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

COMMUNITY VACCINE ADVISORY COMMITTEE

REFLECTIONS FROM CVAC MEMBERS
Compiled June 21, 2021 in Preparation
for the June 23 Community Vaccine Advisory Committee Meeting

Community Vaccine Advisory Committee (CVAC) members were all asked to prepare a short set of reflections for the June 23, 2021 meeting, sharing their thoughts on the CVAC process including what worked, what could have been improved and lessons learned as we move forward. CVAC members were told that their reflections would be compiled as written, posted as part of the June 23 meeting materials and shared in advance with CVAC members. One member of each sector who contributed thoughts will present on behalf of that sector at the CVAC meeting on June 23, 2021 and there will be time for other members to comment.

Agriculture

- **Jose Padilla, California Rural Legal Assistance**
- **Diana Tellefson Torres, UFW Foundation**

Jose Padilla, California Rural Legal Assistance

I share just a few thoughts regarding the COVID Process and our involvement.

First—the coordination of the committee work with such a large task group had to be very daunting to the Planning Team that brought it about, in particular, you and co-chairs Dr. Erica Pan and Dr. Nadine Burke. The Data provided at each meeting through the extensive Power Point presentations was critical for many of us trying to figure out how we, as an advocacy group, could assist with the vulnerable communities we serve. In CRLA's case, knowing how Farmworkers as essential workers were suffering differently because of language barriers and basic health disparities helped us figure out how our staffs could best work locally and with who.

Second--- especially important was the focus from the beginning on EQUITY. To have the CVAC leadership put that heart and center of these efforts was such an important framework for us doing Social Justice in rural places. In this regard, it was important for some of us who work with vulnerable

communities like farmworkers to be provided insights and data and information from experts like Ed Kissam, as we were trying to understand how the campaign messaging was progressing as the efforts went forward.

Finally, being able to have questions answered in real time with the CHAT function was an important way to see how other committee members were addressing related problems and allowing some of us to share relevant knowledge to assist them. At the end, I appreciated being invited to join so many others who, from their unique spaces, were also trying to effectively use limited resources to stem the devastation that this plaque had brought upon those we seek to serve.

Diana Tellefson Torres, UFW Foundation

The UFW Foundation appreciates the opportunity provided to serve on California's Community Vaccination Advisory Committee. While CVAC draws to a close, our organization looks forward to continuing collaboration with the California Department of Public Health to ensure farm workers are vaccinated and protected from COVID-19.

Even before the virus struck, agricultural workers were among the most vulnerable employees in America. They are constantly mobile and regularly live in overcrowded, substandard and unsanitary conditions, often in multifamily households; carpool to work packed into vehicles out of necessity and as a result of how poorly they are paid; frequently toil shoulder to shoulder in fields and packinghouses; and speak languages other than English as their first language. Finally, at least half are undocumented and most are uninsured[1].

Farm workers are also disproportionately sick and dying from COVID-19. A UFW Foundation text message survey completed in February showed of farm worker respondents who reported being tested for COVID-19, 46 percent (N=2,214) were positive. Similarly, a U.C. San Francisco study[2] documents "relative excess mortality was highest in food/agriculture workers (39 percent increase)." And while "Latino Californians experienced a 36 percent increase in mortality," there was "a 59 percent increase among Latino food/agriculture workers."

Farm Worker Vaccination Prioritization

Given that COVID-19 exacerbated farm workers' vulnerabilities that existed prior to the pandemic, their unique circumstances merited a targeted approach to mitigate spread of the virus. As you know, UFW Foundation recommended state and local health authorities prioritize farm workers for vaccinations and allocate vaccines for this population as soon as they were available. Many farm workers' lives were undoubtedly saved when the California Department of Public Health prioritized them under Phase 1B, Tier 1 for vaccine distribution. Still, most counties were very slow responding to this prioritization. It was imperative for CDPH to centralize pandemic responses and guidelines to ensure counties addressed needs of this vulnerable population. Additionally, the decision by Governor Newsom and CDPH to

[1] 75% of the 11,921 self-identified California farm workers who responded to a UFW Foundation text message survey on December 7, 2020 said they did not have health care and 13% said they had *never* been to a doctor for a check-up.

[2] UCSF Survey Abstract https://www.medrxiv.org/content/10.1101/2021.01.21.21250266v1

allocate vaccines for agricultural workers also aided efforts to establish mobile vaccine clinics through community-based organizations, the United Farm Workers and employers.

Lack of Data

Unfortunately, CDPH did not separate out "food" from "agriculture" as an occupation category on MyTurn or CAIR, databases used to register vaccine appointments and administer doses. Given the vulnerabilities already detailed and high migratory patterns of farm workers who often move between counties and states, data on agricultural workers should have been disaggregated from meat processing, grocery and other food industry data. So it is still unclear how many farm workers have been vaccinated.

Sick Leave and Employer Compliance

Many agricultural workers expressing insecurities and skepticism over COVID-19 vaccines cite possible side effects and fears over losing work days and wages. Employers do not inform them about their right to paid sick leave. There is a need for CDPH and other agencies to increase public education relating to SB 95 to ensure that low-income workers are aware that their employer legally must provide sick leave.

California's investment in enforcing the law is also crucial to ensure employer compliance of SB 95 and the continued safety measures that are necessary when not all employees are vaccinated at a workplace beyond the state's "reopening". Our outreach shows there are farm workers who continue reporting their employers are not following safety precautions and are not tracking whether employees are vaccinated.

Investment in Mobile Vaccination, Outreach and Education

California has already begun allocating financial resources to ensure community-based organizations, unions and community health clinics representing vulnerable populations conduct multi-faceted outreach and mobile vaccination events. This investment will continue to be necessary beyond California's reopening as the pandemic is still evolving.

- Many farm workers with limited digital literacy or no phone, technology or transportation will benefit from in-person outreach and local mobile vaccination events that do not require registration.
- Pairing vaccine events with incentives such as food and cash-card distributions has proven a useful community motivation. Resources for ancillary services or incentives are needed beyond the reopening.
- Many parents are now more willing to get vaccinated as Pfizer is available to children as young as 12. Increasing Pfizer vaccines in low-vaccine uptake areas would support vaccination efforts targeting vulnerable communities.

We look forward to our continuing collaboration to vaccinate community members and mitigate inequities that continue to disproportionately impact farm worker communities.

Behavioral Health

- **Moisés Barón, California Alliance for Child and Family Services**
- **Dr. Veronica Kelley, LCSW, County Behavioral Health Directors Association (CBHDA)**

Moisés Barón, California Alliance for Child and Family Services

The CA Alliance for Child and Family Services represents 150 Community Based Organizations providing a range of behavioral health and educational services to California's children, youth, and families. We are thankful for the opportunity to have been a member of the CVAC, with our CEO Chris Stoner-Mertz participating in the first meetings and me joining at the 5th meeting on December 23, 2020.

We would like to express our gratitude to Dr. Nadine Burke Harris and Dr. Erica Pan for their leadership. There is no doubt that CVAC members felt heard and valued, and it was clear throughout the whole process that real efforts were made to be responsive to the many questions, concerns and recommendations brought forward by committee members and the public. Thank you also to Bobbie Wunsch who managed the difficult task of coordinating the committee's efforts with great skill.

The process of deciding how the COVID-19 vaccines would be allocated, especially when supply was so limited, was indeed challenging. Having clear foundational and procedural Allocation Equity Principles was of great importance. One of the clear benefits of being part of the CVAC was the opportunity to review and clarify the phase approach to vaccine allocation developed by the National Academy of Sciences. Having access to communicate directly to Drs. Brooks and Schechter of the Drafting Guidelines Workgroup was crucial in our efforts to get clarity about access to the vaccine for behavioral health workers. The prompt response we received to our inquiries allowed us to quickly mobilize early in January 2020 the California Alliance membership and other behavioral health community based organizations to get access to the vaccine as we continued to provide in-person services to the state's most vulnerable youth and families.

Health and Human Services Agency Secretary, Dr. Ghaly, has stated that one of the important impacts of the pandemic has been the "unmasking of inequities." Our committee clearly struggled with this issue firsthand. Despite the tremendous resources allocated to the vaccination campaign and the fact that equity was clearly stated as a guiding principle, the vaccination outcome data today speaks to the challenges to effectively address the systemic factors underlying these inequities. From a public health perspective, we believe that the difficulties the vaccination efforts have faced to reach and engage underserved and marginalized populations provide important information and possible insights into the factors that require attention for the future. We will not be successful implementing important statewide initiatives such as ACES Aware and the Children and Youth Behavioral Health Initiative, if we do not identify what strategies can help in effectively engaging underserved and marginalized populations, and which factors hindered or did not help with those efforts. Identifying and cataloguing lessons learned in this area could be of great help into the future.

It was important for CVAC to have broad representation, however, the large number of participants made it sometimes difficult to participate in the meetings. Upon reflection, we believe that it would have been helpful to create workgroups by sector between meetings or during CVAC meetings, to better

identify needs, provide prompt feedback to the important information being presented, and to develop recommendations to improve the state's vaccination efforts.

In closing, participation in CVAC made the complexity of the task of developing and implementing an equitable state-wide vaccination effort very clear. Despite the challenges, and the need to sometimes pivot and correct course, we are grateful for the State's tremendous effort to create an inclusive process in order to achieve a successful outcome.

Dr. Veronica Kelley, LCSW, County Behavioral Health Directors Association (CBHDA)
The process to bring various representatives to the table to address community needs was a necessary and admirable one. I was honored to be present, but the lone voice for those in behavioral health, which made it even more important to be outspoken, which I can be.

I found that all members worked together, as we all have so much overlap, or intersectionality with those we represent. I did find having outside forces respond via written comments, as well as working outside of CVAC via the larger membership of various associations, mine included, was helpful to get movement on certain issues. For example, I brought up numerous times the fact that behavioral health was not called out explicitly in the CDPH guidance for vaccinations and as such, local jurisdictions did not attend to it, excluding behavioral health as healthcare in many places. This was brought up numerous times and eventually was added, with support of fellow CVAC members and outside forces. Having things in writing- as explicit is often required in bureaucratic systems.

I learned that during grave times, strength can still be found in numbers and that inequity in one group results in inequity in all groups in some fashion. It was clear that one doesn't have to give up anything for another to receive. It was also clear that stakeholders are but one cog in the wheel and that many things were constantly going on behind the scenes, some of which were not as well received as others, such as the Third-Party Intermediary, and that we all live in a political environment, even during a Pandemic.

I appreciated the numerous allies who supported the behavioral health focus and hope that I provided support in kind to my fellow CVAC members. Nothing was more important when we started then getting the vaccination out and I hope that the process we went through emboldened the masses to consider the issues caused by inequities that will persist if we do not change the bigger system.

Finally, I thank the Co-Chairs, Dr. Pan and Dr. Burke-Harris, as well as our amazing facilitator, Bobbie Wunsch, who is exceptional! Thank you for the opportunity to serve.

Black, Indigenous and People of Color

- **Thomas J. Kim, MD, California Rural Indian Health Board**
- **Carolyn Pumares, PharmD, MS, Indian Health Service – California Area Office**
- **Jeffrey Reynoso, Latino Coalition for a Healthy California**
- **Chang Rim Na, MD, representing Asian & Pacific Islander American Health Forum**
- **Rhonda M. Smith, California Black Health Network**

Thomas J. Kim, MD, California Rural Indian Health Board

First of all, thank you for inviting the CA Rural Indian Health Board to be a part of this group. We truly felt solidarity with the various groups represented and it was both encouraging and learning experience to hear from them. While there was a diversity of issues brought up, for example since almost all Tribes and Tribal clinics obtained their vaccines through direct federal channels, being a part of this groups provided opportunities to make connections that we may have not otherwise made. A challenge for our communities a deeper understanding of culturally-specific and community-specific reasons for vaccine acceptance, hesitancy and refusals. Being on CVAC connected us and the Indian Health Service to Dr. Arlene Brown's group at UCLA and their focus groups work in that very topic. So we've been able to join with them to add rural Tribal focus groups to expand their data collection. This has also inspired us to move forward with a follow up but separate qualitative study that will go further in producing and testing an intervention to increase intention to get vaccinated among Tribal community members. In all, CVAC reminded me that we are all in this tremendous effort together, and it served as a conduit of critical information that I was able to pass onto our member Tribes/Tribal Health Programs, and it connected us with partners that we critically needed. Thank you so much Bobbie for all your hard work in making all of this possible for us and the many communities here in California.

Carolyn Pumares, PharmD, MS, Indian Health Service – California Area Office

As a representative for the Indian Health Service California Area Office, I am grateful for the privilege to be a part of CVAC. I appreciate the transparency displayed during the meetings through presentations made by Dr. Burke-Harris, Dr. Pan, Dr. Ghaly and Ms. Wunsch's reading of public comments as well as the attempt of presenters to answer all questions during our limited time together.

As you may know Indian Health Service is one of the jurisdictions for vaccine distribution. As such, I felt it necessary for others to be able to advocate for their groups during the initial rollout of the vaccine, because these groups were completely dependent on the State of California's allocation of vaccine. Whenever necessary, I made sure to include comments in the chat section when compelled to during the discussions. The most utility for IHS, in my opinion, was the discussion on considerations for improving vaccine confidence.

In my opinion, CVAC was a wealth information for Tribal and Urban Indian health programs. I really appreciate the ability to reach out to Ms. Wunsch on various issues and I appreciate Ms. Wunsch's ability to respond in a timely way for such things like Vaccine Confidence resource connections, availability of Vaccine Assessment Questionnaire in Spanish, access to My Turn Volunteer, consideration for inclusion of Tribal and Urban Indian health programs in the state's Vax to Win program to name a few. I feel the information provided allowed our Area Office to communicate to our health programs current up to date state information and available resources. We also appreciate the participation of these state resources in our weekly Vaccine Office hours.

As CVAC disbands, I would like to again express deep appreciation for the state's inclusion of IHS in the meetings. I look forward to future collaborations.

Chang Rim Na, MD, representing Asian & Pacific Islander American Health Forum
We thank the committee leads and members for their commitment and diligence throughout the process. The pandemic has been a trying time for all of us, and the one silver lining has been that many realized that we are all in it together and there is strength and power in a shared experience. We are grateful to have been part of CVAC with its lens firmly focused on health equity, as dramatic social and health inequities were exposed in our health system.

Up to this point, Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI) have oftenbeen relegated by national recommendations for vaccination to the sidelines or have been completely ignored. This does not bode well for equitable allocation, administration, or acceptance of adult vaccination, particularly for COVID-19. A September 2020 report from Kaiser Family Foundation and Epic Health Research Network showed that AANHPIs were 57 percent more likely to be hospitalized and 49 percent more likely to die compared to Whites withsimilar sociodemographic characteristics and underlying health conditions.[3] AANHPI communities are at higher risk for serious illness from COVID-19 due to pre-existing chronic disease such as diabetes and other cardiometabolic diseases. Other social determinants of health pose risks to AANHPI communities, such as large proportion of AANHPI essential workers, particularly in the frontline medical and food production (meat- and poultry-processing) industries, as well as high proportions of AANHPI families living in multi-generational (3 generations or more) households.[4],[5],[6] To make matters worse, their suffering remains largely overlooked in the form of incomplete data representation and increases in deadly racial bias.

The AANHPI communities face unique challenges due to their extreme diversity. In the US, 23 million AANHPIs live in every state, territory, and US-affiliated jurisdiction of whom nearly 7 million are limited-

[3] Yee, A. May 6, 2021. Covid's Outsize Impact on Asian Americans Is Being Ignored. *Scientific American.* https://www.scientificamerican.com/article/covids-outsize-impact-on-asian-americans-is-being-ignored/

[4] Lim S, Bae JH, Kwon H-S, and Nauck A. 13 November 2020. COVID-19 and diabetes mellitus: from pathophysiology to clinical management. Nature Reviews Endocrinology 17: 11-30. https://www.nature.com/articles/s41574-020-00435-4

[5] Editorial. The plight of essential workers during the COVID-19 pandemic. May 23, 2020. The Lancet395: 1587. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31200-9/fulltext

[6] Centers for Disease Control and Prevention. Guidance for Large or Extended Families Living in theSame Home. March 9, 2021. https://www.cdc.gov/coronavirus/2019-ncov/downloads/living-in-close- quarters.pdf

English proficient (LEP), speaking over 100 languages.[7],[8],[9] To address COVID-19, it is critical that these communities get clear, accurate, and accessible information toprotect themselves, their loved ones, their communities, and the public's health and welfare, including information about and access to COVID-19. To help mitigate these factors, APIAHF and 27 local and national partner organizations formed the National AA and NHPI Health Response Partnership. Through this collaboration, a website was launched as a hub for COVID-19 materials developed by APIAHF and partners in over 26 AANHPI languages. This includes various resources like factsheets, webinar recordings, toolkits, infographics, and more.

The Partnership continues to tailor strategies and resources based on community needs. Because of the large immigrant population in the AANHPI community and residual fears of immigration enforcement, APIAHF and our partners recently developed "Know Your Vaccine Rights" fact cards (translated into 26 AANHPI languages) to inform our immigrant community members about their rights to a free vaccine despite immigration status or insurance coverage.Furthermore, through this Partnership, our community-based organizations have developed a network of trusted messengers and leaders to educate their communities and combat misinformation for COVID-19 and beyond.

Unfortunately, the COVID-19 pandemic also brought an increase in anti-Asian violence. Manyelders are especially afraid to leave their homes due to the threat of violence, an influencing factor in vaccine uptake. In response, some of our partner organizations have utilized mobile and pop-up vaccination sites to decrease the distance traveled by community members.

Additionally, APIAHF collaborated with the National Asian Pacific American Bar Association(NAPABA), to create a hate crimes toolkit (translated into 26 AANHPI languages) which provides basic and critical information for victims, community-based organization, and community leaders.

Lastly, we recognized that certain subgroups, especially the Native Hawaiian and Pacific Islanders were disproportionately ravaged by COVID-19. CDC data from March 2021 show that6,692 NHPIs per 100,000 have or have had the disease, the largest proportion of any group for which data were disaggregated and over twice the rate of Whites. In all, 208 NHPIs per 100,000died as a result of the disease, a figure 68% higher than for Whites.[10] AANHPI is a large umbrella of various groups of people and the pandemic

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[7] Ko Chin, K. October 4, 2020. A History of Asian American, Native Hawaiian, Pacific Islander Health Policy Advocacy: From Invisibility to Forging Policy. Commentary, Asian American Policy Review. Volume30.

[8] Islam NS, Khan S, Kwon S, Jang D, Ro M, Trinh-Shevrin C. Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: historical challenges and potentialsolutions. Journal of health care for the poor and underserved 2010;21:1354-81

[9] U.S. Department of Transportation, About Limited English Proficiency (LEP), January 5, 2016. www.transportation.gov/civil-rights/civil-rights-awareness-enforcement/about-limited-english-proficiency- lep.

[10] Simmons A, Chappel A, Kolbe AR, Bush L, and Sommers, BD. March 16, 2021. Health Disparities byRace and Ethnicity During the COVID-19 Pandemic: Current Evidence and Policy Approaches. Issue Brief, US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation.

further highlights the importance of complete and accurate data collection, reporting, and disaggregation, in order to have a true roadmap on where health inequities exist.

We are relieved that perhaps the worst of the pandemic is behind us. The vaccines were instrumental in getting us to this point. We are thankful to have been able to participate in thiscommittee.

Jeffrey Reynoso, Latino Coalition for a Healthy California

The purpose of this memo is to provide both personal and organizational reflections on the CDPH Community Vaccine Advisory Committee (CVAC) process, with a focus on the 1) Process, 2) Accomplishments, and 3) Lessons Learned.

CVAC process

- Positive (+)
  - 1.1. Established and reiterated clear values (safety, equity, and transparency) to guide the work of the CVAC activities
  - 1.2. Provided public comment summaries at the beginning of CVAC meetings
  - 1.3. Addressed CVAC member questions either through open Q&A and/or via chat
  - 1.4. Shared CVAC member chat document post-CVAC meetings
  - 1.5. Shared CDPH staff answers to CVAC member questions post-CVAC meetings

- Delta (Δ)
  - 1.6. Improve clarity on how CVAC input would guide CDPH/the State's decision making on vaccine allocation, distribution, and administration
  - 1.7. Improve meeting facilitation to ensure a diversity of voices are heard (i.e. ask CVAC members who always speak up to step back, ask CVAC members who don't always speak to step up)
  - 1.8. Improve engagement with CVAC members in-between public calls; for example, received CDPH staff outreach to support with CVAC member engagement in January 2021, but that was limited to 1 touchpoint
  - 1.9. Improve coordination with CVAC members on education and outreach efforts; appreciated opportunities to align messaging with Vaccinate all 58 campaign, but need more lead time to incorporate toolkits, messaging, and resources to distribute to our organizational partners and community members

CVAC accomplishments

- Positive (+)
  - 1.10. Prioritized essential workers in Phase 1B, specifically farmworkers (and the broader food and ag sector)
  - 1.11. Included promotores/CHWs as part of the state's essential health workforce prioritization
  - 1.12. Operationalized health equity metric allocating 40% of vaccines to highest-need zip codes across CA; this policy change resulted in increased vaccine allocations to the hardest-hit regions and communities across the State

1.13. Convened and maintained engagement of a diverse group representing multiple intersectional identities (i.e. race/ethnicity, gender, sexual orientation, disability and/or immigration status), multi-sector, multi-issue, and multi-regions

- Delta (Δ)
  1.14. Closed the gap on allocations across HPI quartiles, but didn't necessarily see dramatic reductions in disparities by race/ethnicity. For example, Latinx Californians account for 26.9% of those receiving at least 1 dose of the vaccine as of June 8th 2021, far below its 39% share of the state's population
  1.15. Improve timely reporting of COVID-19 data

CVAC lessons learned

1.16. If the CVAC had not been established (the counterfactual), the above accomplishments might not have occurred and, thus, there would have been even wider health disparities with the vaccine rollout
1.17. Health equity work is hard and messy but is strengthened when impacted communities are "at the table" making their voices heard
1.18. California's public health infrastructure needs substantial investments to improve outdated data systems
1.19. Partnerships between government and CBOs are key to overcoming mistrust and increasing access to vaccines, healthcare, and social services for "hard to reach" communities
1.20. Funding CBOs to be the trusted messengers are critical to overcoming linguistic, cultural, and other barriers and for achieving health equity
1.21. The CVAC process should be formally evaluated and lessons learned should build upon future CDPH/State efforts to engage with California's diverse communities

Rhonda M. Smith, California Black Health Network

The Good

It was good to have representation on the committee of a very diverse group of members and perspective. Think the steering committee did a great job of the outreach to ensure that all communities were represented and had voice at the table. It was also great to be part of the process to shape the equity lens for the OVID-19 vaccine distribution across the state.

I think what I like the best was that our voices were heard and was factor into the decision making to ensure more equitable distribution. I also liked having the opportunity to have early access to information that would eventually be shared more broadly to take back to our constituents that enabled them to be aware of information that they probably would other be privy to or know where to go or how to access it.

Also, you all did an excellent job of managing the time and get through all of the content at each meeting.

The not so good

The meetings at the end of the day after marathon zoom calls already were a bit tough. Also, everyone wanted their community to be prioritized so it often seemed like a "my community is more important than yours" kind of thing but in the end it worked out. I think we were all just feeling the pressure of being in survival mode, wanting something to happen as soon as possible, and having a heightened sense of urgency about it.

Lessons learned from the CVAC Process

Having a diverse community voice at the table is critical to impart a health equity lens for any community-based work.

Business

- **Preston Young, California Chamber of Commerce**

Preston Young, California Chamber of Commerce

California's economy has been hit hard by the COVID-19 pandemic, decimating entire industries and disproportionately affecting small and minority-owned businesses. Over the past year, California has lost 1,253,400 jobs - the most of any state. New York, which saw the second-highest job loss during the pandemic, lost only half that number, approximately 674,200 jobs.

Since March 2020, the business community has invested hundreds of millions of dollars to protect employees and customers, while dealing with unpredictable openings and closings, capacity limitations and other economic disruptions. Our efforts helped slow the spread, but it became clear that the key to opening California's economy safely and responsibly was to get every Californian vaccinated.

The CVAC's leadership, guidance, and broad-based membership ensured that this goal was brought to fruition in an equitable manner. Thanks to vaccination rates staying up and hospitalization rates remaining low, California has reopened for business. This accomplishment is, thanks in large part, to the effective distribution of vaccines. Vaccines have been crucial to our success and will be critical in moving forward.

CVAC's diverse group of community leaders collaborated on numerous recommendations to an evolving crisis that contributed to a robust policy response from state and local leaders. We worked hard to provide solutions and, as of today, California's COVID-19 numbers tell an optimistic story—we have one of the lowest positivity rates in the country.

Counties

- **Kim Saruwatari, Riverside County, representing County Health Executives Association of California (CHEAC)**
- **Eric Sergienko, MD, Mariposa County, representing California Conference of Local Health Officers (CCLHO)**
- **Kristin Weivoda, EMS Administrator Association of California (EMSAAC)**

Kim Saruwatari, Riverside County, representing County Health Executives Association of California (CHEAC) & Eric Sergienko, MD, Mariposa County, representing California Conference of Local Health Officers (CCLHO)

The CVAC Process

- It was very beneficial to have an external facilitator to organize and facilitate the meetings. Bobbie kept us on track and helped us meet the objectives for each meeting.
- Interacting with the different stakeholder groups provided a perspective that wasn't always complete at the local level.
- CDPH brought in subject matter experts that were able to accurately address questions and provide information.
- CDPH and the Office of the Surgeon General showed their commitment to the process by having their highest-level executives involved in facilitating and presenting information.
- Meetings were well organized and packed full of information.
- Because of the focus on statewide efforts, some of the work being done at the local level was not highlighted. It would have been helpful to have the local perspective on many of the topics addressed – and yes, the two of us could have spoken up during the question-and-answer period, but we really wanted to hear from the stakeholders, too.
- Distribution of materials, including articles and information from CVAC members, prior to the meetings was very helpful and allowed for maximum preparation for the meeting.

CVAC Accomplishments

- CVAC provided input in the roll-out of initially scarce vaccines during a global pandemic while highlighting the impact of the pandemic on many different populations (particularly those disproportionately impacted).
- Strong information sharing with a diverse group of stakeholders.
- Hearing about concerns from stakeholders helped public health as a discipline, and local public health specifically, really think about how we were approaching the vaccination efforts in terms of the equitable distribution of vaccines, trusted messengers, and information management.
- CDPH presented current and relevant information at every meeting that really helped stimulate discussion among CVAC participants.
- CDPH, OSG and Bobbie heard feedback from stakeholders and incorporated that feedback into subsequent meetings – including things like request for speakers, request for data, etc.

- CVAC stakeholders were able to see the media/outreach campaign and provide input into how effective the various strategies would be with their respective populations.

CVAC Lessons Learned

- There is power in bringing together such a diverse group of stakeholders to share ideas, express concerns and work together to best serve the residents and visitors of California.
- Soliciting public comment helped us to know if we were addressing the issues that other groups or the general public felt were most concerning.
- State and Local Public Health works best when fully engaged with and supportive of the communities we serve.
- Clear, consistent and unambiguous information is critical to gaining trust with populations.
- Trusted messengers are critical to gaining trust and encouraging people to get vaccinated.
- Stakeholder organizations are well-poised to assist with vaccine roll-out activities – either through a consultative role or a more direct service pathway.

Kristin Weivoda, EMS Administrator Association of California (EMSAAC)

- The goal and mission of the workgroup were clear, supporting the State's equitable approach to vaccine distribution.
- CDPH staff presenting information were knowledgeable about the current guidance and guidance in consideration.
- During meetings, CDPH would share important trends and developments related to vaccine distribution in a transparent way. In addition, when urgent items came up in-between sessions, emails were sent to share the information before any meeting.
- It was informative, but at the same time, sitting on other meetings with the State, a lot of the information was redundant.
- Members of the advisory board were diverse and represented California. Unfortunately, the majority were unaware of the formal public health process with the diverse group, which then delayed meaningful discussion.
- It was a very satisfying and rewarding experience being a part of this advisory board. It allowed a consistent flow of information to our organization.

Education and Child Care

- **Carol Green, California State PTA**
- **Melissa Stafford Jones, First 5 Association of California**

Carol Green, California State PTA

Overall I/we felt the process was fair and inclusive. The early discussions, although evolving, we productive and felt as if input was considered and appreciated. The preview and explanation of changing

tiers was helpful, understandable and frustrating, but I don't think there is anything we could have done to change that. I thought the meetings were, well organized and fairly inclusive. A few people/organizations did dominate the conversation, but I appreciated the attempts to include others.

The three hour meetings were a little long. Perhaps two hour meetings with shorter presentation and more input time would have been helpful. I felt engaged and interested through most of the meetings and credit the chairs and organizers for a good job.

I think the community groups could have done more in terms of promotion and information earlier on if we had been given some further guidance. You can share this newer information after each meeting would have helped guide us in knowing how to promote and share information.

Melissa Stafford Jones, First 5 Association of California

I would share the following overarching reflections regarding the Community Vaccine Advisory Commission.

- The combination of clearly articulated goals and values, creation of space for a range of perspectives to be raised and heard, and brave, unwavering public and community/stakeholder voices committed to equity—and to holding each other to account for authentically and actively focusing on people at greatest risk and facing the greatest systemic barriers—was powerful.
- The format, facilitation, and ongoing dialogue of questions, requests for information and responses created a respectful space that was essential given the very difficult issues under discussion and consideration.
- The CVAC created an understanding for the State of needs and risks of populations and a set of factors for vaccine prioritization that could only be developed with the extensive range of participants and perspectives involved. I appreciated the dedication, relentless focus on critical issues that had not yet been addressed, and the continual highlighting of the impact of covid on certain communities by my colleagues on the CVAC.
- A strength of the CVAC and the participation of its membership was that, while intensely highlighting the critical considerations, needs, and circumstances of the pandemic affecting the group of people or organizations they were on the committee to represent, the vast majority of CVAC members also continued to hold a broader community view in mind and did not seek to diminish the perspectives and needs of others.
- At times, the larger context and processes for the state's policy, planning and decision making for vaccine distribution planning happening on a separate track from the work of the CVAC made it challenging or unclear how the CVAC could meaningfully inform those decisions.
- The engagement and back and forth dialogue, sometimes in real time, between government officials and stakeholders in which: stakeholders sought to ensure relevant information was available and acted on and that government actions followed stated goals and values; and policymakers and state officials identified the realities, limitations, strengths and challenges of the efforts; with everyone working to keep in mind the larger context and needs due to the pandemic and the specific, detailed issues that also were critical to address; was different than many other stakeholder processes. Structures and approaches that allowed for this higher than normal level of exchange and responsiveness should be utilized more in public stakeholder processes.

- The tremendous loss of life, illness, and other impacts of the pandemic created, as would be expected, a very intense focus on vaccine prioritization given the initial limited supplies. I wonder if we all might have been able to step back a bit sooner and see that in a relatively short period of time, it would not be vaccine supply but vaccine access and uptake that would be very significant issues, and perhaps have spent more time and energy gaining the group's wisdom and insights on those issues.

Foundations

- **Brian L. Mimura, The California Endowment**

Brian L. Mimura, The California Endowment

The CVAC provided a much-needed and effective space for diverse representatives of various communities to collectively inform and provide advisory information to the State's vaccine planning and deployment efforts. It was challenged by the rapidly unfolding situation with COVID 19, which at times outpaced the ability of the group to meet, keep apprised, and provide information and input all along the way. But, the State and its excellent facilitator did a noteworthy job keeping a large, diverse group of individuals involved, informed, and engaged despite the unrelenting pace. The facilitation of meetings and support to CVAC members was excellent. The steps to optimize public accessibility to the meetings and relevant information, resources, data, etc., were significant and appeared to be successful from the perspective of the amount of regular community input/comments, and meeting participation by members of the public. The CVAC meeting space allowed for the identification of important issues, challenges, and needs particularly of specific populations at increased risk for inequitable vaccine distribution (e.g., farmworkers, seniors, etc.). This allowed for important needs to be raised and shared for incorporation into the State's efforts. Data needs, for example, were frequently raised, which prompted responses by the State to explore available information and secure it when possible and provide through the CDPH website/dashboard.

An accomplishment of the group was providing thoughtful guidance to inform the initial vaccine criteria for priority groups (e.g., starting with health care workers, first responders, high risk occupations, etc.) while simultaneously advocating for vaccine distribution based on community or place-based criteria, which ultimately influenced the adoption of the Healthy Places Index to allocate vaccines to communities most in need/at-risk—another significant accomplishment. In fact, the CVAC's early and ongoing commitment to equity, and its ultimate utilization of the HPI to direct vaccines to the highest quartile places is one of the most noteworthy successes of the group. At times, expanding the CVAC's representation appeared warranted in order to add important perspectives to its membership, but adding representation to the CVAC was not provided for. While this was understandable, direct representation of some voices, particularly those historically excluded and disproportionately impacted by COVID 19 such as those incarcerated and formerly incarcerated (and others) would have benefited the CVAC and its depth and breadth of contributions.

The agendized presentations that described funding opportunities to respond to the pandemic, both from state sources and collaborating philanthropies, were helpful in sharing information with CVAC members and the community. These opportunities and the CBO's that were funded are providing

critical support to complement and extend pubic / county efforts with local, trusted grassroots organizations. A related accomplishment and lesson learned was in fact the increased recognition and role that CBOs play in reaching diverse communities in culturally-responsive ways. Funding from the philanthropic community (e.g., the Together Towards Health funding collaborative) and from CDSS/CDWI allocated through Sierra Health Foundation and California Community Foundation provided support to CBO's throughout California that has been instrumental to the state's successful responses to the pandemic. The CVAC meetings, whose members advocated consistently for a prominent role and support for CBOs, provided for a critical space for this advocacy which in part contributed to the funded CBO's and essential public-private partnerships and community collaborations that have an integral part of California's response to COVID-19.

Health Advocates

- **Amanda McAllister-Wallner, California LGBTQ Health and Human Services Network**
- **Kiran Savage-Sangwan, California Pan-Ethnic Health Network**
- **Anthony Wright, Health Access California**

Amanda McAllister-Wallner, California LGBTQ Health and Human Services Network

Thank you for the opportunity to serve as a part of the Community Vaccine Advisory Committee (CVAC), and to comment on both the vaccine distribution effort in general and the CVAC process specifically. It has been an honor to participate in this process and serve the people of California – and represent the needs of LGBTQ Californians – during this trying time.

I appreciate the intentionality behind creating the CVAC and the opportunities to hear from experts on vaccine prioritization, efficacy, and questions. The presentations throughout the meetings were incredibly informative and I gained a lot from being able to participate in the process – especially being able to take the information learned during CVAC meetings back to LGBTQ communities throughout the state.

We knew that there would disparities in vaccine access and uptake among communities of color and LGBTQ communities. The state created the CVAC in part to address these concerns; state and county public health departments created tailored messaging and worked with community-based partners to encourage vaccinations. And yet, these disparities persisted, with significant percentages of Black and Latino Californians still unvaccinated and expressing hesitancy around getting vaccinated. We would likely see similar numbers among LGBTQ Californians, but don't have sufficient data to understand community hesitancy.

For me, the current state of the pandemic and vaccine penetration – after months of dedicated work – underscores the need for continued deliberate action to eliminate these disparities ahead of the next pandemic. This means engaging stakeholders, creating actionable plans and timelines, investing in systems of evaluation and accountability, diversifying the public health pipeline, and addressing social determinants of health, and dismantling systemic racism, homophobia, transphobia, ableism, and other forms of oppression. These are big tasks, which is why we must keep up the momentum of the CVAC

and continuing bringing people to the table and investing our time and energy into making these changes a reality.

One of the themes in reflecting on this pandemic, is the ways in which it exposed and exacerbated existing challenges. A few of these include:

- Data collection: There are many breakdowns in the collection of demographic data, and other disease-specific data within the public health system (and beyond). Whether it's the need for training among frontline workers, the need to update forms and data reporting systems to include up-to-date data measures, or assistance with identifying and translating demographic data measures – especially sexual orientation and gender identity. Without quality and consistent data, we still don't know about vaccine uptake and hesitancy among LGBTQ Californians. Many of these data challenges have made it difficult to target people at the intersections – it took several weeks to get data about older adults of color. The better we understand the problem, the better our solutions will be. I hope we can continue to work to prioritize and improve our data collecting and reporting systems.
- The health disparities faced by our communities are all interconnected. There is a lot of overlap among the communities who were being hospitalized and dying at disproportionately high rates from COVID-19 with communities that have low vaccination rates. While seeing the impact of COVID-19 up close could have been a motivating factor for some, we are not operating in a vacuum. These communities are also impacted by poverty, housing instability, high rates of HIV, other STIs, depression, substance use, and other chronic health conditions. It's not realistic for a short-term process to overcome these barriers. To prepare for the next pandemic, we need to address these disparities and the social determinants of health now.
- Our public health system has been underfunded for over a decade. Since at least the last recession, the state and counties have not prioritized the public health infrastructure. Many public health programs are dependent on finding their own funding – whether through tobacco taxes or federal sources such as the Ryan White program – which has led a piecemeal approach to public health. Funding deliverables are often based around downstream interventions and measuring impact on one specific health issue. However, we could make an impact the many public health challenges facing our state by allowing public health departments to work more collaboratively across programs, incentivize getting outside of silos, and focus our efforts on the root causes that connect these disparate challenges. This will require vision and leadership form the state, as well as a committing funding in a way that can be more flexible.
- There is a need for clear leadership at the state level and a way to balance the desire for county-level authority with the need for guidance and enforceable direction at the state level. California is a huge state, and there are many different health and public health players at the table. This can make it hard to move quickly and with confidence. I don't pretend to have a clear answer on how to account for the diversity of needs throughout the state, while also offering clear direction, but I think there are opportunities to better equip local governments, and protect communities whose local health infrastructure may be lacking.

I would also like to reflect on a few of the specific challenges surrounding messaging, in the hopes that this can inform our work going forward.

- The messaging efforts started too late. CVAC members warned of concerns about vaccine hesitancy, even while we were focusing as a committee on how to prioritize the limited supply of vaccine that was available in the early months of roll-out. In hindsight, I think we could have benefitted from more early messaging encouraging vaccine confidence.

- As I write this, I'm reflecting that we still have not been able to overcome some of the barriers that we knew would be an issue from the outset: distrust of government, concerns about cost of the vaccine, concerns about documentation, hesitancy about the safety of the vaccine, and the need to motivate healthy people to get vaccinated in order to protect community health. These are big barriers, that have been stoked by years of anti-vaccination messaging and negative experiences with government and health care systems. Combatting those messages and reaching the remaining unvaccinated population will require continued vigilant efforts on our parts.
- For much of the time we met, I was unclear about follow up on CVAC recommendations – specifically those regarding communications and collaborating with community-based organizations. Toward the end, these updates were more integrated into the agenda; however, it was difficult to know how to support communications efforts at many times.
- I'm disheartened to have seen only minimal messaging to LGBTQ communities. In talking with local partners throughout the state, I have heard a need for more tailored messaging and especially messaging that comes from trusted LGBTQ messengers. While I have been in touch with Lucas Affairs about some communications opportunities, I would love to see more. We have a large pre-existing network that we could tap into; folks who can serve as trusted messengers and who have good ideas about what LGBTQ people need to hear. Yet, without the resources or direction, much of the potential to utilize these partners has gone untapped.
- There was a lot of talk about using Complete Count/Census 2020 partners to conduct outreach, but no specifics were ever provided. It left me unclear about how to follow up on those conversations and contribute to the messaging and outreach efforts. We were a subcontractor on Complete Count and would love to have more resources to get vaccine information out to our communities.
- I have heard quite a bit from partner organizations throughout the state in the last month about questions and concerns regarding the re-opening, as well as hitting a plateau with vaccination efforts. Specifically, I have heard quite a bit of confusion around changes to mask guidelines and how people who have gotten vaccinated should continue to take care of their own, their families', and their communities' health. I know some of this is beyond the scope of the CVAC, but I wanted to flag for the continued outreach efforts that I know will continue throughout the summer and beyond.

Overall, I have really appreciated the opportunity to provide input and to be of assistance in this critical process. Thank you for taking the time to read these comments – I know many of them are beyond the scope of the charge of our committee. However, seeing how much we have accomplished throughout the last year, I am heartened to think of what we can do if we dedicate time and resources to tackling health equity in all of our public health challenges.

I support any additional evaluation and assessment, to be ready for not just the next pandemic, but for ongoing public health issues we continue to confront. Please don't hesitate to reach out with questions or to follow up at any point at awallner@health-access.org or (916) 205-4699.

Kiran Savage-Sangwan, California Pan-Ethnic Health Network

Accomplishments/Strengths

The inclusivity and diversity of the CVAC membership was the greatest asset to the process. The CVAC included many community-based organizations and communities that are often left out of state

policymaking. Prioritizing these voices and perspectives enhanced the process and the outcome. The CVAC, the public, and the state were able to learn from the people most connected to vulnerable communities.

In addition, the commitment to bring timely, responsive, and accurate information to the CVAC to inform the discussion helped to facilitate the process. It was a lot to ask of staff who are on the frontlines of pandemic response, but having local health department leaders, the scientific advisory committee, and the outreach staff present and respond to questions was incredibly important. I also appreciate that the co-chairs were responsive to CVAC questions and worked hard to bring back information to future meetings or in written follow-up, and were often available outside of CVAC meetings to answer questions and engage in discussion.

Challenges/Lessons

There was a lack of clarity around the role and scope of the CVAC. While many critical discussion topics were brought forward the group, it was unclear who or what the CVAC was advising and to what extent discussions from the CVAC were being considered as events unfolded and decisions were made. In my opinion, the CVAC served as a public venue to share information and ask questions that were in the minds of many populations in California. This is a critical function and it would have been better designed with this as the explicit purpose, rather than creating an impression the group had any kind of decision making authority.

The group size was too large to allow for meaningful discussion and engagement. Perhaps future committees of this kind can utilize a subcommittee format or breakout groups on priority discussion topics.

I recognize the logistical and resource challenges of this suggestion but front end investment in a more engaging format is likely to be worthwhile.

My sincere thanks to the co-chairs, Drs. Burke Harris and Pan, Bobbie Wunsch, and all of the state and local health department staff who contributed not only to the CVAC process but also to leading California through our pandemic response.

Anthony Wright, Health Access California

Thank you for the opportunity to be on the Community Vaccine Advisory Committee (CVAC), and to comment on both the vaccine distribution effort in general and the CVAC process specifically. Even with all the problems endemic to a pandemic, there's much to appreciate about California's response, including the sincere efforts at an efficient and equitable vaccine distribution.

My biggest hope for the final meeting is that, beyond the ongoing discussion of the work left to do to realize a widespread and equitable distribution of the vaccine, we focus on how we can take the lessons learned and infrastructure built over the last year to help improve our public health and health delivery systems in general. Are there things we have done that should be replicated/reinstated if we need to provide COVID-19 booster shots? Are there structures that we put in place that should remain, or is it all being dismantled post-pandemic? Are there systems or strategies that can help us improve our annual

penetration of flu shots, where there is room to improve? Did we learn new tactics to advance equity that seemed effective in other venues? Are there partnerships or programs we leveraged (or didn't) that would be useful for other types of public health interventions? What would be useful to put in place prior to the next pandemic?

Some of these post-pandemic post-mortem questions are fairly specific: Are there community groups or health providers that piloted especially effective outreach efforts? Is there specific technology like MyTurn that we built that should be applied to other uses? Should we continue to use stadiums and county fairgrounds places for more drive-through vaccinations on a regular basis?

Part of this is a much broader assessment of what strategies worked and what didn't. In our famously fragmented health system, California started this effort by building our distribution on top of existing infrastructure to disseminate other vaccinations, including the flu shot. The vaccine distribution efforts also laid bare some of the shortcomings in our existing systems of evaluation and accountability: we were not able to fully tap into the benefits of an existing network of health providers and county pop-up efforts also due to lack of real time data, technology, and accountability in some areas. What was the overall experience with using the statewide vendor (while taking into account it came online at a different point in the process)? Health Access supports the proposed investments in local public health infrastructure being debated in the budget now; such investments would be better informed with some assessments about the right balance between local initiatives and on-the-ground experience and state structure and accountability.

Another set of questions were how much we were running this effort through our health system, and with specific types of providers, whether integrated health systems, hospitals, community clinics, pharmacies, and other health providers--each with their own questions and issues--versus using other public health approaches, including pop-up and place-based efforts. I would be particularly interested in seeing how we can better have our health system be better complemented and coordinated with grassroots, place-based and other public health strategies.

It may be that some of what was done was unique to the urgency of the moment: a global pandemic, with vaccines that were coming online but where there was supply scarcity for a prolonged time. But surely there are technology and tactics and other items we can use for the future.

On the CVAC process, it was useful to have a forum to discuss these weighty issues in a public setting, and we thank the public health and governmental officials who worked so hard and long through this crisis, and yet who made time for these public deliberations and conversations. We also recognize the incredibly complicated context we were all working in: not just of a raging pandemic; but changing conditions and understandings of the science, a federal government that was at first fickle and then in transition, struggles with supply, and the inherently hard nature of the question of prioritization in a period of scarcity where any answer would leave some people behind, at least initially.

I appreciated the opening agenda items of having the public comments summarized and read—it was an important moment of acknowledging the varied public questions and concerns. It was unclear who they were read to—as Committee members, we were merely advisory and only had the ability to amplify

particularly good points or ideas. I was comforted by the state and public health officials that were present to also hear them. As key issues were debated, it would have been good to be clearer about who was the decider on key issues: in some cases, the federal government, ACIP, and others were providing parameters. In other cases, it was unclear whether decisions were up to the public health department, the Governor, the Drafting Committee, or some other mechanism? The CVAC was the sounding board, which was a useful role, but distinct from actually providing a recommendation.
The public and press was confused when the guidance seemed to switch, often driven by the federal government, or the differences in approach by different counties. Sometimes, the state was unclear or at least imprecise in its guidance. We appreciated when decisions were run by the CVAC for discussion, even to tease out nuances and considerations. This was not always the case, raising question even when the direction was supportable. This was most notable when CA announced it was shifting to a purely age-band strategy, but essentially needed to return to a more hybrid approach of age bands alongside some workforce categories, people with certain medical conditions, and those in congregate settings.

While we spent a lot of focus on vaccine prioritization, we probably needed to spend more time on the actual logistics of the "last mile" of getting vaccines to people—issues which were as impactful on equity, from time to transportation to technology. We needed this practical lens to inform our vaccine prioritization discussions more in the beginning, as they did become greater issues.

When this is over (which it is not), it would be useful to look at how different states did prioritization (some did pure age bands, some were stricter or looser with their guidelines, some went much more quickly through their tiers)—recognizing that comparing different states are hard, given how they were situated very differently with regard to transmission risk and the different cycles of surges.

The platform was an advisory committee with 70 members, which had its challenges. It was hard to get everyone's comments in, but I am glad we at least had time for questions and some engagement. Recognizing that state and public health officials were severely time-crunched, sometimes those questions were not answered for multiple sessions, and it may have been useful to have some time, either publicly, or in small groups or one-on-one, just for clarifications. I am glad we used the chat efficiently and effectively to get a lot more commentary in than we would have otherwise, and created an informal way to support each other's comments that resonated.

Finally, I think many committee members turned ourselves informally into an outreach coalition, to get the word out about the vaccine distribution, key messages, and clarifications. Many of us did a lot, working with our networks, the media, and within our own capacities. We probably could have made that role more explicit, and there's more CDPH could have asked of us.

Overall, we appreciate the opportunity to provide input and to be of assistance in this critical process, and recognizing the work is not done. We support any additional evaluation and assessment, to be ready for not just the next pandemic, but for ongoing public health issues we continue to confront.

Health Care

- **Charles Bacchi, California Association of Health Plans**
- **Joe Diaz, California Association of Health Facilities**

- **Catherine Flores Martin, California Immunization Coalition**
- **Jodi Hicks, Planned Parenthood Affiliates of California**
- **Linnea Koopmans, Local Health Plans of California**
- **Maria Lemus, Visión y Compromiso and The Network of Promotoras and CHWs**
- **David Lown, MD, California Association of Public Hospitals and Health Systems (CAPH)**
- **Jeffrey Luther, MD, California Academy of Family Physicians**
- **Andie Martinez Patterson, California Primary Care Association**
- **Mary McCune, California Dental Association**
- **Hendry Ton, MD, MS, UC Davis, representing California Medical Association**

Charles Bacchi, California Association of Health Plans
I would like to thank the tireless effort put into the Community Vaccine Advisory Committee by officials, staff, and participants. It was a truly historic endeavor.

Joe Diaz, **California Association of Health Facilities**

1. Process early on, demonstrated the significant lack of initial coordination between CDC, State of California, 58 counties, including those with their own separate health departments.
2. In addition to lack of early coordination, the entire communication strategy often suffered from contradiction and mixed messaging which to this date, continues at all levels. Because early on, nursing homes in California and elsewhere in the country, were the epicenter of the early high rate of deaths among the elderly, confusing daily communication was a significant challenge to providers. Contradictory mandates on infection management to changing testing and staffing requirements. Compounding the environment within California nursing homes was the severe lack of PPE, testing supplies and the challenges of the vaccine rollout.
3. While the process of having frequent and focused meetings of the CVAC was clearly needed in view of changing timeframes , sometimes it appeared that the direction and messaging from the CVAC to the state, simply was ignored and/or the state simply came out with an opposite guidance .
4. The positive side of the work of the CVAC was the diverse representation of community groups and providing a platform to better understand the diverse needs of different communities and challenges they faced in getting PPE, testing and vaccines.
5. A recommendation in the event another CVAC organization or structure is created to address future emergencies, is get all government entities who have any type of responsibility for addressing the crisis, into the same room along with the professional and community organizations. In some instances during this process it did not appear the left hand knew what the right hand was doing.
6. Recommend that CVAC, CDPH or someone with leadership authority in the state, prepare a detailed After Action report on what was done right in 2020, what went wrong and; provide recommendations for future crisis.

Catherine Flores Martin, California Immunization Coalition
On behalf of the California Immunization Coalition (CIC) we are grateful for the leadership of Dr. Erica Pan and Dr. Nadine Burke Harris and the impressive skill of Bobbie Wunsch in coordinating the work of this distinctive and passionate group of community representatives.

The California Vaccine Advisory Committee served two main roles. First, it provided a forum for community stakeholders to state their case to public health officials for why their group should receive prioritization in the COVID vaccination model and second, was a forum for state public health officials to communicate to these stakeholders the decisions made by the state of California in regards to the COVID vaccination model.

CIC's mission is to ensure access to vaccines for all Californian's and we advocate daily for immunization and public health; we were pleased to be included in the discussion. The issues and concerns brought forward by representatives at every meeting was enlightening and helpful. We will be reaching out to all partners in hopes that we can keep the momentum going in ensuring that all Californians are aware of the vital connection between vaccination, disease prevention, public health and the impact it has on our entire world.

The past 17 months must not be forgotten. There is going to be a strong desire to forget the recent past, to put 2020 behind us, move on and forget what happened. As we move forward, we must not forget.

We need to use what we have learned and as best we can, continue to develop and maintain the partnerships that have been built to make the most of this opportunity to develop a stronger public health infrastructure for a healthier California.

Again, our thanks to the leadership and support team for the California Vaccine Advisory Committee. We look forward to working with everyone in the future.

Jodi Hicks, Planned Parenthood Affiliates of California
The Community Vaccine Advisory Committee has been a helpful venue for obtaining information from various state officials, especially because its formation designates a timeframe for when information will be provided. At times, this has also meant we already had clarity on who could help answer questions or provide more detail on specific issues.

As the state grappled with vaccine eligibility decisions and distribution plans (roughly December through April), the CVAC did seem to be a catalyst to get information assembled by state departments and offices, as well as the TPA once that was launched. That said, planning and decisions sometimes seemed to move so fast that, while the Committee was a useful designated venue for stakeholder Q&A and feedback, it was not well positioned to truly advise on issues ahead of time. This could be the nature of such a large group and in some cases would be inevitable, but is a reflection, nonetheless. Opportunities to think through pitfalls in a small group or subset of relevant stakeholders may have been useful, specifically for items like vaccine distribution logistics for hard-to-reach populations, or outreach and education funding through state departments.

Bobbie has been a very responsive facilitator outside of the meetings, which we have appreciated. The CVAC meetings and emails were also a very helpful way to hear concerns or other updates from the perspective of other stakeholders.

Linnea Koopmans, Local Health Plans of California

The CVAC was a valuable forum for both receiving the latest information about the status of state vaccine roll-out and for informing what data and metrics we should be tracking to monitor our success in reaching all Californians eligible for a vaccine. The group was persistent in raising important questions and recommendations around equity, focusing on the diverse populations in California whom COVID disproportionately impacted. I appreciated the leadership and responsiveness from CHHSA and CDPH who led and facilitated this process and engaged in meaningful discussion about the challenges we faced with the vaccine roll-out, particularly in the initial months. Although the CVAC process is ending, there should continue to be a sense of urgency around the need to increase the rate of vaccination for vulnerable populations who live the lowest HPI quartile many of whom are enrolled in Medi-Cal.

Maria Lemus, Visión y Compromiso and The Network of Promotoras and CHWs

Thank you for asking for comments. It seems to have been a long time since the first meeting. I will not speak to the technical issues as there are many organizations and individuals who are better versed in that area. I will however respond to what I saw and felt as the process evolved.

I appreciate the CDPH's response to the pandemic in bringing together such a variety of stakeholders and community activists. There seemed to be a cross-section of interests and leaders. That said, it also contributed to competing priorities. For example, raising the priority of farmworkers took a lot of discussion, advocacy and understanding on the part of many of the members. It took several meetings and months of discussion at a time when farmworkers, and other essential workers, needed to be vaccinated. Unfortunately, once the urgency and need for this community had finally been prioritized, the frustration level was high for many of us who had aligned with them and advocated on their behalf at every meeting. And I felt the same level of frustration when advocating with and for promotoras because the designation of CHWs (and not promotoras too) as a 1A group was significant. What we needed was the Director or Surgeon General to step in to say to all County agencies that promotoras, and other community leaders, also belonged in this group as a matter of fact., therefore, vaccinate them! The inclusion of community promotoras as part of that designation took too many conversations and too many assumptions. In the end, once it was finally acknowledged, again it was too little, too late. Promotoras had already been active in the community across California providing COVID-19 education and outreach and vaccination navigation at clinics, pop up sites and CBOs. This disregard for an army of community leaders/promotoras was felt by many of us at the community level. I understand that CDPH understood the issues, but to disregard the request based on the assumption that Counties would understand and support it was both a practical and political miscalculation. Promotoras in the field and in our most at risk communities, continued to work without vaccinations putting themselves and their families at risk. What we got in return was a philosophical presentation about race and justice. That was a high-level response to a community issue.

As a recovering bureaucrat, I understand the maze of policies and procedures that rule CDPH and which often combine to inhibit creativity and integration of real solutions. Many of us advocated for the integration and support of community solutions early on: pop up sites in neighborhoods, local clinics supported by promotoras and other community members. Reliance on a small group of "go to" agencies for solutions actually created barriers – counties did not always have an understanding of their residents, agencies with longstanding relationships with CDPH would not or could not relinquish control

of funds to CBOs, status quo approaches funded agencies who had to do it their way only to have to re-do or revise the work, as it was with the State's contact tracers and cultural humility training.

The lack of real time data highlighting actual numbers of vaccinations with key community level details was frustrating. There were many powerpoint presentations with data not directly related to solutions and top level staff talking. Community and agencies were only able to add to the conversation by adding "++" marks in the chat when someone was able to get a point in the conversation., and some comments were supported more than others. It seemed as if we had to reach a "herd" level of agreement before the idea in question could move forward. Moreover, each meeting moved so fast. Bobbie you provided masterful facilitation of the meetings and I am in awe of your preparation and appreciate that you were giving directives and "guidance". However, the agenda was full before we even clicked into zoom. I would have liked to have seen subgroups meet in between the large group sessions to bring ideas and issues to the table. Community organizations have a long history of navigating to consensus in this way.

None of our communities are monolithic. I would have liked more presentations highlighting successful and creative solutions across California that were reaching racial/ethnic, English/non-English/non-Spanish speakers, immigrants/native born, multigenerational families, and more. I would have liked more support for these community level successes including both funding and recognition. Also, even though we were in the same room/discussions with other sectors who in their own right had priorities, however, I saw little alliances created across sectors.

I have great hope that the newly appointed CDPH director and our surgeon general, who both bring knowledge and experience working in communities most in need, will be able to mitigate the bureaucracy of CDPH. I have great hope that we can find/create new paths for integrating community knowledge and successes such as the promotor model across sectors and actualizing financial support for all CBOs who work with these amazing community leaders.

Let us help you help us!
My favorite quote: "that which we manifest is before us" from The Art of Driving in the Rain.

David Lown, MD, California Association of Public Hospitals and Health Systems (CAPH)
CAPH greatly appreciated the opportunity to participate in CVAC and I appreciated the regular updates on vaccine availability, distribution and communications planning provided by the state. The communications plans and materials alone were very useful as we distributed those to the public health care systems for their own use. I felt that the CVAC team (Bobbie, Nadine, Erica, etc) did a fantastic (and momentous) job facilitating the discussions, getting committee member input and keeping everyone up to date on the latest info, data and plans.

As I'm sure others have noted that while the overarching goals of equitable distribution of vaccination remained through the time of CVAC, the various constraints on the system (and by system I mean across CA) changed over time, most obviously the massive mismatch between supply & demand, very heavily weighted to demand for most of the and then it flipped, by which time eligibility was just reaching into

younger ages (50+, then 16+ just two weeks later). The main question/comment I have about CVAC is knowing what we know now, how would we (CVAC) have done things differently?

I think it would be an interesting and very insightful exercise to mathematically model a few things. First, a match up, over time, of the people/sectors who were eligible for the vaccine, the people who were actually getting vaccinated and the people getting infected, hospitalized and dying of the virus. The question is did the eligibility criteria we endorsed and implemented have the impact we had intended?

Second, using actual vaccine take up rates amongst various communities (age, zip code, etc), assess the number of Californians that might have been fully vaccinated against the # who became infected, # hospitalized, and # died, and all stratified by race/ethnicity/income/disability/essential worker status/zip code/HPI, etc under two scenarios (Was CA obligated to follow national guidelines? I've forgotten):

1. A scenario under which, California just made it available to everyone from the beginning with no eligibility criteria other than age 16+.
2. A scenario under which after HCW and SNF, CVAC recommended and CA implemented eligibility only for those communities that were being disproportionately impacted by the virus as of the date vaccine first became available and the state putting all its resources towards just those communities. I.e., if California put all it's vaccine efforts into the highest impacted communities. Although this clearly would still have been focused on age but also some category of HPI quartile, essential worker status, etc, maybe the state could model out the impact of using HPI vs essential worker status for eligibility (or some other means of identifying "highest risk communities" and seeing differential impacts. I believe the essential worker status, while conceptually the right thing to do based on the data, was too fraught with logistical problems and caused a slowdown of vaccine distribution, whereas geographical/community-based distribution could have achieved the same goal (and in fact it has) but much more quickly with less confusion across the population. Course that's just my belief and it should be investigated using actual data.

I think these kinds of data driven analysis would be useful because while CVAC was a fantastic forum for widespread community input, I think that once we moved passed eligibility for HCW and SNF/LTCF residents, there was a too-be-expected jockeying for position of "my people are at the greatest risk" "my community is being overlooked, again", all of which was true, but did CA suffer from logistical sludging (I just made that up) causing a slowdown of vaccine administration due to trying to implement complicated eligibility and distribution schema? Again, we have the data, so we should assess it to see if that assumption is in fact true or not.

If it is true, it would be an interesting discussion to have with stakeholders in preparation for the next pandemic (or next wave of this pandemic).

Jeffrey Luther, MD, California Academy of Family Physicians

When I was first invited to participate on the Community Vaccine Advisory Committee in late November, it did not matter that the first meeting was only two days away. Having studied vaccines and vaccine-preventable diseases for the better part of the last twenty years it felt like the opportunity was right up my alley. I didn't really know what to expect, but I hoped that I could contribute in some way.

On reflecting over these last six months, what strikes me is how our conversation and the focus of the committee has evolved in parallel with the status of the pandemic and our collective response to it. At the outset our focus was heavily on vaccine development, mechanisms of action, and prospective timelines. I have to admit that this part really fascinated the vaccine nerd in me. At the same time we were also starting to address concerns regarding distribution, access and equity. It is remarkable to think that just three weeks after our first meeting the first doses of the Pfizer vaccine arrived in California. I still remember the collective sense of hope the day I and my colleagues received our first doses.

As the first, and then second and third, vaccines were authorized, the real work of the CVAC kicked into high gear as the focus became far more concerned with equitable distribution, access and communication. And this is the point where I truly began to appreciate my colleagues on the committee, who were clearly well recruited for their roles.

I had not originally anticipated that there would be relatively few healthcare professionals present, but this proved to be a strength of the committee. Listening to the ideas and concerns of the committee members, representing an amazingly broad spectrum of constituents, was inspiring and humbling. However much I might provide myself on being socially aware, our deliberations taught me so much about so many different communities and the risks and barriers they faced during the pandemic.

To be honest, there were times during our meetings when I was concerned that I was not being more vocal or contributing enough to the question-and-answer sessions. But that helped me reflect on what my specific role ought to be in these proceedings. I was not representing a particular demographic or social community, and certainly not a group at risk of inequitable treatment or access. Rather, I was representing nearly 11,000 family physicians and physicians-in-training throughout the state. Though our members may have scientific knowledge, we were all similarly in the dark regarding vaccine rollout and distribution during a very chaotic time in the pandemic. And because we serve all ages and all communities in California, equity was a significant concern for us as well.

So, though I did try to bring the primary care medical perspective to our committee meetings, I ended up spending even more energy communicating with my fellow family physicians throughout the state. Regular social media posts and traditional media interviews gave me the chance to share and amplify what we were debating and deciding at the committee level and hopefully demystified the process for some. And what I tried to share, as much as anything, were the values and passion that this committee brought to its work.

At times I have found it frustrating, though probably inevitable, that recommendations coming out of the CVAC weren't always implemented as originally intended. That is the nature of an advisory committee, and the constant flow of information throughout the pandemic necessitated frequent changes in course on the part of policy makers. But what has been consistent throughout the last six months has been the passion, thoughtfulness, and creativity of those on this committee. All of their constituents are incredibly well represented, and it has been a privilege to be a part of this process.

Andie Martinez Patterson, California Primary Care Association

1. Incredibly important that the CVAC was formed.
    a. A transparent process to apprise the points of all the main communities a sign of inclusion for CA.
    b. The members invited were important – messaged to CA citizens California's values
    c. The members invited also helped the rest of us not as intimately connected to one another hear each other out and broaden our perspectives
2. The materials were always rich and well put together
    a. I cannot imagine how much time and energy was spent on them
    b. The leads of the CVAC I'm sure circulated the ppts so the time and energy was well spent
3. The tight structure and facilitation was important because of the immensity of the content and number of interested participants
4. CVAC was really important for networking and connecting the larger advocate community
    a. CPCA has never really worked with the disability rights groups and we did this time. That was a great connection
    b. We also connected offline with the leadership of the CVAC because of the conversations at the CVAC- meaning the side conversations that stemmed from the formal less detailed conversations were very important
5. I was excited at the beginning of the CVAC process and felt used in the middle feeling that the formation of the group was a "check the box" exercise and that the feedback wasn't really taken
    a. I often felt like everyone presenting used inclusive language but decisions coming from Governor's office and Blue Shield were exclusionary and tone deaf to the CVAC input
    b. At these point I admittedly starting engaging less with CVAC feeling my time was better spent in other places
6. A few decision makers should have participated and listened more for CVAC to have really been impactful. We all know these folks were making decisions and hundreds of us were spending hours providing consensus oriented input that felt often over ridden.
    a. Governor Newsom
    b. Ana Matasantos
    c. Paul Markovich

Mary McCune, California Dental Association

Participating in the CVAC was a very rewarding and educational experience. Not only did the CVAC serve as a forum for organizations and individuals to submit questions and share challenges, but participants were also able to more wholistically see near and long-term implications for new policies affecting access to vaccines. It was incredible to see organizations from so many different sectors who normally would never interact come together with a common purpose while also earlier this year, operating in a zero-sum game to get communities access to COVID-19 vaccines.

The biggest accomplishment I think this group achieved was engaging in regular deliberative dialogues that helped form and adapt new government policies on vaccines as public health officials struggled to make large-scale decisions with limit amounts of information available. Moving forward, I think forums like the CVAC committee can be helpful for stakeholders to interact with public health officials. This process has underscored the importance of how community health impacts individual health and that equitable access to vaccines and other healthcare is imperative to the success of California.

Hendry Ton, MD, MS, UC Davis Health, representing California Medical Association
I have really appreciated the strong advocacy and wisdom of my colleagues in the committee. The collaboration, spirit of equity, and respectful accountability pushed by all members of the CVAC was inspiring, and certainly needed in this endeavor. I appreciated the Department's responsiveness to CVAC's questions, concerns, and recommendations. The explicit attention paid to health equity, embedded into the process and structure of vaccine prioritization, outreach, and distribution, is unprecedented and should serve as a model--and improved upon-- for all that we do in our health and public health systems.

While the time spent on the committee is significant, it is time well spent. Yet, despite our best efforts, the inequities around covid vaccination continues to persist. I think the work of CVAC is not yet finished, and I hope there is an opportunity for CVAC to continue.

Finally, I would like to thank the chairs, Bobbie Wunsch, and the staff at DPH for their leadership, hard work, and strong facilitation skills!!

Housing/Homeless

- **Lisa Hershey, Housing California**

Lisa Hershey, Housing California

A. The Process: In a few short moments, our world changed. We had to pivot from business as usual, to incredibly unusual business. And our California leadership did just that. With little time to spare, the Governor and his administration took bold, prevention-based steps to address the unprecedented global COVID-19 pandemic. This process included setting a clear vision, expectations and accountability for, and effectively establishing, engaging and incorporating guidance from the CVAC during the height of the pandemic. The process incorporated 3 key elements for success:

1. Seating the "right people" to lead, facilitate and serve:

    - Leadership – Dr. Nadine Burke Harris and Dr. Erica Pan
    - Facilitation – Bobbie Wunch
    - State support – Governor's Office, HHS, CDPH, other state agencies and departments
    - Committee Members

2. Identifying and confirming what success looks like, expectations with, and accountability for all parties from the onset of the process –

    - Values driven process – **Equity,** transparency and safety; clear, open, and inclusive
    - Incredibly diverse and inclusive committee representing California's rich fabric – geographically, demographically (e.g., race, gender, disability, age, income), and embracing a SDOH and health equity (e.g., housing, education, food, job security) framework
    - Data driven (evidence-based approach)

- Listened to both technical and lived expertise
- Adopted learnings from the CA Complete County Committee – engaged their staff, the structures, and their learning

3. Staying adaptive, resilient and committed to staying the course

The process also had a few bumps that impacted people experiencing housing instability/homelessness including:

1. Almost from the onset, public health and health care recognized that being able to shelter in place in a safe, stable, affordable home was the best prevention from contracting the virus and fundamental to stopping the spread and recovery. In late January, CDPH announced a shift to an age-based system vaccine-priority framework. That age-based framework eliminated any priority for people living in congregate settings, including in prisons, jails, immigration detention centers, shelters for people experiencing homelessness, and others. Moving to a strictly age-based framework was a grave concern. The sudden shift to deprioritize people in congregate settings abandoned the state's original commitment to equity as a core principle in vaccine distribution and disregarded the CVAC's recommendations. And, that shift threatened to compound the danger to an already at-risk group. As members of the CVAC and other organizations with community and equity expertise in California, we requested that CPDH immediately make clear that people in congregate living environments are prioritized for vaccine access and distribution at the state level and release a clear plan for operationalizing that priority.
2. Needed to stay the course, investing deeply and supporting fully the public health infrastructure and non-profit sector organizations on the ground that focus on prevention, keeping people healthy, safe and sheltering in place with the resources needed in lieu of pivoting to a big health care player who is coming late to the game and trying to ramp up on top of the critical systems and structures that exist. The following article describes the why and the how this makes sense - Why the First Mile, Not the Last, Is the Key to Healthcare.

B. Accomplishments: From the perfect storm, transformation can be born. Grateful to the Governor and the Administration for the courage to lead with equity, truly engage an enormous advisory committee and the public in an inclusive and clear process.

To ensure success, the CVAC planning and implementation process required leading with health (racial, economic) equity and centering people most impacted by inequities. In addition, state agencies and leaders needed to adopt and implement solutions that cut across the jurisdictions, sectors and communities. The CVAC, with its strong leadership, facilitation and multi-faceted make-up successfully:

1. Created a statewide equity centered plan to guide the equitable vaccine distribution system that considered key factors impacting people and communities – poverty, job loss , housing and food insecurity, segregation, disinvestment, exclusion, and displacement.
2. Ensured that solutions are grounded in and emerge from the experience of our most affected communities, including Black, Latinx, Indigenous, people of color, formerly incarcerated individuals, and people with disabilities, by engaging leaders from these communities in design and implementation.

3. Brought in experts from different spaces and places (e.g., Dr. Margot Kushel, strategic communications, Complete Count staff) to help the CVAC develop a deeper understanding of key issues facing our communities on the ground (e.g., housing instability and homelessness) to provide real time solutions to California's most vexing challenges.
4. Extended benefits and protections to people regardless of immigration status.
5. Began to use, develop, and publish data to track and improve racial and disability justice outcomes.
6. Expanded capacity to robustly respond to crisis statewide and at the state level.

Bottom Line: We are reaching for and moving towards achieving our goal of getting California vaccinated, centering our residents who have historically and continue to experience the greatest inequities. We still have a way to go; but we stay committed to our value-centered direction.

C. Lessons Learned: Like building the High-Speed Rail while also trying to speed across the state on the train, is incredibly challenging and seems almost impossible. Similarly with California's COVID-19 response, we were building the evidence base while also needing to make real time bold decisions to keep the state safe, our residents healthy, and our economy vibrant. Essentially, we were learning, while doing. California also had to re-invest in California's local, statewide and state level public health and other social safety net government and non-profit infrastructure that previous administrations dismantled.

On top of that incredible challenge, the world kept shifting with varying responses to COVID-19, civil unrest and social justice awakening/reckoning, natural disasters and a gubernatorial recall for the person in charge of making declarative decisions in real time.

Bottom Line: We need to -

1. Focus our efforts, energy and resources first on people and communities who struggle the most to make ends meet (e.g., BIPOC, essential workers, low-wage, immigrant communities).
2. Meet people where they are (affordable housing developments, homeless encampments) and build off existing relationships with trusted messengers from community and non-profits, connected to local government, business and other community organizations and services.
3. Invest deeply and sustainably through an equitable, SDOH framework to scale our local successes and "concretize" California's locally connected, regionally organized statewide public health and community benefit infrastructure constructed first through the Complete Count 2020 experience and strengthened and refined through the COVID-19 emergency response. With the current historic budget surplus complimented by unprecedented federal dollars, California can both meet this moment and stay in place to keep Californians healthy and safe for the long game. Structural reforms and systems changes will build back better or "roar back" as Governor Newsome states, and create our equitable California with homes, health and prosperity for all where everyone thrives.

Labor

- **Rocelyn de Leon-Minch, California Nurses Association/National Nurses United**
- **Alia Griffing, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO**
- **G B. Perdigones, BSN, RN, Service Employees International Union (SEIU) Local 1000**
- **Mitch Steiger, California Labor Federation**

Rocelyn de Leon-Minch, California Nurses Association/National Nurses United
Thank you for all the hard work put into each meeting. While I appreciate the thorough and engaging discourse, I feel I must voice some concerns that I have with the outcome and method for getting there. I have an issue with how abrupt the changes in policies were, like the de-prioritization of worker eligibility, contractual agreement with Blue Shield, and partnership with CVS and Walgreens, to name a few. Not only did I feel they were abrupt, but these changes were often made without consideration of the committee members' input. Several committee members expressed their frustration about this dynamic during the meetings, but it was neither remedied nor addressed. This, coupled with the push for "trusted messengers," caused the CVAC process to feel, at times, more like we were brought in to communicate information to our respective organizations rather than to provide valuable input.

Again, I respect and understand all the work that you and your colleagues have done, especially during a crisis at this scale, and appreciate being a part of this important process. But I feel I would be remiss if I didn't voice the issues above.

Alia Griffing, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO
The American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO, very much appreciates being included in the CVAC. Our engagement on CVAC gave us a mechanismto express the interests of our workers – largely essential workers in the public sector, who continued to work during the pandemic – and be able to receive the latest updates about stateefforts. This information was invaluable and informed our efforts to support and educate our members during the pandemic.

The Committee was, however, prohibitively large. At times it was unclear what my role on CVAC was as the varying interests would push and pull the discussion in different directions. At times, it seemed as if the same questions were being asked week-to-week rather than being addressed or answered. Perhaps in the future, for a group this large and diverse, smaller workgroups could be set up to tackle different components, then report to the larger group for feedback or discussion. Additionally, there was some frustration, feeling as though the advice and feedback from CVAC did not lead to vaccine policy changes – I also understand the advisoryrole of the Committee and the competing interests and the sheer size of the group were all limiting factors.

Upon reflection, CVAC spent a lot of time discussing the "who" before getting to the "how," as the vaccine distribution piece was less of a focus than I had anticipated going in. Thankfully, thiswas addressed later, but was concerning. The mechanics of distribution, resources and infrastructure could have been taken up simultaneously.

Challenges aside, serving on the CVAC was a positive experience and provided valuable information. I have no doubt that our members benefited from our participation, and that thestate benefited from the important work the CVAC did to shape and support the COVID-19 vaccination efforts.

G B. Perdigones, BSN, RN, Service Employees International Union (SEIU) Local 1000

More than a year ago, COVID-19 adversely affected my worksite and my community, as I observed the cases and deaths increasing in the local, national, and world news. I observed my own family members, who mostly work in the nursing and medical fields, compelled to be exposed to COVID-19 as essential frontline workers, and my co-workers who were required to work for more than eight hours, back-to-back, during this pandemic. I empathized with their feelings of apprehension about bringing COVID-19 home to their babies, children, parents, and grandparents. When I observed these, I thought to myself "I need to be part of the solution, and NOT part of the problem."

I went back to school to seek answers in ending the pandemic, at the same time searching for my purpose and role during this pandemic. I found out in one of my evidence-based research classes that COVID-19 disproportionately affects underserved and marginalized Black, Indigenous and People of Color (BIPOC), and I knew then and there that I had to do something to be part of bridging the already widening gap of health inequities in our communities of color.

As a child growing up in the Philippines and coming from generations of local community leaders and public service employees, I remembered my grandfather's words: "Study hard, reach for your goals, and wherever you are, touch as many lives around you as you can."

Eight months after the State of California's first "stay at home" order, SEIU Local 1000 Statewide President Yvonne Walker appointed me to the California Vaccine Advisory Committee (CVAC) to be a voice for all people and all Californians, as written in our SEIU Local 1000 Purpose Statement "to give our members—and all Californians—the opportunity to have a good life, live in sustainable communities and enjoy the fruits of social, economic and environmental justice by engaging and developing our members and by creating strategic alliances with key leaders and organizations who share our purpose and values." I would help make recommendations on how COVID-19 vaccines would be allocated and distributed across the State of California based on the core values of safety, transparency, and equity. A month after my appointment to the State of California CVAC, Yvonne also appointed me to the SEIU Local 1000 Statewide COVID-19 Task Force.

My journey in the CVAC and COVID-19 Task Force had been inspiring and humbling at the same time. As a Registered Nurse, leader, SEIU Local 1000 Steward, a trusted messenger, a member in my worksite and of multiple and diverse communities, I feel that the multiple processes applied in the decision-making to allocate and distribute an initial scarce vaccine were eye-opening and, as a community, we gathered together and found intersectionality in the common values of making recommendations and

advocating – not only for a safe vaccine, but also to address the inequitable distribution and allocation of vaccines while utilizing a transparent and inclusive process. We tried to ensure that there was a balance among the three core values of safety, equity, and transparency while we considered the lives of Californians who were depending on us to make ethical decision to save lives, acquire population immunity, and eventually end this pandemic.

In my many years of leadership training, SEIU Local 1000 gave me the tools and prepared me to be able to lead and be a voice for all people and be a part of a diverse, inclusive, and dynamic CVAC team, as well as to be part of the solution – from actively participating in the process of accomplishing population immunity, to our input and recommendations, to participating in pop-up clinics – to make a difference not only for my worksite and my community but also for the whole State of California. So that wherever I am in this world, I can touch as many lives around me as I can.

Mitch Steiger, California Labor Federation

The California Labor Federation writes to express our appreciation at the opportunity to participate in the Community Vaccine Advisory Committee (CVAC) process. Below are some thoughts on the committee and its work.

Likely the greatest benefit of CVAC membership was the ability to represent workers' interests directly to those making decisions regarding vaccines. Especially when vaccinations began, and we all had so much to learn about how best to distribute such a scarce and valuable resource, the direct line to CPDH officials and others streamlined our efforts to put the essential worker perspective front and center.

CVAC was also a helpful opportunity to receive regular and fairly comprehensive updates on various vaccine distribution metrics. These updates allowed us to quickly pass on such details to our membership, enabling them to in turn make timely and informed decisions with respect to vaccines.

Perhaps the greatest weakness of CVAC, however, was the relationship between the size of the group and each individual representative's ability to influence the process. With so many different voices pulling CVAC's advisory function in so many different directions, no one should be surprised that many felt as though their advice and feedback did not translate into corresponding vaccine policy changes—this outcome would have been essentially impossible, given the size and breadth of the group.

Also, CVAC—and the entire vaccination distribution process and infrastructure—would have benefitted from greater initial focus on logistics and less on research presentations. We would respectfully argue that from day one, the almost exclusive focus should have been on how to get vaccines to people quickly, and this focus frankly should have began long before CVAC did. Fortunately these problems were eventually addressed, but they likely could have been handled much sooner if all involved had more directly prioritized dismantling inevitable distribution challenges.

Overall, however, we believe CVAC was a great success and many lives were definitely saved as a result of its work. Everyone who participated should feel proud of their work and contributions. We again express our appreciation for the chance to weigh in on this critically important component of our COVID-19 pandemic response.

People Living with Disabilities

- **Andy Imparato, Disability Rights California**
- **Christina Mills, California Foundation for Independent Living Centers (CFILC)**
- **Silvia Yee, Disability Rights Education and Defense Fund (DREDF)**

Andy Imparato, Disability Rights California

Thank you for the opportunity to offer some reflections on the Community Vaccine Advisory Committee process and accomplishments. I appreciated the opportunity to participate and I feel that what I learned from our meetings helped me be a better advocate for equity for people with disabilities in vaccine prioritization and deployment and for equity within the disability community. I think that a multi-stakeholder advisory group with such high stakes was an inherently difficult project, and I appreciated the grace that Bobbie and the co-chairs exhibited as they shared news that was at times disappointing to many of us, and as we pushed back on some of the State's decisions during the meetings and outside of the meetings.

Here are some of my overarching reflections:

- The California Department of Public Health needs to build deeper knowledge of and connections to the disability community and the programs that serve the disability community. As we tried to develop strategies for deploying the vaccine to high risk people with disabilities across California, it became clear that CDPH did not have a lot of in-house expertise about the State's Regional Center System, In-Home Supportive Services, and other programs that can be leveraged to reach people with disabilities during a pandemic. The California Office of Emergency Services has a senior staff person who is responsible for working year-round on issues for people with "access and functional needs" when it comes to emergency preparedness and response. I believe that CDPH would benefit from creating a similar in-house capacity so that it can be more connected to the disability community and use the connections and knowledge it develops to make better-informed decisions during the next public health crisis.
- **Data gaps should not get in the way of equity.** At different points during our first few months of meetings as a CVAC, it seemed like CDPH used the government's underinvestment in collecting disability data during the pandemic against the disability community when it was making decisions about who to prioritize for vaccines. Consistent with the State's goal of advancing equity in vaccine deployment, I think the State should have acknowledged that the incomplete disability data was an equity issue, and that the problem of under-investing in disability data should not be exacerbated by delaying vaccine access to vulnerable populations because of the data deficits. That State could have used common sense to prioritize people who had workers coming into their homes because of the nature of their disabilities, who inherently had greater risk than people who were able to shelter in place without extending their household "bubble." In the long run, we also need to invest in more robust data collection that identifies people with disabilities as a demographic group that experiences disparities in access to healthcare and is more vulnerable to a pandemic.

- Secretary Ghaly, Kim McCoy Wade, and others listened to the disability advocates on the CVAC and made good adjustments to vaccine deployment based on our input. I do want to acknowledge that when we pushed back hard against age being used as the primary factor for vaccine prioritization, Secretary Ghaly personally engaged and listed to the disability community's concerns and ended up moving up the timeline for vaccine deployment for under 65 high risk people with disabilities. I also want to acknowledge that as the March 15 deployment date approached, Kim McCoy Wade and other State officials listened to the disability community about the value of letting people self-attest to their high risk status, instead of forcing people to produce medical evidence of their high risk status. This self-attestation seemed to work well and we avoided some serious equity challenges and public health risks that would have accompanied a system that required individuals with disabilities to produce medical documentation of their personal risk levels.

Thanks again for the opportunity to provide feedback. I am grateful that I was invited to serve on the CVAC and I look forward to helping California learn from this experience and apply those lessons moving forward.

Christina Mills, California Foundation for Independent Living Centers (CFILC)
It was a honor to serve on the CVAC and to not feel personally tokenized as I often do as the only disability representative selected to serve on a committee. However, maybe tokenisms did not exist because of the virtual environment in which we did our work. For the first time in my life, my disability was non-apparent. In some of the early meetings I had to reflect on how I was feeling about the CVAC process because my level of frustration was elevated from the constant disrespectful language that was being used by those who do not see disability from a social model or human rights perspective.

Having a small number of additional disability advisory committee members on the CVAC made me personally feel validated and understood when we were advocating for disability access and equity for in the vaccine prioritization. I don't think any of us representing disability would have been as effective without each other.

I've served on a number of advisory committees and yet the CVAC experience is was a bit different. Typically, when advising on an issue committee members do that before action is taken. With the CVAC it felt like we were constantly hearing things after they were implemented and that more change was occurring between meetings rather than after. It was also challenging to hear public announcements on vaccinates right before CVAC meetings. It started to feel like CVAC was an afterthought.

I do appreciate the comments and insight that our large and diverse committee members brought to each meeting. It was amazing that we worked together given the limited resources originally available. I feel like we all learned a lot from each other and gained critical insight on why each communities needs were and to some degree continue to be important.

I did feel that the administration did not understand the disability vulnerabilities as we explained it and we got a lot of push back because of the level of data available, but that's a long historical problem that continues to plague our community when it comes to prioritizing disabled people on any level. The state

really needs to work with the disability community leaders to deal with the data issue and find resolution to ensure that our population is accounted for accurately and equitability. Equity and transparency were major factors that were consistently said, but we didn't see that playing out for the disability community and I'm sure other communities also didn't feel that transparency was played out in the way it was expected.

In the end, I am humbled to have played a role and hope to be a resource to the state again in the future, but I do hope that the state will invest in understanding and elevating disability issues through an equity and inclusive lens moving forward on varies policies that have long-term effects for all Californians.

Silvia Yee, Disability Rights Education and Defense Fund (DREDF)
Being on the CVAC was a disorienting experience for me as a disability advocate. I have spent two decades talking about the right and capacity of people with disabilities to live independently and productively in the community, arguing that the course, length and quality of one's life is not determined by the fact of having a disability. But while I was on the CVAC, I searched for and reviewed numerous medical studies on how people with different disabilities were more likely to be infected by the coronavirus or at greater risk of hospitalization or death from COVID-19, I learned how many health conditions Medi-Cal beneficiaries with In-Home Supportive Services (IHSS) had on average, and I obsessed over all the ways that people with disabilities were increasingly vulnerable to isolation, death, ill-health, and lost function as the pandemic wore on. This was after spending months earlier in 2020 fighting the medical establishment's assumptions on how people with disabilities had a lower quality of life and were less likely to benefit from COVID-19 treatment and therefore could logically be placed at the back of the line for ICU admission and ventilator use.

Aside from the apparent contradiction in my job's focus, the weeks spent as a CVAC member were demanding, sometimes surprising, and equally frustrating and rewarding. The first few weeks were especially intense and I believe every member felt the weight of coming up with a prioritization for vaccine distribution that balanced known medical risk factors, historic health and healthcare disparities, and the unequal costs exacted by the pandemic on Black, brown, Indigenous, and Asian lives. I also believe that the CVAC members were uniformly surprised at least twice, once by the state's turn in early January to an age-based framework, and later on by the state's decision to retain a Third Party Administrator (TPA) over the vaccination process. As CVAC members, our engagement in good faith with our co-chairs, the state, and one another rests on a fragile base: we have to trust that we know all the relevant facts and that state officials attach fair weight to our words and efforts. Surprises were not helpful.

For me, the single most frustrating aspect of the CVAC process was feeling forced to somehow answer for the healthcare system's systemic failure to maintain granular data about people with disabilities. The reason that the public, the media, academics, and states know about racial and ethnic disparities in coronavirus infections, hospitalizations, and death rates is because information about race and disability is recorded. The reason we know how many nursing home residents have died from COVID-19 is because a count is required (even with imperfect methodology and some questionable practices in states such as New York). To this day I cannot tell you if there have been disproportionate COVID-related

deaths among people with specific disabilities or functional impairments. From original research that Dr. Steve Kaye conducted for us, I know that Medi-Cal beneficiaries with IHSS have multiple health conditions on average and are at higher risk of severe illness and death from COVID-19, but I cannot give you a number for how many disabled California residents who receive home and community-based services have died from COVID in the last 15 months because death certificates don't require information about chronic conditions except if a disability is a cause of death. These are long-standing data gaps that the disability community cannot overcome on its own. Our state must change the status quo on this.

If there was a single acknowledgement that I wanted to hear from a state official, it was recognition that factors other than physiological comorbidities could increase risk for and from COVID-19. That is, people with disabilities are subject to higher exposure because of the unavoidable need for home and community-based services. Systemic and implicit disability bias affects access to hospital care for people with disabilities as well as their trust in and willingness to go to hospitals. As disability advocates on the CVAC, we knew people with disabilities were subject to a unique risk of having COVID-19 treatment denied or delayed because of medical rationing during a surge. We had also brought complaints on behalf of people with significant disabilities whose support persons were turned away by hospitals, greatly minimizing their chances of getting effective medical care while they were hospitalized for COVID-19 or anything else. And we, along with everyone on the CVAC knew the state's case numbers and the strain on California's hospitals and healthcare personnel. I never sought or expected some kind of personal confession from a healthcare professional or a binding declaration from the state, but recognizing what disability communities, including people whose identities encompass being a person of color, LGBTQ+, older, and/or an immigrant, were going through because of discrimination was the right thing to do.

The most rewarding aspect of being on the CVAC was hearing and learning from fellow CVAC members, and I include here our co-chairs and state representatives such as those engaged in community outreach strategies. Many advocates came from, and still were embedded in, the communities with whom they worked. I deeply appreciated the chance to learn how the pandemic was impacting farm workers, low-income families of color, community health workers, older LEP persons, and so forth. I especially valued how we increasingly came to support one another, support common causes, and refused the temptation to fight one another for a scarce vaccine supply.

There is nothing inherently contradictory in asserting both equality and a unique vulnerability. Equality is not something to be meted out among those deemed "worthy" or who take less effort. Ultimately, people with disabilities were fighting not only to preserve a life at particular risk, but because they wanted to return to the rich independent lives they enjoyed as a part of their communities. It is easy now, with California among only thirteen states to have achieved 70% vaccination, to feel satisfaction and look ahead. But I cannot help but worry that the past and its lessons will easily away as we rush toward a post-pandemic future, and not lead to the changes in implicit bias and data collection that must occur for people with disabilities to avoid being an afterthought in future public health emergencies.

Senior Services/Long Term Care

- **Dean Chalios, California Association for Health Services at Home**
- **Denny Chan, Justice in Aging**
- **Leza Coleman, California Long-Term Care Ombudsman Association**
- **Michael Dark, California Advocates for Nursing Home Reform**
- **Susan DeMarois, Alzheimer's Association**
- **Rafi Nazarians, AARP CA**
- **Michael R. Wasserman, MD, CMD, California Association of Long Term Care Medicine**

Dean Chalios, California Association for Health Services at Home

I cannot express how grateful I am to have been able to serve on the Community Vaccine Advisory Committee (CVAC). This group of dedicated Californians representing the full range of our state's community at large, was completely and totally dedicated to serving our fellow citizens to ensure fair and equitable distribution of COVID-19 vaccines. While it did appear initially that we may have been "flying blind" on this critical issue, the leadership of Dr. Burke-Harris, Dr. Pan, and their teams as coordinated by Bobbie Wunsch effectively led us to rethink, retool, and reimagine with the ultimate goal of getting vaccines into arms across the state. The discourse throughout the process was incredibly respectful toward all points of view. As a representative of home care, and the multitude of caregivers treating patients and clients in the comfort, familiarity, safety, and security of their homes, I truly felt heard when emphasizing the importance of vaccinating homebound Californians with the same priority as those who could travel to designated vaccination sites. Again, I am so grateful to have been part of this historic effort and look forward to serving in a similar capacity in the future.

Denny Chan, Justice in Aging

Serving on the Community Vaccine Advisory Committee (CVAC) has been a unique, rewarding, and challenging experience for me as an advocate for low-income older Californians. Even prior to the inception of the CVAC, Justice in Aging's advocacy during the COVID-19 pandemic has focused on ensuring those who are most at-risk of adverse health outcomes from the virus – low-income older adults and others – are healthy, safe, and protected. My time and energies on the CVAC have focused on prioritizing low-income older Californians and ensuring they have access to the COVID-19 vaccine, especially among communities of color and other underserved groups.

Since the inception of the CVAC in fall 2020, we have been asked to center equity in our approach to allocation and distribution. I have truly appreciated the state's commitment to equity throughout our meetings. Even when the task seemed particularly daunting (especially when vaccines were scarce and the supply was even more limited), we were consistently asked to prioritize an equitable allocation.

Although older adults and individuals in congregate settings were prioritized early on, younger older adults and individuals with disabilities and high-risk conditions were only later prioritized after significant discussion among CVAC members. And even for those who were prioritized, accessing an

appointment to get the shot sometimes felt like the same chances as winning the lottery. While the situation improved as the supply increased, systems of transportation to/from vaccine appointments and at-home vaccinations did not materialize until several months into the distribution process. Even now, as California proceeds toward reopening on June 15, data from the California Department of Public Health (CDPH) suggest **more critical work remains to be done**. Vaccination rates for older adults of color in California, particularly Latino older adults, trails behind other groups – some as low as 40-50 percent – despite the fact that these individuals have been eligible for months. Because COVID-19 has disproportionately impacted communities of color, a responsible re-opening strategy must ensure that the older adults in those communities, like Latino older adults and others, have equitable access to the vaccine. Reopening without those strategies in place risks further exacerbating the existing disparities COVID-19 has already highlighted.

I have genuinely enjoyed serving on the CVAC during these critical and unique times. My colleagues have been a pleasure to collaborate with and learn from, and Bobbie's seamless facilitation took it to the next level. I am so grateful for this experience and the hard work of Drs. Pan and Burke-Harris and their colleagues in state government for steering us through this public health emergency.

Leza Coleman, California Long-Term Care Ombudsman Association

I want to thank CVAC for including me as the representative of the California Long-Term Care Ombudsman Association (CLTCOA), a membership organization comprised of 35 Local Long-TermCare Ombudsman Programs.

LTC Ombudsman organizations are the local program representatives mandated in federal and state law to provide advocacy services to protect the health, safety, welfare, and rights of residentsliving in licensed long-term care facilities.

The program provides on-site monitoring of facility conditions and resident well-being. As the eyesand ears in facilities, Ombudsman representatives are trained to spot systemic problems and develop personal rapport with residents who may fear reporting problems or abuse. Ombudsman representatives can intervene on behalf of a resident and identify, investigate and resolve complaints often before they result in more severe and costly cases of abuse and neglect. The regular and ongoing presence of the LTC Ombudsman improves both the quality of life and quality of care for residents and enhances facility compliance with state and federal laws.

In mid-March 2020, out of an abundance of caution and to avoid any unnecessary risk of exposureto COVID-19, these local facility advocates transitioned from in-person advocacy to remote assistance. While not ideal, they learned that communication and providing aid for the residents was not dependent on entering a facility. The programs prioritized communication with facility owners and staff by phone calls and emails. The initial goal was to identify any resources the facilities lacked and determine, given the facility's specifics, how best to facilitate resident to Ombudsman and resident to family communication.

The many months of facility residents being denied in-person access with their Ombudsman representatives denied visits from loved ones, the growth in COVID-19 infections and deaths of

residents, the reports of facilities being short-staffed, and persistent PPE storages resulted in significant emotional trauma. Trauma that the LTC Ombudsman representatives are just now beginning to uncover, with the recent return of in-person advocacy activities.

As a member of CVAC, I was provided the opportunity to share with the local programs what I learned during our zooming meetings and the many links to statewide and national resources. Consistently the information shared was the most up-to-date information available on COVID-19. Ifound the collaborative activities of CVAC helpful in identifying the state's priorities. Working withfellow stakeholders leaders from a vast array of industries promoted the most inclusive decision- making process, with the common goal to best serve all of California through the COVID-19 pandemic.

In turn, I shared the information with the local LTC Ombudsman programs, many of who thenwould push that information out via social media to their local stakeholders.

I am grateful for the opportunity to share the LTC facility residents' advocates' perspective with theother CVAC members and then forward the CVAC meeting information with the CLTCOA members. My participation helped me feel like I was doing something positive during a very anxious and seemingly powerless time.

Thoughts from the field: Quotes from local LTC Ombudsman after first returning to in-person visits:
I was surprised that even after six months, three of the four residents recognized me. Like kids on a special day...they all expressed how long it's been and how happy they are for the visit...wanting promises that I comeback :) Asking me what I thought of their hair...girl talk :)
Karen jones- Central California

"I can't describe what a difference an in-person visit made. I was able to assist a resident in filing a police report for alleged financial abuse and, because the resident is hard of hearing, this would have been impossible to do over the phone. I was also able to view documents in person, rather than trying to have theresident describe them via telephone. Advocating in person is so much more effective."
Libby Anderson- Southern California

While I was doing an in-person visit at a six-bed RCFE, one of the residents grinned from ear to ear when shesaw me. My past experiences were that this woman might smile, but she does not grin. During my first visit after so many months, this resident kept saying, "I am so happy to see you my dear! It's been so long since you've come because of the virus, right, dear? Thank you for protecting me by wearing a mask and gown... that's so thoughtful of you, my dear." She just kept grinning and then asked... "have you noticed that I'm nowcalling you dear? I always will from now on...thank you for coming to see us!"
Karen Jones

I am profoundly touched by the joy reflected in the residents' face when they first see the Ombudsman. Thejoy swiftly changes to deep sadness because they haven't seen or held their loved ones in such a very long time. A resident wondered out loud if she would ever hug her grandson again before she dies. It broke my heart.
Debra Hanschar- Northern California

Residents were so happy to see me, and I was even happier to see them. We responded to a closure of an RCFE where all of the residents were not afforded a 60-day notice and were not provided a choice in where they were being moved. Additionally, during our visit, none of the residents were wearing masks. We were able to educate the residents on the importance of wearing masks, get the facility to give them masks, discussthis concern with the facility, and notify CCL.

After so many months of absence, returning to facilities has been a more powerful experience than I had expected. As ombudsmen, we have always worked hard to advocate for social interaction, open communication, and residents' rights. In some cases, it has been heartening to see that staff have gone beyondto create ways to continue these important qualities of life. In others, it has been painful to see the effects of their absence. Overall, returning to these facilities - these "homes" - has been profoundly rewarding: to know we are that link, that connection they have with the world they have left outside." Deb Jackson- Northern California

Michael Dark, California Advocates for Nursing Home Reform

If you had told me last May that in just a year I would be writing a short statement marking the final stretch of the vaccination efforts in the State, I would have been relieved—and grateful. Getting to this point is the culmination of tremendous efforts by the scientific and medical communities, as well as advocates and activists. I offer below some thoughts on where we stand with respect to vaccinating Californians living in long term care, as well as some reflections on the CVAC's process and accomplishments.

There can be no doubt that the State has made great strides in vaccinating residents of nursing homes and residential care facilities, but the encouraging statistics are something of a moving target. While current rates of vaccination in these communities are good, every day more elderly and disabled Californians enter congregate settings, and many of them bring with them vaccine hesitancies and concerns that are common in the wider community. Accordingly, the effort to reach long term care residents must be a continuing project, with special attention paid to the small, under-resourced and often geographically isolated "six bed" assisted living facilities that too often fell through the cracks in the first months of the vaccination effort.

The statistical picture of where vaccination efforts really stand in the long term community is also hampered by a lack of transparency on the part of the State. While the public can obtain data on aggregate numbers of vaccinations in assisted living facilities and nursing homes, the State does not make available any data on the *proportion* of staff and residents to have been vaccinated in *specific facilities*. This information is critical to families assessing which facilities might be safest for their relatives to enter, and without it they have no certainty about the actual degree of vaccine uptake among the health care workers known to be a critical vector for the spread of the virus. We know the State already collects this data and uses it to communicate with facilities seen as laggards, but it does not share it with the public—we fear for reasons that are largely political and business-oriented.

The CVAC itself must be seen as a success, in that it was able throughout the darkest days of the pandemic to provide channels of communication between the State and disenfranchised communities

that have little access to the levers of power and to accurate information. The bulk of its efforts, it seems to me, was devoted to the prioritization process, clearly a critical component of ensuring equity in the distribution of the vaccines as they became available, but not the only one. Other aspects of equity and access for the communities CANHR represents were not directly addressed by this process.

Issues of capacity and informed decision-making are crucial to individuals living in congregate settings, and residents in these facilities have far less power to meaningfully participate in their own care than people living in the broader community—a striking example of a lack of equity in the healthcare system, but not one addressed in any substance by the prioritization process. Nor did decision-making about vaccine priorities address concerns about how smaller assisted living facilities disproportionately housing poorer Californians were slipping through the State's safety net—again an issue of equity and access that did not fit neatly into the prioritization schemes we discussed.

While I was able to pose questions relating these matters orally and in the chat feature of the Committee's meetings, the press of business and the number of participants meant that these questions were often not answered, and some questions, like access to facility-specific vaccination data, remain unanswered to this day.

Notwithstanding these concerns, I on behalf of CANHR thank you and the state officials participating in the CVAC for your hard work in especially trying times, and for the care and attention you gave and continue to give to keeping Californians safe.

Susan DeMarois, Alzheimer's Association

The fact that we're being asked to share our reflections summarizes the thoughtfulness, respectfulness and good intent of California's leaders. It was an honor to represent the Alzheimer's Association on the Community Vaccine Advisory Committee; the information I obtained transferred directly to countless older adults, people living with Alzheimer's disease and their caregivers because of our active participation. This improved quality of life, health outcomes and mortality for more Californians than we'll ever know.

The Alzheimer's Association hopes lessons from COVID-19 fatalities and the federal pharmacy vaccine partnership in LTC communities will ultimately lead to better integration of these facilities into local public health work. In our experience, valuable time was lost when it was unclear who was ultimately responsible for these settings, whether for PPE, testing or vaccines.

First off, this was a learning process for everyone: government, providers, insurers, community-based organizations, stakeholders and the public. I applaud the Administration for letting us all learn together. It made for a bumpy start, but we saved valuable time with this efficient model. And it allowed our incredibly busy leaders – Dr. Burke Harris and Dr. Pan, to get quick feedback, identify resources and deliver information in real time.

It became clear immediately that the Community Vaccine Advisory Committee was a valued partner. The frequency and duration of the meetings sent a clear signal that this work mattered, and the commitment of Dr. Burke Harris and Dr. Pan to every single meeting for the entire process was inspiring and motivating – they never wavered. This built trust and credibility – two critical ingredients in what was a life or death process for so many of our constituents.

Dedicating resources to Bobbie Wunsch was brilliant. The flow of information was rapid and voluminous; Bobbie did an incredible job preparing us for each meeting, sharing materials between meetings, and incorporating public comments. Bobbie also skillfully facilitated challenging conversations and never rushed difficult topics.

In true public health fashion, this advisory committee built capacity. Whether it was through the media side or interests aligned on the calls, our health and human services network expanded because of this work. Should another crisis arise, we have an informal infrastructure to tap into now.

In hindsight, and we couldn't have known it then, we spent so much time on eligibility when – as Denny Chen at Justice in Aging noted, the real issue was access – and still to this day is access, now that nearly everyone in the state is eligible. Conversations around access – and accommodations, must continue for people with cognitive impairments, people with disabilities, people without access to technology/broadband, homebound seniors and others. We found that initial community vaccination sites weren't compatible with the needs of older adults with Alzheimer's and their caregivers, the highest priority for early vaccines. This is an important lesson to remember for other public health crises or natural disasters.

It was fascinating to watch the media strategy and campaign unfold as new populations became eligible and data was collected on who was obtaining the vaccine and who was not. To witness a concept translate into an ad almost overnight was incredible as California was in a race against the winter COVID-19 surge. Kudos to the entire communications team for their high-quality work under incredibly tight timelines, and a very special thanks for the consistent focus on diversity, equity and inclusion.

Thank you Dr. Burke Harris and Dr. Pan for your laser focus on data, equity and evidence. In a fast-moving environment, with information sometimes finalized at the federal level an hour before our meetings, you both led with science and the facts.

Finally, after the last meeting I was able to volunteer at two community vaccine clinics where 3,000+ people were vaccinated in two days. I didn't fully appreciate – as a meeting participant who wasn't eligible for the vaccine myself until recently, the scale and complexity of standing up a vaccination site. These were massive undertakings going on in all 58 counties. I was so impressed by volunteer turnout, organization, cultural competence, language access, appointment process, data collection, etc. As I write this, nearly 38 million vaccines have been administered in California. This is an amazing human and technological feat. The Alzheimer's Association thanks every person who played a part in this important effort, and continues to do so.

Rafi Nazarians, AARP CA

At the outset of the Community Vaccine Advisory Committee the primary issue revolved around how to prioritize distribution of limited vaccine supply. Despite scientific evidence that age was a significant factor in the serious illness and death among COVID-19 patients, many special interest groups advocated for the prioritization of vaccine distribution by employment sector rather than age. Knowing the limited supply of vaccine doses for those choosing to get vaccinated, the issue became one of sub-prioritization. In early January, the committee began to seriously consider moving away from age-based prioritization and instead prioritize individuals working in Education & Child Care, Emergency Services, and Food & Agriculture.

In response, on January 24th, AARP California sent a letter to Governor Newsom and key statewide health officials expressing our support for an age-based prioritization vaccine distribution system. The letter was well-received by state officials and the Governor's office announced that California would prioritize vaccinating "health care personnel, including vaccinators, and all persons 65 years of age or older." They also indicated that future phases would also be "age-based."

As vaccine supply stabilized in March, much of the discussion then centered on outreach and engagement efforts, particularly in the African-American/Black and Latino communities. AARP California worked with other member organizations and individuals on the committee, such as the California Surgeon General, to do outreach to these communities.

AARP CA has appreciated being a part of the Community Vaccine Advisory Committee and working with so many committed community based organizations, health experts, and state officials as the vaccine was introduced and distribution ramped up throughout the state.

Michael R. Wasserman, MD, CMD, California Association of Long Term Care Medicine (CALTCM)
First, I want to thank the Administration for the opportunity to participate on the Community Vaccine Advisory Committee. It was an honor and a privilege to serve with such an incredible group of dedicated and knowledgeable individuals. My comments and reflections are twofold. First, from the perspective of a "stakeholder" advisory committee, I believe that the process was organized and managed exceptionally well. I particularly want to thank Drs. Burke Harris and Pan for their professional and even-handed stewardship of the process. There is no question that the members of the committee were given ample opportunity to share their concerns and recommendations throughout the process.

However, I would be remiss if I didn't point out the weaknesses inherent in such a "stakeholder" process. As a geriatrician, representing the California Association of Long Term Care Medicine on the committee, I did everything in my power to point out a number of weaknesses in the vaccine rollout. When I testified before the Assembly Health Committee in June, over 2,000 California nursing home residents were known to have died from the pandemic. When I testified before the Assembly Budget Committee in October, that number had risen to over 4,000. The experts in geriatrics and long term care medicine were quite concerned about the impact of the winter surge. Our worries turned out to be well founded. Long term care resident deaths peaked in December and January, and while nursing home residents were finally vaccinated, those living in assisted living facilities lagged behind, leading to a preventable loss of life. There have been over 45,000 deaths in people over the age of 65, and deaths in the long term care setting accounts for a significant number of these deaths. Others on the committee were similarly pointing out the lack of effective vaccination efforts in minority and poor populations, with the knowledge that deaths among Latinos far exceeded their proportion of the population. While progress has been made recently in vaccinating communities of color, I believe that the state needs to reflect on the process and learn from it. The "stakeholder" approach has significant limitations, particularly during an emergency. Theoretically, hindsight is 20:20. However, the voices of the underserved and vulnerable older adults accurately predicted what was to come. I strongly urge the administration to review the process and develop an improved methodology for addressing the needs of these vulnerable populations in the future.

Once again, thank you very much for the opportunity to participate. This was hopefully a once in a lifetime situation, and we can't expect perfection. Nevertheless, too many lives were lost not to reflect and learn from the experience.

Veterans

- **Chuck Helget, California Association of Veteran Service Agencies**

Chuck Helget, California Association of Veteran Service Agencies

CVAC Accomplishments:

First, I would like to offer my compliments and thanks to Bobbie Wunsch, Doctor Aragon, Doctor Burke Harris, Doctor Erica Pan and Secretary Richardson. It was an honor to be selected to represent the veteran community on the Commission. Your patience and guidance were invaluable, informative, and effective. I believe that this group, with your guidance, helped provide a transparent roadmap that delivered vaccination safely and equitably to those with the highest risk of becoming infected and spreading COVID-19.

The Commission was an incredible resource for our veteran service organizations as we struggled to contend with the onslaught of this pandemic. How do we reach homeless veterans? How do we manage our housing and supportive services while keeping our staff and veterans safe for COVID 19? The resources provided to the Commission were invaluable and throughout the early stages of the pandemic, we were able to vaccinate our veteran clients and our staff eliminating completely any outbreaks at our facilities.

CVAC Process:

I was skeptical initially. A group this large and this diverse trying to contend with the complexities of developing a responsive and equitable vaccination response to a pandemic!

The initial meetings were somewhat overwhelming given the vast amount of information shared by our organizers and other members of the Commission. Thankfully, the meetings were effectively structured, the presentations organized and the Commission discussion while passionate remained respectful throughout the many hours of deliberation. Bobbie, you did a fabulous job of keeping us on task!

Lessons Learned:

My primary concern with our allocation decisions is what I consider a delayed response to the problem of vaccinating the homeless. Not just homeless veterans, but our homeless population generally. To this day I am concerned that we focused our attention on the homeless population to late in our deliberations. I am still not sure what goals were set for the homeless and if we accomplished those goals. Early this year CAVSA conducted a survey of our member agencies regarding lessons learned. A common theme among respondents was concern about our ability of reach homeless veterans during a future pandemic to provide medical care and vaccinations.

Final Comment:

I would like to thank each Commissioner for their participation. This shared video experience was a challenge made easier because of your depth of knowledge and respect for each other!