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

COMMUNITY VACCINE ADVISORY COMMITTEE

MEETING #13 – April 14, 2021 – 3:00pm – 5:00pm
MEETING SUMMARY

Committee Members Attending

Rafi Nazarians, 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); **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); **Moises Barron**, California Alliance of Child and Family Services; **Lisa Mancini,** California Association of Area Agencies on Aging (C4A); **Joe Diaz,** California Association of Health Facilities (CAHF); **Carolyn Pumares,** California Area Indian Health Service; **Heather Harrison,** California Assisted Living Association (CALA); **Dean Chalios,** California Association for Health Services at Home (CAHSAH); **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); **Christina N. Mills,** California Foundation for Independent Living Centers (CFILC); **Jackie Garman,** California Hospital Association (CHA); **Orville Thomas,** California Immigrant Policy Center (CIPC);**Catherine Flores-Martin,** California Immunization Coalition; **Mitch Steiger,** California Labor Federation; **Amanda McAllister-Wallner,** California LGBTQ Health and Human Services Network; **Lance Hastings,** California Manufacturers & Technology Association (CMTA); **Hendry Ton,** California Medical Association (CMA); **Rocelyn de Leon-Minch**, California Nurses Association (CNA**); Kiran Savage-Sangwan,** California Pan-Ethnic Health Network (CPEHN); **Andie Martinez Patterson,** California Primary Care Association (CPCA); **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); **Loriann DeMartini,** California Society of Health-System Pharmacists (CSHP); **Carol Green,** California State Parent

Teachers Association (CAPTA); **Lisa Constancio,** California Superintendent of Public Instruction; **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); **Melissa Stafford-Jones,** First Five Association; **Anthony Wright,** Health Access; **Lisa Hershey,** Housing California; **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
Mary McCune, California Dental Association (CDA); **Ron Fong,** California Grocers Association; **Leza Coleman,** California Long-Term Care Ombudsman Association (CLTCOA); **Susan Bonilla,** California Pharmacists Association (CPHA); **Pamela Kahn,** California School Nurses Organization (CSNO); L**aura Kurre,** California Teachers Association (CTA); **Liugalua (Liu) Maffi,** Faith in the Valley; **Pastor J. Edgar Boyd,** First African Methodist Episcopal Church; **Naindeep Singh**, Jakara Movement

California State Representatives Attending
Nadine Burke Harris, MD, MPH, California Surgeon General**; Erica Pan, MD, MPH**, State Epidemiologist; **Marta Green,** Government Operations Agency

Public Attending
There were 13 members of the public attending by phone, none on the Spanish line, and 163 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

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 Bobbie Wunsch reminded the committee of meeting processes.

Review Public Comments since March 16, 2021 Meeting #12

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Bobbie shared a summary of the public comments submitted from March 16 through April 12. There were 112 individual and organizational submissions of public comment, totaling 21 pages, with links to additional pages of comment. The summary is:

- 69 people wrote to encourage the California Department of Corrections and Rehabilitation to reduce incarceration in state prisons to below 50% capacity and prioritize vaccinations for staff and inmates
- 1 person wrote that public messaging and communications across the state regarding where to get vaccines should be improved
- 27 people wrote about getting higher up on the prioritization list for their occupations or medical conditions. This included: utility workers (2), ordained clergy (1), mail carriers (1), parents/caregivers of children with California Children's Services (CCS) eligible children who are not connected to regional centers (1), single parents or solo caregivers of children (1), people with Type 1 diabetes (3), people with cystic fibrosis (1), people with sleep apnea (1), people with BMI under 40 (1), people with HIV/AIDS (1); people with lupus (1), people with schizophrenia (1), and people who travel internationally (1).
- 1 person asked that the state allow nuclear medicine technologists to vaccinate others
- 1 person highlighted the need for in-home vaccinations for the elderly
- Many young people getting vaccinated before those over 55 years
- 2 people asked the state to address equity more effectively
- 1 person suggested that masks should be optional

Opening Comments from Co-Chairs

Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Erica Pan, MD, MPH, State Epidemiologist, Co-Chair

Dr. Burke Harris reviewed the values that guide the process: safety, equity and transparency. This is especially important given the national pause on the Johnson & Johnson (J&J) vaccine to investigate safety concerns and a recognition that this pause demonstrates the state's vaccine surveillance system is working. Dr. Burke Harris reflected that a lot has happened related to equity since the last meeting that will be shared today, and she reviewed the agenda. Blue Shield of California has been working hard on equity and looks forward to CVAC input to inform future efforts. Dr. Grace Lee who is a member of the CDC's Advisory Committee on Immunization Practices (ACIP) will offer an update.

Dr. Pan thanked the committee and reflected that this was the first week that no counties stayed in the purple tier. By June 2021, California should be in a very different place if we use all the tools we have, such as masks and physical distancing, to get to immunity. Dr. Pan expressed her gratitude to this committee for its input, her state colleagues, and others.

Update on Vaccine Supply, Eligibility for Vaccines and Guidelines for Vaccine Verification

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

Dr. Pan reviewed the current epidemiology. There are 3.6 million cases in California to date, but the case rate is low at 4.7 new cases per 100,000 per day. Deaths continue to decrease. Testing has decreased; testing positivity has remained less than 2% for a few weeks. Over 23 million doses of vaccine have been administered. New cases have been declining since the end of February. Dr. Pan acknowledged slight increases in new cases and new hospital admissions. Dr. Pan shared the current vaccine dashboard. 23.7 million doses have been administered to date, with about 9 million individuals (27% of those eligible) fully vaccinated. Of those over 65, 57% are fully vaccinated, and about half of eligible people have had at least one dose. Some states are experiencing surges due to variants and the UK variant is increasing in California.

Dr. Pan shared a slide depicting the Vaccine Equity Metric. In Quartile 1, 17.6% of people 16 and older have been partially vaccinated and 22.2% fully vaccinated, in contrast to 23.1% and 35.8% in Quartile 4. This gap has been decreasing over time, approaching equality, but there is a long way to go before achieving equity, where more people are being vaccinated in Quartile 1.

The state is currently receiving about 2.1 million doses a week from various sources. This supply is relatively flat for the next 3 weeks due to J&J manufacturing delays and now the recommended pause in use of the J&J vaccine. Supply is projected to increase over time given greater production of Pfizer and Moderna vaccines. To date, J&J has represented less than 5% of doses given and 4-7% of California's overall allocation. Dr. Pan briefly reiterated the current eligible groups and the fact that every Californian 16 and older will be eligible starting April 15.

The topic of vaccine verification has been coming up in California and nationally. Questions include: how to make verification convenient, what standards will make the information accessible, and how it can be equitable and ethical, including the use of digital apps being piloted now. In the short term, proof of vaccination may include vaccination cards, photos of this card, photos from an electronic device, or other documentation from a health care provider. This information is included in an appendix to the Blueprint for a Safer Economy. The state also added an addendum to the Blueprint which includes "capacity bonuses" that allow more people to be in shared spaces safely. The CDC has posted guidance that fully vaccinated people can gather together inside without masking or physical distance and this can include unvaccinated low-risk individuals like young children. In the orange and yellow tiers, capacity can be increased by 50-75% if everyone shows proof of vaccination or negative test within 24 hours. Businesses can also consider sections or events for vaccinated persons only.

Dr. Pan also announced that Pfizer has applied to expand their use in adolescents 12-15 years old and is pending FDA approval, possibly in the next month. These requests are based on very encouraging data from their Phase 3 trials. This would cover about 2.6 million Californians. Finally, Dr. Pan shared that there are trials currently underway for 0-12 year-olds, and there are projections that they may become available at the end of 2021 or early in 2022.

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

- Are we tracking the real-world effectiveness of the vaccines – i.e., new cases and disease among those who have been vaccinated?
    - CDPH: The CDC reported very high levels of real-world effectiveness for Pfizer and Moderna vaccines. Even at 95% effectiveness, there will be people who get sick, but people who have been vaccinated either have no symptoms, very mild symptoms or very low levels of virus (suggesting they will not be infectious). Hospitalizations are closely monitored. Finally, we have increased the percent of specimens sequenced up to about 7% and have seen an increase in the UK variant (B.1.1.7) which now represents about 10% of cases. Sequencing hospitalization and especially ICU cases is becoming more systematic.
- Parents are worried about the long-term reproductive health of their daughters, especially with the J&J data coming out now. There is a lot of hesitancy among those with general immunization hesitancy that might become a barrier to school re-opening.
    - CDPH: Demand for the vaccine is lower than anticipated. Although we don't know the long-term impacts of the vaccines, COVID-19 itself can have long-term impacts, even in children, and these should be weighed and balanced. There have been 60,000 deaths from COVID out of 3.5 million cases, and for the J&J vaccine there have been almost 7 million doses given and only 6 serious side effects – very different benefits and risks. In schools we will focus on the other

tools for mitigation, including masks and testing. We need to allow people to ask questions and behave with safety, equity and transparency. The *Let's Get to ImmUNITY* campaign reflects this. We need to provide trusted, rigorous information that people can believe in. We want to demonstrate to the public that the government takes concerns about safety seriously. The fact that 6 cases were identified out of 6.8 million doses given, and the CDC/FDA and all states paused offers a model of reassurance that if there is a real concern about reproductive harm or safety, government will take it seriously.

- Thank you for highlighting the concerns of parents. If you think that having a Town Hall Q&A with healthcare experts would help, please reach out and please encourage them to talk to their own trusted physicians.
- I'd love to hear more about the proof of vaccination issue and also hope that we don't need to have proof as we get closer to herd immunity.
- Is there an effort to ensure information about vaccinations gets integrated into people's medical records and to track cases like the J&J incidents?
    - CDPH: There is a California Immunization Registry (CAIR) and a few smaller registries linked to it. These are most robust for children's vaccinations. Health care providers and vaccinators are not required to use them, although an increasing number do. All COVID-19 vaccines are being integrated with this state database. There has been work on bi-directional health information exchanges and interfaces but these issues are very complex, even for the largest health systems. People do not enter their primary care provider into My Turn so there is no way for information to flow automatically when they are vaccinated outside their health home.
    - Does the state have enough data to inform trends and concerns like the ones that caused the J&J pause?
        - CDPH: We have data about who has received which COVID vaccine. Right now we and the CDC are working on clinician alerts and messaging. These incidents were picked up through the Vaccine Adverse Event Reporting System (VAERS), and heightened awareness is helping ensure better use of this important tool.
- I agree that taking time to build trust and answer questions is critically important. While the J&J vaccine has been so helpful from a public health standpoint, the issues of informed consent and choice are paramount. Do those who have privilege have the choice to get any vaccine while others with less access will have fewer choices, and what are the implications of this long term, especially if there are differential outcomes associated with different vaccines? In times of scarcity we want to get whatever we can into communities, but we will have more plentiful vaccines soon. How will we ensure

that as people ask questions those questions translate into choice and how can we equitably distribute the ability to have choice?
    - CDPH: These are important points. We are fortunate in the US to have three vaccines and are confident every person who wants a vaccine will be able to get one. Other countries have fewer options and are seeing surges and mortality.
- Can we get more details on the 60,000 deaths? For example, there have been 9,000 recorded deaths in nursing homes, but this understates those that are transferred to the hospital before they pass away. This is true for other data points we don't collect, like who is low-income or lives in multigenerational housing. Data matters and nearly 70% of 60,000 deaths of those under 65 have been among Latinx persons. In other states like Michigan the virus is creeping back into these vulnerable populations and there is an uptick in nursing home cases. When case rates surge in the community, especially with variants, they ultimately will kill our most vulnerable. Can we see more specificity in the death data – e.g., those in memory care units, living in multigenerational households – to inform our efforts, push us to achieve equitable vaccination rates sooner, and hold ourselves accountable to vaccinating vulnerable populations? My op-ed: https://www.sandiegouniontribune.com/opinion/commentary/story/2021-04-08/opinion-vaccine-covid-19-safety
    - CDPH: There is a lot of work to validate the data – e.g., coding about multiracial people. There will be updates based on the Healthy Places Index (HPI) data in the next few days, but race/ethnicity data is taking longer. Ms. Goode from Blue Shield of California is looking at what steps will allow us to drive toward equity.
    - We have been assured that outreach to homeless populations is ongoing. Is there data to show how effective those efforts are at education and in vaccinating our homeless?
        - CDPH: We were hoping to have a presentation on reaching unhoused populations today but unfortunately with the breaking news on J&J, we revised the agenda and are hoping to have more on that at our next meeting.
- I would love to see available info on those who self-attested or otherwise indicated that they have high risk conditions or disabilities and *any* info on the disability status of anyone vaccinated. I think that data has not been robustly collected.
- Some of us with disabled kids are not comfortable sending them to campuses until they are vaccinated. I hope we prioritize those children as vaccine options become available.
- According to the CDC, orders for children's vaccines are down by more than 10 million doses. School-aged vaccination rates have dropped 5-21% during the pandemic. Catch-up vaccinations prior to the COVID vaccine being authorized for pediatrics are an essential component of preventive pediatric care and critical for a safe return to in-person schooling.
- Have we seen documented cases of COVID-19 triggering onset of Type 1 Diabetes?

Achieving and Monitoring Equity

Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Marta Green, Government Operations Agency
Peter Long, Blue Shield of California
Kimberley Goode, Blue Shield of California

Dr. Burke Harris reinforced the concept that equity is not a target but a system, and that hundreds of decisions are required every day to drive toward this North Star. She expressed her gratitude to Marta Green, Kimberley Goode and Peter Long for driving toward equity.

Marta Green refreshed the committee on California's 5-point plan for vaccination equity, including the allocation of 40% of vaccine to the lowest quartile; the network strategy, focusing on providers that reach those communities with disproportionate disease burden; transportation for those most in need of vaccinations; allocation adjustments based on need and performance; targeted support for community partners to do outreach and expanded hours; data analytics; and the state public education campaign.

Ms. Green showed a map of the current vaccination network, which could deliver 6 million vaccines to Californians on a weekly basis. This exceeds the goal of 4 million doses. There is 99% access overall, even in the first quartile, and the system continues to add more access points to ensure all Californians can access vaccine. She re-shared the formula approach of how first vaccine doses are allocated across counties. This approach includes a 20% concentration to zip codes in the lowest HPI quartiles with COVID disease burden, effectively doubling vaccine supply for those communities. Ms. Green and Ms. Goode shared the process for allocation of vaccine to specific providers in those zip codes. For example, in the lowest HPI quartiles, more vaccine is allocated to federally-qualified health centers (FQHCs) – directing doses to providers that serve Medi-Cal and low-income populations. As you go up the quartiles to more affluent zip codes, the distribution moves toward pharmacies and away from FQHCs. The diversity of the provider network is one key to a robust vaccination system.

Ms. Goode shared that FQHCs are critical to achieving equity goals. Blue Shield of California is pleased that 75% of FQHCs are engaged or contracted with the network. Others are not vaccinators or chose not to participate. Ms. Goode reinforced that all providers need to be equity providers to reach the most vulnerable. The network includes those that readily and regularly reach vulnerable populations, but everyone needs to be engaged in supporting equity goals. There are smaller providers that may be needed to get to the next phase.

Ms. Goode shared information about OptumServe, a 27-site organization with wide geographic distribution and highly concentrated in the lowest HPI quartile. This allows flexibility and functionality for throughput including in hard-to-reach areas through mobile, pop-up sites and

other strategies. Beyond allocation and network, the Third Party Administrator (TPA) is using data to address challenges. For example, where access challenges exist, data is used proactively to identify and augment mobile and pop-up solutions to support equity. If they hear from a Local Health Jurisdiction (LHJ) about special needs they can quickly mobilize and adjust. All LHJs have defined equity plans and they are being actively adapted as new information emerges.

Real time data also is used to see how the network is performing across the quartiles, age, county, provider, zip code and gender. (Race/ethnicity is still a work in progress.) This data is used to see where vaccine is being allocated and to whom it is administered. Data also helps illuminate possible needs to extend coverage. A chart demonstrated that things are moving in the right direction, with vaccinations in the 1st quartile increasing, and closing the gap, but a remaining gap and the goal to have *more* vaccines in Quartile 1 than 4. This data is being used by partners at the local level to achieve the equity goal. An important next step will be to pilot programs in LHJs with lower vaccination rates in the lowest quartile HPI and targeted efforts are planned to test different approaches. The TPA will capture these learnings and try to spread them to other counties and regions. Ms. Goode requested ideas and suggestions from the committee to extend vaccine coverage in Quartile 1, especially weekends.

Ms. Goode summarized that the partners are moving in the right direction together. The goal to have a robust network has been achieved, and California is doing well in saving lives and reducing case rates. The goal to deliver an improved and connected experience via My Turn is also being met. This central source of data has been critical in driving real time decisions and in helping ensure a quick pause on J&J vaccinations, as one example. More than 500,000 appointments were rescheduled or cancelled quickly and easily because of the success of this system, minimizing the impact and burden on individual providers. There has been great progress and there are great opportunities to learn and do more.

Dr. Burke Harris highlighted how important it is to have data, goals, targets and metrics at every step of the way. This highlight the role of structural factors such as extended hours. Even with disproportionate vaccines allocated to Quartile 1, if vaccines are not available during working hours, equity will not be achieved. Dr. Burke Harris posed the question of how we can incentivize vaccinators to bring the resources in line with the need.

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

- At the March meeting, we were told there would be a state dashboard by age and race/ethnicity combined and that is still not available. The information we have at the local level shows that, for example, in Orange County, Latino older adults are 10% behind White older adults in terms of vaccinations. I support the use of HPI but it is not by itself an adequate measure. If part of the problem holding us back is that the data is not perfect, I think we should still see it and I urge it to be released now. Isn't part of the

reason we moved to a TPA to get better and more timely data? Starting tomorrow everyone will be in the queue and we still don't know how we're doing with older adults of color, our most at-risk population.
    - CDPH: Normally we try to respond to CVAC questions before each meeting, but the news about the J&J vaccine pause by the CDC threw us off our plans. We did not follow up on that but you have my commitment you will have an answer before our next meeting.
- Using HPI made a lot of sense for re-opening and vaccine allocation, but as we evaluate our progress, it's important that we don't overly rely on HPI. As we look at statewide race data, it is not budging even as we see improvement on HPI. I understand there are a lot of data integrity issues, and I wonder why the data is not showing progress. I assume it's related to access barriers. We are also hearing a surprising amount of concern about costs, despite our clarity that the vaccine is free. Messaging needs to lift up this fact, especially for the uninsured and undocumented.
- How is vaccinating homebound Californians being addressed? There are at least 2 million homebound seniors, as well as homebound children, adults with developmental disabilities and temporarily homebound persons.
    - California Government Operations Agency (GovOps): We are working on a partnership with the Emergency Medical Services Authority to deploy EMT strike teams to vaccinate homebound individuals and their families. We will identify them through multiple sources such as health plans, existing providers and LHJs. This information will be given to each LHJ to coordinate with strike teams through the mutual aid system. There will also be a toggle on the My Turn website that allows individuals or caregivers to click to trigger a call center agent to reach out to the individual, figure out the barrier and arrange for transportation or other supports.
- Does the state disaggregate data within "Food and Ag" to see who in those employment categories are getting vaccinated? CVAC has given a lot of attention to farmworkers. Is it possible to see how successful those vaccination equity efforts have been if farmworkers are grouped in the very large "Food and Ag" umbrella? Or for other prioritized sub groups within tiers? We need to see data on progress by occupation.
- I know there are certain agricultural companies where the office staff (who do not go to the fields) were also eligible as they fall under Food and Ag (even though the intention was for farmworkers who have been out picking in the fields throughout the pandemic).
- In the last set of Q&A from this meeting, Question #18 was: "Can we separate out Food and Agriculture in My Turn, or otherwise differentiate farmworkers from other people working in this large sector?" The answer was: "Over 1 million people have already used My Turn. It is not possible to go back and differentiate who were farmworkers who

already signed up in My Turn." But that does not prevent the state from changing the Food/Ag category starting asap. Whatever the lack of specificity in the past, we can and should work to get better data. It won't be a complete data set but it will give a picture for a critical community that has been a focus of equity efforts.

- Is there another way to measure vaccine reach/saturation?
- How is vaccinating homebound Californians addressed in the allocation strategy?
- Concentrating doses is only the first step. The truly hard (and necessary) work is making sure that people in these settings actually get vaccinated.
    - CDPH: Allocation is only one part of our 5-point strategy. It must be overlaid with the hard work of outreach by trusted messengers, public education, developing an accessible network, etc.
- Does the 2 million doses/week being received by California mean 2 million first doses or total doses? Just a few weeks ago, the numbers on the dashboard appeared to show receipt of 3-4 million total doses/week
    - CDPH: For 3 weeks, when FEMA sites were still here, including federal allocations we had 3.3-3.8 million doses/week but after that it went down to 1.2 million total doses. We've definitely been hitting up to 3 million doses administered per week a few weeks but not consistently.
- I'm thrilled to see the FQHCs engaged. We need them fully engaged ASAP.
- We are prepared to share efforts to reach and serve people experiencing homelessness, living unhoused, in single room occupancy (SROs) and shelters. Based on conversation with Dr. Margot Kushel, director of the Benioff Homelessness Initiative at the University of California, San Francisco, efforts are rolling out and we are learning while doing.
- Other than vaccine confidence (trust vs mistrust) data, can we have data on vaccine complacency (waiting for the preferred vaccine rather than receiving the vaccines that are available now)? If we have this data across the state, can we correlate data on communities or population groups that have high incidence of vaccine hesitancy (complacency and confidence), then utilize the data to understand why the community or population group is hesitant and create a process to address messaging in communities where there are more cases of vaccine hesitancy?
    - CDPH: We were going to have another presentation on outreach and public education efforts to include data on how we are measuring hesitancy and other factors affecting vaccine confidence. For today's meeting, we had to prioritize the time to address the emerging J&J info and to make sure committee members understand our transition to open eligibility tomorrow. We can share information offline.
- I am worried that we are going to fall further behind once we open up vaccines to all. In Ventura County, our estimates are that 37% of farmworkers have been vaccinated and

we are worried that the unvaccinated farmworkers will get lost in the shuffle after April 15. We have the infrastructure in place to get shots in arms, but we have been repeatedly told that there is vaccine scarcity
    - CDPH: That's why we prioritized this conversation about equity today. We want your best suggestions to make sure that we do not lose ground.
- I continue to worry that the vulnerable will be left out when we open up more.
- Where can the TPA Network Equity dashboard shown here be viewed?
    - CDPH: We are aiming for the end of the week to have public equity dashboards.
- Where can the counties' vaccine equity plans be accessed by the public?
- We know folks are working around the clock on California's vaccination efforts and want to uplift that, on the ground, it seems our biggest barrier to equity is vaccine scarcity.
- Weekend hours are certainly needed to ensure we are reaching vulnerable workers who cannot attend during weekdays. Can additional funding be provided for weekend (particularly Sunday) mobile vaccination? Farm workers often work 6 days a week, especially during peak.
- It's great to see a closing of the gap across the HPI quartiles. But when we look at the race/ethnicity data, we are not seeing huge improvements. For example, Latinx are at 22% of those vaccinated so far (lower than their 40% of the overall population). How are these indicators connected (if at all)?
- Accessibility in rural areas in all parts of the state remains problematic. In our experience supporting outreach asking hard working people to lose a day's pay to wait in long lines adds to their stress.
- I much appreciate the focus on the structural/practical issues of access: after-hours availability, time, technological barriers, transportation options, etc.
- Given the opening up of vaccination tomorrow and the growing contractual network of the TPA, are specific vaccine providers still able to prioritize vaccine supplies for prior groups, such as those with high risk conditions? I cannot figure out how #11 and #12 in the Q&A fit together. One states self-attestation is fine, while #12 says "According to the letter issued by the California Department of Health Care Services (DHCS) on March 8, 2021 people with serious mental illness and substance use disorders are eligible if they provide documentation from a licensed behavioral health clinician indicating the high risk status if the client with one or more of the following applied:
    - 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 because of the individual's disability.

- I still think a technology barrier exists in navigating these systems. I realize local counties are making some progress in this area but I do think it's an equity barrier.

Update on Johnson & Johnson COVID-19 Vaccine Pause and CDC Advisory Committee on Immunization Practices (ACIP) Recommendations

Erica Pan, MD, MPH, State Epidemiologist and Co-Chair
Grace Lee, MD, Stanford University School of Medicine, Member, Western States Scientific Safety Review Workgroup and ACIP

Dr. Pan introduced Dr. Lee and thanked her for her service to the state and nation. Dr. Lee is an expert on vaccine safety. She co-chairs the ACIP Vaccine Safety Technical Subgroup (VaST) and is a member of the Western States Scientific Safety Review Workgroup.

Dr. Lee shared a high-level summary and key points of the latest information as presented at an ACIP meeting earlier in the day. First, some context: The J&J vaccine is a single-dose vaccine recommended for use in the US on February 28 and distributed on March 2, 2021.

Starting April 7, the European Medicines Agency (EMA) and the Medicines and Healthcare products Regulatory Agency (MHRA) announced their concerns for rare clotting events seen after AstraZeneca vaccinations in the UK and Europe. At the same time, the US was starting to query data across vaccine surveillance safety systems and found some similar clinical syndromes and presentations for J&J vaccine.

The adverse conditions that have been most notable have been Cerebral Venous Sinus Thrombosis (CVST) – clotting of the large vessels draining blood from the brain. This tends to occur more frequently among younger women 20-50 years old who are pregnant, using oral contraceptives, or have other coagulation risks whether genetic or acquired. Symptoms typically include headache, nausea, vomiting and other neurologic symptoms that are persistent and worsening over time.

VaST reviewed data on April 12 that there were three cases of CVST following Moderna vaccine, 0 cases following Pfizer, and 6 cases following J&J vaccine administration. The 6 cases following J&J were associated with thrombocytopenia (low level of platelets), which is atypical. The three cases seen following Moderna vaccines are believed to be associated with background risk.

These are rare but serious adverse events. The risk factors are not yet well understood, and there is not yet a clear pattern among the six cases. The main concern and reason for the pause is the unusual presentation, which could result in delayed recognition and timely management by healthcare providers. In addition, providers should not use heparin, the typical treatment for CVST, in these cases. Given these events, there was a strong feeling at VaST that information

about this potentially life-threatening adverse event, although rare, should be provided to clinicians to enhance early recognition and ensure appropriate treatment. The group also wants to further evaluate the specific risk-balance of using the J&J vaccine in specific sub-groups. And it was felt that timely and transparent communication with providers and the public would be crucial to maintain confidence in the vaccine program.

The next steps are to ensure that case identification is enhanced in the coming weeks through notifications and increased awareness. All patients are strongly encouraged to report any adverse events into v-safe, the CDC's after vaccination health checker application, and VAERS.

Dr. Lee explained that after a safety signal like this is identified, the system generally moves into stages called signal refinement and evaluation to better estimate the risks and assess causality. For the short term, the groups are reviewing findings to determine the risk of developing these conditions and inform risk mitigation strategies.

Prior to March 30, there were about 3.5 million J&J doses administered and between March 30-April 13 another 3.8 million doses were administered. The goal for now is to enhance awareness and surveillance for any pending cases 6-13 days after vaccine receipt.

On February 28, the ACIP voted to approve the J&J vaccine for people 18 and older in the US under Emergency Use Authorization (EUA). Dr. Lee shared that on April 14 the ACIP deliberated on whether it has enough information to make interim age or risk factor based recommendations for use of the vaccine. The ACIP concluded that additional information is needed. The information continues to evolve because now vaccine safety colleagues are intensely evaluating data, and Dr. Lee anticipates a re-convening in 7-10 days. They will then make an informed decision about recommendations for use of the vaccine.

Dr. Pan recapped the related vaccine supply issues: A reduction in J&J vaccine was already predicted due to manufacturing delays, and J&J represents a small proportion of the total supply, so this pause is disappointing but does set California back significantly. Dr. Pan expressed her gratitude and appreciation for Dr. Lee.

Dr. Burke Harris summarized the demographics of the people who had this rare but serious event. Out of the 6.8 million diverse people who received the J&J vaccine, the 6 cases were all among women between 20-50 years old, and 5 of 6 were White. One was using oral contraceptives. This information is being compared to the AstraZeneca events in Europe since the vaccines use a similar vector and the clotting events appear to be similar.

Questions and Comments from Members

- The J&J vaccine seemed to offer a good solution for certain populations – e.g., those in nursing homes who did not have informed choice for one year about their isolation and quality of life. Now we may find ourselves in this same situation where someone else is prioritizing safety and risk to life over quality of life. Is there a way to think about this differently for those populations (disabled, older, homebound)? I appreciate that there are additional questions of perception, equity, etc. but I still think that the safety for this group may not be the only or overriding concern.
    - Dr. Lee: It's helpful to hear your comments. This vaccine offers many unique advantages. ACIP is evaluating a combination of population risk/balance and individual risk/ benefit balance. Whenever possible we want to mitigate the risks. For example, anaphylaxis is a known risk associated with vaccination so we spent a lot of time trying to recognize mitigate these risks. We always need to balance risks holistically. It's important to make recommendations that support population-level risk mitigation wherever we can, and also support individual level risk assessment by educating providers and the public. I don't know what the decision will be but those are the strategies we can put together in this case. This vaccine has been found to be efficacious and important to global equity. We're trying to decrease uncertainty around risk estimates since we were only looking at 6 cases and we need a more quantitative understanding of the risks and benefits in context before we can make an informed decision. I hope we will have more robust information soon.
- How might trans folks be affected by these risks? Trans women taking estrogen or other hormones and trans men taking testosterone and other hormones are at increased risk of blood clotting, blood thickening, and stroke/heart disease risks. Is there education or safety guidance you can offer as we promote vaccinations and vaccine confidence?
    - Dr. Lee: We will be exploring this as we want to understand other risk factors since they could help advise individual benefit/risk balance.
- What outcome do you envision in terms of the specificity of the recommendation?
    - Dr. Lee: I can't really predict. There will be another ACIP meeting soon. It's hard to make an informed, evidence-based decision based on 6 cases alone and we haven't yet seen the detailed data from the European cases. As information evolves, it may be imperfect information but we need more clarity around risks and risk factors to safeguard the public health and risk-benefit balance.
- The United States has a very robust system for monitoring vaccine safety. This is not a new system and the recent events illustrate how well the system works. Vaccine Safety Data Link: https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/index.html

    - CDPH links provided: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html and https://vaers.hhs.gov/
- Do we know the proportion of J&J vaccines going to HPI Quartile 1 communities?
    - CDPH: We don't have that data at our fingertips but can get back to you.
- Has the state planned to use J&J vaccines for 'house call" vaccines or populations with particular needs such as migrant workers who may move before their second doses?
    - CDPH: We have anticipated using J&J for any populations that would benefit from a one-dose vaccine such as those who are homebound; however, in light of the pause, we will use other options for now.
- The news about J&J is creating concern especially in populations that were wary to begin with. What do you think would be helpful to combat these concerns? In Europe, the rate of no-shows increased in some countries using AstraZeneca.
- As Mixteco Indigena Community Organizing Project (MICOP) has been supporting vaccine registration, we have noticed a lack of choice because of vaccine scarcity. Our people want to know what they are getting before they register and some have cancelled their appointment when they learn it is J&J.
- Regarding the cost/benefit analysis of reaching vulnerable populations with the J&J vaccine: Many farm workers were specifically asking for the J&J vaccine due to the ease of one dose. Many of our mobile vaccination events were utilizing J&J.
- This event highlights how very important it is for clinics and providers to encourage their patients to read through the immunization fact sheets which have information about how to report an adverse event.
- Having more vaccination opportunities that do not require registration would help increase the number of vulnerable people who access the vaccine. It's been challenging to help individuals register for vaccine appointments outside of events that we are coordinating. This should be encouraged as much as possible to support equity.
- The pandemic has highlighted how we've underfunded and under-valued investment in public health and infrastructure. Thank you for highlighting this.
- We are together because of this emergency but after it is over, we cannot just return to the prior status quo when it comes to public health and data.

Closing Comments and Adjourn

Nadine Burke Harris, MD, MPH, California Surgeon General, Co-Chair
Erica Pan, MD, MPH, State Epidemiologist, Co-Chair

Dr. Burke Harris thanked the presenters and members for a wonderful and robust discussion. She noted that because of the emergent J&J issue, there were items on the original agenda that were not discussed. There will be more information at future meetings regarding outreach and communications, particularly on supporting vaccinations for unhoused populations. She

reminded the group to send suggestions to improve and operationalize equity to Bobbie Wunsch. Dr. Burke Harris acknowledged the importance of data by age and race. The state will share information it had prepared regarding outreach and community engagement given that equity is a multi-pronged strategy that needs to be deployed thoughtfully and continually.

Dr. Pan thanked Dr. Lee and CVAC members for the ongoing constructive dialogue. She noted that data has been one of the biggest challenges and that it can and will continue to improve. The pandemic has magnified racial disparities and also highlights the lack of investment in public health infrastructure. It is helping push for resources needed to serve the entire population and uplift equity. Today also highlights the importance of transparency and safety and the difficulty of weighing benefits and risks with limited information.

Finally, Dr. Burke Harris highlighted the bi-directional nature of information sharing at CVAC. She asked members to act as trusted messengers in their communities to share this information about J&J and the state's equity strategies, then to bring those voices back to the state so the work can continue on behalf of Californians. She encouraged the public to make comments at COVID19VaccineOutreach@cdph.ca.gov and closed with thanks to all.

Next Meeting

- Wednesday, May 12, 2021 from 3:00 – 5:00pm