does not account for the impact of medical rationing and implicit disability bias.
- We urge adoption of the ACIP recommendations as the data is indisputable: 74% of mortalities in CA are 65+ consistently since March. Including 75+ in 1b and 65+ in Phase 1c demonstrates our commitment to safety, equity, and transparency.

Phase 1b – Essential Workers

- ACIP is recommending food service workers in Phase 1c. Is there clarity on which definition is being recommended in California?
- Can planning coordinate with the labor unions representing essential workers to notify them and prepare for the next wave of workers?
- How will farm workers who cross into the US daily be notified?
- Non-profit workers that provide essential services should be given high priority.
- Can you clarify where child welfare workers that go into families' homes to help support highly stressed families and prevent abuse and neglect are in the proposed essential workers prioritization framework?
- What about workers who go into nursing homes or assisted living facilities, such as medical and non-medical home health, lab, x-ray, etc.?
- We appreciate and support the use of an intersectional approach and the resulting prioritization of child-care workers in all settings, formal and informal, in Phase 1b, Tier 1. Child care workers in all settings can only do their work in person, their work allows other workers to do their jobs, and many child care providers are older women of color.
- Is there a reason to prioritize child care workers above other direct care workers who work with elders and people with disabilities?
- Under food and agriculture, are we including senior nutrition providers – e.g., Meals on Wheels staff and volunteers who deliver meals to vulnerable older adults?
- In the ACIP criteria for Phase 1c, does "other essential workers" include state workers, most of whom are not given the option to telework and who were deemed "essential" by various state departments earlier this year? If yes, what is the timeline for other essential workers to receive the vaccine?
- Public sector and non-profit frontline workers with occupational exposure who provide safety net services to vulnerable populations should be prioritized. This includes: Child Protective Services and Adult Protective Services, workers who assist those facing homelessness, library workers, low-wage workers who work and sometimes live in affordable housing communities, people working in senior housing developments, Foster Family Agencies (FFAs), and CBOs providing in-home services and supports to this population.
- Can we get a better understanding of the term "frontline workers"?
- We believe public transit workers should move from Tier 2 to Tier 1 of Phase 1b. They are indoors all day in close proximity to essential workers and other vulnerable populations, including the homeless. Their risk is incredibly high and when they get sick, there is direct societal impact. If California adopts the ACIP recommendations, will public transit workers be moved back in the tiers?
    - CDPH: ACIP recommended public transit workers in Phase 1b and so does California. ACIP does not have tiers; California does.

- Will there be guidance on subcategories within the sectors? Sectors may include many job categories where the criteria may not put them at risk.
- Please consider other essential workers who work with healthcare workers in a given worksite. Can we consider vaccinating a whole population per building or institution with healthcare workers and other essential workers? This seems especially relevant in settings facing outbreaks such as the prison system.
- Can we get in writing the inclusion of people caring for people with disabilities?
- Farm worker employers in border communities are not trusted messengers: How will we ensure equitable distribution of vaccine to undocumented essential farm workers?

Timing and Logistics

- How are estimated doses lining up with the actual receipt?
    - CDPH: By the end of December, we will have about 2 million doses in California, with 2.5 million in the first week of January. Total December numbers have been fairly close to what was predicted.
- Can you repeat the process and timing for how CVAC input impacts state decisions?
    - CDPH: The input from this conversation is going to the Drafting Guidelines Workgroup on December 30, at which point they will send their recommendations to the Governor's office. Today's meeting input, public comment and chat are the opportunity to impact this discussion.
- How will people know it's their turn to get vaccinated? How can they prove they are eligible? Will workers get a notice from their employer? Can the employer provide a letter or voucher? How will the vaccinator know they are eligible?
- Is there a sense of processing time for COVID-Ready applications?
- Logistical issues shared by providers: No centralized website to find how to register and provide information on numbers needed; Is there a way to edit what health centers are ready to administer as they become ready? No way to confirm that CDPH received COVID-Ready information; How do they find information on where to send workforce if they are not administering the vaccine?
- Is there a statewide list of COVID-19 vaccine providers broken out by county?
- When is Tier 2 of Phase 1a expected to begin?
- Will there be sufficient supply to complete the two doses in a particular phase in a given month or to only begin the series?
- I am interested in efforts to bring the vaccine to specific worksites/locations, rather than having people figure out their own time/transportation to get to a vaccination site.
- Will the entire state shift from one tier/phase to the next phase at the same time or will it differ from county to county?
- What is the process for providers like community health centers (CHCs) to know that they can order vaccine for their patients in various phases? Will the county take orders

only for Phase 1a and then let providers know when there is more for 1b? Will the CHC place orders weekly? Will the county be doing daily/weekly reports to inform ordering?

- Ideally, we could hear about discussions of logistics and simplicity, and include those as criteria to inform prioritization: both how these priorities could be implemented and how to prevent "gaming" in the real world.
- How can validation not become a barrier for communities that are already uncomfortable with vaccines?
- To ensure the areas hardest hit by the pandemic are accessing the vaccine, is it possible to begin publicly reporting vaccine availability and utilization data by region?
- Soon, we will know about the COVID-19 relief package Congress passed with vaccine distribution funding. Can we be updated on how resources are used and unmet needs?
- Pharmacists are also deploying mobile clinics for immunizations.

Operationalizing Distribution of Vaccines with Local Health Departments

Erica Pan, MD, MPH, Acting State Health Officer
Eric Sergienko, MD, County Health Officer, Mariposa County Health and Human Services Agency and California Conference of Local Health Officers (CCLHO) Representative
Kim Saruwatari, MPH, Director, Riverside County Public Health Department and County Health Executives Association of California (CHEAC) Representative

Dr. Burke Harris noted there have been many questions about how vaccination distribution will work on the ground. Therefore, committee chairs invited local health leaders to share information about logistics. She shared some questions from the chat such as: How do people know they are on the list? How do you get vaccine if you're a healthcare worker not working in a hospital? How are we getting the word out to healthcare workers not working in hospitals? These and others will be addressed by Dr. Eric Sergienko and Kim Saruwatari, MPH.

Dr. Sergienko described that the 61 Local Health Jurisdictions (LHJs) are organized and structured differently and differ in what they do. All health agencies have to address ten essential services: assessing the health needs in their communities, developing policy around those needs, and assuring those policies make changes. Central to all these functions is addressing equity and equitable services in improving the public's health. LHJs vary as to whether they provide direct patient care services or only population health.

LHJs work closely with the state, especially during

this and other pandemics. They coordinate this through three organizations: the California Conference of Local Health Officers (CCLHO) (a statutory entity that advises policymakers on all matters affecting health); County Health Executives Association of California (CHEAC) (an advocacy organizations); and Health Officers Association of California (HOAC) (a membership and advocacy organization). To address LHJ capacity, Kim Saruwatari, MPH shared the history of what California LHJs have done in past vaccination campaigns. Depending on the structure and resources, most LHJs provide vaccine administration such as flu vaccination clinics; others partner with providers to ensure vaccinations in their jurisdictions. The Vaccines for Children (VFC) program Is another established network for immunization resources at the local level.

Dr. Sergienko outlined the process for LHJs ordering and distributing vaccines. COVID-Ready is the distribution system established by CDPH for LHJs to enroll providers. Ms. Saruwatari, MPH and Dr. Sergienko are representing CVAC in meetings with CHEAC and CCLHO respectively, to ensure they understand the state prioritization guidance and allocate vaccine doses through COVID-Ready providers. Approved orders are forwarded to CDPH for processing. LHJs track orders while they are processed by manufacturers to maintain situational awareness. The initial shipment of vaccine last week went direct to the counties. Future shipments will also be shipped directly to some providers (e.g., hospitals and multi-county entities). Recipients will need to maintain the cold chain and use the vaccine registry to track administration of the vaccine.

To ensure equitable distribution, COVID-19 vaccine plans are based on templates developed by the CDC at both the state and LHJ levels. The intent is to identify and quantify at-risk populations by asking for a plan to reach vulnerable populations in subsequent phases. This is important because it may be easier for LHJs to reach Phase 1a populations, including behavioral health providers, than future groups. Dr. Sergienko also stated that his LHJ is considering the workplace setting when making decisions about Phase 1a – e.g., anyone working in an Emergency Department should be vaccinated in the first tier, even if they are not technically a "healthcare worker." In Phase 1b, greater delineation and guidance will help LHJs monitor distribution and ensure vaccinators are adhering to the guidelines as is feasible.

Ms. Saruwatari, MPH stated that LHJs are oriented to equity. For example, Riverside County has a Vaccine Equity Task Force that includes comprehensive representation from vulnerable communities. Riverside County also has existing partnerships with community-based organizations (CBOs) to reach the lowest California Healthy Places Index (HPI) equity quartile. They are working together on vaccine education and outreach – for example, creating videos for farm workers using CBOs as trusted messengers prior to vaccine release. They also work with the faith community, especially the Catholic Archdiocese. LHJs seek bi-directional communication with the various groups, often using surveys and other methods to share and solicit information. Outreach efforts are intended to reach people with the most current information from multiple different angles, including detailed information on websites, working

with local medical associations and clinic consortia to reach healthcare providers, and many other methods.

Both presenters encouraged members to reach out to their LHJs via the public health director or agency director, health officer, public health emergency preparedness (PHEP) program, immunization coordinator and/or public health department operations center director.

Member Comments and Questions

Outreach and Education, Notification and the Role of CBOs

- How will LHJs build on the local vaccination infrastructure to address the needs, strengths and concerns of particular tiers and groups (e.g., child-care workers needing after hours vaccinations)? Might there be workgroups at the local level focusing on specific populations? How can other agencies partner in logistical planning?
    - Ms. Saruwatari, MPH: First 5 Riverside (Riverside County Children & Families Commission) has been a great partner to Riverside County. Together we created outreach materials for child-care providers to offer specific consistent contact tracers. We should build on the existing networks of your organizations.
    - Dr. Sergienko: In working with other organizations, we set up a Joint Information Center to coordinate messaging across the community. Sharing expertise about your "wedge" of the community will be especially helpful to the Joint Information Center. Mariposa County is now reaching out to IHSS workers and it is helpful to partner with organizations that have contact information.
- Where should healthcare workers prioritized in Phase 1a go to receive a vaccine if they are not associated with a hospital or long-term care facility? Is there a list of providers in each county serving Phase 1a workers? Will groups be notified that they are in a category that has access to the vaccine? Who is this tracking this and who is responsible? For home care, IHSS and Regional Center workers, there is no common workplace. It's important to communicate the decisions and think through the implications and implementation.
    - Dr. Sergienko: LHJs message in many ways and no single avenue will reach every at-risk person. We all need to work with our community partners so please reach out to your public health department. With In-Home Supportive Services (IHSS) workers, we started with a roster since they are workers in a state system and we also retain a roster at the county level. Other more informal groups like child care workers will be much harder since not all are registered. Verifying eligibility will be easy for some groups and harder for others. It might make sense to wait until we have a single dose vaccine to vaccinate some of the highly mobile populations.
    - Kim Saruwatari, MPH: Our Department Operations Center would look at IHSS workers as they are coming up and coordinate with the California Department of Social Services (CDSS) to review the list of who they are, communicate through

existing networks and any other ways to notify those eligible. We would also try to identify any limitations – e.g., need for after-hours vaccinations – and try to be accommodating. And we would leverage existing consortiums and networks to get information out.
    - CDPH: More conversation about outreach is planned for the January 6 CVAC meeting.
- Are counties thinking about how to reach vulnerable populations at home? With mobility issues, some of those in Phase 1b will need to be vaccinated at home with the vaccinator staying to ensure there is no allergic reaction.
    - Dr. Sergienko: Rural communities like ours have thought this through. Paramedics can provide community vaccines under expanded scope of practice. Home health can also do this if we can identify the individuals.
- Without centralized information it is difficult to know who is eligible, and this will be confusing for the public. Will the state centralize information or specify on the website?
- Can you share how LHJs are protecting workers' health privacy with their surveys?
- Are LHJs working to establish how individuals can document they belong to a given category?
- How do LHJs keep track with accountability after an identified group had been vaccinated, especially those groups that cannot go out to the community (e.g., incarcerated populations)? What is the process after 21 days or after the 2nd shot?
- We can assist LHJs to identify home health and hospice agencies licensed by CDPH and home care aide organizations licensed by the California Department of Social Services (CDSS) to assist in reaching the most vulnerable and high-risk patients receiving care in their homes.
- How are LHJs getting the word out to healthcare workers providing care outside of acute care hospitals and long-term care facilities about when and where to receive a vaccination? We want to make sure nurses and health care professionals providing services in schools know they are eligible in Tier 1a and how to be vaccinated locally.
- We should not wait to vaccinate mobile populations. We should work with CBOs to help with the outreach and mobile settings.
- At the last meeting we discussed that census work was a critical model to learn from in the vaccine outreach work. That model included funding at the state and local level, including support for training and trusted messengers. Is there a framework at the state level to support state and local level outreach and communications around the vaccine to reach key groups in ways that are meaningful for those groups?
- Communities look to their community pharmacy/pharmacists as a source for vaccinations. These are trusted members of the community. How will community pharmacists and pharmacy technicians be vaccinated themselves as they are deployed to vaccinate their communities? (The Board of Pharmacy just issued a waiver to allow the state's 90,000 pharmacy technicians to administer COVID-19 vaccines.)

- Hard-to-reach counties with COVID-19 community online surveys need to partner with local CBOs to get the message out. Materials should be at 5th grade reading levels with clear and transparent messages.
- Counties not partnering with CBOs and promotoras should be encouraged to reach out.
- There is concern that immigrant communities need to hear repeatedly about the vaccine, its safety and that it won't affect their immigration status.
- Are counties contracting with CBOs to be formal, funded partners, recognizing the expertise and trusted voices and connections they bring? Will there be state or local funding for CBOs to conduct outreach and education?
- Mobile strategies in rural areas will be critical.
- I am concerned about the resources allocated to vaccinate vulnerable workers who are hard-to-reach. Logistics should not deter from reaching vulnerable communities.
- Vaccine information, including information about adverse events and those investigations, should be readily shared to help build trust.
- Trusted messengers need to conduct outreach and education efforts that are in-language and in-culture.
- CBOs are trusted messengers. Outreach and education to vulnerable communities needs to happen now. CBO staff are essential workers that need to be prioritized for vaccination.
- I'm already hearing a lot from patients and providers in the community that people won't want to miss out on the vaccine now that others are getting it.
- Because of near-term scarcity, we need to simultaneously educate why it is safe and necessary to get vaccinated, but also respect the prioritization. We almost need a pledge, for those of us who are younger/healthier/working from home, to agree to wait to accept the vaccine only when supply is more plentiful.
- Grocery pharmacies are organizing and engaging now with CDPH and local health authorities. We hope to get our vaccine registries done soon and can help not only grocery workers but the community at large when it is their turn.

Local Discretion, Accountability and Enforcement

- When CDPH guidance comes to LHJs, do County Supervisors or other political actors have the opportunity to intervene? Is there a risk of equity plans not being implemented as intended? Many vulnerable groups are marginalized with less political voice and power. What assurances do we have and what precautions can we take to prevent political actors from muddying this process?
    - Kim Saruwatari, MPH: In Riverside County, the Department Operations Center (DOC) briefs the Board of Supervisors regularly to keep them informed about local activities and state recommendations. The Board has been supportive of public health efforts and help get information out through social media and other channels. The DOC reviews and plans for upcoming tiers and groups. For

example, they met with first responders and decided to set up centralized pods to bring vaccine to farm workers. Communication is important to determine the needs of the population, and the DOC centralizes the plan, execution, accountability, reporting and evaluation.
    - Dr. Sergienko: Vaccine distribution is squarely within the public health wheelhouse. This is what LHJs do well and I would not expect undue influence from elected officials.
- Can counties override the state vaccine distribution recommendations and make local decisions?
- What if an employer in a sector wants to vaccinate not just his workforce, but his friends and family? What protections or enforcement is there?

LHJ Planning and Inclusion

- We have been reaching out to counties to encourage them to bring leaders with disabilities from their local communities to the table and are not getting very far. It would be helpful to encourage the counties to have disability representatives from their local Centers for Independent Living. Disability is not being considered as a diversity issue or a part of equity locally.
- Is there an overarching Medi-Cal/IHSS strategy with each county?
- Are LHJs using or planning to use algorithms to determine further prioritizations among big categories such as those in Phase 1b? (We've seen the risk of algorithms in the Stanford Medical example.).
- Are LHJs able to use an intersectional approach and analyses to develop their vaccine dissemination plans to assure equity?
- Are counties considering place-based approaches that can embed equity and our understanding of communities and their social determinants of health?
- How does the local public health office ensure equity using our guidelines as well as messaging and doing health education?
- Strong partnerships and inclusive decision making between government and the public community is important in terms of the trust in communities and ultimate effectiveness.

Dr. Burke Harris thanked Dr. Sergienko and Kim Saruwatari, MPH for their presentation and ongoing CVAC participation. This conversation will continue at our next meeting and beyond.

Closing Comments and Adjourn

Erica Pan, MD, MPH, Acting State Health Officer, Co-Chair
Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair

Dr. Burke Harris thanked committee members for their robust commitment and engagement throughout this process. She commented on the fact that people are participating actively,

bring excellent input and ideas for the challenges we face, and engage collaboratively. She acknowledged that there was a lot in the chat about which groups should be given priority, and all of this will be shared with the Drafting Guidelines Workgroup. The state will respond to all questions raised. **Please send any additional comments for the Drafting Guidelines Workgroup by December 29, 2020.**

Dr. Burke Harris reminded the committee to stay safe this holiday season by wearing a mask, washing your hands, watching your distance, and waiting to gather.

Next Meetings

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