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

## COMMUNITY VACCINE ADVISORY COMMITTEE

## MEETING #10 – February 17, 2021 – 3:00pm – 6:00pm
## MEETING SUMMARY

**Committee Members Attending**

**Fred Buzo,** AARP; **Jacob Snow,** American Civil Liberties Union Northern California (ACLU); **Alia Griffing,** American Federation of State, County and Municipal Employees (AFSCME); **Susan de Marois,** Alzheimer's Association; **Andrew Nguyen,** Asian Americans Advancing Justice – Los Angeles; **Dr. Chang Rim Na,** Asian and Pacific Islander American Health Forum (APIAHF); **Dr. Ron Williams**, Association of California School Administrators (ACSA): **Jeff Luther, MD,** California Academy of Family Physicians (CAFP); **Michael Dark,** California Advocates for Nursing Home Reform (CANHR); **Lisa Mancini,** California Association of Area Agencies on Aging (C4A); **Carolyn Pumares,** California Area Indian Health Service; **Heather Harrison,** California Assisted Living Association (CALA); **Dean Chalios,** California Association for Health Services at Home (CAHSAH); **Joe Diaz,** California Association of Health Facilities (CAHF); **Charles Bacchi,** California Association of Health Plans (CAHP); **Michael Wasserman, MD,** California Association of Long-Term Care Medicine (CALTCM); **David Lown, MD,** California Association of Public Hospitals and Health Systems (CAPH); **Vicky Reilly,** California Association of Rural Health Clinics (CARHC); **Chuck Helget,** California Association of Veteran Service Agencies; **Veronica Kelley,** California Behavioral Health Directors Association (CBHDA); **Rhonda M. Smith,** California Black Health Network; **Preston Young,** California Chamber of Commerce; **Eric Sergienko, MD,** California Conference of Local Health Officers (CCLHO); **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); **Liugalua (Liu) Maffi,** Faith in the Valley; **Melissa Stafford-Jones,** First Five Association; **Anthony Wright,** Health Access; **Lisa Hershey,** Housing California; **Naindeep Singh**, Jakara Movement; **Denny Chan,** Justice in Aging; **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**

**Vivian Reyes**, American College of Emergency Physicians; **Virginia Hedrick,** California Consortium for Urban Indian Health, Inc. (CCUIH); **Pastor J. Edgar Boyd,** First African Methodist Episcopal Church; **Jeffrey Reynoso**, Latino Coalition for a Healthy California

**California State Representatives Attending**

**Nadine Burke Harris, MD, MPH,** California Surgeon General**; Tomas Aragon**, MD, Dr.P.H., Director, CDPH and State Health Officer; S**ecretary Yolanda Richardson**, California Government Operations (GovOps) Agency; **Maricela Rodriguez**, Office of Governor Gavin Newsom; **Marcela Ruiz**, California Department of Social Services; Agency; **Martha Dominguez,** CDPH**; Eric Norton**, CDPH; **Kim McCoy Wade**, Director, California Department of Aging; **Vance Taylor**, Governor's Office of Emergency Services (Cal OES)

**Public Attending**

There were 7 members of the public attending by phone, 0 on the Spanish line, and 409 views of the meeting by YouTube livestream.

**Committee Co-Chairs**

Dr. Nadine Burke Harris, MPH, California Surgeon General

Dr. Tomas Aragon, Dr.P.H, Director, California Department of Public Health and State Health Officer

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

## Welcome, Purpose of Today's Meeting and Meeting Logistics

*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 to its 10th meeting. She shared her gratitude to the members for their participation in the process. She shared that Dr. Pan would not be available for the meeting but Dr. Aragon would join as CDPH co-chair.

Bobbie Wunsch welcomed the committee and reminded them of meeting process guidelines.

## Review Public Comments since February 3, 2021 Meeting #9

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

Bobbie Wunsch reviewed and summarized public comment submitted between February 2 and February 15. There were 80 pages of public comment representing 351 individual and organizational submissions, with links to hundreds of additional pages of comment. A summary of these comments:

- 39 people asked that the process of vaccinations be simplified, including notifications, sign-ups, phases and tiers, My Turn app, reliable vaccine forecasting, flexibility, and consistent rules across counties, with multiple examples given of county inconsistencies
- Many people asked to be prioritized earlier in the process, including:
    - Immigrants in detention facilities and others incarcerated (183)
    - Frontline workers (62)
    - People who are homeless and the employees who work with the homeless, regardless of age (57)
    - Public transit workers (20)
    - School staff and teachers, including appointments not during school hours (4)
    - Age-based approach (2)
    - Animal shelters and zoos (2)
    - Logistics and manufacturing industry (2)
    - Dock and port workers (2)
    - Cosmetologists and barbers (2)
    - Chief Justice of California on behalf of judicial and court employees (1)
    - Local government employees including law enforcement (1)

    - Community services districts (1)
    - 48 people under 65 with the following underlying medical conditions be vaccinated sooner than March 15: Type 1 diabetes, cancer, HIV/AIDS, autoimmune conditions, paralysis, developmental disabilities, Parkinson's disease, cystic fibrosis, schizophrenia and kidney disease
    - Cannabis industry (1)
    - Airline industry (1)
    - Independent living facilities/retirement communities (1)
- 3 raised questions or concerns about Blue Shield being selected as the TPA
- 2 people suggested that community health centers should be primary vaccine sites
- 1 acupuncturist organization offered to assist in giving the vaccine
- 1 person suggests delaying second doses of vaccine
- 1 person shared that they were charged $71.38 to receive a vaccine
- 1 person said they couldn't find where to send public comment on the CDPH website
- A number of groups requested to join CVAC membership, including representatives of airline flight attendants, obese people, disability justice, Commission on Aging, Native Hawaiians and Alaskan Natives

Dr. Burke Harris thanked the public for sharing their important comments. Members should have received these comments for review ahead of the meeting.

**Opening Comments from Co-Chair and Director of CDPH**

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

Dr. Burke Harris grounded the meeting in the values of safety, equity and transparency. She reminded CVAC members that the purpose of the committee is to receive member feedback and to carry forward the information, resources and insights from CVAC back to the communities they represent. This bi-directionality is important to the process. As an example, this meeting will include a demonstration of the My Turn system and Dr. Burke Harris encouraged members to help others learn how to use it.

Dr. Aragon greeted the committee and gave a few updates:

- Things continue to get better; new COVID infections and cases are dropping across the state.
- The effective reproductive number is down to 0.65, lower than Dr. Aragon has seen it. This means each individual who is infected will infect on average less than one person, which is really good news for reducing spread and stopping surge.
- The 7-day case rate is down to 20.

- The positivity rate is down to 3.3%.

As these figures improve, the average risk goes down, and it's fair to assume that vaccinations are contributing to this decline. All the mitigation strategies are also working. CDPH will re-emphasize how important these strategies are during the transition to community immunity.

Dr. Burke Harris previewed the agenda. She noted that the Third Party Administrator (TPA) agreement with Blue Shield has been executed, and the contract is available on Open Gov and members should have received a link. Secretary Richardson will be available to answer questions about this arrangement.

**Questions from Last CVAC Meeting**

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

Dr. Burke Harris introduced two questions raised by CVAC and the general public. To the question of when individuals in federal immigration centers will be vaccinated, the answer right now is unknown. There are some complex jurisdictional issues that Dr. Burke Harris was not able to resolve for today's meeting. The second question is whether the state will use census tracts or zip codes when it applies the Healthy Places Index as an equity tool. Dr. Burke Harris shared that the state is still in the process of modeling the impact of each approach, as well as soliciting input from vaccinators and other entities on how these approaches would impact their implementation. The state welcomes input from CVAC members so please share recommendations, resources or concerns on the merits of the two approaches.

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

*Nadine Burke Harris, MD, MPH, California Surgeon General*
*Maricela Rodriguez, Director, Civic Engagement and Strategic Partnerships, Office of Governor Gavin Newsom*
*Martha Dominguez, MA, MPH, Ph.D, CDPH*
*Marcela Ruiz, JD, Director, Office of Equity, CDSS*

Martha Dominguez updated the committee on research findings and the communications strategy. A new multimedia agency, Duncan Channon, has been brought on, as well as partnerships with Baru Marketing and NUNA Consulting Group, to ensure that messaging reaches California communities. Ms. Dominguez shared that, based on the research, the next steps in the state's communication strategy will include efforts to *Educate*, *Motivate* and *Activate*. The current paid media campaign underscores key messages about vaccine safety and

reminders about the importance of masks. As of March 15, the state will launch new creatives based on the research and targeted to diverse communities. A public relations strategy is being developed to focus on engaging communities on the ground, and local health departments using earned and social media. It will focus on key audiences such as healthcare workers, farmworkers, age 65+ as well as Latinos, African Americans and Pacific Islanders. The strategy is informed by the formative research, creative testing, sentimental analysis, mis- and dis-information monitoring, and the eligibility phases and operations of the state.

Ms. Dominguez shared that the messaging follows a communication strategy with four pillars intended to happen simultaneously to maximize impact. The pillars are: Connect, Educate, Normalize and Activate, and each have objectives. For example, TV ads may have a primary goal to connect emotionally and share strategic information. Another example is to have social media or digital influencers normalize information and create emotional empathy with an audience. These four pillars are research-based, and the state will continue to do research and quality improvement to ensure they are reaching the audience in a culturally congruent manner and advancing the goal to reach all Californians. There is intention about which media channels and platforms are used to ensure that the messages are effectively delivered.

Marcela Ruiz provided a brief update on the community engagement campaign funded by the California Department of Social Services (CDSS) and the Labor Workforce Development Agency (LWDA). In the next meeting more specifics will be presented. Subcontractors for Cohort 1 through The Center at Sierra Health have been announced. Awards of $17.3 million were announced for 210 organizations throughout the state. All selected partners have been engaged in a robust schedule of onboarding and are receiving information and training from state partners regarding the public health situation, vaccine updates, state resources for people with economic needs due to COVID, and opportunities to learn best practices from their Community Based Organization (CBO) peers. Onboarding for Cohort 1 ends February 19 and outreach partners will begin outreach. CDSS is also working with the California Community Foundation which was a critical partner during census outreach and this project builds on that infrastructure. They will announce Cohort 2 awardees next week. Philanthropic partners working with the Public Health Institute will announce awards next week.

Ms. Ruiz shared a list of organizations funded through Cohort 1. CDSS and LWDA are collaboratively administering this funding with joint infrastructure, reporting and administrative burden. The CDSS campaign is primarily focused on public health messages and resources to address economic needs. They will refer people to the My Turn platform and address vaccine hesitancy, focusing on vulnerable populations including Black/African American, Latinx, Native Hawaiian/Pacific Islanders and Native Americans. The LWDA cohort is focused on labor rights and new protections signed into law associated with COVID. It is expected that CDSS-funded organizations will also encounter workers so there will be joint messaging across both campaigns. More information will be presented at future meetings from the outreach projects.

Maricela Rodriguez shared highlights from the communications campaign:

- There are activations targeted to the Black/African American community including Community Champion efforts focused on Black History Month. This includes radio, print and social media. If anyone has a community champion to highlight for their role in the COVID pandemic, nominate them using the hashtag **#COVIDCommunityChampion**.
- A Town Hall focused on African American community engagement is planned with Dr. Burke Harris in partnership with Charles Drew University and other trusted messengers, to offer information and address mis-and dis-information.
- Ethnic media briefings are scheduled for February 27 through early March in partnership with ethnic media groups and NUNA. Updates will be shared at the next meeting.
- The state has conducted direct pitching and other efforts for earned media, generating more than 360 stories in 9 languages, at nearly a daily cadence. The intention is to ensure consistent information in language through trusted messengers.

Ms. Rodriguez shared the latest Public Service Announcement (PSA) – Moms as Messengers. Previous PSAs featured mothers encouraging their children to stay home, and now mothers are being leveraged to encourage their children to get vaccinated. CVAC reviewed the PSA in English and Spanish with the theme "Love means getting vaccinated." The message uses real people and real voices, is very personal, and leverages families' desire to return to normalcy and be together – key learnings from the state's research. CVAC members gave great feedback about the videos and Dr. Burke Harris congratulated these teams for their excellent work.

<u>Comments and Questions from Members</u>

**Promotoras and Community Health Workers (CHWs)**

- Are outreach workers contracted with the state eligible to get vaccinated now? How will this process work?
    - CDPH: These workers are eligible only if they meet current prioritization guidelines. Dr. Aragon referred to the essential worker classification list on the state website. M*s.* Rodriguez added that each county is different and therefore the project recognizes that some outreach may be remote until workers can be safely connected to at-risk populations.
- Outreach workers, promotoras and community health workers need to be immunized under Phase 1a. They're exposed now and they're dying. I want to highlight the need for the state to guide the counties to vaccinate those people working for the CBOs they contract with. A statement is needed so county variations are not based on relationships.
- It's been county by county in our experience as Mixteco Indigena Community Organizing Project/ Proyecto Mixteco Indígena Organización Comunitaria (MICOP). We have had to coordinate directly with our public health departments to get our promotoras and CHWs vaccinated (which happened last week in Ventura County).

- Riverside County Health Department does vaccinate promotoras and people doing outreach in the community. We consider them part of Tier 2, Phase 1a.
- Same in San Bernardino – Phase 1a.
- The vaccination of CHWs/promotoras in the community is essential. It is not appropriate to dismiss them as we continue to give grants to CBOs and ask them to go into the community. These are people in the community, interacting with the public, and part of the public health team. We wouldn't be effective without them, so we want to keep them healthy!
- Outreach staff are focusing on vulnerable populations who have high rates of COVID-19. In a recent text survey by the UFW Foundation, 46% of agricultural workers who had been tested for COVID-19 received a positive result – much higher than national averages. We hope that CDPH considers adding these outreach workers given that our collective experience will reach those that the state has a hard time reaching.

**PSAs**

There was positive feedback from CVAC members on the PSA shared by CDPH/CDSS, including: appreciation for the multigenerational direction; love moms as messengers; great job connecting with the community ; this is exactly what constituents are saying compels them to vaccinate; very moving; beautiful. Other comments:

- These PSAs can be used in churches and quinceaneras . Please use “tomar” not “poner” la vacuna in the Spanish language PSA. The California Association of Health Facilities can take this to our 1,400 facility members for employees and residents.
- We are happy to try to play the PSA in clinic waiting rooms (though less traffic in those rooms now) and amplify the videos on social media through #medtwitter, Instagram, etc.
- I’m sure we’ve all read stories about how women end up being the main caretakers in families signing family up for vaccines.

**Other Questions and Comments about Community Engagement and Communications**

- Will there be another round of outreach grants or is the list of CBOs final?
    - CDSS: The state is currently looking at any gaps and there will be a few more awards through The Center at Sierra Health, but the balance is small. Through other philanthropic partners, there have been more investments for similar outreach projects to reach vulnerable populations. Local Health Jurisdictions are also partnering with CBOs.
- Can you say more about the communications strategies planned for 65+ year-olds? Different methods are needed for different groups of older adults.
    - Governor’s Office/CDPH: We are just starting with this group and plan to learn from some of the formative research testing. We welcome CVAC recommendations. The focus is on disproportionately impacted communities, reaching them directly in language or through their families.

The PSA that was shared will touch some of these people. We also want to focus on-the-ground efforts in these communities since online efforts may not work. It will be important to highlight phone resources and other sources of support beyond My Turn and the state is looking at unconventional, creative ways to reach different communities in how they access information. Ongoing research will then check to see if this is working. The paid campaign will be nimble to meet people where they're at – including guerilla marketing for places with a lot of foot traffic like grocery stores.

**Update on Vaccine Supply and Distribution**

*Tomas Aragon, MD, Dr.P.H., CDPH and State Health Officer*
*Secretary Yolanda Richardson, California Government Operations (GovOps) Agency*

Drs. Burke Harris and Aragon agreed that when CDPH adjusts guidelines, CVAC will be updated and that final PSAs will be distributed to CVAC to disseminate and imbed on their websites. Dr. Aragon shared information about total doses administered thus far. The Centers for Disease Control and Prevention (CDC) website, under Vaccines, includes a data dashboard that shows how California compares to other areas. He demonstrated how to hover one's cursor over California and review data points including total doses delivered and administered. The ratio of these two figures is the percentage that is reported publicly. This is how California reports its data also. Sometimes a small discrepancy is because the CDC data is slightly behind. Currently, 75.9% of doses delivered to California have been administered, which is a big improvement from earlier months, due in part to data collection improvements.

The Federal Pharmacy Partnership includes three different programs:

- The Long-Term Care Program
- The Retail Program (with CVS and Rite Aid in California)
    - Long-Term Care Pharmacy (separate from LTC program)
- The Federally Qualified Health Centers (FQHC) program (new)

Right now the CDC dashboard only includes information on the Long-Term Care Program. There have been over 560,000 doses administered through this program. The website https://covid19.ca.gov/vaccines/ includes the vaccine dashboard. Again the doses delivered and administered are available for the state or by county. The dashboard also includes the CDC Pharmacy Partnership Programs (delivered and shipped). At the very bottom it mentions the Pharmacy Partnership Program which is currently the Long-Term Care Program and Federal Retail Pharmacy Program. It will include the FQHC program as it gets rolled out.

Dr. Aragon highlighted another data source showing that 9 million total doses have been *allocated* to California and that over 1.4 million people have completed a two-dose series with

either Pfizer or Moderna. Doses administered by race and ethnicity, in California or by county, are also available to compare those vaccinated by race/ethnicity to their percent of the population. For example, 0.3% of doses have been given to American Indians who represent <1% of the California population and the pattern for Native Hawaiian or Pacific Islander is similar. 13% of vaccines have been given to Asian Americans, representing 15% of Californians. African Americans represent 6% of the population but have only received 2.9% of vaccines – they are underrepresented in vaccines. Latinos have received only 16% of doses though they represent 39% of the state population. There may be discrepancies between the way people answer race/ethnicity questions here vs. the census. There are larger percentages of those identifying as Multiracial or Unknown in COVID data. Finally, Whites are 37% of the population and have received 32% of the vaccines. People of color are basically underrepresented in vaccinations thus far. 54.7% of vaccines have been given to those above age 65. Younger groups vaccinated have been primarily Phase 1a healthcare workers. Females are 58.5% of those vaccinated. Dr. Aragon offered to make these population breakdowns available.

The Federal Pharmacy Partnership for Long-Term Care included CVS and Walgreens reaching out to Skilled Nursing Facilities (SNFs) and Assisted Living Facilities (ALFs). This should be completed by the end of February with three visits to all locations. Over 16,000 SNFs and ALFs (98% of total signed up) have clinic schedules. Not everyone is accepting the vaccine, particularly staff, but counties, the Long-Term Care Pharmacy Program and others will circle back to those who declined to offer them another opportunity.

Dr. Aragon then shared information about the new Federal Pharmacy Partnership with Federally Qualified Health Centers (FQHCs). The initial cohort included five California FQHCs; Cohort 2 starts February 22 and includes 8 more FQHCs; and Cohort 3 starts March 1 and adds 29 more sites. The FQHCs were selected by HRSA based on criteria like the number of people served in a priority population, such as people experiencing homelessness, agricultural workers, residents of public housing, staffing, and ability to handle vaccine storage. Additional FQHC sites may be selected in the next phase of the program, which might occur in March. At least 100 doses per service site per week are being shipped to FQHCs, and second doses will follow. This will increase over time as vaccines become more available.

<u>Vaccine Supply Moving Forward</u>

Dr. Aragon shared projected vaccine supplies going in the future. The numbers are beginning to increase and another vaccine is being considered for FDA approval at the end of February. He also shared that this week the state received more vaccines than it was allocated.

<u>TPA Contract Implementation</u>

Secretary Richardson spoke about onboarding Blue Shield as the TPA. The state announced February 15 that Blue Shield would be the TPA to streamline vaccine allocation and distribution.

Blue Shield is talking to counties about the provider network. Their primary purpose is to develop a network that can reach all the target populations and ensure coverage across the state. They are building a scalable infrastructure for when vaccine supply becomes more available. They will collect and report accurate data about race/ethnicity, geography and other characteristics. They will support the provider network to transition to the new My Turn platform, reflecting all the good work done so far by counties and providers. Secretary Richardson reflected that part of the important work ahead lies in partnering with CVAC and others to operationalize equity.

Comments and Questions from Members

**TPA and Provider Network**

- On the ground, we see that guidelines in counties vary from the bulletin sent to public health and vaccinators last week. How are we continuing to operationalize these priorities via Blue Shield and capture this data? Will the TPA provide FQHCs with direct vaccine allocation? Flexibility with the TPA will be important for vulnerable undocumented and uninsured communities.
    - Gov Ops: Mega sites went up early and are a great strategy for speed and volume. Now we're trying to turn our attention to specific strategies to reach vulnerable communities via mobile clinics, pop-up sites and home-bound individuals. A direct relationship between FQHCs, public hospitals and other providers with the TPA will help ensure the allocations are sufficient to reach each target population, while consulting with counties who have experience.
- Understanding that My Turn will play a critical role to reach partners in communities to get on the platform for scheduling, and understanding the incredible ways that providers are already achieving the goals of speed, equity and transparency with the systems they built, what problem is being solved by requiring providers to shift to My Turn? In many places, the TPA contract references either "My Turn "or other electronic health system interfaced with state agencies."
    - Gov Ops: The problem we're trying to solve is inconsistent and missing data. One system will help with this. It will allow us to reserve and allocate appointments to those that need to be seen. We hear that people in line to get vaccinated are not always those we want to get vaccinated. My Turn should help address this problem. Blue Shield is entering into discussions with providers to see whether their existing systems will get to this outcome.
- Who is responsible for this algorithm? I'm concerned that clinical experts in geriatrics, chronic disease management and underserved communities, who understand clinical and operational workflows, are not involved, and am skeptical that IT people will come up with effective algorithms. We need robust ongoing interactive engagement with experts to

continue tweaking it, since the pandemic keeps throwing us curve balls. Where is Blue Shield in engaging clinical experts, the aging and disabled that represent 80% of the deaths?

  - Gov Ops: Maybe incentive isn't the right word to use – we're trying to ensure that clinics and others have the financial support they need to do what we want them to do. The state is responsible for the algorithm. Drs. Burke Harris and Pan are passionate about reaching the populations we want to reach. They will ensure we bring the right expertise and professionalism outside of their own, including public opinion which the governor wants to include.

- There are 2,000 independent pharmacies across the state, 56% serving high-risk underserved populations. When will they be included in the network as part of the plan? We would also like some clarification about credentialing and hope that being Medi-Cal providers will count as being credentialed to avoid further barriers.
  - Gov Ops: I don't have a direct timeline but we will follow up with you to address this concern.
- People with disabilities, especially those with serious mental illness or addiction, are best served by their current providers who they trust. The scope of work has lots of requirements to get re-credentialed with Blue Shield. What is the difference between the new system and Cal Vax to become a point of distribution?
  - Gov Ops: I don't know. We'll get back to you about the comparison between the two processes.
- Could you talk a little more about the transition? The Blue Shield network is appropriate for the commercial side, but more than one third of our population has Medi-Cal or is uninsured. What is the state requiring Blue Shield to do to augment their experience, and how will this work technically? Are we tracking who has Medi-Cal or is uninsured? And are we ensuring this information gets back into their health records? And finally, what is the oversight and mechanism to fix problems, for example, with the provider directories?
  - Gov Ops: Blue Shield is developing networks in collaboration with the counties to ensure they have the needed reach. They are in contact with Local Health Plans of California to get data on the Medi-Cal population. Those conversations are shaping the development of the network, including lots of conversations with California Primary Care Association (CPCA) and FQHCs. This is a collaboration of many people who have been doing this work to reach these target populations. The state is taking those partnerships and information, giving it to Blue Shield, and asking them to execute on our behalf. It is the state's responsibility to have oversight and make sure it gets done the way we want, with clear metrics to measure and evaluate our success, then adjust if needed, on a regular basis. All state agencies and especially DHCS are very focused on the populations we need to reach. I will

get back to you about where people go when they don't like what's happening.

- We were excited to get information this week about the Federal Emergency Management Agency (FEMA) sites and the ability for CBOs to register and suggest mobile vaccination sites. I hope Blue Shield can replicate this with mass distribution in other sites because it helps operationalize equity. The contract is very specific about many things but there was no specific monthly goal around reaching underserved populations or operationalizing equity. How will Blue Shield be held accountable for specific equity metrics?
    - Gov Ops: We are currently looking at zip code level information and overlaying it with the HPI to make sure we're allocating doses appropriately to reach those in the lowest quartiles, while also looking at which providers are in those zip codes and trying to make sure they have doses. There will be more information about this soon as the network is developed and we will continually update the targets as we vaccinate in these communities.
- The statewide network of promotoras and community health outreach workers are doing this work daily. How do we fit into the discussion? I advocate that CBOs be part of this discussion early on, as part of the planning discussion. I encourage you to reach out to us as part of the initial planning with Blue Shield.
    - Gov Ops: I agree and this is in the plan. CBOs were the backbone of community outreach under Covered California. We just announced $17 million in grants to CBOs. Hopefully, we can partner CBOs, who can navigate in those communities, with vaccinators.
- What is the role of Kaiser Permanente in the TPA?
- What will the TPA's role be in relation to the retail LTC pharmacy and FQHC program?
- My understanding is that Kaiser will have a carveout on the vaccine distribution with the understanding they will vaccinate their members. What information is available to understand how this will be done and communicated to the public?
- How will complaints be handled, and what will happen if someone is turned down for vaccination? It can take a tremendous amount of effort to plan and execute a trip for vaccination for people with high risk conditions. If they don't think a problem is worth raising or will change anything, they may just decide that they cannot get vaccinated, regardless of their recognition on the official vaccination priority list.
- In the discussion between Blue Shield and Madera County, two independent pharmacies were included as they reach out to a critical/hard-to-reach population.
- We really want to try and send the public to ONE place to start but offer options also.
- Public schools have historically been a trusted messenger for families. Are we moving away from utilizing this network to reach families in regards to vaccination hesitancy and safety?

**Migrant Farmworkers**

- How is Blue Shield preparing to address these issues related to second doses for migrant or transitory populations? What will the transition look like? Will My Turn track those who migrate across the state and need a second dose, or work in California but reside in Mexico?
    - Gov Ops: Yes, My Turn collects information about the doses given, and the question is what we do with it. Secretary Karen Ross is very involved with the best strategies to reach farmworkers until we get a one-dose vaccine. We're focused on first doses. Mobile clinics and trusted messengers will help.
- We know farmworkers are coming from Arizona and Mexico traveling through California to Oregon and Washington. California is the first point of entry. What is the plan for them to get a first/second shot? Is the state incorporating this movement of farmworkers in the allocation to the impacted counties?
- Imperial County's essential farmworkers have not yet been vaccinated. This will have a great impact as in a few months farmworkers will migrate to other areas to follow harvest.
- Natividad Medical Center, the public hospital in Salinas, is anticipating an influx of 40,000 farmworkers next month.
- Farmworkers will also be migrating in other state regions - Coachella Valley, Central Valley, Central Coast.
    - CDPH: Thanks for lifting that up. We have been hearing this from others as well. We're working to address this concern.
- Many vaccine sites are scheduling the second shot for patients when they receive the first shot. This would be a good opportunity to ask where that patient may be located when their second shot is due – it could help some patients who have a good idea that they will be moving to another location between the first and second shot.
    - CDPH: Great idea. We will pass that suggestion on.
- Migrancy is a real obstacle in need of a creative solution.
- We'll also need to reach H-2A temporary agricultural guest workers and those living in migrant camps, employer housing, etc. A specific plan is needed.
- There are other populations who are subject to changing locations (e.g., persons who are homeless, persons in jails/prisons whose terms may end between the 1st and 2nd shots).

**Phases, Tiers and Equity**

- Anecdotally, as we transition from Phase 1a to Phase 1b, healthcare workers have had a hard time accessing vaccines even if they qualify because the worksite or employer started Phase 1b. They changed dates for their second doses without adequate notice, vaccinating inmates over frontline healthcare workers. A new mother on leave was denied her COVID vaccine and required to present a medical certificate of clearance. This leaves nurses and

frontline essential workers in the prison system with only 60-68% protection. Shouldn't the process be prioritizing health care workers who qualify before transitioning to Phase 1b?
    - CDPH: Phase 1a should continue even as we start Phase 1b, just like with airline boarding. This is a reason we need to move to a consistent system that is uniform across California.
- Should the guidelines for transition between phases be coming from CDPH, local health jurisdictions, worksites or vaccinators?
    - CDPH: Perhaps this is not obvious to everyone. We can make this more clear.
- Hot spots should receive higher allocation of vaccines but our supplies have been very limited. Please allow our counties to provide vaccinations to farmworkers.
- I am not speaking for the other disability advocates on the CVAC who continue to work with the state on implementation for people with high-risk conditions, but I know that all of us are concerned with equity and the prioritization of essential workers and those over 65 who are already on the state's list, as well as congregate living groups that are not yet clearly on the list. Implementation has been challenging on so many levels and has varied all over the state. Our intention is to make equitable vaccination possible, not to "leapfrog" over others.
- We're trying to pin down the current status of informal family caregivers and whether they're eligible. I don't see where that fits in the existing tiers in the guidance at CDPH.
    - CDPH: Family members who are caregivers need verification that they are official caregivers, and then are eligible to be vaccinated. We will find where this is documented.
- This prioritization will continue to halt essential workers vaccination. We are already receiving very limited vaccines.
- This expansion will further delay essential farmworkers receiving vaccines . Will the state send additional supply to those counties who are still not vaccinating farmworkers?

Can we get an update on the CDPH announcement that beginning March 15 healthcare providers will begin to vaccinate individuals 16-64 with high risks? How does this overlay with Phase 1b, Tier 1 that has not been completed yet in most counties?

- How and when can a food/agriculture manufacturer (Phase 1b, Tier 1) begin vaccination?
- Where do incarcerated individuals 16-64 fall in the phases/tiers?

**Caregivers**

- We're trying to pin down the current status of informal family caregivers and whether they're eligible. I don't see where that fits in the CDPH guidance or tiers - the current language is limited to only In-Home Support Services (IHSS) and home health, but the same reasons apply. My Turn does not appear to have a question to determine eligibility by caregiver status.

    - CDPH: Family members who are caregivers need verification that they are official caregivers, and then are eligible to be vaccinated.
- Unpaid family caregivers need to be recognized as frontline healthcare workers. https://www.sandiegouniontribune.com/caregiver/news-for-caregivers/story/2021-02-16/family-caregivers-now-eligible-for-vaccination-while-some-care-recipients-are-not
- The need is to verify unpaid family caregivers. Verification is in place for IHSS and Regional Center family caregivers. Those outside of those systems are being left out.

**Vaccine Dashboard**

- Are the retail pharmacy vaccinations included in California's vaccination dashboard? https://covid19.ca.gov/vaccines/#California-vaccines-dashboard
- Is the county data on the site for county-administered vaccines, or for all vaccines in the county (including Multi County entities, pharmacies, etc.)?
- Does the demographic data on the vaccine dashboard include vaccines administered under the federal Long-Term Care Pharmacy Partnership?
- The mixed-race and other categories seem much bigger than expected (especially given a whole other category of unknown). Do we have an idea about how folks are self-classifying?
- Has occupation been added to the required data being collected?
- Is there demographic data that relates to disabilities or functional limitations?
- Do we have data on health insurance status? I am interested in uninsured and those in Medi-Cal coverage, which is a key indicator of equity.
- Latinx numbers are embarrassing.
    - CDPH: You'll get no argument on that. This data is a starting point.

**Pharmacy Partnerships**

- Could you clearly delineate the differences between the Long-Term Care Program and the Long Term Care Pharmacy Partnership?
- Would the CDC Long-Term Care Pharmacy Program be able to shift to outreach to other populations like agricultural workers so vaccines can go out to where workers are?

**Vaccine Supply**

- Are there projections for ramping up supply? We have heard federal estimates - has that timetable been included in state planning?
- The White House announced on Tuesday a 23% increase in vaccine allocation. In past CVAC meetings, CDPH had already projected weekly numbers to increase by about 20%. Is the federal 23% increase "on top of" the increases CDPH has already predicted and on top of the numbers in the slides?
    - CDPH: We don't believe these numbers until we see them. Other vaccines are coming to California that aren't part of our allocation via FEMA and the Federal

Pharmacy Program. We're not sure how these figure into decisions made in Washington. In general, the dedicated allocation and supply has been increasing and we've been assured this will continue so we are hopeful.

**Frontline Social Workers**

- Frontline social workers providing food, rental assistance and other safety net services should be vaccinated.
- Frontline social workers perform critical evaluative and assessment work with people with disabilities who receive home and community-based services and need vaccination as front-line healthcare workers.

**Incentives**

- I am incredibly skeptical that health care incentives will do anything other than pass the buck. The evidence for successful health care incentive programs is absent. During a pandemic our goal should just be to get people vaccinated.
- There are myriad ways incentives are good for everyone - the providers and the enrollees.

**Miscellaneous**

- Many childcare workers will not be able to make an appointment during the times the vaccines are being made available. Many childcare providers open their homes very early and remain open late. I think this needs to be considered especially since they are in Tier 1b.
- Wonderful to have Secretary Richardson join us. She brought clarity and transparency to the conversation. Thank you for bringing key decision makers to meet with us.
- If not all vaccines are used at the end of a vaccination event and will expire, it is my understanding that organizers then contact people on their waiting list. If there are still vaccines available, would it be possible to provide these vaccines to people willing to physically wait for it even if they are not part of the current tiers to prevent wasted doses.
    - CDPH: We are definitely not wasting any vaccine. That is a top priority.

## My Turn Demonstration

*Eric Norton, CDPH*

Eric Norton gave a demonstration of the My Turn platform. Mr. Norton mentioned that there is a whole ecosystem of systems to serve vaccination needs for the state. My CA Vax (formerly CalVax) Is the backbone of the system for ordering and vaccine distribution. My Turn has two systems – Public and Clinic. The demonstration today for CVAC is My Turn Public: the public access point for COVID vaccine registration and scheduling (both first and second doses). CAIR2 is one of the three immunization information systems (IIS) in California. The others are SDIR (for San Diego) and RIDE (for 8 Central Valley jurisdictions). Following an immunization, the

information is uploaded into the IIS which is the repository for vaccine information in the state. He walked through My Turn Public registration for someone who was eligible and vaccine is available; then for someone who was not eligible.

The system is currently operational in English and Spanish with very high priority to complete translation into 8 languages by this Friday (Chinese traditional, Chinese simplified, Korean, Tagalog, Arabic and Vietnamese). Eligibility is determined based on age, industry, county, and an optional accessibility code. Those eligible move directly to scheduling first and second vaccine doses, displaying local clinics available based on zip code. Available clinics and appointments can be selected. Most clinics allow patients to schedule both doses at the same time. Appointments can also be cancelled or modified on the website. There is also a chat feature that links to FAQs and is monitored, as well as a link to the California COVID hotline.

After selecting appointments, more information is requested including name; gender (includes Non-Binary and Prefer Not to Say); and race/ethnicity. A mobile number is required and email is optional. There is an optional question for health care coverage. There are 13 CDC questions which don't preclude eligibility but are sent to clinics to inform the process. A security code is then sent to prevent bots and fraud. Confirmation emails include a QR code to print or bring by phone. Reminders are sent by SMS and/or email.

The flow for someone who is ineligible offers to register the user to be notified when they become eligible. Co-morbidities and underlying health conditions have not been mapped out yet. Notifications will be sent by Local Health Jurisdictions (LHJs) when they become eligible. If a special population is being targeted, the state can set up clinics linking to Accessibility Codes, working through LHJs and CBOs to distribute those codes. The codes allow a person to bypass the eligibility criteria and point straight to a special clinic.

<u>Comments and Questions from Members</u>

**General Questions and Comments**

- Who owns My Turn?
    - CDPH: CDPH does.
- Can anybody use My Turn?
    - CDPH: Yes.
- Can you make appointments anywhere with My Turn?
    - CDPH: Because there is a lot of pent-up demand, the current focus is on LHJs and some large providers. Currently live is Los Angeles, San Diego, 9 LHJs in the Central Valley, Kaiser mega clinics in San Francisco and Pomona, the Dignity mega clinic in Carson focusing on Medi-Cal patients, and the FEMA and OES clinics in Oakland and Southern California. The TPA is working to

make decisions about priorities and capacity to deploy the system. The goal is to move quickly but there are some capacity constraints.

- What if someone doesn't have a mobile number?
    - CDPH: You can use a landline and get email notifications. If you have neither we encourage people to contact our call center. Call centers can share booking information. At the clinics, no ID is required except for healthcare providers; you just need to give your name.
- To the extent the issues are local and specific (for example, the senior community seeking to be vaccinated as a congregate care setting), are these comments forwarded to the relevant county or public health official?
- Can family members or other helpers sign up for My Turn?
    - CDPH: Yes, you can register on behalf of someone else and we are building out a way to prevent duplication.
- Can we call the My Turn call center instead of using the online system?
    - CDPH: Yes, and the system allows walk-ups as well. This can be helpful for those who are insecure about citizenship status but are otherwise eligible.
- Is there an option to specify that a person is homebound or needs transportation?
    - CDPH: No, not yet.
- Has there been consumer testing done? We could help!
    - CDPH: No but it has gone live with LHJs and at the clinics we are soliciting feedback about people's experience getting reservations. We are looking to build in those measures to the system.
- Can the vaccine information be linked to a person's medical record? To be clear, we would want it worded carefully to make clear that any question about health insurance or provider is only for connecting medical records and shouldn't discourage anyone.
    - CDPH: We're working with Kaiser and Dignity so they can extract and link to their electronic health records.
- When is demographic information collected?
    - CDPH: It's not collected prior to eligibility determination but after, for those who are eligible, whether or not there is an appointment available. This can be used to target doses to certain groups later.
- Can My Turn account for the Healthy Places Index?
    - CDPH: We are trying to build into My Turn a way to reserve a certain number of appointments for vulnerable communities – e.g., for CBOs doing outreach in a given census tract. We are considering this as we operationalize equity.
- Can the same email address be used for multiple patients?
    - CDPH: Yes, the duplicate check is based on name, date of birth and phone number. So one person can enroll multiple people.

- How are the accessibility codes shared or distributed?
    - CDPH: We're working with the vaccination clinics to distribute these codes to populations they work with.
- How does the My Turn app determine what groups are eligible for vaccines by county? What information is being used? Since each county makes decisions based on supply and estimated population sizes, is the information accurate to what is actually happening?
- In advising our communities, would you suggest they start with My Turn or start with their doctor, their health plan or their county?
- What's been the volume of calls to the COVID hotline, what's the capacity of the call center, and can they provide interpretation in multiple languages?
- What about after-hours appointments?
- We have seen the mega sites being overwhelmed with large turnout. It's taking up to 4-5 hours before people actually get their vaccine. Will this system help reduce wait times?
- In San Diego County they will not advance you through My Turn if you are not in Phase 1a or 65+. Is this a real time assessment? I'm curious how nimble the platform is.
- Do you get a text when appointments are available if you start the My Turn process but don't get an appointment?
- If it's the same path for "I am eligible but there is no vaccine now" and "I am not eligible," how would someone in the second category figure out if they just made some kind of inputting mistake (something fixable that can change the assessment of eligibility)?
- In My Turn one of the drop-down questions asks to identify the business/industry you're in, but it lists all kinds of critical infrastructure jobs that are no longer being prioritized. What is the thinking around listing them?
- What is the process to verify that the information logged into My Turn is accurate?
- Can you clarify how My Turn will update categories of people eligible to sign up for a vaccine appointment? Will the state do it on a specific date for specific phases and tiers? Will each county be able to adjust that separately?
- Does My Turn track if someone takes the first vaccine then is migrated/harvest season) moved and will need a second dose in another county?
- What happens to people who received their first shot through their health care provider after My Turn kicks in? Do they schedule the second shot through My Turn or the provider?
- Not all American Indian/Alaskan Native (AIAN) individuals would use My Turn. Those that are connected with a Tribal or Urban Health Program would go there first. AIANs not connected with a Tribal or Urban Health program may use My Turn, but are also more likely to have private insurance.
- It would be great to have explicit language within the system that tells folks it is OK to assist someone and use their own email and/or phone for the person needing the vaccine.

**Pharmacy Linkages**

- How does My Turn communicate with CVS and Rite Aid?
    - CDPH: We are in conversations with both of them. Probably you will go through eligibility and then get a link to their site, but no warm handoff.
- Would it be possible to add a notification that if people do not find an appointment on My Turn they should consider checking their local pharmacy website?

**Language Access**

- Is there a plan to increase languages beyond the 8 you mentioned e.g., to the threshold 15 Medi-Cal languages or any African languages?
    - CDPH: This feedback will help prioritize. We're balancing language and accessibility with functionality for the system. We are also building out My Turn Clinics. We will accept additional language suggestions.
- For the indigenous interpretation services that Vance Taylor is mentioning, who are the providers and how are they vetted? We have experience with the Language Line service saying they offer Mixteco phone interpretation, but it's actually someone speaking Spanish slowly. 25% of California agricultural workers are Indigenous.
    - Governor's Office of Emergency Services (Cal OES): Our vendor provides indigenous language services. We have used/vetted the vendor via previous experiences at shelters, town halls, etc.
- What's the name of the vendor?

**Accessibility**

- Do screen readers work on My Turn?
    - CDPH: It was tested when it went live but we haven't checked since enhancements were made.
- I would recommend testing both the interface and the language on different populations, esp. low-income older adults given the allocation prioritization.
- We would be glad to help review the site for accessibility, like for screen readers.
- Please check to also ensure that Dragon can also be used when using My Turn.
- Older adults have less access to the internet , especially older adults from communities of color.
- Mobile sites associated with the mega sites and at Independent Living Centers have made it easier for people who can't manage crowds.
- In the Q&A, is there information about physical accessibility of different locations?
    - CDPH: We will be asking whether assistance is needed so clinics are prepared in advance. We don't have other information like how far someone would need to walk right now.

**Verification**

- There have been issues with providing identification at the vaccination sites. Some people do not have valid ID. What do they do?
- For farmworkers, documentation and verification is often challenging.
- Please don't require verification, it makes no sense.
- There is a difference between identifying disabilities and chronic health conditions as a demographic identifier (for which self-attestation is fine) and proving you are in a high risk category for a vaccine screener.
- If verification of conditions is required please make sure they know that at registration and they're told what to bring to the appointment so people aren't surprised or frustrated.
- Verification requirements create a barrier to access especially if people were not informed to bring verification to the vaccination site.
- What the UFW Foundation has done with an FQHC partner is to confirm farmworkers just by requesting their name and phone number if they have one - the clinic then captures more demographic information when the person arrives. We'll need flexibility for mobile vaccine and walk-up events that target farmworkers. Farmworker organizations know how to identify agricultural workers but may not have verification documentation.
- As a provider working at vaccine sites, we want to extend trust and lower the threshold for access but also want to ensure that doses are going to priority groups.

**Disabilities and Underlying Health Conditions**

- When will eligibility be updated for individuals under 65 with underlying medical conditions?
    - CDPH: The current functionality is for the current priorities. The system can have eligibility set by local health jurisdictions, and we can activate a given industry or age based on this. The default is the state-established priorities for phases and tiers.
- Does the question about disability or underlying health condition make it a self-certification system, or will verification be required?
    - CDPH: We're building that out; it's not clear yet. There may be verification requirements at the vaccination site even if My Turn does not require it. Some of these new requirements may be operationalized through My Turn and others will not. LHJs that have implemented My Turn have found some gaming of the system which they need to assess – although this seems to be declining now. Our goal is to make the system accessible and if it's too un-gameable it will degrade the usability. Many decisions will be made at the site level.
- Is it possible to use My Turn now as a younger person with a high risk disability and be "in the system" even though vaccination will not occur until March 15 or after?

- We have been assisting individuals with underlying health conditions through My Turn in both LA and Alameda. It's been great! The sites were organized and easy to get through.

**Recommendations re: Underlying Medical Conditions and People with Disabilities and Update on Access Strategies**

*Tomas Aragon, MD, Dr.P.H., Director, CDPH and State Health Officer*
*Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup*
*Kim McCoy Wade, Director, California Department of Aging*
*Vance Taylor, Governor's Office of Emergency Services (Cal OES)*

Dr. Aragon shared framing remarks. During the surge, CDPH focused on those most impacted – elderly people, people of color, the Latino community. As CDPH worked to prioritize age, the prior federal administration came out with guidelines expanding to over 65, those with medical conditions 16-64, and all this happened very fast. The state spent time getting input and considering how the criteria could be used to prioritize saving lives while achieving equity given supply shortages. It was clear that speed and simplicity were critical. There are a lot of tradeoffs in this decision-making, and no perfect decisions. The intent is to have the greatest impact.

On February 12, the state announced that starting March 15 it would expand priorities to include people with severe chronic medical conditions and disabilities. The CDC list of those at increased risk of morbidity and mortality from COVID was too broad given supply limitations and therefore the Drafting Guidelines Workgroup narrowed it based on input from disability groups. The definition is being fine-tuned so that it can be operationalized and it won't be perfect.

As vaccine supplies improve we will broaden this definition. Starting March 15, healthcare providers may vaccinate individuals age 16-64 who are at the highest risk for morbidity and mortality from COVID-19 as a direct result of cancer, chronic kidney disease (stage 4 and above), chronic pulmonary disease (oxygen dependent), Down syndrome, immunocompromised state from solid organ transplant, pregnancy, sickle cell disease, heart conditions (excludes hypertension), severe obesity (BMI ≥ 40kg/m2) and Type 2 diabetes mellitus (hemoglobin A1c level greater than 7.5%); OR If as a result of a developmental or other severe high-risk disability one or more of the following applies:

- Individual is likely to develop severe life-threatening illness or death from COVID-19 infection
- Acquiring COVID-19 will limit the individual's ability to receive ongoing care or services vital to their well-being and survival
- Providing adequate and timely COVID care will be particularly challenging due to individual's disability

Dr. Aragon then shared some examples of people who would be eligible or ineligible based on their circumstances. The list is not perfect and the state recognizes there will be gaps to be addressed working with county public health, public hospitals, and those who focus on the homeless, and mental health and substance use disorders. These are not yet addressed in this list, but there is an intention to address them more systematically with local partners.

Dr. Brooks added that the Drafting Guidelines Workgroup worked on this list through its meetings and submitted it to the state for final determination as to how Phase 1b will be structured. CVAC was instrumental in these recommendations. The things being discussed, including the Provider Bulletin released February 12, are at www.covid19.ca.gov/vaccines.

Kim McCoy Wade shared that she, Dr. Aragon and Nancy Bargmann, Director of the Department of Developmental Services are convening a group focused on the how of implementing vaccines for people with high-risk medical conditions and serious disabilities. This small working group includes several CVAC members representing disability, aging and labor, as well as the California Medical Association. The first two meetings have covered multiple topics, many of which were covered in the My Turn demonstration. Some areas of focus included mobile points of distribution, transportation, in-home options, and outbound registration such as how partners can book appointments on behalf of clients or patients as navigators might do. The next step will be a deeper dive meeting with the Blue Shield TPA next week. Great models have been implemented on mobile and home vaccinations for aging communities already, which can be replicated through the TPA for those with disabilities.

Vance Taylor presented on OES vaccination sites. President Biden chose California to stand up mega vaccination sites including the Oakland Coliseum and Cal State LA. They opened February 16 and the goal is to vaccinate 6,000 people per day. To ensure that those sites are physically and programmatically accessible, there is in-person ASL interpretation and every staff member has an iPad with a Video Remote Interpreting (VRI) app for remote interpreting to supplement in-person interpreters representing six languages and telephonic language services. There is "Just Ask" signage, signage to and from transportation hubs, and a designated lane for para-transit. They are working with partners like Bay Area Rapid Transit (BART) to provide free paratransit to and from bus stops and other locations. A host of other resources include wheelchairs and isolation rooms for those with sensory issues. They worked with the Pacific ADA Center to develop a fact sheet and are hearing great things about access. Each site has two mobile clinics and are working with three Independent Living Centers and other CBOs to schedule the mobile units to vaccinate up to 220 people a day. Vance thanked the group for all their direct input.

Comments and Questions from Members

- The recommendations that came from disability representatives on CVAC have not been to adopt the CDC list. We recommended that the state prioritize Regional Center clients, IHSS recipients and other individuals at high risk of dying from COVID, which is a broad, diverse category. We think using the CDC list for this purpose is a mistake.
    - CDPH: We will be reaching out to Regional Centers to help with verification and outreach for the highest risk groups. The CDC list includes Down Syndrome but nothing about developmental disabilities; that's where the state is including a broader population and where the disability groups' specificity has been influential.
- What is the estimated size of this new (March 15) group? And is it being thought of as Tier 2 under Phase 1B or a new Phase 1C?
    - CDPH: We will get you the estimated population after the meeting.
- Can we get clarity on how this overlays with the existing eligibility guidelines? Does this group begin throughout the state on March 15 and override the remainder of the essential worker group in Phase 1b, Tier 1?
- Is Type 1 diabetes truly not a recognized high-risk diagnosis?
- Type 1 diabetes is on the CDC's list of "might be a high-risk co-morbid condition" rather than the "is definitely a high risk co-morbid condition." The CDC list has not been updated for a few weeks and I think it has a number of inherent weaknesses for this purpose. I know many of us recognize that there is very significant overlap between people with high risk conditions and those who are homeless or incarcerated, which speaks to including those groups within the state's vaccination prioritizations.
    - CDPH: The challenge of doing this work in a pandemic is that we have to work with the best available evidence and recognize we don't have all the needed information.
- Thank you for pointing out that there will always be a lag to what we know through the scientific research that is being undertaken. That's why we appreciate the state's recognition that people with high risk disabilities can establish that fact through other means than being on a closed list of conditions.
- I think those with mental illness and addictions are at risk per the disabilities' inclusion as acquiring COVID would impact their ability to receive ongoing services such as methadone.
- What does "closing the gap" mean related to homeless with mental health or other high risk disabilities?

**Closing Comments and Adjourn**

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

Dr. Burke Harris closed by sharing comments about the guidelines posted Friday. She noted that as the state moves from a sector- and age-based strategy – i.e., after Tier 1 of Phase 1b – we will move to the more age-based strategy, and in part because of the input of this group have added those at high risk due to medical conditions or disabilities. After concluding Tier 1 of Phase 1b the state will move to a more age-based implementation. Dr. Burke Harris thanked all the presenters and members. The agenda today was based on CVAC questions, concerns and suggestions. She also reflected a few questions that the state will bring back later:

- Does the race and ethnicity data include the federal long-term care partnership?
- What is the role of Kaiser Permanente in the TPA?
- What is the difference between the CVS/ Rite Aid pharmacy partnership and the federal long-term care partnership?
- Where should the public start? Doctor, My Turn, county, other?

Dr. Burke Harris thanked the group for these excellent questions and committed to bringing the best answers back. She thanked the committee for continuing to make time in their busy schedules to improve California's vaccine allocation and implementation process.

Next Meetings

- ❖ March 3, 2021 from 3:00 – 5:00pm *
- ❖ March 17, 2021 from 3:00 – 5:00pm *

*Note change to 2-hour meetings

CVAC will likely meet once each month in April, May and June.