

California Health and Human Services Agency (CHHS)

California Department of Public Health (CDPH)

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #6 – January 6, 2021 – 3:00pm – 6:00pm

MEETING SUMMARY

Committee Members Attending

Fred Buzo, AARP; **Jacob Snow**, American Civil Liberties Union Northern California (ACLU); **Vivian Reyes**, American College of Emergency Physicians; **Alia Griffing**, American Federation of State, County and Municipal Employees (AFSCME); **Susan de Marois**, Alzheimer’s Association; **Andrew Nguyen**, Asian Americans Advancing Justice – Los Angeles; **Dr. Chang Rim Na**, Asian and Pacific Islander American Health Forum (APIAHF); **Dr. Ron Williams**, Association of California School Administrators (ACSA); **Jeff Luther, MD**, California Academy of Family Physicians (CAFP); **Michael Dark**, California Advocates for Nursing Home Reform (CANHR); **Lisa Mancini**, California Association of Area Agencies on Aging (C4A); **Carolyn Pumares**, California Area Indian Health Service; **Heather Harrison**, California Assisted Living Association (CALA); **Dean Chalios**, California Association for Health Services at Home (CAHSAH); **Joe Diaz**, California Association of Health Facilities (CAHF); **Charles Bacchi**, California Association of Health Plans (CAHP); **Michael Wasserman, MD**, California Association of Long-Term Care Medicine (CALTCM); **David Lown, MD**, California Association of Public Hospitals and Health Systems (CAPH); **Vicky Reilly**, California Association of Rural Health Clinics (CARHC); **Chuck Helget**, California Association of Veteran Service Agencies; **Veronica Kelley**, California Behavioral Health Directors Association (CBHDA); **Rhonda M. Smith**, California Black Health Network; **Preston Young**, California Chamber of Commerce; **Eric Sergienko, MD**, California Conference of Local Health Officers (CCLHO); **Virginia Hedrick**, California Consortium for Urban Indian Health, Inc. (CCUIH); **Mary McCune**, California Dental Association (CDA); **Christina N. Mills**, California Foundation for Independent Living Centers (CFILC); **Jackie Garman**, California Hospital Association (CHA); **Orville Thomas**, California Immigrant Policy Center (CIPC); **Catherine Flores-Martin**, California Immunization Coalition; **Mitch Steiger**, California Labor Federation; **Amanda McAllister-Wallner**, California LGBTQ Health and Human Services Network; **Leza Coleman**, California Long-Term Care Ombudsman Association (CLTCOA); **Lance Hastings**, California Manufacturers & Technology Association (CMTA); **Hendry Ton**, California Medical Association (CMA); **Rocelyn de Leon-Minch**, California Nurses Association (CNA); **Kiran Savage-Sangwan**, California Pan-Ethnic Health Network (CPEHN); **Susan Bonilla**, California Pharmacists Association (CPHA); **Andie Martinez Patterson**, California Primary Care Association (CPCA); **Michel Feyh**, California Professional Firefighters; **Jose R. Padilla**, California Rural Legal Assistance, Inc. (CRLA); **Debra Schade**, California School Boards Association (CSBA); **Pamela Kahn**, California School Nurses

Organization (CSNO); **Lorian DeMartini**, CEO: California Society of Health-System Pharmacists (CSHP); **Carol Green**, California State Parent Teachers Association (CAPTA); **Lisa Constancio**, California Superintendent of Public Instruction; **Laura Kurre**, California Teachers Association (CTA); **Shannon Lahey**, Catholic Charities California; **Esther Bejarano**, Comite Civico del Valle; **Kim Saruwatari**, County Health Executives Association of California (CHEAC); **Andy Imparato**, Disability Rights California; **Silvia Yee**, Disability Rights Education and Defense Fund (DREDF); **Kristin Weivoda**, Emergency Medical Services Administrators of California (EMSAC); **Pastor J. Edgar Boyd**, First African Methodist Episcopal Church; **Melissa Stafford-Jones**, First Five Association; **Anthony Wright**, Health Access; **Lisa Hershey**, Housing California; **Naindeep Singh**, Jakara Movement; **Denny Chan**, Justice in Aging; **Jeffrey Reynoso**, Latino Coalition for a Healthy California; **Brianna Lierman**, Local Health Plans of California (LHPC); **Genevieve Flores-Haro**, Mixteco Indigena Community Organizing Project (MICOP); **Tia Orr**, Service Employees International Union (SEIU) California State Council; **G Perdigones**, Service Employees International Union Local 1000 (SEIU 1000) (Unit 17-Nurses); **Aaron Carruthers**, State Council on Developmental Disabilities; **Brian Mimura**, The California Endowment; **Gabriella Barbosa**, The Children's Partnership; **Diana Tellefson-Torres**, UFW Foundation; **Matthew Maldonado**, United Domestic Workers (UDW/AFSCME); **Maria Lemus**, Vision y Compromiso; **Crystal Crawford**, Western Center on Law and Poverty; **Amber Baur**, Western States Council: United Food and Commercial Workers (UFCW) California

Committee Members Absent

Jodi Hicks, Planned Parenthood Affiliates of California (PPAC); **Thomas J. Kim, MD**, California Rural Indian Health Board; **Liugalua (Liu) Maffi**, Faith in the Valley

California State Representatives Attending

Tomas Aragon, MD, DrPH, Director, CDPH and State Health Officer; **Nadine Burke Harris, MD, MPH**, California Surgeon General; **Erica Pan, MD, MPH**, State Epidemiologist; **Tricia Blocher**, Deputy Director, Office of Emergency Preparedness; **Rob Schechter, MD, MPH**, Chief, Immunization Branch; **Ron Chapman, MD, MPH**, Former Director, CDPH; **Maricela Rodriguez**, Office of Governor Gavin Newsom; **Suanne Buggy**, CDPH; **Martha Dominguez**, CDPH

Public Attending

There were 182 members of the public attending by phone, including 2 on the Spanish line, and 2,224 views of the meeting by YouTube livestream.

Committee Co-Chairs

Dr. Erica Pan, MPH, State Epidemiologist

Dr. Nadine Burke Harris, MPH, California Surgeon General

Consultant

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

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

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

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

Tomas Aragon, MD, DrPH, Director, CDPH and State Health Officer

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Dr. Burke Harris welcomed the committee and thanked them for their participation. She noted the remarkable events transpiring in the country today, recognizing that these events can be distressing and that it important to practice self-care and seek and offer support. There are resources on the COVID-19 website for emotional wellness and stress relief. She offered her gratitude to all participating in this process and grounding the values of safety, equity and transparency.

Dr. Pan welcomed the group and echoed Dr. Burke Harris' comments. She acknowledged how stressful today and this year have been. The Governor's comments in the press conference today will include a message that vaccine administration needs to be accelerated. The state has stepped up its efforts to bring other resources in, including allowing some flexibility within the priority guidelines. Feedback shows the need to balance priorities and get to the highest risk people soon. Also, some smaller jurisdictions are able to get through priority groups very quickly. The state is trying to be clear in communications that flexibility is possible and encouraged, as long as localities do a good job of offering and making available the vaccine to priority populations first. The state is emphasizing the need to use every single dose and therefore giving some flexibility to vaccinators to move to a next group to avoid wasting vaccine. Dr. Pan noted that many people have been vaccinated yet we to need to move fast in light of the latest surge.

Some additional strategies the state is planning: partnering with other health care agencies to expedite vaccinations; expanding flexibility; creating a larger pool of vaccine administrators; adding state support for vaccine clinics; vaccinating the vaccinators; making sure dentists are trained to vaccinate; and working with partners to reach an additional one million vaccinations in the next ten days. Almost two million doses have been shipped. California had administered almost 490,000 doses as of January 5. Dr. Pan reminded the group that Phase 1a is healthcare workers and residents/staff of long-term care facilities.

Impact of Federal Funding for Vaccine Distribution in California

There is about \$300 million available for vaccines including: (1) information technology such as appointment scheduling, reporting and [CalVax](#); (2) logistics and commodities such as dry ice and freezers; and (3) culturally competent public education campaigns.

Dr. Pan then introduced Dr. Tomas Aragon, the new state Public Health Director. Dr. Aragon, in his third day on the job, expressed his thanks and gratitude for being able to work with Dr. Pan, Dr. Burke Harris and this group. He shared some of his background in infectious disease and experience in San Francisco. Dr. Aragon noted that his leadership style is aligned with CVAC, emphasizing universal values of dignity, equity and compassion for all people. He views equity challenges as large and incredibly important. Dr. Aragon serves on the Western States Scientific Safety Review Workgroup and this group met Monday to consider three strategies for extending supply: using half doses, delaying the second dose, and mixing and matching different mRNA (Moderna/Pfizer) vaccines. These strategies are being considered or utilized in some other countries. Currently, the FDA and Western States Scientific Safety Review Workgroup do not see sufficient evidence to adopt a new approach and therefore are not recommending a change at this time. The committee will continue to study these strategies for possible future consideration and is creating a statement that explains its rationale.

Bobbie Wunsch welcomed the committee and briefly reviewed meeting protocols and welcomed the ASL interpreters. The public is in listen-only mode by telephone in English and Spanish and is being livestreamed on YouTube. Public comments are welcome at COVID19VaccineOutreach@cdph.ca.gov. These comments are shared with the committee, posted on the website, and Bobbie summarizes them at each meeting.

Review Public Comments since December 23, 2020 Meeting #5

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Bobbie Wunsch summarized public comments submitted between December 22, 2020 and January 4, 2021. There were 387 pages of public comments from 1,034 individuals and organizations. These comments have been shared in their entirety with the committee and are posted on the website. A summary of these comments:

- 4 individuals asked to become CVAC members (including senior services, representatives of people with disabilities, hair stylists and personal services)
- 4 individuals and organizations offered to provide vaccines or offered locations to be utilized for vaccinations (including music venues)
- AARP shared an education campaign that is launching
- 3 comments about health and safety of vaccines
- 2 comments about the slow distribution process
- 5 comments about poor messaging by the state about where and how to get vaccines
- 1 comment about expanding the scope of practice for healthcare professionals like dentists so they could be vaccinators
- 231 comments and questions about where and how to get vaccinated and notified, and indicating confusion about this process

- 2 questions about identification needed to prove eligibility for the vaccine
- 3 people suggested creating a waiting list on the website so they could sign up
- Additional questions about Phase 1 a including:
 - 88 questions from healthcare workers about where they fit in the phase and how to get themselves/their staff vaccinated (includes those not part of a major health system, private providers, oncology centers, physical therapists, audiology, midwives, anesthesiologists, nurses, school nurses, nursing students, psychologists, optometrists, ophthalmologists, behavioral health providers, assistive technology providers, surgeons, nurses at border patrol stations, dentists, medical interpreters, hospice workers, jail medical providers, pharmacy staff, dialysis centers, alcohol and drug treatment centers, and acupuncturists)
 - 7 comments from workers in long-term care and assisted living facilities who are unclear about how to get themselves or their residents vaccinated
 - 6 requests for how non-licensed senior living facilities and HUD facilities could receive the vaccine
 - 43 comments from IHSS workers, home health agencies, non-IHSS private caregivers for the elderly and disabled and other informal caregivers about where and how they could be vaccinated
- Requests to prioritize seniors and people with disabilities:
 - 69 comments urging the state to prioritize people over 75
 - 85 comments suggesting people over 65 go first
 - 11 comments suggesting other age ranges between 55-72
 - 12 comments requesting to prioritize adults with disabilities, including those in the Home and Community-Based waiver programs
 - 10 comments urging that adults with intellectual and developmental disabilities be prioritized
- Questions about the allocation process:
 - 3 suggested keeping the process simpler
 - 11 suggested following the age-based UK approach
 - Physicians requested the ability to use their discretion about who gets the vaccine
 - 1 person suggested not giving the vaccine to people who don't wear masks
 - The Mayor of Oakland requested vaccinating people of color first
 - 41 comments requesting that people with a variety of underlying medical conditions that put them at high risk be prioritized (this included the immune-compromised, people living with HIV/AIDS, people with cancer, weight issues, people with Type 1 and Type 2 diabetes)
 - 1 person suggested allocation be based on job categories only
 - 7 people suggested vaccinating essential workers over age 60 first
 - 3 people suggested prioritizing people who cannot work at home

- 48 comments urging teachers and school personnel be prioritized so school can resume in person
- 4 people suggested only teachers who are back in the classroom should be vaccinated
- 1 person suggested vaccinating spouses of teachers
- 8 people and a petition with almost 2,000 signatures asked that child care providers be vaccinated
- A letter from the mayors of Tulare, Watsonville, Gonzales and King City urged that farmworkers and others in agriculture and dairy be prioritized first
- 361 comments suggested classifying various workers in Tier 1 of Phase 1b, including: workers and detainees in immigration detention facilities, both public and private (39); people working with the homeless (4); clergy (1); health care administrative services (2); food and agriculture including beverage industry, meat packing, poultry plant, dairy, grocery workers, grocery deliveries, wholesale produce, cannery and food processing (18); California Chamber of Commerce suggested those in the food supply chain (1); food banks (3); retail clerks (1); public transportation (26); airline crews (2); utility and water districts/workers(38); veterinarians (154); funeral industry/death care (4); media and journalists (2); commercial fishermen (1); waterfront and port workers(19); security workers (1); massage therapists (1); trucking industry (1); recycling industry (1); Certified Public Accountants (1); semiconductor industry (1); small businesses (1); hotel workers (1); postal services (4); Amazon workers (3); construction workers (4); public defenders, federal and state court-appointed lawyers (6); canine search and rescue (1); and workers providing business/residential services like phone and internet (1).
- 2 people suggested that single mothers be prioritized
- 1 comment suggested vaccinating college students and teachers first
- 2 comments suggested landlords and those who provide housing of all types
- 13 comments urged the state not to vaccinate people who are homeless or incarcerated
- 1 person recommended we forget the vaccine and focus on creating herd immunity
- 23 questions from medical device manufacturers, lab workers, pharmaceutical manufacturers, nutritional products manufacturers asked where they fit in
- 3 comments from clinical researchers requested earlier prioritization

Bobbie urged everyone to review these serious, heartfelt and passionate comments and questions.

Update on Vaccine Allocation and Distribution

Tricia Blocher, Deputy Director, Office of Emergency Preparedness, CDPH
Oliver Brooks, MD, Co-Chair, Drafting Guidelines Workgroup

Robert Schechter, MD, MPH, CDPH and Co-Chair, Drafting Guidelines Workgroup
Ron Chapman, MD, MPH, CDPH

Dr. Burke Harris recapped for CVAC that the purpose of the Drafting Guidelines Workgroup is to take the science and data and combine it with comments from this diverse committee to create guidelines for the governor to endorse. While more doses arrive every week, California does not expect to have enough vaccine to cover everyone at once and therefore the purpose of the guidelines and the workgroup is to prioritize during this period of vaccine scarcity.

With Phase 1a already underway, Dr. Brooks reviewed recommendations for Phase 1b and Phase 1c. He reiterated the goal of giving 1 million vaccines in the next 10 days. He also noted that several CVAC members have submitted comments and the Drafting Guidelines Workgroup reviews these comments carefully. Dr. Brooks shared that there is good alignment between the Advisory Committee for Immunization Practices (ACIP), CVAC and Drafting Guidelines Workgroup, reflecting considerations for equity, safety, transparency, and workplace exposure.

Recommendations to the Administration on Phase 1b and Phase 1c from Drafting Guidelines Workgroup

Dr. Schechter shared the guidelines for Phases 1b and 1c as announced by Governor Newsom this week. These guidelines are very similar to our earlier discussions and also the federal recommendations and many other states. There is no ranking within any of these categories.

- Phase 1b Tier 1 includes:
 - people 75 years and older
 - workers with risk of occupational exposure in 3 essential sectors: education and childcare, emergency services, and food and agriculture
- Phase 1b Tier 2 includes:
 - people ages 65 and older – *expanded since last CVAC meeting*
 - people working in these essential sectors: transportation/logistics; industrial, residential and commercial sheltering facilities/services; critical manufacturing
 - people living in high-risk congregate settings including incarcerated individuals and sheltered people experiencing homelessness
- Phase 1c includes:
 - people ages 50 and older – *expanded since last CVAC meeting*
 - people 16-29 with underlying medical conditions and/or disabilities – *expanded since last CVAC meeting*
 - workers in all the remaining essential sectors: water and waste management; defense; energy; communication and information technology; financial services; chemicals/hazardous materials; government operations/community service

Many questions have been raised about where specific occupations and individuals fit within these various phases and tiers. Dr. Schechter shared some sample language from the CDPH website about essential workers and how they are defined. This is what the Drafting Guidelines Workgroup is generally using when referring to eligible occupations and roles.

Vaccine Eligibility Determination

Dr. Chapman presented information about how the state is responding to CVAC and the public's increasing demand for information on vaccine eligibility. Other states are putting systems in place to push information out and keep people informed. As we move into the phases with high numbers of individuals, more communication strategies are ramping up. Members will hear more about outreach and education later in this meeting.

Dr. Chapman shared the state's list of occupations in various phases:

<https://covid19.ca.gov/essential-workforce/>. Dr. Chapman shared the state's COVID-19 hotline number, 1-833-422-4255, and email address, novelvirus@cdph.ca.gov. The state is also exploring the possibility of an online tool and considering tools from other states that will support a quick determination of eligibility based on a brief questionnaire.

Monitoring Equity in Vaccine Coverage

There is a need to ensure that the vaccine is getting to prioritized populations, especially as we move to phases that include the general public. The state is considering a vaccine equity metric and contemplating using the Healthy Places Index (HPI). This would mean comparing the percent of eligible population vaccinated in vulnerable communities (based on the HPI) to the percent vaccinated in less vulnerable communities. The benchmark for success would be equal coverage – i.e., no disparities across vulnerable and less vulnerable communities. Dr. Chapman shared questions for the group to consider, including: Is the HPI the most appropriate measure of vulnerability to monitor equity in vaccine coverage? If not, what other equity measures do you recommend? Do you agree that equal coverage is an appropriate benchmark for defining success?

Questions and Comments from Members

Phase 1b-Essential Workers

- Where do truck drivers fit in? What are the vaccination and distribution mechanisms? Does this include Department of Transportation employees who do not have the option to telework?
 - CDPH: Truck drivers can be included Tier 2 of Phase 1b as a member of the Transportation sector or, if they work in Food and Agriculture or Education, for example, can be included in Tier 1 of Phase 1b.
- Does government operations/community services include local and state government employees? If so what is the process for this? Are vaccines going to be given at the worksite or through a healthcare provider?

- Where do nonprofit frontline workers providing public safety net services to vulnerable populations fit in?
- Who makes the decision about whether a worker is in a relevant industry in an "exposed" role - the employer? self-attestation? public health officers?
- Are long-term care ombudsmen included in emergency services personnel for responding to APS/elder abuse reports?
- Leza Coleman: the LTC Ombudsmen fall in the tier with public health officials that enter into facilities.
- School nurses provide health services similar to the type of roles designated for Phase 1a, Tier 2, yet some counties are delaying school nurse vaccine access until Phase 1b.
- The Governor's suggestion that teachers who return to the classroom are prioritized over others increases the complexity for vaccination in school systems. We need simplicity and vaccines for school employees to return ALL teachers and students back to classrooms. Will the Governor's suggested priority supersede our decisions here?

Phase 1b – Seniors and People with Health Risks

- Will incarcerated individuals over age 75 be vaccinated in Phase 1b Tier 1?
- I appreciate the clarity of the age bands and the elimination of need for a doctor's notes which will simplify messaging and addresses groups most likely to need hospitalization.
- Will disabilities and co-morbid conditions be limited to the list of comorbid conditions compiled by CDC? How are "underlying medical conditions and/or disability" defined?
- Will people over 75 need to go to a county/LHD vaccine clinic registry or will they hear from their own doctor? There are concerns about scams during COVID and many older adults have been warned to be extra cautious right now.
- Functional disability is not typically included in demographic information; this should change when collecting information with vaccine implementation.
- How are disabilities and chronic conditions being defined?
 - CDPH: Currently we are pointing to the CDC list of factors associated with higher risks and disabilities, which is an evolving list. We also know people's providers will use clinical discretion and judgment in making these decisions.

Monitoring Equity in Vaccine Coverage

- The HPI will work for a number of factors but does not work very well for people with disabilities especially to the degree that they have exercised their civil rights to live in integrated housing within the community rather than a nursing home. This is a disproportionately affected population that may or may not be living in lower income communities. Unfortunately there is a data lag between learning more about how the disease and the vaccine affects those with various disabilities.
 - CDPH: Are there other tools to recommend that will help the state assess risk for individuals with disabilities?

- The HPI has value to identify historically and currently undeserved communities. Although the index does not include race or language as indicators, and other tools do, the advantage to the HPI is that the state is already using it in its re-opening planning.
- I do not agree that the proposed benchmark for success is the right one. It would be a more equitable strategy to strive for higher vaccination rates in communities that are more impacted by COVID.
- It feels like there is a disconnect between what is happening at the state level vs. what is happening locally. How are we ensuring that implementation is happening as recommended?
 - CDPH: This is really important to the state. Along with challenges related to data collection, we are trying to collect data to track this well – e.g., through the immunization registry now exported directly from Electronic Health Records. The state is working on solutions for tracking and is surveying local health jurisdictions. We are interested in this equity metric and how it is getting implemented at the local level.
- Other metrics are important, but we are constrained by what data exists. How will we remedy the situation if we do find there is inequity? If there is a region which is underserved relative to risk factors, there should an allowance for taking aggressive regional effort in that area. If we are getting information from contact tracing and/or ICU utilization, that information could be used for Public Health Officers to target places with high risks.
- I hope that we think about equity with respect to sub-prioritizing groups within Phases 1b and 1c. Even if there aren't specific occupations or age bands within these groups, older adults in communities of color are more at risk; therefore, if we rush to ensure doses do not get wasted, implicit bias will creep in.
 - CDPH: Along with the general eligibility about phases and tiers, there will be additional guidance with parallel language to guide sub-prioritization within allocation decisions and at vaccination sites based on risk factors and criteria such as level of occupational risk, underlying conditions, age, race/ethnicity, and residence in a vulnerable community.
- Please consider CDC's Social Vulnerability Index (SVI) for equity. The SVI refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The SVI uses 15 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters.
- It would be helpful to have a dashboard that includes what populations in each county have been given the vaccine.
- Helpful reading for this discussion: <https://jamanetwork.com/journals/jama/fullarticle/2771874>
- HPI is a thoughtful measure and a great place to start.

- Utilizing the HPI does not accurately indicate those areas that have been disproportionately hit by infection and economic impact. Should this metric be added?
- Poor older adults and the disabled in multigenerational housing are at significant risk.
- Will "equal coverage" be defined by the number of people actually vaccinated, or number of persons to whom vaccine is offered? Vaccine hesitancy affects specific populations in particular ways. There must be greater outreach to overcome hesitancy, and vaccination rates still might be lower.
- We should specify that for equity we measure people receiving the vaccine and not just allocation, as there are many steps and barriers between allocation and vaccination.
- One solution would be to use the HPI for the measures it was built for and include a separate consideration for people with disabilities.
- Another idea is to merge the HPI and SVI to include all people from vulnerable groups and underserved communities.
- Vaccinating Community Health Workers and not promotoras is an equity issue. We need a system to reach promotoras in community. What can we do now? This disparity may cause a problem with trust as we move into the general community.
- Can we review again what the HPI is and how it is an evidence-based, public health tool designed to help determine what communities are disproportionately impacted from a public health perspective and that these communities rate significantly higher from a "social vulnerability" perspective?
 - CDPH: More info on HPI can be found here: <https://www.phi.org/thought-leadership/the-california-healthy-places-index/>
- The CDC co-morbidity list, as well as most disparity tools, ignores the impact of Crisis Standard of Care guidelines and medical rationing on people with disabilities, as well as disability implicit bias. With California in a surge, this is another way to identify people with disabilities who are at risk (there is clear overlap with measures such as "who is receiving home and community-based services, who is on a Medi-Cal waiver, and who urgently needs medical care to remain functional in the community)."
- The COVID-19 Resource Map on the HPI index incorporates a "COVID-19 vulnerable populations" section which includes Seniors with disabilities (Percentage of population 65 years and older with disabilities) and Disabled (Percentage of population with a disability) indicators, among others. They use American Community Survey (ACS) data. I understand that this data may have multiple limitations. It may be worth connecting with the Public Health Alliance of Southern California to understand how they're looking into this important equity issue. <https://phasocal.org/california-healthy-places-index-interactive-covid-19-resource-map/>
- Some other equity tools that might be helpful are mapping tools from UCLA. One uses four indicators 1) pre-existing health conditions, 2) barriers to accessing services, 3) built-environment risk and 4) social vulnerability. The other identifies five COVID "vulnerabilities" to COVID-19 and their disparities across neighborhoods:

1. Communities with high numbers of renter households experiencing extreme financial hardships; 2. Communities most at risk from job displacement in the hospitality, retail, personal care, and service sectors; 3. Communities at risk due to a disproportionate high percentage of resident ineligible for Unemployment Insurance benefits; 4. Communities most burdened by shelter-in-place mandates; and 5. Communities with low self-response rates to the 2020 Census. See <https://knowledge.luskin.ucla.edu/california-covid-19-medical-vulnerability/> and <https://knowledge.luskin.ucla.edu/ca-renter-vulnerability/#top>

- I agree that these tools provide a broader definition to account for American Indian/Alaska Natives not associated with a California Tribal or Urban health program.
- We need more transparency from counties on who is being vaccinated and influencers should be held accountable if there is tier-jumping.
- We won't know if we've achieved our goal of equity if we don't collect and report demographic data.
- Is there a process to consistently identify what percentage of an eligible group is actually getting vaccinated?
- Is CDPH collecting race and ethnicity data on vaccine doses administered? If so, can race and ethnicity data be added to CDPH's public data [here](#) on vaccine doses administered ASAP?
 - Silvia Yee: The number of doses shipped and how many have been injected is at <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineDoses.aspx>. The format of the site seems to be evolving.

Operationalizing Distribution of Vaccines with Local Health Departments: *Continuing Discussion*

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

Eric Sergienko, MD, Health Officer, Mariposa County and California Conference of Local Health Officers (CCLHO) Representative

Kim Saruwatari, Director, Riverside County Public Health Department and County Health Executives Association of California (CHEAC) Representative

Dr. Burke Harris welcomed two local health leaders to continue the discussion from last week about operationalizing the distribution of vaccines on the ground. She introduced Dr. Sergienko and Kim Saruwatari.

Dr. Sergienko mentioned that CVAC feedback is critical to the local implementation process. The overarching question this group has been focused on is how people will know when it's their turn to get vaccinated and where to go to get their vaccine. Local Health Jurisdictions (LHJs) are trying to solve this distribution and logistics problem while having adequate supplies.

Federal Partnership for Long Term Care Facilities

The state COVID Vaccine Task Force has been distributing spreadsheets of dates to counties and notifying individual long-term care facilities (LTCFs), including both Skilled Nursing Facilities (SNFs) and Assisted Living Facilities (ALFs). That notification has gone reasonably well.

Drs. Sergienko and Pan talked about informed consent in LTCF, saying that this has gone well since many patients have Durable Powers of Attorney and like other medical consent, there is an effort to get formal or implied consent on paper or electronically. Although this is not a legal requirement, effort is being made to ensure patients or their caregivers are voluntarily accepting the vaccine. Kim Saruwatari added that in Riverside County, there are weekly calls with SNFs and LTCFs. All SNFs have been contacted and clinic dates set up, with 29 of 58 having had their first vaccine clinics already. One big lesson learned is that 2-3 people are needed at each facility to assist with coordination onsite since logistics and paperwork is burdensome. In general, Kim shared that the process is working and the population is getting vaccinated.

Dr. Pan shared that Part B of the federal pharmacy partnership has been activated and will start next week.

Using Equity to Prioritize Vaccination Efforts

Dr. Pan shared that the current Phase 1a recommendations include sub-prioritization recommendations at the facility level so that if doses are scarce, the priority is facilities that serve more vulnerable people. The state is looking at the HPI as it considers where to offer state assistance and resources. Kim Saruwatari added that Riverside County is using the HPI, monitoring positivity by zip codes and census tracts in lowest quartile zip codes. Positivity rates are up to 41% in some of these areas. They're working with the Catholic Church, which has a big presence in the county, and other faith- and community-based organizations. There is also a local equity committee which is considering equity as the county develops vaccine plans and rolls out vaccines.

Update on Vaccination of Health Care Workers in Phase 1a

Every LHJ has differences in how they conduct outreach. Mariposa County has found that outreach through social media and professional societies has been effective, then using call centers to connect people to the correct vaccination teams. They have also used US postal service for some IHSS workers and others.

Mariposa and Riverside Counties are both doing outreach to behavioral health workers at risk. Personal care attendants are being treated like IHSS workers so notification is a challenge but they are considered eligible in Tier 1.

In Riverside County, the vaccination campaign has three buckets:

1. Existing Provider Networks – for their own staff in Phase 1a, then patients and others

2. Points of Dispensing (PODs) – schools, pharmacies across the county
3. Community Vaccination Teams – for those unlikely to get to a POD or provider – e.g., farmworkers

Riverside County will work with professional associations and are also combing the internet for lists for outreach, reaching out to ensure their efforts are comprehensive. For IHSS staff, the County met with their Department of Public Social Services (DPSS) and the Union of Domestic Workers (UDW) to reach out to the 33,000 IHSS workers, starting to survey them and messaging through DPSS and UDW. For personal care attendants, they are reaching out to home health agencies, regional centers and others. Independent care practitioners not part of an existing network is challenging. They are using social media and their website for now.

Implementation Steps for Vaccination of Essential Workers and People 75+ in Phase 1b

Counties are building out registries on various databases, then using social media and outreach to get people in by individually scheduling for vaccinations. Mariposa County has chosen to create appointments because of the 15-30 minutes needed to observe people after vaccination, and space is needed during that time. LHJs are very eager to engage trusted messengers. Please reach out to them. If you can't get in touch with your health officer or director, the Joint Information Center is a great alternate source and very well connected.

Questions and Comments from Members

Phase 1a – Healthcare Workers

- Where do promotoras fit in? Does it depend on whether they work in health care or another setting? There are hundreds of promotoras working with CBOs that are not public health departments or hospitals and are not being included.
 - Dr. Sergienko: The CDPH website shows promotoras in Tier 2 of Phase 1a regardless of sector. The challenge in reaching promotoras is likely to be outreach and linkage with their CBOs.
 - Kim Saruwatari: Riverside County is vaccinating promotoras and CHWs this week by reaching out to CBOs for staff lists and sharing vaccine clinic information.
- I hope the state can share proactive outreach strategies for reaching promotoras with other counties for consistency.
- San Bernardino is working on all Phase 1a healthcare workers and has trained appropriate people to deploy vaccines. The issue the amount of vaccine received.
- Should CBOs who employ promotoras and CHWs reach out to local health departments to secure the vaccine for them since they are part of Phase 1a? There were many reports in the public comment about how health workers in 1a who are not affiliated with a hospital are not being given access to the vaccine.
- California Department of Health Care Services informed all counties that behavioral health workers are part of Phase 1a. They received amazing support from CDPH on this.

- About how much declination are we seeing in Phase 1a?

Timing and Logistics

- How will we know when we're moving from one tier or phase to the next?
 - Dr. Sergienko: There is a local feedback loop with the vaccinators, supplier(s) of vaccine and the state. In a small county, it is not difficult to estimate unmet need and accommodate some overlap. Dr. Sergienko noted a preference from some healthcare workers to receive the Moderna vaccine, which means we need to go back to previous declines and offer a second opportunity. Once all demands are met for previous tiers, there is consideration of moving into the next tier or phase which requires coordinating with the state and adjacent LHJs.
 - Kim Saruwatari: The feedback loop exists in larger LHJs too and the goals are the same: to vaccinate people safely and quickly. The pace is getting faster as challenges are solved. The goal is to leverage traditional infrastructure for vaccines whenever possible.
 - CDPH: Many people in health centers and other settings have experience with mass vaccinations, but some challenges are new. The vaccine arrived during the holidays and amidst a major surge, so the workforce and system are frayed.
- Will the start of a phase be posted on the CDPH site? What happens when a county goes into a tier? Who will provide the notice/credential to get vaccinated?
- Who will make the decision of who meets criteria for grey areas?
- Will Tier 1 of Phase 1b go before Tier 2?
 - CDPH: Those in Tier 1 get access before those in Tier 2, but within the tiers there is equal access.
- When a county moves to Phase 1b, will those in 1a continue to have access?
 - CDPH: Yes.
- If there is low uptake of vaccine by Californians in one phase do those doses go immediately to next phase or do they wait?
 - CDPH: See <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Allocation-Guidelines-for-COVID-19-Vaccine-During-Phase-1A-Recommendations.aspx>, Recommendation B2: Sub-prioritization by location of facility. When there are inadequate doses to reach all workers in a tier or facility category (e.g., acute care hospitals), doses should be prioritized to facilities serving the greatest proportion of vulnerable persons in their catchment area, as measured by the HPI or comparable health department knowledge, followed by facilities serving fewer vulnerable persons.
- Is all the information collected about vaccine recipients from pharmacies and other private partners (e.g., social security number) required? How can we prevent this from being a barrier and how can the state address the hesitance with its partners?
 - CDPH: We will take this question back. The CDC is working with pharmacies regionally on some of these issues.

- How can we address transportation barriers to the vaccine?
 - Dr. Sergienko: Arranging for transportation to a vaccination site is a logistics hurdle. Some registries ask about this need, and even though Medi-Cal pays for this, there has to be a transportation system and the driver has to be able to protect themselves, have PPE and be offered the vaccine before transporting.
- When will Phase 1b begin? Has there been an update to the timing for Phases 1b or 1c?
 - CDPH: We anticipate a formal announcement within the next few weeks about when Phase 1b will begin.
- Eligibility verification is crucial. We need a plan for farmworker vaccination, especially the undocumented, as employers are not always a trusted messenger.
- How are counties receiving vaccines? Many community health centers (CHCs) are reporting that their staff and providers are being vaccinated, but others do not expect to see the vaccines until end of January. CHCs are Phase 1a, Tier 2. Also I have heard that some counties are only allowing CHC providers that do vaccination administrations to receive the vaccine and no other CHC staff and if that is violated the county is threatening to remove the provider's license. I'd love to understand the county allocations and the overall approach. Can the state help resolve this?
- How will you account for people who don't want to be vaccinated?
- How is vaccine allocation to health care systems being determined beyond Phase 1a as those health care systems move to vaccinating their patients and community members?
- Will demographic information, county, and occupation/industry be added to the CDPH Vaccine Doses Administered Report?
 - CDPH: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Allocation-Guidelines-COVID-19-Vaccine-Phase-1A.aspx>
- If the Astra-Zeneca or other vaccines are approved that don't require cold storage, could their use be prioritized for rural areas and people with significant disabilities of all ages who cannot go to vaccination centers?
- What would be helpful to local health officers for an effective, equitable and speedy distribution? Is the need money, volunteers, other strategies and tactics? On the guidelines, would they want more flexibility, or more specificity? Flexibility could allow for more nimble response to local needs, but specificity at the state level could prevent confusion and having to take time locally for a time-consuming process.
- Are counties reaching out to Regional Centers to reach direct support workers?
- I strongly recommend all LHJs work with labor unions.
- Could we get an update of the projected number of doses received, progress with vaccinations, and when different phases will be vaccinated, ideally at each meeting?
- Will there be enough vaccine doses to cover all Phase 1b Tier 1 at the same time? How will you establish who gets the first allocation within the phase?
 - CDPH: Doses are coming in each week. There will be enough doses to vaccinate Phase 1b, but not all at the same time. There will be a rollout over time.

- The Governor is putting together a school re-opening plan. His target dates are February/March— how close to a vaccine timeline is that for educators?
- We still haven't heard "Who decides if I am eligible?" "How does the vaccinator verify that I am who I say I am?" This will impact equity if those with more connections can access the vaccine more easily.

Expanding Vaccinators and Vaccination Settings

- Currently pharmacists in independent pharmacies, who are trained and ready to serve in many underserved communities, have no clear direction on how to sign up to become vaccinators and receive the vaccine. So far, no county has a clear way for pharmacies to enroll and with 58 counties there is potential for inconsistent direction. State guidance to counties would greatly help pharmacies be ready to vaccinate.
- Home health agencies are ready, willing, and most importantly able to have our nurses administer the vaccine to both our workforce and all our eligible patients.
- One immediate way to increase vaccinators is to use the hundreds of pharmacy students who are trained in their first year to vaccinate and can vaccinate under the supervision of a pharmacist. The Board of Pharmacy issued a waiver to allow pharmacist to oversee up to 4 pharmacy students provided they are engaging in vaccination. Additionally about 70,000 pharmacy technicians are now allowed to vaccinate under the supervision of a pharmacist after they complete training.
- The California Dental Association has submitted a proposal to partner with the state and other healthcare professionals to begin to roll out mass vaccination clinics for Phase 1a, and larger populations in the long term, using our large scale free dental clinic (CDA Cares) as a model. A copy of the proposal was provided via the public comment email.
- In Orange County, we have a partnership between the Department of Education and our LHJ to utilize school nurses to administer vaccines to the educational community in Tier 1b. School nurses are ready and willing to help statewide.
- Regional Centers can play a role helping identify and prioritize individuals with disabilities they serve.
- Has there been any thought given to enabling IHSS workers to help in administering the vaccine to those who are already receiving personal assistance in their homes, possibly with health plan "back up" to bring the vaccines into the community.
- Grocers have identified 5 grocery chains operating 1,000 in-store pharmacies in California. We are happy to work with urgency to get these pharmacies registered and ready and would love to move fast with the pharmacy partnership.
- There is an existing network of pharmacies and pharmacists who work in long-term care - they are not being used and are very frustrated.
- Can IHSS workers distribute the vaccine to people in their homes?

- Dr. Sergienko: It would be difficult (although not impossible) to maintain the cold chain in this situation. Also, adverse effects can happen so doing this in a rural area or far from EMS is risky.
- I recommended that IHSS providers bring their clients to receive a vaccine at the same time even if their clients are in different tiers. Large employers in the state with health professionals on staff can help enable large-scale vaccinations in Phase 1b and beyond. The manufacturing community is well positioned to do that and offer assistance.

Long-Term Care Facilities (LTCFs)

- Even with Part B of the pharmacy partnership starting, vaccination clinics are not being scheduled in Assisted Living Facilities until the end of February or even March. How can we speed this up and are there any alternatives?
 - CDPH: We understand the pharmacies will be trying to reach these facilities over the next 3-4 weeks. CDPH and the LHJs will watch this closely, and LHJs are looking at other options to bring vaccines sooner.
 - Dr. Sergienko: Tuolumne County decided to vaccinate the most at-risk clients and workers by county healthcare workers in SNFs. This impacts the numerical calculations and now CVS/Walgreens will have more doses than needed.
 - Kim Saruwatari: Riverside County is also tracking cases by facilities (both residents and staff), and is open to vaccinating in congregate settings themselves if the calendar looks too slow since these are the most vulnerable populations.
- On January 3 CDPH released a spreadsheet of SNFs and ALFs participating in the pharmacy partnership. Of 1,230 SNFs, 465 of those should have been vaccinated by today. How close to this number have we gotten?
 - CDPH: As of January 5, we think 200 facilities in the federal partnership program and another few hundred in Los Angeles have started vaccinations. It's below that one third mark but we don't know how current these numbers are. Information is being shared with local partners as soon as it's available.
- 2,200 long term care residents have died in the last month alone in California. There's a reason that these people and their families are scared.
- I am very concerned that lack of an effective vaccination effort in long term care facilities will lead to ignoring this vulnerable population as we "move on" to the next phases. How can we move on to other phases when we have not upheld our obligation to the most vulnerable who have been taking the brunt of this virus?
- I hope we can get greater transparency on the progress with SNFs. What about a statewide dashboard, hosted by CDPH, that shows when LTCF vaccination clinics are assigned and actually held? We need to see which nursing homes, assisted living facilities and group homes have had their first doses given and how many were given to staff and residents. It is important to see vaccine confidence data.

- We absolutely need to maintain focus on Tier 1 of Phase 1a as assisted living facilities are waiting to get clinics calendared and are hearing of clinics in late February and March. We can and must do better for our seniors and workers in this setting.
- Given the current and growing resistance of the general population to staying at home, I believe we need to focus on long-term care facilities because it is the death rate in these facilities that is most negatively impacting county risk rates and tiers.
- How can we realistically forecast future tiers and phases when we don't yet have data to confirm that LTCFs have been successfully vaccinated as projected?
- Consent and risk disclosures are required for all EUA products but are not called informed consent per se.
- Is there any tracking for vaccine refusals in LTCFs?
- If CVS/Walgreens are unable to do the job, are there any remedies or enforcement mechanisms within the provisions of the pharmacy program?
- How can we accept comments that "logistics and paperwork are quite a load" and that the process is "labor intensive." How can we be satisfied with the fact that there are so many doses of vaccine sitting in warehouses when LTCFs haven't been vaccinated?
- Can we get a regular update during CVAC meetings moving forward about the rollout of Phase 1a in LTCF, including the numbers of facilities actually reached, etc.?
 - CDPH: Yes.
- The existing network of independent pharmacies who traditionally vaccinate LTCFs for flu and pneumonia each year have not been included or authorized as the LTCFs were directed to work with CVS/Walgreens who do not have existing relationships. We can quickly increase the LTCF vaccination rates by authorizing and providing the vaccines to the independent pharmacies who have long standing contracts with LTCFs.
- I've been doing educational webinars for nursing home leadership and nursing home staff for a few weeks now. My first mantra is "Respect, Honor and Value." This must start with hearing people's concerns. We need to have some patience in this process. Our power points are at <https://www.caltcm.org/covid-19-vaccine>.

Community Engagement and Vaccine Acceptability: *Continuing Discussion*

Nadine Burke Harris, MD, MPH, California Surgeon General

Maricela Rodriguez, Office of Governor Gavin Newsom

Suanne Buggy, CDPH

Martha Dominguez, CDPH

The state shared information about its *Vaccinate ALL 58* campaign and plans to launch communications. Returning to the key foundational principles, Dr. Burke Harris suggested ways equity is operationalized. One part is tracking the data to track various metrics – thanks to Dr. Chapman and his teams – and then using that information in various ways. The Drafting

Guidelines Workgroup is using this data and concepts to incorporate equity into the framework. This has happened in part through your input going back to the Drafting Guidelines Workgroup.

The communications framework is another way to operationalize equity so that every Californian has access to evidence-based, culturally relevant information about how they can get the vaccine. As a reminder, this framework is:

- An **acknowledgement** of complex and nuanced personal and community experiences, and an understanding that lived experiences shape willingness to accept the vaccine
- A commitment to **engagement** by partnering with diverse communities across the state to share knowledge and information about the COVID vaccines; and
- **Action** by providing everyone living in California with culturally competent, fact-based messages so they can make an informed decision to vaccinate.
- This Communications Framework is informed by the principles of **safety, equity, and transparency**

Martha Dominguez presented the preliminary results from a comprehensive literature review that CDPH is conducting. Early findings resonate with CVAC feedback and show that communities want:

- access to detailed, credible information
- transparency on vaccine development
- to understand vaccine safety standards
- details on vaccine ingredients
- education on the types of vaccines so they can make informed decisions
- to know about the phased distribution including eligibility, safety, cost and logistics
- to understand risks and benefits of vaccines (i.e., side effects)
- whether cultural and social factors impact vaccine safety and efficacy, whether doctors like them approved the vaccine or had input

Martha also noted that perceptions are divided and changing, and CDPH continues to monitor community willingness to accept the vaccine.

Other groups have been conducting surveys in California and nationally which show that key motivators to accept the vaccine include a return to normalcy, family, the safety of the vaccine and immunity. Some messages that are testing well:

- At 95% efficacy, this vaccine is extraordinarily effective at protecting you from the virus
- Vaccines will help bring this pandemic to an end
- The vaccine will help keep you, **your family**, your community, and your country healthy and safe

Martha noted that family is an especially powerful motivator.

The Latino/Latinx community is more motivated by the statement that taking a vaccine is “the right thing to do” rather than keeping friends and family safe. This group is also more motivated than the general public by the potential to stop wearing a mask. (CDPH Note: People still need to wear masks after they are vaccinated.) Compared to some other groups, Latino/Latinx respondents expressed more concerns about keeping their friends and family safe than supporting an economic recovery.

Within the Black/African American community, there is a larger generational divide. For African Americans under 50, returning to normal is the highest priority, whereas saving lives is more important to those over 50. Protecting family and friends was also a very high priority.

CDPH is continuing to monitor research for key insights for other populations including indigenous, Asian, Pacific Islanders, Middle Eastern, North African, people with disabilities, LGBTQ+, people with pre-existing conditions, people experiencing homelessness, farmworkers, and various cultural and language groups.

Dr. Burke Harris asked members to comment on whether these insights resonated and what communication tools they felt would be beneficial.

Questions and Comments from Members

Do these messages resonate?

- These messages resonate, and we have to remember that the messenger also matters. The importance of having people of color who identify with the populations in dialogue should not be understated.
- Listening sessions with communities of color are a helpful way to help people feel heard.
- The mental health community has a long history of being mistreated by the medical community. People with serious mental illness trust their therapists and psychiatrists. If we listen to them it will help advance their ability to make decisions and get vaccinated.
- Healthcare providers in Tier 1 of Phase 1a who choose not to take the Pfizer vaccine could create a vaccine barrier. People know health care systems are not getting high rates of penetration and we need to find a message about this.
- We need a strategy and tools to combat misinformation such as the belief that the vaccine will sterilize people.
 - CDPH: The vaccine does not sterilize people.
- We need to emphasize this is a good choice to protect their family and friends and not that you’re a bad, irresponsible person if you don’t do it. That will work better for those who are mistrustful. We need to emphasize choice and empowerment.
- Although the message that "returning to normal" is vital, there must also be a balance with informing people that even if someone and their full immediate circle, gets vaccinated, they must still wear masks and practice social distancing until herd

immunity is reached, and that may take a while. People receiving personal care assistance in their homes will remain vulnerable until they get their own vaccination.

- I encourage continuing the level of disaggregation you did with Black/African Americans looking at what resonates with different age groups.
- Sharing this resource (a little dated) about how different racial and ethnic communities in Los Angeles prefer to get information:
<http://www.dualsdemoadvocacy.org/customers.tigertech.net/wp-content/uploads/2015/02/Metamorphosis-Communication-Maps-Multiethnic-City.pdf>
- The person's ability to relay messages is critical to how it is received. We need training!
- I would be interested to know if there are messages that are less effective, so we know if there are paths to avoid (especially those that might be counter-productive).
- In constructing messaging for American Indian/Alaska Native, please include trusted messengers in relaying information as well as acquiring input.
- As an internist, I am discovering there is no shortcut to convincing patients about vaccines. We have to take the time to listen to each patient for their individual reasons about vaccine hesitancy and spend the time necessary to talk them through.
- Vaccinating promotoras will help generate confidence and trust for others.
- I think that one (implicit) message that will not be very effective is the degree to which some employers make vaccination mandatory for employment, or higher ranks of employment, or better benefits, etc. I think this will be interpreted very negatively among those who are distrustful, and will impact employees of color negatively.
- Self-determination about vaccinations will add to trust and buy-in, especially as people decide what is best for themselves based on their medical history and complexities.
- People tend to consider their doctors (especially primary care providers) and nurses/medical assistants as trusted sources of information. Equipping health care providers with useful messaging will be helpful. There is also a growing social media presence of physicians promoting vaccination using #ThisIsOurShot; a like-named Facebook group was formed 2 weeks ago and already has over 1,000 active members. #ThisIsOurShot community is looking to expand its reach even further.
- There is also a (closed) Facebook group called Shots Heard Round the World that exists solely to counter vaccine misinformation in social and traditional media.
- I recommend we commission focus groups among Phase 1a vaccine refusers ASAP to see what is driving their refusal and what might work to convince them to vaccinate. This can inform our work in preparation for the next phases.
- We should examine what is happening at health facilities with high and low vaccine acceptance rates in order to duplicate or avoid those practices in the broader rollout.
- We must respect the issue, hear people's concerns and educate them.
- Some recent studies note that in health care settings, non-clinical staff represent a disproportionate share of refusers relative to care providers/professionals.

What communication tools would be beneficial?

- The lessons learned from the census outreach is that targeted messages directed to specific localities by trusted messengers resonate best. 15-30 second customized videos from trusted messengers to be used in the moment in various formats and settings can be very powerful. Public Service Announcements (PSAs) are also important in areas with limited internet and social media access.
- Communication modes for Native American communities matter since many rural communities do not have email or internet capabilities. Tribal and urban health care programs could really use some toolkits and flyers that they can customize.
- Brief messages from those with star power would be powerful in Latinx communities. Using a model of telenovelas will also resonate.
- Health literacy is a huge issue. Having tools with more infographics, less text and readability at 5th-6th grade reading level is very helpful.
- I appreciate the *Vaccinate ALL 58* toolkit. Indian Health Services has shared it with our Tribal and Urban health programs. However, it would be really appreciated if they were more customizable – e.g., if sites could take out and add their own pictures and logos.
- The California Immunization Coalition has resources about how to respond to misinformation on COVID-19 and other vaccines, how to communicate about vaccine hesitance, vaccine safety, how to managed and respond to social media attacks, etc.
- Our organization has used community resource guides which seem to work well. They are colorful, small (1/2 page size), easy to read and carry, and include all our health programs and community resources. We need to include key tailored messages for specific groups, not cookie cutter approaches. Toolkits sound great. Messaging has to be county-wide. Our community lacks banners, huge posters, awareness of COVID-19. We only see such a large, dedicated effort during campaign modes and need a sustained approach.

Community Outreach and Engagement

Maricela Rodriguez noted that Martha Dominguez was a lead on the census work and her involvement with this project will build on this experience and expertise. This is one way the state is leveraging its knowledge and infrastructure to help accelerate a strong campaign.

A few tools and graphics have been developed for social media and print. The state continues to translate them in multiple languages and add them to the toolkit. There is a special page for partners that includes logos and brand guidelines. Logos are included for each county to jump start their campaigns. In Phase 1b, there will be a multipronged communications approach. One is vaccine basics for all Californians to build confidence and combat misinformation. The other is tailored for Phase 1b populations. These two tracks will run in parallel.

For all audiences, CDPH is creating two assets:

- “Just the Facts” Public Service Announcement
- “Just the Facts” infographic
- Testimonials from healthcare workers (working with partners on this)

For Phase 1b populations, they are creating a nimble campaign that includes the following:

- Tailored social and digital content
- Ethnic and multicultural media (news articles, live reads for radio including DJs as trusted messengers, news articles, radio programs)
- Organic and paid tactics
- Testimonials from healthcare workers (working with partners on this)

CDPH has been working with CBOs along the way and is now working with the California Department of Social Services (CDSS) and the Labor & Workforce Development Agency (LWDA) to create a coordinated network of CBOs to emulate the coordinated “air game and ground game” that was successful with the census. The state is investing \$30 million to fund 150 CBOs and will work with philanthropy to leverage this investment with additional resources.

The timeline for this effort has begun. CDSS and LWDA are reaching out to known partners with a successful track record in reaching vulnerable populations and will onboard selected partners in February. CVAC input about tools and messages will help create toolkits for CBOs. CDPH is working with staff from its census campaign to identify what did and didn’t work. They will provide PPEs for all partners. Maricela asked members to flag any additional organizations.

Dr. Burke Harris thanked Maricela and added that the state is trying to move this process forward as quickly as possible. The Governor’s Office, in conjunction with CDPH, the Public Health Institute (PHI) and other funders, is working with philanthropic partners on a pooled fund to support COVID response, including funding CBOs to promote public awareness about vaccines, particularly in vulnerable communities. If members have recommendations about CBOs that are well positioned to educate communities, they are invited to share those ideas with CVAC leadership and they will be shared with PHI.

Questions and Comments from Members

- Those being treated in home health are equally vulnerable as those in long-term care facilities and SNFs. We have nurses so please get us the vaccines and we’ll get them done. We can also share the list of home health and hospice agencies with LHJs.
- Can you highlight lessons learned from the census campaign about how to reach hard-to-reach communities?
 - CDPH: Using a multi-layered approach is critical. This includes utilizing on the ground trusted credible individuals and organizations complemented by an “air game” using partners that included general market, ethnic media and trusted

messengers in the media (e.g., key hosts, TV personalities, social media influencers). CBOs are important because they are in contact with the communities we want to reach. With the census we created a hard-to-count index which allowed us to target efforts to specific communities. We want to leverage data like COVID positivity rates and the HPI, using data to ensure our outreach targets are informed and that we're intentional in working with CBOs.

- I'm glad we will build on the Complete Count infrastructure and lessons learned. Housing California works with affordable housing developers that have huge numbers of multi-family developments with many people affected by inequities. They are interested in helping with outreach, both for staff to get vaccinated and also communities.
- It's important to recognize the diversity of indigenous communities. A lot of agencies do messaging already and I hope they can be engaged.
 - CDPH: We want to reach all diverse communities and try to have relationships with ethnic and multicultural media and other partners.
- Who is creating the criteria for grant reviewers – PHI, DPSS, funders or someone else? Contract tracing requires a high school diploma which leaves out promotoras and others, and when asked why, no one claims responsibility for this decision.
 - CDPH: We will get back to you.
- Who are the partners for this philanthropic initiative?
 - CDPH: We can bring that information back. The Governor's Office of Social Innovation and The California Endowment are participating. Dr. Burke Harris will bring this information back, and Brian Mimura from The California Endowment can provide information about PHI's role.
- Are there written details on the public education campaign? Is there a proposed timeline for the funding allocation, eligibility guidelines, an application process, or scope of work? Will this go to the One California service providers?
- How can CBOs and smaller grassroots organizations apply for Phase1b community outreach? How can CBOs contact the Governor's Office to partner on outreach?
- Can you provide more information about who staffs the state COVID hotline and what guidance are they using? Do they speak the Medi-Cal threshold languages?
 - CDPH: There is a live person to answer many questions about COVID, including a number specific to vaccines. You can share what work you do, they tell you what phase you are in, what's coming next, and what groups are in those phases. They cannot handle challenges with a high degree of specificity and may have to get help with these. Because they won't be able to answer all questions we're exploring other resources and mechanisms with more details. There are many languages spoken, believed to be the Medi-Cal threshold languages, but not confirmed.
- How is the state hotline coordinating with local county public health departments? Will the state hotline be aware of where counties are in the tiers and phases? If so, can CDPH publicly post the status of each county?

- Are you also keeping a record of people who are refusing the vaccine? Are we using that information to improve communications and outreach efforts moving forward? Will this help us identify if those declining are disproportionately from a certain community?
- It is important for LHJs to resource CBOs for this work and not just assume they can take on additional efforts without resources. They bring invaluable relationships and assets and should be part of the formally supported infrastructure for optimal success.
- Is there specific outreach being planned for Deaf communities, including Deaf persons who are also part of immigrant communities?
- Faith based organizations know how to communicate with the people they serve. They are trusted messengers.
- For the immigrant community, please use the CBOs and service providers already utilized by CDSS's One California program. These are trusted partners who have long established relationships with immigrant groups and are trusted legal service providers that help families navigate safety net benefits.
- Schools are an established partner for educating communities. Can school districts' educational personnel be formally partnered with and trained in providing facts and information about the vaccines to communities they serve?
- The Disability Rights Education and Defense Fund and Center for REDF and California Foundation for Independent Living Centers were the statewide census leads on disability and older adults. We subcontracted with trusted disability messengers locally. It was a very positive experience.
- Could we have further information on the rollout plan for state prisons? Are prison staff Phase 1b, Tier 1 but incarcerated people Phase 1b, Tier 2? Are incarcerated people over age 75 in Phase 1b, Tier 1 or Tier 2 because they are incarcerated?

Closing Comments & Adjourn

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

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

Dr. Burke Harris shared some key themes from the day: the importance of trusted messengers; CDPH plans for engaging with CBOs and trusted messengers via the state and philanthropic partners; support for the Healthy Places Index and the notion of using a social vulnerability index; a request for further consideration of tools that reflect individuals with disabilities; and the balance between focusing on expediting vaccine distribution while ensuring that we adhere to the concepts of priority and equity. She thanked the committee for its time and excellent suggestions to make the CVAC a useful and productive process. Everyone in government is working tirelessly right now to fight the pandemic. Dr. Burke Harris invited members to continue sharing how things are working on the ground and how they can be better.

Next Meetings

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

Agenda for Next Meeting – January 20, 2021

The agenda will be sent out in advance of the next meeting.

How to Make Public Comment

Thank you for tuning in and sharing your comments; they are all reviewed and considered.

Please email COVID19VaccineOutreach@cdph.ca.gov.