

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

**COMMUNITY VACCINE ADVISORY COMMITTEE**

**MEETING #11 – March 5, 2021 – 12:00pm – 2:00pm**

**MEETING SUMMARY**

**Committee Members Attending:**

**Fred Buzo**, AARP; **Susan de Marois**, Alzheimer’s Association; **Vivian Reyes**, American College of Emergency Physicians; **Alia Griffing**, American Federation of State, County and Municipal Employees (AFSCME); **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); **Moises Barron**, California Alliance of Child and Family Services; **Lisa Mancini**, California Association of Area Agencies on Aging (C4A); **Carolyn Pumares**, California Area Indian Health Service; **Heather Harrison**, California Assisted Living Association (CALA); **Dean Chalios**, California Association for Health Services at Home (CAHSAH); **Joe Diaz**, California Association of Health Facilities (CAHF); **Michael Wasserman, MD**, California Association of Long-Term Care Medicine (CALTCM); **David Lown, MD**, California Association of Public Hospitals and Health Systems (CAPH); **Vicky Reilly**, California Association of Rural Health Clinics (CARHC); **Veronica Kelley**, California Behavioral Health Directors Association (CBHDA); **Rhonda M. Smith**, California Black Health Network; **Preston Young**, California Chamber of Commerce; **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); **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); **Andie Martinez Patterson**, California Primary Care Association (CPCA); **Michel Feyh**, California Professional Firefighters; **Thomas J. Kim, MD**, California Rural Indian Health Board; **Jose R. Padilla**, California Rural Legal Assistance, Inc. (CRLA); **Debra Schade**, California School Boards Association (CSBA); **Pamela Kahn**, California School Nurses Organization (CSNO); **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); **Silvia Yee**, Disability Rights Education and Defense Fund (DREDF); **Kristin Weivoda**, Emergency Medical Services Administrators of California (EMSAC); **Melissa Stafford-Jones**, First Five Association; **Anthony Wright**, Health Access; **Denny Chan**, Justice in Aging; **Jeffrey Reynoso**, Latino Coalition for a Healthy California; **Linnea Koopman**, Local Health Plans of California (LHPC); **Genevieve Flores-Haro**, Mixteco Indigena Community Organizing Project (MICOP); **Jodi Hicks**, Planned Parenthood Affiliates of California (PPAC); **Tia Orr**, Service Employees International Union (SEIU) California State Council; **G Perdigones**, Service Employees International Union Local 1000 (SEIU 1000) (Unit 17-Nurses); **Aaron Carruthers**, State Council on Developmental Disabilities; **Brian Mimura**, The California Endowment; **Gabriella Barbosa**, The Children's Partnership; **Diana Tellefson-Torres**, UFW Foundation; **Matthew Maldonado**, United Domestic Workers (UDW/AFSCME); **Maria Lemus**, Vision y Compromiso; **Crystal Crawford**, Western Center on Law and Poverty; **Amber Baur**, Western States Council: United Food and Commercial Workers (UFCW) California

#### **Committee Members Absent**

**Jacob Snow**, American Civil Liberties Union Northern California (ACLU); **Andrew Nguyen**, Asian Americans Advancing Justice – Los Angeles; **Michael Dark**, California Advocates for Nursing Home Reform (CANHR); **Charles Bacchi**, California Association of Health Plans (CAHP); **Chuck Helget**, California Association of Veteran Service Agencies; **Eric Sergienko, MD**, California Conference of Local Health Officers (CCLHO); **Jackie Garman**, California Hospital Association (CHA); **Orville Thomas**, California Immigrant Policy Center (CIPC); **Loriann DeMartini**, California Society of Health-System Pharmacists (CSHP); **Susan Bonilla**, California Pharmacists Association (CPHA); **Andy Imparato**, Disability Rights California; **Liugalua (Liu) Maffi**, Faith in the Valley; **Pastor J. Edgar Boyd**, First African Methodist Episcopal Church; **Lisa Hershey**, Housing California; **Naindeep Singh**, Jakara Movement

#### **California State Representatives Attending**

**Nadine Burke Harris, MD, MPH**, California Surgeon General; **Erica Pan, MD, MPH**, State Epidemiologist; **Marta Green**, California Government Operations Agency; **Dave Smith**, Office of the Governor, California Volunteers

#### **Public Attending**

There were 21 members of the public attending by phone, none on the Spanish line, and 297 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 and Meeting Logistics**

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

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

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

Dr. Burke Harris welcomed the committee and thanked them for accommodating a change to the meeting schedule. She expressed her gratitude for members' flexibility.

Bobbie Wunsch reviewed meeting processes and introduced two new ASL interpreters.

## **Review Public Comments since February 17, 2021 Meeting #10**

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

Bobbie Wunsch reviewed 216 thoughtful individual and organizational submissions of comment representing 59 pages of public comment with links to an additional 16 pages. A summary of those comments is below:

- 3 people asked that the state simplify the whole system, making public announcements and making it much easier to get appointments
- 12 individuals representing flight attendants requested that the flight attendant association be allowed to join CVAC to represent the transportation industry
- 6 organizations asked that existing local childcare collaboratives be used to reach and vaccinate childcare workers throughout the state with the 10% set aside for education and childcare sectors
- 1 person urged the state to use an age-based approach for all vaccinations
- 1 person requested not to use an age-based approach for vaccinations
- 1 organization suggested using zip codes with the highest COVID incidence as the only way to target vaccinations
- 6 people with high-risk conditions and disabilities and those on In-Home Support Services (IHSS) acknowledged that they cannot wait until March 15 to receive their vaccinations
- 1 person suggests that California use the same list of underlying medical conditions and disabilities as other states
- 1 individual asked the state to publicize what verification or documentation individuals with high-risk medical conditions and disabilities need to produce to get vaccinated

- Several people asked to include the following underlying medical conditions and disabilities on the list of those that can receive vaccines starting on March 15, 2021: cystic fibrosis (12); type 1 and type II diabetes (4); all types of cancer (2); serious mental illness including schizophrenia (2); people living with AIDS and HIV (2); rare lung disease (1); pneumonia (1); allergies to medications due to immune dysfunction (1); early onset of Alzheimer’s disease (1); B cell antibody deficiency (1);bone marrow transplant (1); breast cancer (1); Crohn’s disease (1); multiple sclerosis (1); cerebral palsy (1); leiomyosarcoma (1); chronic respiratory disease (1); and immunosuppressed due to disease modifying therapy (1)
- 1 person suggested prioritizing people having surgery with an inpatient hospital stay
- A plea to send more vaccines to Imperial County which has high infection rates and thousands of agricultural workers
- 78 organizations asked the state to give higher priority to people experiencing homelessness and the organizations serving them
- 64 organizations and individuals asked the state to prioritize people living in congregate settings, especially prisons, county jails and immigrant detention facilities
- 30 organizations and individuals asked the California Department of Corrections to reduce incarceration rates in state prisons to below 50% capacity and prioritize vaccinations for staff and inmates
- 2 individuals asked to clarify which teachers should get vaccinated (e.g., those going back to in person teaching or those who work only online)
- Several sectors and workers were asked to move higher on the prioritization list: Hardware store and home improvement store employees (15); airline flight attendants (7); nannies and family childcare providers (2); cosmetologists, hair stylists and personal services (2); public transit workers (2); all essential workers based on Governor Newsom’s list (1); Boys and Girls Clubs (1); foster parents (1); automotive retailers and their employees (1); letter carriers (1); workers in banks (1); critical manufacturing sector (1); construction (1); and veterinarians and their staff.

### **Opening Comments from Co-Chairs**

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

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

Dr. Burke Harris reflected on how far the state has come in this process. Last week the US surpassed 500,000 COVID deaths and California surpassed 50,000 deaths. Dr. Burke Harris acknowledged the exhaustion and sadness associated with these milestones and asked the committee to consider the following signs of progress: the Food & Drug Administration (FDA) emergency use authorization for the Johnson & Johnson one-shot vaccine; the announcement from President Biden supporting a partnership between Merck and Johnson & Johnson to

produce more vaccine; and anticipating enough supply for all adults in the US by the end of May.

Yesterday, Governor Newsom announced California's plan to address equity by allocating 40% of vaccine doses to the communities in the lowest Healthy Places Index (HPI) quartile, which are the communities that experience roughly 40% of morbidity and mortality from COVID-19. California reviewed the data on equity and made an intentional effort to address the impact that prioritizing healthcare workers had in skewing the data on populations vaccinated. In mid-March, a transition to the Third Party Administrator (TPA) will occur. Dr. Burke Harris shared that the meeting will include a deep dive into the TPA's work, including the vaccine distribution plan. Members are asked to share their thinking about how this implementation can go even more smoothly.

Dr. Pan welcomed the committee and thanked them for their partnership and flexibility. She shared updates, acknowledging the sobering anniversaries, such as the first stay-at-home order. Dr. Pan also shared the trend curve for the epidemic curve, showing steep decreases in cases, hospitalizations and deaths since late December and January. Test positivity is also declining. The state is watching for variants, improving its capacity for sequencing, and modeling them closely. So far, all trends look positive. Dr. Pan showed a graph illustrating the total vaccine doses administered by day and week. California has administered 10 million doses, with 3 million people now fully vaccinated. 23% of people over 65 are fully vaccinated, and the pace of vaccinations significantly increased to 200,000 doses per day or 1.6 million doses per week. Dr. Pan acknowledged the state has a long way to go to achieve equity.

The state continues to vaccinate those in Phase 1a – healthcare workers and long-term care residents. Tier 1, Phase 1b individuals are also being offered vaccinations as supplies allow, including 12 million people over 65 and working in the sectors of agriculture and food; education and childcare; or emergency services. Additional details and clarity, responding to many of the questions being raised, will be added to the guidelines on the CDPH website soon.

Beginning March 15, healthcare providers can use their clinical judgement to vaccinate individuals aged 16-64 who are deemed to be at the highest risk for serious illness from COVID-19 because they have the following severe health conditions:

- Cancer, current with weakened immune system
- Chronic kidney disease, stage 4 or above
- Chronic pulmonary disease, oxygen dependent
- Down syndrome
- Solid organ transplant, leading to a weakened immune system
- Pregnancy
- Sickle cell disease

- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies (but not hypertension)
- Severe obesity (Body Mass Index  $\geq 40$  kg/m<sup>2</sup>)
- Type 2 diabetes mellitus with hemoglobin A1c level greater than 7.5%

This list is based on the CDC list of conditions.

In addition, the following individuals become eligible March 15, 2021:

Individuals for whom, as a result of a developmental or other severe high-risk disability one or more of the following applies:

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

Dr. Pan praised CVAC members and the Drafting Guidelines Workgroup for these decisions. Other states are modeling their guidelines after California's and the Drafting Guidelines Workgroup continues to consider other medical conditions and further refine these criteria. One of the major challenges relates to implementation. The Vaccine Implementation Workgroup includes many people from CVAC and has been meeting to discuss issues such as how to balance the need to uphold priorities and verify eligibility criteria, while minimizing barriers to vaccination and operational complexity. Before March 15, 2021 there will be an update about these issues. Dr. Pan shared that after this round it is likely that California will move to an age-based framework but it's possible that things will shift again as ongoing data and science evolve.

Dr. Pan shared the announcement from March 4, 2021 that the state is going to demonstrate its commitment and accountability to equity through the concept of the Vaccine Equity Quartile as a critical indicator. The greatest disease burden – including 40% of COVID cases and death – is in the lowest quartile of the HPI, so the state will monitor how well it's vaccinating people in that quartile vs. others. This will be addressed through modifications to California's Blueprint for a Safer Economy by shifting tier thresholds to higher case rates per 100,000 per day once certain benchmarks within Vaccine Equity Quartile communities are achieved.

Currently there have been 1.75 million doses given in the Vaccine Equity Quartile statewide (compared to 3 million doses in the highest quartile). Once 2 million doses have been administered in that quartile, counties in the red tier will become more liberal in terms of what is allowable. Then when 4 million doses are administered in that quartile, criteria for the yellow and orange tiers will be adjusted. This approach aligns what is needed to end the pandemic

soonest. Another data point Dr. Pan shared is that 6% of people over 16 in the lowest HPI quartile have been fully vaccinated, and over 15% have received one dose; whereas 13.5% of those in the highest quartile have been fully vaccinated and 27% have received one dose.

Finally, Dr. Pan mentioned that the state has updated its masking guidance to include double masking indoors and allowing more outdoor activities. New mask guidance is here: [Get the Most out of Masking](#)

## **Update on Third Party Administrator/Blue Shield of California COVID-19 Vaccine Distribution Plan**

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*Marta Green, California Government Operations (Gov Ops) Agency*

*Kimberley Goode, Blue Shield of California*

*Andie Patterson, California Primary Care Association*

Dr. Burke Harris introduced Marta Green who talked about equitably accelerating vaccine distribution and administration. Ms. Green introduced the purpose of the agreement with Blue Shield of California. The goal is to deliver more options to vaccinate Californians faster through a large statewide network of providers that is geographically diverse, home visits for individuals that cannot leave their homes; mobile providers to reach hard-to-reach communities; and pharmacies to reach many different people. The state wants more resources in communities, with networks designed to reach the most vulnerable and those disproportionately affected by COVID-19. Providers and local health jurisdictions (LHJs) will continue to be supported for costs that are eligible for Federal Emergency Management Agency (FEMA) reimbursement, helping patient navigators direct hard-to-reach populations to vaccinations. California wants to support services that will make it easier to be vaccinated, including extended hours, language capabilities and physical accessibility.

Another goal is a more consistent experience given so many local health jurisdictions. The TPA will be one place for all Californians to go to sign up and know when it's their turn to get vaccinated. The state wants to know where the vaccine is at all times, with more transparency and daily updated data to adjust strategies. Finally, the state wants to continue the robust community and stakeholder engagement that has been built. Ms. Green shared there is a gap between the doses reported as delivered to California and the doses administered in California. Some doses are appropriately in freezers awaiting upcoming appointments; some have been administered and the data is not available, creating a data lag. First dose allocations to California are flat due to this and the state must demonstrate its capacity to hit speed and equity goals in order to see increased supply from the federal government.

To achieve these goals, Blue Shield of California as the TPA began managing the statewide vaccination network on March 1. All providers currently in the system as vaccinators remain in

the system. The new methodology, co-developed by CDPH and Blue Shield of California, will concentrate doses in the lowest quartile HPI. The state will be working with the existing provider network to get onto My Turn (<https://myturn.ca.gov/>) and the performance management system. Blue Shield of California is working with every local health jurisdiction to create an in-depth transition plan. Ms. Green shared that there are waves for onboarding with the TPA across the state. The approach to prioritize the counties is based on five factors: (1) percent of population living in lowest quartile HPI; (2) percent of population eligible to be vaccinated; (3) COVID cases as percent of population; (4) COVID deaths as percent of population; and (5) administered vaccine doses. This resulted in a composite ranking used to target counties to achieve the greatest impact on slowing COVID cases and deaths.

Wave 1 represents fewer counties with high case rates and low vaccination rates. Wave 1 counties are almost fully onboarded, and the TPA is working closely with LHJs in the second wave. Ms. Green shared an example from Fresno, a Wave 1 county. After identifying areas that did not have adequate access to the vaccine, they are now working with partners in the LHJ on innovative strategies to extend vaccinations in that region – e.g., pop-up and mobile clinics.

Starting this week, the new allocation formula will allocate second doses based on the following methodology:

- 1) Remove doses off the top for state hospitals, correctional facilities and other urgent unmet needs such as second dose shortages.
- 2) With the remaining pool of vaccine, apply 80% of these vaccines using geographical weighting as in the past. This is an “even layer” by zip code and includes estimates for age 65 and over (weighted at 70%) and the 3 essential sectors (weighted at 30%).
- 3) The remaining 20% is the equitable layer and is spread based on the lowest quartile HPI tracts which receive a double share (40%).
- 4) Then the vaccines allocated by geography are allocated to LHJs and other major providers who have direct contracts. Over time, more providers will have contracts and the state will be able to better target doses directly to zip codes.

\*Second doses automatically follow first doses and are sent out based on first dose data.

#### How the Third Party Administrator Supports Our Goals

Kimberly Goode introduced her role in the TPA process working on the Communication, Education and Equity workstreams of the project. Blue Shield of California works closely with state partners and local health jurisdictions to optimize the current network as they expand and accelerate vaccinations. Their goal is to ensure that they are building on what is working well and work together to enhance vaccine allocation and administration. The intent is to save more lives in an equitable way, using data and tapping into expertise on the ground, approaching it with many points of connection. They are meeting with every LHJ and many other stakeholder groups and she expressed appreciation for the open feedback and collaboration.



Ms. Goode shared a 5-point plan for vaccination equity. Blue Shield of California imbeds a Diversity, Equity and Inclusion focus in everything they do and will imbed this same focus in the TPA. Specifically:

1. Allocation: Blue Shield of California will use data to make recommendations to the state in order to achieve equity goals
2. Network: They are focused on enhancing this network to make it robust and to reach hard-to-reach populations
3. Community Partners: They are working with partners to ensure outreach and support for those disproportionately affected
4. Data Analytics: Blue Shield of California will play a big role with timely, transparent and accurate data and analytics, getting vaccine where it needs to be as fast as possible and adjusting as needed, which is where My Turn really helps
5. Public Education: They are also in a supportive role here

Blue Shield of California is well on its way with the Wave 1 network. More than 1,000 sites are secured in these counties including contracting with all but one multi-county entities. They are expanding Optum locations and Federally Qualified Health Centers (FQHCs) are all contracted. They are finalizing details for homebound and disabled Californians. They are also finalizing agreements with LHJs including equity plans that engage CBOs and providing additional supports as needed. Ms. Goode shared a map demonstrating the CBO partnerships across counties and regions, with a focus on those counties in the lowest quartile HPI. Blue Shield recognizes the iterative, well-coordinated and dynamic process needed to reach communities effectively. As data and circumstances evolve, the process will change based on feedback mechanisms in partnership with CDPH and many others. Blue Shield of California's commitment is to be a good partner in this process, to exhibit care and concern for the health and well-being of Californians and partner with CVAC and the state to restore the state and the economy.

#### Role of Community Health Centers in Vaccine Distribution

Andie Patterson shared that the California Primary Care Association (CPCA) is working closely with Blue Shield of California to ensure that all Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs) that want to vaccinate can do so. Blue Shield of California has been very responsive and collaborative in trying to make this happen. There are remaining implementation issues with My Turn given the many different Electronic Health Record (EHR) systems. CPCA's goal is to create as seamless a process as possible with My Turn. CPCA appreciates the state's goal for real-time data and daily feeds. Ms. Patterson expressed appreciation to Accenture and Blue Shield of California for trying to make this happen.

On the federal side, FQHCs are getting a direct allotment as the Biden-Harris administration leverages the strength of FQHCs and also the Indian Health Services system. FQHCs serve 30 million people in the US. Five of the first 25 FQHCs in this program are in California and were selected based on serving special populations, like agricultural workers and homeless. The

Wave 2 cohort has started to receive vaccines and Wave 3 has ordered vaccine. The state is integrating the federal shipments with state allocations in the hope that federal allocations to FQHCs are not deducted from state allocations since most health centers are located in medically underserved areas and serve medically underserved populations. Most are getting the Moderna vaccine and will also receive the Johnson & Johnson single dose vaccine.

### Comments and Questions from Members

#### **Equity and Pay-for-Performance**

- Does the equity plan with the TPA and vaccinators include pay-for-performance in serving individuals with disabilities and pre-existing conditions?
  - Gov Ops: We were originally planning incentive payments to achieve our equity goals. We have since realized that the real need is providing support to providers to reach those communities. Therefore, as part of the onboarding process, we are now asking providers what they need to reach vulnerable/ hard-to-reach communities. Then the state is planning to fund those costs up front to support these needs. This does include reaching people with disabilities and co-morbid medical conditions.
- Does this mean there will NOT be P4P incentives?
  - Gov Ops: There is still room in the contract to develop Pay-for-Performance (P4P) incentives but these are not FEMA reimbursable and also everyone wants the vaccine right now so our effort seems better spent on upfront costs to help administer more vaccine to the right people in the right places. Incentives no longer seem like the most effective approach to reach the target communities. There is still a possibility that P4P might be implemented.
- Thank you for the move toward equity. It is very appreciated so thank you to the whole team. (Many members echoed this compliment.)
- How are we ensuring that the 40% carveout will also include people with disabilities within those communities?
  - CDPH: The metric we are using is HPI. We examined how HPI overlays with populations of individuals with disabilities, and there is some good utility there. It's not perfect, but still very useful.
- Is the equity distribution targeting those in eligible sectors? Or are you targeting a larger population in these vulnerable communities?

Can you say more about what equity plans include that Blue Shield of California is partnering with local county departments to accomplish?

- I'm excited to hear about the provision of technical assistance (TA) and funds to vaccine providers in the lowest HPI quartiles to ensure accessibility and the removal of physical and programmatic barriers for people with disabilities, but these can also be highly technical

and detailed issues. Who will be providing universal design, barrier removal and communication outreach expertise?

- How are you engaging Community-Based Organizations (CBOs)? If a CBO in a low HPI county would like to support vaccine distribution efforts in priority populations, how would they go about getting connected?
  - CDPH: We have allocated \$57.3M to 337 CBOs across the state through partnerships between the state and the philanthropic communities. We can ask the Director of Social Innovation to give an update at a future meeting.

### **Vaccine Supply and Allocations**

- Some health centers are reporting a decrease in allocations; is this related to the TPA change? Or is it something with manufacturing? Different decisions at county level? We were told the Blue Shield of California transition wouldn't impact allocations.
  - Gov Ops: Vaccine allocations to LHJs have been flat or slightly up but the mix of vaccine changed with many LHJs getting less Moderna or Pfizer. If the mix changed and the FQHCs were receiving one of these, this might have impacted their specific sub-allocation.
- Soon there will be abundant vaccine. What are the projections about what's coming into the state so we can move away from the scarcity mindset? What's the plan to get everyone vaccinated by the end of May?
  - Gov Ops/CDPH: This is challenging because the only concrete information we have is the 3-week projection from the CDC, which is flat and will probably feel more constrained because of second doses. We hope that the delivery amounts will be higher than the projections and that the new partnership with Merck will increase volume but that is not on the immediate horizon.
- Are the peaks in vaccine distribution on the weekends?
- Does the process of spreading out the vaccines apply to all the different vaccine streams (e.g. FQHC, pharmacy partnership (non Long Term Care Facilities (LTCF), FEMA)?
  - CDPH: It includes FQHCs but not FEMA.
- What are the week-by-week projections for vaccine supply to California for each of the coming 3 weeks, for first and second doses?
- So even as we get folks registered there will be very little or no availability for an entire population that is becoming eligible?
- When will all of the long-term care pharmacies in the state be signed up and allocated vaccine? This is singularly the most effective way of assuring the nursing home residents and staff continue to increase their rate of vaccinations. It is also a start in terms of getting Residential Care Facilities for the Elderly fully vaccinated. This significantly impacts those with dementia and disabilities.

### **Community Health Centers**

- Are community health centers planned as part of Wave 1?
- We need to ensure the state is augmenting the federal allocation for FQHCs.
- How is the state supporting resource allocation to community health clinics to ensure that they have resources to scale and expand to reach the vulnerable?
- Additional resources are needed in rural areas so FQHCs can reach vulnerable folks.
- Is there a plan to more aggressively push out existing inventory while waiting for federal allocations to increase?

### **People with Disabilities and Co-Morbid Conditions**

- Primary care physicians are concerned with the prioritization of those 16-64 with co-morbid conditions. Many patients with asthma and obesity are requesting letters to verify their eligibility. The prospect for a deluge of patient communications is taking over patient care time and many physicians and clinics are worried about this. This needs to be standardized, clear and well-communicated with a plan that is not dependent on doctors and nurses rifling through patient charts or doing a lot of random letter writing.
  - CDPH: The Vaccine Implementation Workgroup is working on this issue. Templates have been shared and there will be more communication before March 15.
- Also, many people do not have primary care physicians, even when they are insured. This requirement could be a barrier.
- Are people with serious mental illness and substance use disorders, especially schizophrenia, going to be included in the list of people with disabilities and co-morbid conditions? What is the timeframe for deciding this?
  - CDPH: The Drafting Guidelines Workgroup is looking at the conditions advocates and others have been recommending.
- How many people are in the 16-64 with significant risk/underlying conditions group that will be eligible March 15? How large is this group?
  - CDPH: We estimate that 4.5 million people are eligible in this category.
- What is the process starting March 15? Will individuals that fit the criteria go to My Turn? Call or email their primary care physicians? Or, do they do both?
- What is the plan to vaccinate people who are homebound?
- What is the definition of "disabled community" that is being used?

## Data Clarifications and Requests

- Older adults of color are not monolithic. South Carolina and Washington are reporting vaccination rates by race and age combined. Does this data currently exist? In moving to the TPA, will we get this intersectional data faster? When can we expect to get this data?
  - Gov Ops: We are bringing all providers into My Turn to give us this real-time transparency. This is a transition process; we have 1,600 unique sites statewide in contract and we are onboarding them into My Turn. That system is integrated with other ordering, inventory and vaccine registry systems. This will allow us to know when the vaccine is in transit, onsite, and administered – and to whom. For network providers, we will be able to provide greater granularity of data.
  - CDPH: HPI data went up yesterday and this is one of the next goals to work through. Decentralized data systems have been challenging nationally with many behind-the-scenes issues about how data is transferred between EHRs. This includes not only race/ethnicity but sexual orientation and gender identity data. The key is balancing how clean and valid the data is with the desire for speed and further detail. We hope to have something soon.
- I'm excited about the TPA providing technical assistance and funding for accessibility, staffing and accommodations. Can some of this also go toward technical assistance for data collection? Data is vital and we can build on this for future emergencies. Can we include as part of technical assistance helping collect good intersectional data on sexual orientation, gender identity, functional disabilities and limitations, race, ethnicity and residence?
  - CDPH: We acknowledge that data issues are some of the most challenging. A lot of data is still being collected via pen and paper. Our state is so large and we have more work to do to build up our health and data infrastructures.
- In Phase 1b, Tier 1, we have been registering farmworkers through our call center but My Turn uses Food & Agriculture as an aggregate sector. Farmworkers should be a distinct category. They move from county to county and are often uninsured and undocumented. Can we separate out these categories ASAP? This would help track whether we're reaching the most vulnerable. Even separating out Agriculture from Food would be helpful.
  - CDPH/Gov Ops: With teachers, which may be an easier group to manage, the school districts know who is teaching remotely and who is teaching in-person. They're able to sort by occupational risk, quantify those with greater risks and share this information with the state so the state can give individualized codes to those school districts for distribution. This is being done with small chunks of vaccines at a time. It will be harder with the other sectors where the structure is not as defined but we envision a similar process of working with group leaders to identify target populations, release

individualized one-time use codes and distribute them to group leaders (e.g., CBOs, Regional Centers). Codes can then be used at closed clinics or get target populations to the front of the line at open clinics.

- The disability community is greatly in need of data! Even if it's optional.
- Can we also include sexual orientation/gender identity (SOGI) data?
- I like the idea of using this as an opportunity to collect data that will be helpful in the future, beyond pandemics.
- I agree with voluntary provision of data. The middle of a pandemic may seem like a weird time to try and build data collection, but it's also a time when we have an elevated public awareness of how much data relates to equity. It took me years to understand that "personal questions" about race/ethnicity had a much larger societal purpose, and that same level of awareness needs to be built for disability and SOGI data.
- Gathering American Indian/ Alaskan Native (AI/AN) data from AI/AN people accessing care outside of Tribal or Urban Health Programs is deficient.
- Is the 23% of 65+ year-olds vaccinated just those who have gotten two doses, or does it include older adults who have gotten just one dose?
  - CDPH: >3.5 million persons >65 have received at least one dose. We estimate that is 54% of the 65+ population.

### **Communication, Outreach and Messaging**

- We need something that explains clearly to the public how they can get the vaccine.
- Local health plans appreciate and applaud the new equity-based allocation methodology. Many individuals living in lower quartile zip codes and census tracts are Medi-Cal beneficiaries and most of those are local health plan enrollees. Already local plans are identifying beneficiaries who are eligible and sharing those lists with provider partners, calling to let them know they are eligible and connecting them to vaccine appointments. As the rollout continues with the TPA and the new methodology, we hope this partnership and work between plans, providers and counties will continue. Plans can be an additional resource especially as volume increases.
- Health plans are important for low-income older adults who are likely to be plan members.
- We should post details of the process of scheduling how to get vaccines on My Turn, CDPH and other relevant websites.
  - As CVAC members, what are the ways to communicate the approach to communities in an understandable way? Is there an easy-to-follow chart to explain the routes to get a vaccine?
    - CDPH: This is complex, but much of the complexity is "back office" - allocation, support, contractual agreements. For the public we want to focus on

simplicity in terms of signing up through My Turn and supporting folks with navigators, CBO partners and other resources.

- Especially given that My Turn is onboarding counties in waves (which isn't stated on the My Turn website), it's important for people to know how to schedule appointments.
- Will there be public facing communication tools we can use?
  - CDPH: Yes. More on public messaging materials at our next meeting.
- We'd love to have an opportunity to provide feedback on the materials.
- The Bishops of the Catholic Church in California fully supports all three vaccines and is urging everyone to get the shot available when it is their turn.
- Have you seen any statements from them or messaging in Spanish targeting Spanish-speaking communities?
- The California Catholic Conference of Bishops has issued statements in English and Spanish. Most of the work is being done at the Diocesan level.
- Link to article about the Pope's comments.  
[https://linkprotect.cudasvc.com/url?a=https%3a%2f%2fwww.ncronline.org%2fnews%2fcoronavirus%2fall-vaccines-are-morally-acceptable-says-member-pontifical-academy-life&c=E,1,KRU7Ij9UIoDQaM4fk38JsCNk6F94Lj-npFsLAWdWuOrn03-PVSQwudDywbDLFs2Gv6hQxXvayBQOOxU\\_WUfCkZdMXfs1L-Dq0VS4-68S7xyggBQJIXZjsMqSw,,&typo=1](https://linkprotect.cudasvc.com/url?a=https%3a%2f%2fwww.ncronline.org%2fnews%2fcoronavirus%2fall-vaccines-are-morally-acceptable-says-member-pontifical-academy-life&c=E,1,KRU7Ij9UIoDQaM4fk38JsCNk6F94Lj-npFsLAWdWuOrn03-PVSQwudDywbDLFs2Gv6hQxXvayBQOOxU_WUfCkZdMXfs1L-Dq0VS4-68S7xyggBQJIXZjsMqSw,,&typo=1)
- What are we doing to help those without internet or computer access or ability? I've seen local efforts but don't know about any statewide efforts.

### **Vaccination Sites**

- Thanks to the state for its commitment to equity and revolutionary leadership and approach. We're hearing comments from the community about long waits to get through My Turn on both the portal and phone. Please monitor and staff up if possible.
- Is it possible to reduce the military and police presence at some of the large vaccine sites? It can present a very intimidating appearance for undocumented people.
- I am curious to hear the state's guidance is on how providers confirm an individual meets the respective phases. I have heard that Sonoma and LA have self attestation, and San Diego does not require attestation. There are questions about how much documentation should be maintained and what if any audit risk exists?

### **Congregate Settings**

- Where are congregate care settings in the framework and prioritization? Where do incarcerated individuals fall in terms of vaccine priority?

- CDPH: This is an ongoing issue that we're very close to addressing. It's a priority because congregate settings are very high risk but it has been complex to resolve. We hope to have an update at the March 17 meeting.

### **My Turn**

- This week Sutter had to cancel appointments because of supply issues. Will the My Turn system help with this in the future?
  - Gov Ops: The problem was caused by a conflict between Sutter's actual vaccine inventory and what the system showed. My Turn will reschedule appointments and manage inventory to prevent problems in the future.
- I'm looking forward to the TPA improving physical and programmatic access through the updated streamlined system. Counties greatly need this support.
- I've been helping people sign up on My Turn. I agree that we don't want to make it more complex.
- Please continue updating and upgrading the My Turn process and vaccination scheduling because we want our communities to be confident to increase the uptake of vaccinations.

### **Farmworkers and Other Essential Workers**

- We had our first vaccine clinic for farmworkers in Imperial County. All employers and employees who wanted to register could. I saw people who could have waited, who work in the offices, whereas some farmworkers who came without letters and verification were turned away. We need clarity on which frontline workers in the sectors are prioritized.
- We need detailed clarification on who falls under "Agriculture."
- Will you be providing clarity re: promotoras as part of Phase 1a designation?
- Not all counties have triggered the agricultural worker prioritization. Is the expectation that all counties start vaccinating agricultural workers as of now?
  - CDPH: As of 3/1 all counties should have opened up access to all eligible Phase 1b sectors.
- Sacramento County and some other counties have still not opened to Food and Agriculture. Soon pre-existing condition folks will join the pool. Can you advise why some counties have not opened to Food and Agriculture?
- I am concerned that frontline social workers who provide public safety net services and community outreach have not been prioritized.
- When do we see the update/clarification on Agriculture Vaccinations?
- Will there be some discussion re: vaccine access for farm workers' families? Many do not have a healthcare provider to verify they have health conditions meeting vaccine eligibility.



### **Age-Based Framework**

- Is there a proposed date for moving to the age-based guidelines?
- How are we incorporating age into the planning? Over 65 is somewhat arbitrary, especially as one looks at the >50 data and people of color. It seems like there is an opportunity to combine the approaches – i.e., age is an important component of equity, especially including people 50-64 who are homeless.
  - CDPH: We are definitely looking at the intersection of age and equity.
- 50-64 year-olds with chronic conditions are also a higher risk population.

### **Process Comments and Requests**

- Please give CVAC members a heads up on policy changes if possible so we don't hear about them on the evening news.
- Because there is so much to discuss, I would favor going back to 3-hour meetings. This allows us to better leverage each other and give feedback.
  - CDPH: This is being discussed.
- We did not get an update on the pharmacy vaccination program in LTCFs. I hope we can get one at the next meeting.
  - CDPH: We can provide updates on pharmacy partnerships at the next meeting.
- Can we learn about non-tech outreach and registration in the next meeting?

### **Update on Johnson & Johnson Single Dose Vaccine EUA**

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

Dr. Pan shared that the Western States Scientific Safety Review Workgroup met Monday to review the Johnson & Johnson (J&J) vaccine safety and efficacy. They also reviewed unique aspects of the vaccine. Dr. Pan reiterated that California is very lucky to have a partnership that includes outstanding scientific experts that serve on the CDC or FDA committees.

The Johnson & Johnson vaccine is safe and highly effective against death, hospitalization and severe disease. There were no deaths in clinical trials of 40,000 individuals. The vaccine is over 90% effective against severe disease. The vaccine is only one dose, easier to transport and store at standard refrigerator temperatures, and has been demonstrated to reduce asymptomatic infections and transmissions. The vaccine also performed very well against variants and its side effects may be lower. It takes about 28 days after the vaccination is given to be fully protected. One allocation of 300,000 doses was ordered and the state hopes much more is pending. Dr. Pan reiterated that all three available vaccines are excellent and that the best vaccine is the one you can get when you are eligible. Pfizer also now has authorization from the FDA to be stored at normal freezer temperatures for up to two weeks, a very helpful tool for achieving equity

goals. There may be logistical issues in prioritizing this vaccine for certain populations. Dr. Pan asked the CVAC to spread the word that all three vaccines are excellent choices.

### Comments and Questions from Members

- There is a push among some Black doctors to push confidence in the J&J vaccine so it is not considered a “second class” vaccine.
  - CDPH: Thank you for lifting that up. We think this is really important. This vaccine is just as effective as Pfizer and Moderna in preventing severe infection, hospitalization and death.
- if you get J&J now, does that preclude getting an mRNA one later when there isn't scarcity (to deal with the concern about efficacy, however valid it is)?
  - CDPH: Yes, one dose is all you need to be fully vaccinated. And 300,000 doses of J&J is like 600,000 doses of Pfizer or Moderna. Any time you get one vaccine, it's best to follow that same manufacturer and series.
- One-time vaccines should be prioritized for remote, rural areas such as Imperial, eastern Riverside and Kern counties and mountain counties – and for homebound individuals.
- If there is concern about whether individuals who would be first in line for the J&J vaccine because of logistical ease, we should directly ask individuals in these affected groups (e.g., rural individuals, people with disabilities, people who cannot leave their homes).
- There is some research going on with J&J to look at the possibility of “booster” or second doses. There are currently studies to see whether a booster increases efficacy.
- What about the boosters that folks have been talking about because of the new variants?
  - As we watch for variants, manufacturers might develop booster doses to address those. We might be getting boosters every year as we do with the flu vaccine.
- Has the state developed any messaging regarding moral concerns coming from religious communities about the J&J shot?
  - CDPH: We've heard that North Dakota's statement is helpful and our communications team is looking at this:  
[https://www.health.nd.gov/sites/www/files/documents/COVID%20Vaccine%20Page/COVID-19 Vaccine Fetal Cell Handout.pdf](https://www.health.nd.gov/sites/www/files/documents/COVID%20Vaccine%20Page/COVID-19_Vaccine_Fetal_Cell_Handout.pdf)
- It would be helpful for messaging to provide reassurance about a possible J&J booster.
- Something interesting AARP CA has been hearing from older adults hesitant about getting the vaccine is that they are more comfortable with the J&J because it is only one dose.

### **California Volunteers and My Turn Volunteer**

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*Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair*  
*Dave Smith, Office of the Governor, California Volunteers*

Dave Smith introduced the newest part of the My Turn suite, My Turn Volunteer, which is now live at <https://myturnvolunteer.ca.gov>. He walked through My Turn from the perspective of both a clinic and a volunteer. The system is dependent on My Turn Clinic to post opportunities for people to volunteer. A clinic director helps establish a Volunteer Director on their staff or through a partner organization. This person logs in to My Turn Volunteer and creates shifts based on specific times and roles so they can recruit medical and general volunteers. On the medical side there are opportunities for vaccinators, vaccine prep and patient observers. On the general support side there are opportunities for greeters, volunteer support and registration support. The Volunteer Director can verify and confirm volunteers, and the system automatically messages the details. A dashboard for the Volunteer Director was shown with indicators and metrics. There are job aids for volunteer directors to help them set up opportunities and shifts can be easily cancelled from one place.

Mr. Smith demonstrated the system from the volunteer's perspective. Volunteers enter their zip code to see local opportunities. They can sign up for shifts, provide contact information, and have medical licenses confirmed. Online training is driven by CDC and CDPH. The process is similar for medical and non-medical volunteers. Right now, there are pilot clinics in the system. Members and the public can email [MyTurnVolunteer@californiavolunteers.ca.gov](mailto:MyTurnVolunteer@californiavolunteers.ca.gov) with questions or to bring a clinic on board. Organizations with access to volunteers can also coordinate with this office.

#### Comments and Questions from Members

- Can My Turn Volunteer work with private clinics or tribal clinics or urban sites? Can any clinic access My Turn Volunteer?
  - California Volunteers: Any clinic that's on My Turn Clinic can access My Turn Volunteer. If you're not on My Turn Clinic the system will not be interconnected on the back end but you can reach out to the office to coordinate.
- Do volunteers have to be vaccinated or have an opportunity to be vaccinated?
  - California Volunteers: Volunteers do not have to be vaccinated. The new policy is that volunteers who complete a shift of 4 hours or more are eligible to receive a vaccination if the clinic administrator approves it.
- Can you access My Turn Volunteer through the My Turn site?
- Are the 3 county waves for My Turn the same for My Turn Volunteer?
- Please send me information for volunteers— PTA has thousands of volunteers that would love to participate. [cgreen@capta.org](mailto:cgreen@capta.org)
- Is there any concern that the people who have the capacity to volunteer and then get vaccinated are not the priority populations we want to make sure get vaccinated?
- I volunteered at a vaccination site last weekend and saw improvement in equity first hand.
- Can we please ensure that the volunteer site has accessibility options?

## **Closing Comments and Adjourn**

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

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

Dr. Burke Harris thanked everyone for their time and for an excellent meeting. She shared a brief recap and acknowledged a number of questions asked in this and past meetings that the state is working to answer. She highlighted the fact that suggestions made in this meeting may seem simple but can become complex with multiple state agencies involved. For example, My Turn tracks the appointments scheduled but the California Immunization Registry (CAIR) tracks vaccines given. Different teams are required to work on different systems, so the question about tracking what vaccines have gone to farmworkers cannot be resolved in My Turn as suggested. Another example is questions about verification. It has been determined that childcare workers can have their eligibility verified with a simple letter from their employer, whereas verification for people with co-morbid conditions and disabilities requires conversations with multiple stakeholders. The points, questions and concerns this group raises are being addressed. Dr. Burke Harris concluded by sharing that CVAC voices have helped enrich California's vaccine allocation and implementation process. Drs. Burke Harris and Pan thanked the committee.

### Next Meetings

- ❖ March 17, 2021 from 3:00 – 5:00pm
- ❖ April 14, 2021 from 3:00 – 5:00/6:00pm TBD
- ❖ May 12, 2021 from 3:00 – 5:00/6:00pm TBD