**WRITTEN PUBLIC COMMENT TO COMMUNITY VACCINE ADVISORY COMMITTEE (CVAC) Submitted Between Meeting #2 November 30, 2020 Through December 7, 2020**

**Andrew Diamond, MD, PhD**, Chief Medical Officer, One Medical

I'm the Chief Medical Officer at [One Medical](https://urldefense.proofpoint.com/v2/url?u=https-3A__onemedical.com_&d=DwMFaQ&c=Lr0a7ed3egkbwePCNW4ROg&r=75RymzhAnHtMQeEyqXXnEQodyKHpBtIEHJEcNJhCwU0&m=Zl245nPNcBCnIAhxTlhtlqfKOQ5lIkw6icfkmopcJdM&s=elOVFKWfbYeyZb05zayZNw5fbcOenMPOfn-Dw48LDHo&e=), where our well-resourced team is eager to help CDPH and serve Californians at all stages of the process. We intend to make our services accessible to anyone and everyone, free of charge, in all the cities where we operate (see below).

We're already working with local Departments of Health, as well as our partners at UCSF, UCSD and Providence Health System in LA and Orange County, but we would love to collaborate with you or one of your colleagues at CDPH to help at the State level.

Thanks so much for your lifesaving work as California prepares to emerge from this pandemic.

**Christina Hildebrand, President, A Voice for Choice Advocacy, Inc.**

I am writing to you on behalf of A Voice for Choice Advocacy (AVFCA).  AVFCA advocates for people’s rights to be fully informed about the composition, quality, and short- and long-term health effects of all products that go into people’s bodies, such as food, water, air, pharmaceuticals, and cosmetics.

We understand the mission of the Scientific Safety Review Workgroup is to independently review the safety and efficacy of any COVID-19 vaccine before it is distributed in California and the mission of the Community Vaccine Advisory Committee is to prioritize who receives COVID-19 vaccines in California and to do this equitably.  In the coming weeks, the FDA will likely grant at least one vaccine Emergency Use Authorization (EUA).

A Voice for Choice Advocacy asks in all your deliberations and recommendations, you use extreme caution, first and foremost remembering that, at this stage, all COVID EUA vaccines are live human experiments, with the very real possibility of severe, unknown side effects that may be worse than the COVID-19 itself.  When considering the safety and prioritization of a COVID-19 vaccine, AVFCA has significant concerns regarding vaccine safety, due to the lack of full clinical trials, the lack of manufacturer liability and that the vaccines use novel technology.  AVFCA also has concerns that Californians will not be given full informed consent and may be coerced into taking the vaccine fearing discrimination or retribution.  We ask both Committees, the Governor and the California Department of Public Health, doctors and pharmacists ensure:

* All those offered the vaccine are given full informed consent, explaining the possible benefits, risks, and unknown factors, including information explaining their taking a COVID-19 vaccine under Emergency Use Authorization is experimental, the lack of full clinical trials for safety or efficacy, the lack of manufacturer liability and that the vaccines use novel technology.
* All recommendations, marketing and communication with respect to the COVID-19 vaccine are transparent with respect to the lack of completion of clinical trials and therefore lack of long-term safety and efficacy data, the lack of manufacturer liability and transparent about the possible known and unknown side effects.
* The vaccine is only offered to those Californians for whom the serious risk of COVID-19 outweighs the potential risk of the novel vaccine, even if this means limiting vaccination to a small subgroup of Californians.
* Californians are made aware that they have a right to decline the vaccine and will not be discriminated against or suffer retribution for doing so, and that vaccines cannot be required without medical, religious and disability accommodations.
* Disabled and people of color, who have been experimented on throughout US history, are not targeted by giving them vaccines that have not been fully researched.

**A Voice for Choice Advocacy also asks:**

* COVID-19 vaccines be researched among those who are sick, pregnant or lactating, or have had COVID-19, before recommending them to these groups.
* Antibodies and T-Cell immunity be researched to determine how long vaccine and natural immunity lasts and if immunity will be conferred if the virus mutates.
* The vaccines be researched to understand if they prevent COVID-19 transmission or just reduce the rate of severe symptoms.

These points are further detailed and documented below.  Thank you for your time and consideration.  Please feel free to contact me if you have any questions.

**Tina Werblin**

Thank you for the meeting transparencies and the great work California is embarking on.

(1) Comment regarding "no vaccine differences between races" -

I believe there have been documented issues with medical treatments, vaccines and trials and the African American population and there can be significant differences in outcomes.  Is this correct that the COVID-19 vaccine has no clinical differences?  How many African American or people from the Africa Diaspora have been included in the vaccine trials?

(2) Please post all the meeting dates and times instead of one at a time, so the community can hold the dates on their calendar.

(3) Please add the email address for community feedback on the CDPH's website please.

Thank you.

**Daniel Savino, Government Affairs Director, Association of Regional Center Agencies**

The Association of Regional Center Agencies (ARCA) represents the network of 21 community-based non-profit regional centers that coordinate services for, and advocate on behalf of, well over 350,000 Californians with developmental disabilities.

We urge the inclusion of people with developmental disabilities, as well as direct support professionals (DSPs) and families in the priority list of those who will first access a COVID-19 vaccine.

COVID-19 has profoundly impacted life for Californians. People with developmental disabilities are particularly vulnerable to its impacts. Additionally, the DSPs who make integrated community life possible are one of the most importantelements of ensuring daily life can continue. Similarly, for the many people with developmental disabilities who live at home, particularly those with aging caregivers, their parents are often in high-risk groups.

ARCA urges the Department of Public Health to prioritize people with developmental disabilities in accessing COVID-19 vaccines. We are fortunate to have had a robust, collaborative response by regional centers, service providers, and families in adapting to this temporary “new normal.” Because of this diligence, those served by regional centers are reporting lower morbidity and mortality rates than congregate settings that support many other vulnerable populations.

As of November 13, 2020, the California Department of Developmental Disabilities (DDS) reported1 179 deaths of the 3,600 COVID-19 confirmed positive cases, which compares favorably to the statistics from Skilled Nursing Facilities (SNFs) and assisted living facilities. Those facilities have recently reported 6,364 deaths amongst the 67,551 confirmed positive COVID-19 cases,2 which makes up 34% of the state total. In short, California’s system of services and supports for people with developmental disabilities that keeps them out of institutional settings keeps them safer and healthier.

However, this success is not a reason to overlook our community. The following findings highlight that COVID-19 patients with developmental disabilities are far more likely than developmentally typical individuals to die from it:

* A recent journal article noted that “people with IDD had higher prevalence of specific

comorbidities associated with poorer COVID-19 outcomes.”3

* The death rate among all patients with COVID-19 is 0.6%, but for people with developmental disorders the percentage is 1.22%, and for those with intellectual disabilities the reported percentage is 3.37%.4
* Researchers concluded that for every 100,000 confirmed COVID-19 cases in people with developmental disabilities there would be in estimated 4,500 deaths.5 Comparatively, the findings suggest approximately 2,700 out of 100,000 people without developmental disabilities within the same age range would expire from complications associated with COVID-19.

Because of this, those with developmental disabilities and those who support them should be among those prioritized for vaccination. This priority should also be extended to two other groups, DSPs and family members who live with and support people with developmental disabilities. First, DSPs provide constant support, including communication, mobility, personal hygiene, and other elements of self-care. Their close and extended proximity to those they serve means they are at exceptional risk of being infected by, or transmitting, COVID-19. We cannot overstate the need to ensure DSPs can be an ongoing part of the lives of those they support.

Second are the family members people with developmental disabilities live with. Like DSPs, families provide critical daily support to people served by the regional centers. As of September 2020, nearly 80% of people with developmental disabilities lived in the home of a parent/guardian6. For these individuals, family members are critical support workers. Their health and safety must also be prioritized. Additionally, by virtue of age, many parents of adults with developmental disabilities are often in one or more high-risk groups. Any illness – let alone mortality – would be both tragic and unspeakably disruptive. They, too, must be early candidates for any vaccine.

We thank you for considering the health and safety of people with developmental disabilities, the committed professionals who serve them, and the families that are integral parts of their lives.

1 [https://www.dds.ca.gov/wp-content/uploads/2020/11/DDS\_COVID-19\_demographics-and-](https://www.dds.ca.gov/wp-content/uploads/2020/11/DDS_COVID-19_demographics-and-residence_10302020.pdf) [residence\_10302020.pdf](https://www.dds.ca.gov/wp-content/uploads/2020/11/DDS_COVID-19_demographics-and-residence_10302020.pdf)

2 <https://www.latimes.com/projects/california-coronavirus-cases-tracking-outbreak/nursing-homes/>

**Cevadne Lee, Director, Office of Community Outreach and Engagement,** [**Chao Family Comprehensive Cancer Center**](https://urldefense.proofpoint.com/v2/url?u=http-3A__cancer.uci.edu_Community.asp&d=DwMF-g&c=Lr0a7ed3egkbwePCNW4ROg&r=IXpg2Qds0NOzcffsLLGomAOEHKgNIER_dqZ2_5Tlg9aPlJwV22ej2eSRyNBPJgsD&m=dz0FVlDvcC9rJVw7QPCzoi0tx_sUpcLh_f9m_LP5jxg&s=fYJwH8fOqhdf-ZyjFTIsG4BtohO4vNcr5xKwGZqRrU0&e=), **UCI**

I am the Director for the Office of Community Outreach and Engagement at UCI Cancer Center and Board Director for Southeast Asian Community Alliance, a non-profit organization which advocates for low-income Southeast Asian families in Chinatown Los Angeles, CA.  I am also on the [Orange County, CA COVID Vaccine Taskforce](https://urldefense.proofpoint.com/v2/url?u=https-3A__occovid19.ochealthinfo.com_orange-2Dcounty-2Dcovid-2D19-2Dvaccine-2Dtaskforce&d=DwMF-g&c=Lr0a7ed3egkbwePCNW4ROg&r=IXpg2Qds0NOzcffsLLGomAOEHKgNIER_dqZ2_5Tlg9aPlJwV22ej2eSRyNBPJgsD&m=dz0FVlDvcC9rJVw7QPCzoi0tx_sUpcLh_f9m_LP5jxg&s=4t10bMOuldk-8fVT4c9p5bAw1YqJcsTtAuJYDaZfLYQ&e=) and the L[os Angeles County Department of Health Asian American & Pacific Islander COVID 19 Taskforce](http://publichealth.lacounty.gov/docs/RacialEthnicSocioeconomicDataCOVID19.pdf).

Thank you for taking on California's challenge to rollout equitable allocation of the COVID-19 vaccine.

I am disappointed that the presenters during the Nov 25 meeting failed to include Pacific Islanders and Native Hawaiians (NHPIs) when describing the impact of cases and deaths associated with COVID-19 by race and ethnicity.  California has the second largest NHPI population in the U.S. Native Hawaiians and Pacific Islanders are mentioned in the final NASEM COVID framework as a group that has experienced mortality from COVID-19 at a rate up to five times its proportion of the population compared to the general population.  Which leads to my second point, the race and ethnicity data presented from the CDC/NCHS during your Nov 25, 2020 meeting presentation only shows COVID data of 4 racial groups and fails to mention NHPIs.   NHPIs are now included in the COVID-19 deaths by county and race/ethnicity at NCHS and CDC: [https://data.cdc.gov/NCHS/Provisional-COVID-19-Death-Counts-by-County-and-Ra/k8wy-p9cg](https://urldefense.com/v3/__https:/data.cdc.gov/NCHS/Provisional-COVID-19-Death-Counts-by-County-and-Ra/k8wy-p9cg__;!!OLgoXmg!HS_DGobmGC9KALHHTu-sxi9pEfKVbvtykJGGAGBCQb7EYAnzB2jp35My2T_wLauD1w$).  They’re also now included in the excess deaths page: [https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess\_deaths.htm](https://urldefense.com/v3/__https:/www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm__;!!OLgoXmg!HS_DGobmGC9KALHHTu-sxi9pEfKVbvtykJGGAGBCQb7EYAnzB2jp35My2T__N9fGuA$).  And they’re also now in the COVID-19 Health Disparities page: [https://www.cdc.gov/nchs/nvss/vsrr/covid19/health\_disparities.htm](https://urldefense.com/v3/__https:/www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm__;!!OLgoXmg!HS_DGobmGC9KALHHTu-sxi9pEfKVbvtykJGGAGBCQb7EYAnzB2jp35My2T9UlKKaWg$).

 In addition, I would like to highlight additional challenges and recommendations in vaccine distribution to communities:

1. Review, collect and analyze disaggregated data on COVID-19 testing, infection, and death will help us understand where to distribute vaccine allocation.  Understanding disaggregated data means understanding the considerable social and economic diversity that exists among the ethnic groups that make up our diverse state.  The [Race and Ethnicity data on the CDPH COVID19 Vaccine website](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx)could be improved by showing data in proportion to the racial group and in proportion to all cases and deaths from COVID in the state population.
2. We have and continue to see an increase in delayed access to care and later stage diagnosis of chronic conditions due to fear of contracting COVID-19 by visiting hospitals and doctor’s offices. This fear is compounded by the continued xenophobia and racist hurls, “Kung-flu” and “Chinese virus” made by political leaders and the public towards Asian Americans.  Cancer has been the leading cause of death among many diverse  communities in California. It's important to remember that systemic racism in our health systems has exacerbated COVID-19 under-reporting, lack of testing sites, and lack of in-language services in communities of color. This will pose a particular challenge in comparing disaggregated data and where the data is missing.   [I](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.apitaskforce.org_&d=DwMF-g&c=Lr0a7ed3egkbwePCNW4ROg&r=IXpg2Qds0NOzcffsLLGomAOEHKgNIER_dqZ2_5Tlg9aPlJwV22ej2eSRyNBPJgsD&m=dz0FVlDvcC9rJVw7QPCzoi0tx_sUpcLh_f9m_LP5jxg&s=GxBOjLfQ-QP6PE-tcRHiUdbB0EuiXhFtTFkCipgcekc&e=) hope this committee will work to bridge those gaps and continue targeted outreach and education as it relates to Phase 1b and Phase 2 of the vaccine allocation.
3. Many community-driven efforts have risen during the pandemic. I highly recommend this Committee include a representative from a Pacific Islander community ([https://www.pacificislanderhealth.org/](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.pacificislanderhealth.org_&d=DwMF-g&c=Lr0a7ed3egkbwePCNW4ROg&r=IXpg2Qds0NOzcffsLLGomAOEHKgNIER_dqZ2_5Tlg9aPlJwV22ej2eSRyNBPJgsD&m=dz0FVlDvcC9rJVw7QPCzoi0tx_sUpcLh_f9m_LP5jxg&s=VRPHW7UxIrU_DrSakSlv2G5c18YMRGUc5Mhq4mqK9i0&e=)).   Thank you for selecting APIAHF and CPHEN for representing Asian Americans statewide, but the community health representation from Southern California could be stronger, particularly since half of California's COVID cases are coming from Los Angeles County and surrounding counties.  API COVID Taskforce in Orange County, CA [https://www.apitaskforce.org/](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.apitaskforce.org_&d=DwMF-g&c=Lr0a7ed3egkbwePCNW4ROg&r=IXpg2Qds0NOzcffsLLGomAOEHKgNIER_dqZ2_5Tlg9aPlJwV22ej2eSRyNBPJgsD&m=dz0FVlDvcC9rJVw7QPCzoi0tx_sUpcLh_f9m_LP5jxg&s=GxBOjLfQ-QP6PE-tcRHiUdbB0EuiXhFtTFkCipgcekc&e=) and the Los Angeles COVID-19 Taskforce I mentioned above would be great additional connections with their strong advocacy and work around COVID-19 in Southern California.

It is a pivotal time to become more strategic in mapping a way forward that reimagines greater possibility for community power and strengthening the infrastructure for health systems to continue to serve and support communities of color.  Thank you.

**Rose Acampora, Activist**

As the pandemic rages on, I am writing to call your attention to a segment of the community that is urgently in need of protection against Covid-19 (myself included), and I implore you to use the power and influence of your position in any way that you can to insure that we receive a very high prioritization for the initial distribution of a Covid-19 vaccine.  I can assure you that I am not alone in expressing the feelings and need for help that will be addressed in this letter.

              Perhaps, we are an unseen population as we have literally been left to fend for ourselves, using Instacart, and a skeleton caregiver teams to barely provide us with essential toileting and bathing needs.  We don’t even have the usually assistance from family and friends.  We are a real population, vulnerable, like nursing home residents, extremely vulnerable to Covid with our biggest risk being our caregivers.

            I was born with Type 2 Spinal Muscular Atrophy.  Because of my disability, I live my life in an electric wheelchair and am totally dependent upon personal care attendants for my everyday living:  intimate contact such as getting into and out of bed, showering, toileting, and getting dressed, as well as cooking, feeding and house cleaning, etc.   But more to the point of this letter, the nature of my disability has left me, and many just like me with SMA or other neuromuscular disabilities, with severe pulmonary impairments. Even a common head cold is potentially life threatening.  Pneumonia and death are real possibilities, and each year I am diligent about getting vaccinated against influenza and try my best to protect myself during cold and flu season.

            Many with neuromuscular disabilities and others with severe pulmonary conditions *have literally not left home since early March* because our likelihood of surviving Covid-19 is slim to none.  Our total dependence on personal care attendants, who enter our homes each day to provide essential aids of daily living, leaves us especially vulnerable to Covid-19.  Most caregivers work with multiple clients (outside of our social bubbles) and they physically lift, bath, and feed us under conditions where social distancing and mask wearing are impossibilities.  And as you are well aware, Covid-19 can be spread by people who may be totally asymptomatic or may be in a highly contagious initial phase of the disease just before symptoms appear.  Compounding the risk still further is the reality that most of us employ multiple caregivers each day.

We have tried to weather the storm as best as we can.  As mentioned above, many of us have not left our homes for over eight months to minimize our risks; shopping for essentials (primarily food) is done on-line, with our caregivers carefully unpacking each package as it arrives and thoroughly disinfecting the contents.  Many of us have even furloughed some of our attendants and increased the hours of others so as to reduce the number of people, who are otherwise out and about in the community, that we come in daily contact with.  Some of us, myself included, *have not seen any family members for months*and for us, the forthcoming holiday season will be spent alone.

            What we need is a real advocate to secure Covid-19 vaccine for this extremely vulnerable constituency.  In this real-time planning phase when vaccine prioritizations are now being established, there is an urgent need for advocacy on behalf of the extremely vulnerable, such as myself and others caught up in similar circumstances.  We truly need an advocate in these life-and-death deliberations so that we are not overlooked or considered as a mere afterthought.  I am hoping that you will agree to serve as that advocate, representing us with an early, loud, and firm voice.

            I fully realize that there are many factors to consider, but I implore you to help place us at or very near the head of the queue because of our extremely precarious situation (near certain death from Covid-19, near total isolation at home, total dependency on and intimate contact with others who may be freely circulating in the community).  I think that even health-care workers would applaud such a decision, since (1) they are probably well aware of the seriousness nature of our predicament, and (2) we would not become a burden on our overstretched hospitals and ICUs if we are protected against Covid-19.

            Thank you for your kind attention, and I hope that you will agree to help out with this urgent matter.  Please don’t hesitate to send email or phone if you have any questions or if you can think of any way that I might be of assistance.

**Mark Melanson, Executive Director, California Community Living Network**

We are concerned that there is no representation for Californians with Intellectual and Developmental Disabilities (IDD) on the committee.

350,000 Californians have IDD and the 100,000+ Direct Support Professionals that provide support to them.

Department of Developmental Services or Association of Regional Centers or us (California Community Living Network) should be considered as a member of the committee.

I look forward to hearing back from you.

Thanks in advance!

**Sherry Daley, Vice President of Governmental Affairs and Corporate Communications, California Consortium of Addiction Programs and Professionals (CCAPP)**

In reviewing your slide presentation dated November 25, 2020, we have questions/comments about the following slides:

Slide 41 - The slide defines - “Health professionals who are involved in direct patient care, as well as those working in transport, environmental services, or other health care facility services—who risk exposure to bodily fluids or aerosols.”

Will persons working at licensed and certified addiction treatment programs be considered "health professionals involved with direct patient care" for this definition as they meet face to face with clients, and for licensed facilities, are working in congregate care settings?

Slide 49 - Lists types of healthcare facilities. It does include Chemical Dependency Recovery Hospitals and Narcotic Treatment Programs (NTPs).

When guidelines are formally drafted, can the term "licensed and/or certified alcohol drug treatment program" be added as that is the statutory name for these facilities? There are very few Chemical Dependency Recovery Hospitals in the state. The vast majority of treatment is provided in licensed and certified facilities.

Can recovery residences (sober living homes) be added to the community care facility/congregate living list? They are now defined by Health and Safety Code 11833.05. (f).

Slide 57 - Numerous professions are listed in the chart. However, alcohol drug counselors are not licensed. They are registered or certified by private entities.

Can certified and registered alcohol drug counselors be included in the lists of professionals who will need to be vaccinated early? If there is a need to communicate with this workforce concerning vaccine availability, CCAPP is able to provide messaging to counselors. There are an estimated 30,000 of them in the state. CCAPP also has the ability to determine the race/ethnicity and location of our registered and certified workers.

Please let us know what our workforce and clients should expect as the vaccines roll out. We are particularly concerned for our clients because the smaller 6-bed programs (50% of treatment capacity) must close to new admissions when COVID is present as there is no ability to isolate clients from one another. This is severely impacting capacity and will undoubtedly be impacted further as the virus spreads. People unable to access treatment for addiction are one of the highest risk populations for death by overdose and suicide. It is imperative that people entering treatment and the workers who serve them be prioritized so that lives can be saved.

Thank you for your consideration.

**Grace Li, CEO, On Lok**

 Thank you for your leadership to protect the health and safety of all Californians during the COVID- 19 pandemic. I am writing today to urge you to recognize staff and participants in PACE (Program of All- inclusive Care for the Elderly) organizations in the state COVID-19 vaccine planning process and to prioritize PACE in the distribution of the vaccine.

As you know, On Lok is a non-profit organization founded almost 50 years ago on the belief that all seniors deserve to age with dignity and respect in their homes and communities. On Lok created and is the national prototype for the PACE model of care. PACE is a fully integrated Medicare and Medicaid health and long-term care plan for nursing home-eligible seniors age 55 and older. Today, On Lok’s PACE program serves more than 1,600 frail seniors in San Francisco, Southern Alameda and Santa Clara Counties. As of 2020, there are 19 PACE organizations serving over 11,000 PACE participants throughout California.

Because PACE serves a nursing home eligible population, PACE participants are among the most vulnerable to negative outcomes due to COVID-19. The average age is 76 with an average of 20 medical conditions. Over half of PACE participants have three or more functional limitations in activities of daily living. In addition, over 80 percent belong to racial and ethnic groups at higher risk of COVID-19 exposure and adverse outcomes, and almost 100% of PACE participant are very low income.

On Lok and other PACE organizations took immediate steps to mitigate risk for COVID-19 transmission by implementing rigorous infection control measures and quickly transitioning from providing primarily center-based services to home-based care. We have utilized the flexibilities of the PACE model to ensure that health care services and support services such as home-delivered meals, mental/behavioral health services continued for PACE participants in a safe manner. This has required our direct health workers, including primary care providers, home care nurses, caregivers and drivers to care for our participants in a variety of settings: clinics, participant homes and congregate living settings, such as nursing homes, assisted living, and senior housing.

Because of the high-risk population served and the risks faced by our direct health care workers, we request that PACE be specifically identified in the State of California COVID-19 Vaccination Plan. More specifically, we request that PACE direct care staff be recognized in the vaccination plan Phase 1(a) as high risk health workers and that PACE participants be recognized as a high risk population. We also plan to submit this comment to the Community Vaccine Advisory Committee.

Thank you again for your leadership. We look forward to continuing to work with you in the response to the COVID-19 pandemic and in the coming years to improve the lives of all Californians.

**Kristine Shultz, Interim Executive Director, California Optometric Association**

My comments sent to this email on Nov 24th and 25th were not included in the public comment list published on your website today. Can you please add my comments below?

“Optometrists were deemed “essential” workers by the State of California and have stayed open during the pandemic. We reduced services to only essential care when the CDC recommended it. Now that optometry offices are providing full scope care, can you tell me if optometrists will be considered “front line” health care workers who are eligible to be inoculated in the first phase when a vaccine is available?

We have some optometrists who work in rural areas, Native American health centers, and community clinics that are treating patients with COVID-19. How can an individual provider who treats COVID + patients get considered for the first phase of inoculation?

We also request that the California Optometric Association be added to the Community Vaccine Advisory Committee since optometrists have the statutory authority to administer some vaccines, including flu. We are planning legislation next year to administer COVID vaccines.”

A**ndrew Goldfrach, County of San Bernardino, ARMC-Administration**

 I am writing to request to be a member of the Community Vaccine Advisory Committee. I am representing the County of San Bernardino and leading the County’s task force for the vaccination distribution.

Regarding Phase 1a. I would also like to advocate that “high risk healthcare workers” include all hospital employees as they have significant risk moving about the hospital to be exposed to COVID.

Thank you very much for your consideration.

**Dominic Dursa, District Director, Assemblymember Robert Rivas, 30th District**

Where did the figures for slide 57 come from and what was the definition for an agricultural worker?

**Lisa Dana, UCSF**

I hope all is well. Thank you for all that you are doing to make our community healthy and safe. I know you are considering vaccine distribution this week. I hope you will consider primary care providers near the top of the list. We are seeing the general population and often hear after a visit that someone / a parent or child/ tests positive. We are screening, wearing masks and shields, and keeping visits short. However, we have to see these children and keep them up to date on vaccines and health screens.

Because of the age of our patients, we always have a parent and child in the room. We struggle to keep it to just two, as sometimes siblings need to come along.

We are also treating and testing symptomatic children in an outdoor tent in full ppe. We have never been busier.

As you consider allotment...please consider the family medicine and pediatric practices.

**Patti Owens, Director of Regulatory Affairs**, **California Association of Health**

CAHF’s priority is to help limit the spread of this deadly virus and prevent further tragedies by ensuring residents and staff in all long-term care and senior living settings are among the first to receive a COVID-19 vaccine. We urge CDPH to continue to prioritize long term care facilities and their HCP to be among the first to receive this vaccine. We also want to get residents out enjoying social activities and seeing their loved ones again.

We are cautiously optimistic about the plans to distribute and administer the vaccine quickly to our populations. Nothing like this has ever been done before, but we believe the federal program to vaccinate long term care residents is the best plan out there.

With millions residing in our nation’s long term care facilities, our providers stand ready to help facilitate this monumental endeavor.

If issues arise, we will work through them. Our focus must remain on protecting our nation’s most vulnerable quickly and effectively.

It is urgent that LTCF and their HCP receive the vaccine first.

* [Current data](https://urldefense.proofpoint.com/v2/url?u=http-3A__links.ahca.org_u_click-3F-5Ft-3D3abc5280edfa42b5905fbea7c0fff5c2-26-5Fm-3D9110981308cd4e87a50bab2e5b2728d7-26-5Fe-3DDCw4lnx8K4wSCuFfY12Oa1ntl6c6eEivsBCpkBt0Z6RRWHjtD6u0d47FCGLbvup5M3p-2DD5gwDnKNOVZXU0s-2DEcAes7-5FW7kNdb5IMHuqdz5-2DZmsk9TcLJc408NnPJ2yaIZKZnI-5FTOV-5FwRnt1SW12ap-2DVic4rBl8gatnmTXCsEAPXyy-5FfgJlyjp-2Dnm-2D71uqJQL0r-2D-5FSMJRzcfrG2mTBoNcQ-2DfDOoXPv-5F0GGOJ-2DlzhxkEwyJsc5OfRVhJQGPw9V6WIXtKjqBz5qO5dtRArd0WwwJIYP4TI9yOeQKQBsqP4KiLUDyVG1q8lfmXHtVZ5bHBxM3Y7SPU9yLycJqtpCgUkw-5Ff-5FOKxLXsenx3eg23uM6BM4xMLAkFUBOqW1VWdLQqQIjaOFrqX8yg8oNEOf69RHEE5aqiYicqcLt2stNPvHm1Uhn2jLWNtIJPF0tQGjStXelKvl1MHU-5FPKRLtFecMwPLhsKEyjU7IdntB5GIH3Ot5Kg-253D&d=DwMFAg&c=Lr0a7ed3egkbwePCNW4ROg&r=QVZJ1pGLNSRUbk0Bat3l9rz8IekC4nreOwkxxR6HUuE&m=KDjeociOhVn-BhbDJMRTdYW5b9uQpBoEbWkDGeiEyh8&s=5aBiIz5Xno1cRSziCRwDYLPjrzG0Yxeg9MYQcDYzyF0&e=) shows that while COVID-19 cases in all long-term care facilities account for 7 percent of total cases nationwide, they account for 40 percent of all COVID-19 related deaths.
* The average age of residents in long term care facilities is 85 and almost every one of them has an underlying health condition, and some have multiple chronic conditions. According to CDC data, the risk of mortality in this age group is 630 times higher than those 18-29 years old.
* While other industries may begin to open with new restrictions, long term care facilities will not be able to return to normal until there is a vaccine.
* What makes the virus particularly vicious is the fact that a person can contract it, show no symptoms and unknowingly spread it.
* The highly contagious nature of the virus in congregate settings, namely long-term care facilities, opens the door for rapid spread.
* The combination of these factors, as well as a severe lack of PPE and testing at the outset, led to a disproportionate impact on long term care residents.

The lack of prioritization for long-term care and seniors housing at the outset of the pandemic across the nation led to devastating losses, and we cannot let that happen again.

Vulnerable older adults and the frontline workers who protect them deserve the full support of the public health sector.

Ensuring residents and staff in all long-term care and senior living settings are among the first to receive a COVID-19 vaccine will help limit the spread of this deadly virus and prevent further tragedies.

**Lydia Missaelides**

I noticed that CAADS the CA Association for Adult Day Services is not represented on the vaccine committee but many of our aging and disability colleagues are listed.

What is your advice for getting someone from CAADS to get on the committee?  I worry that adult day services participants and families and staff will be overlooked if not present. We also want to help with the program.

Appreciate your help.

**Carlos Rojas**, **VP - Legal, Risk & Sustainability, Sprouts Farmers Market**

I hope this email finds you well. The Food Marketing Institute (FMI) and the Centers for Disease Control and Prevention (CDC) provided us with your contact info in order to discuss how we could partner on the COVID-19 immunization efforts hopefully set to begin in the next few weeks. As you may know, we are a national grocery store chain with 362 stores in 23 states with over 36k employees. We have 126 of those stores in the Great State of California. [Here](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.sprouts.com_stores_ca_&d=DwMFAg&c=Lr0a7ed3egkbwePCNW4ROg&r=BJItM2YbwSslkvYavpnDs5vHBnfFeZ65v7VhfJ5q5sY&m=dnXR4JEzdPFPIm55PYXgqmI_J5qkzX31-HarIyu_eTY&s=cB5adkBYaEouBoV9lVvSn-1wgiyCddPUPbp--ggIArg&e=) you can find all of our CA store locations.

I understand pharmacies and grocery stores with pharmacies are being prioritized to carry out the vaccination effort for when it officially starts. Our stores do not have a pharmacy, however we would like to explore the possibility of helping in this effort in any way we can. We would be open to looking into options such as sourcing certified healthcare professionals to administer the vaccines, investing in necessary refrigeration equipment for the vaccines, and even retrofitting areas of our stores to provide these immunizations.

Kindly let us know how we could get involved in this crucial effort.

Thank you for any help and guidance you can provide on this topic.

**Michael Smaha, Can Manufacturers Institute**

As the Centers for Disease Control and Prevention (CDC) works with state health officials to finalize its priority list of tiers of American who will receive the COVID-19 vaccine, the Can Manufacturers Institute (CMI) requests that food and beverage can manufacturing workers in California be included in the food industry worker category. It is CMIs understanding that food industry workers will be among the second tier of Americans designated to receive the vaccine.

CMI is the U.S. trade association representing the metal can industry. Early in the pandemic, the Institute was successful in getting can plant employees listed among essential workers, as states began shutting down businesses to help with stay-at-home orders. That designation allowed metal can plants to remain open so they could meet the needs of their customers and make sure the food supply chain continued to function.

You may have seen reports in the media of a metal can shortage, due to unprecedented demand from food and beverage companies that started when the pandemic began, and Americans ate and drank more at home. Customer demand for metal cans continues to this day. Keeping the nearly 825 can manufacturing workers healthy, safe and vaccinated against the virus will allow them to continue playing their vital role in supplying California and the country’s food and beverage supply chain.

I appreciate your attention and consideration of my request.

**Kristine Shultz, Interim Executive Director, California Optometric Association**

Thank you for all your work in developing guidelines for the distribution of the COVID-19 vaccine. In the draft COVID vaccine distribution guidelines released yesterday, we believe inoculation of optometry clinics will occur in the Phase 1A “Type of facility” subcategory on the same Tier 3 as dental and other specialty clinics. If this is correct, we believe additional clarity is needed to ensure the guidelines are followed as intended.

There will be less confusion if optometry offices are expressly listed in the Phase 1A draft guidelines next to dental clinics. Doctors of optometry are at high risk for contracting COVID-19 given the close proximity required during an eye exam. Optometrists must operate within six inches from a patient’s face for several minutes during each exam. While dental/oral health clinics were specifically listed, optometry clinics were not spelled out in the guideline distribution plan. We believe this will cause a tremendous amount of confusion and many unnecessary phone calls into county health departments because of a lack of clarity. We are hoping that the guidelines will be revised to list optometry clinics next to dental clinics under Tier 3 of the “Type of Facility” subprioritization. Dentists and optometrists are the two health care providers that are at higher risk for contracting COVID-19 compared to other non-MD providers because of the nature of the services provided.

While optometry clinics should fall under the broad term “specialty clinics” that is also listed in this tier, many local public health officials may later interpret this to mean “specialty physician clinics” and exclude optometrists from being vaccinated.

We appreciate CDPH’s efforts to be inclusive throughout this process and understand that there are many different interest groups to gather input from. However, given that optometrists have the statutory authority to administer vaccines for flu, shingles, and pneumonia to adults, **w*e hope you will consider adding the California Optometric Association to your Community Vaccine Advisory Committee.***

**Richard Nagy, President CDA and Natasha Lee, Member, California Task Force on Business and Jobs Recovery**

On behalf of the California Dental Association and nearly 36,000 California dentists and their teams providing essential health care, we respectfully urge the California Department of Public Health Community Vaccine Advisory Committee (Committee) to revisit the proposed tiers of vaccine distribution under Phase 1a.

We understand that California’s first shipment of vaccines (approx. 330,000 doses) will not cover every essential health care worker, and that among other factors, sectors serving the most vulnerable populations will be prioritized first. However, we believe that the Committee’s approach to subprioritizing health care workers within Phase 1a does not fully take into account that dentists and their staff have a heightened risk of transmission when compared to the other settings and workers listed in Tier 3. It is important to note that all other settings listed in Tier 3 allow for all patients to be masked and socially distanced during the entirety of the patient encounter. Conversely, in dentistry, patients must be unmasked and dental providers must operate within inches of the respiratory tract for 30-60 minutes at a time. Although dental offices screen out symptomatic patients prior to treatment, the prevalence of asymptomatic patients is at an all-time high. The type of unmasked patient interactions dentists and their staff engage in is more similar to the settings listed in Tier 2 where workers are either in high-volume patient areas or potentially treating patients that need to be unmasked to receive treatment, such as urgent care clinics.

Based on the nature of dentistry and the factors explained above, we respectfully urge the workgroup to reconsider staff in dental clinics to be placed in Phase 1a Tier 2. Once again, thank you for your continued work on this issue.

**Sally Michael, President & CEO, California Assisted Living Association**

The California Assisted Living Association urges the state to ensure that workers in Assisted Living/Residential Care Facilities for the Elderly are included in round 1a of COVID-19 vaccinations. As essential frontline workers responsible for the hands-on care and supervision of up to 188,000 frail elderly living in congregate settings, early vaccination is vital to ensure the ongoing health and availability of this workforce, especially in the face of the current surge. Our residents must also be prioritized for early vaccination as they are among those most at risk for severe illness or death from COVID-19.

Just yesterday, the national Advisory Committee on Immunization Practices voted to recommend the CDC include Assisted Living workers and residents in round 1a. The state’s Community Vaccine Advisory Committee voted the same earlier this week. This strong and broad support clearly shows the significant need to vaccinate this population without delay.

Thank you for all that you are doing to lead the state through this pandemic. We look forward to details regarding the vaccine rollout to protect Assisted Living/Residential Care Facilities for the Elderly and their residents.

**Jennifer Snyder, Partner, Capitol Advocacy for California Retailers Association**

Chain pharmacy members of the CA Retailers Association are willing and interested in being available to distribute and assist in the vaccination of health care workers, essential workers and CA residents as the vaccine becomes available.  There are a couple members that have LTC pharmacies that have already talked with CDPH and are linked into the current discussions.  There are others that have not made the CDPH connection and could be helpful in making sure there is adequate availability of the vaccine (where prioritized).

Can you provide us with the correct person to reach out to at CDPH?  We can bring in all of our chains in one call or email to make it as efficient as possible for CDPH.

**Mickae Lee, The National Coalition for Assistive and Rehab Technology (NCART)**

I am contacting you today on behalf of The National Coalition for Assistive and Rehab Technology (NCART) and its members.  NCART is a nonprofit association of suppliers and manufacturers of Complex Rehab Technology (CRT) products used by children and adults with significant disabilities. Our members operate under the DMEPOS supplier umbrella and collectively serve hundreds of thousands of people with disabilities through over 350 accredited Medicare/Medicaid supplier locations across the country.

DMEPOS suppliers work directly with patients with COVID‐19 and provide essential equipment and services, such as home oxygen therapy, ventilators, CPAP/BiPAP, nebulizers, hospital beds, and more. The hands‐on nature of providing, adjusting, and servicing many of these products in close proximity to patients subjects DMEPOS personnel to considerable risk for exposure to infected individuals. In addition to directly interfacing with infected individuals, many of the products and services provided by DMEPOS suppliers require their staff to enter homes to set up the equipment with other caregivers or family present.

We thank the State for all the ongoing efforts to ensure access to DMEPOS during the pandemic.  Based on the information provided in the attached document, we respectfully request that you include personnel employed at DMEPOS suppliers in the Phase 1a distribution of the COVID‐19 vaccine. This inclusion will allow the DMEPOS suppliers to continue to safely provide their critical frontline products and services to the high-risk individuals in their communities who depend on them.

We would be pleased to offer any additional information needed and look forward to your response.  Thank you for your consideration of this important request.

**Kim Worster, SVP, First Student**

I am contacting you with an urgent request regarding the deployment of COVID-19 vaccines. I ask that you make school bus drivers a high priority as essential employees.

I represent First Student, a school transportation provider serving 900 school districts across the country, including California. Our more than 48,000 employees safely deliver five million student journeys each day. We are an integral part of each community where we operate.

The pandemic has created a challenging operating environment for our industry. We look forward to the day when all students can resume in-person learning. A critical element in achieving a complete return to the classroom will be ensuring an adequate number of skilled, trained, licensed and available school bus drivers.

The National School Transportation Association (NSTA) estimates that 5-10% of school bus drivers are currently sidelined by COVID-19, and those numbers continue to rise. These include drivers who are infected, exposed and quarantined and those on a leave of absence. NSTA also estimates that approximately 33% of industry drivers are aged 60 or older, and they are a racially and ethnically diverse group. Many school bus drivers remain fearful about a return to work without a vaccine. Targeting this front-line group will undoubtedly assist in the prevention of transmissions as well.

NSTA testified last month before the Advisory Committee on Immunization Practices (ACIP), an arm of the CDC, urging that it recommends school bus drivers for phase 1 deployment of the COVID-19 vaccine. ACIP can only make recommendations, whereas your office will ultimately determine the vaccine's deployment.

School bus drivers are included on the Cybersecurity and Infrastructure Security Agency (CISA) list of Essential Critical Infrastructure Workers. They appear in both the Education and Transportation sections of the latest version from August 2020. Inclusion of school bus drivers on this list indicates that CISA validates these workers as essential. We also believe this distinction is probative for you to consider.

Without a healthy and plentiful workforce of bus drivers, more children will be forced into less safer ways to get to school. Many students may not have access to pursue their educational opportunities.

We implore you to carefully consider the ramifications to our school children by not including school bus drivers in the priority deployment of this critical vaccine.

Thank you for your prompt consideration of this important matter.

**Brian R. Marvel President, Peace Officers Research Association of California (PORAC)**

I write to you today on behalf of the Peace Officers Research Association of California (PORAC), representing 77,000 public safety members in over 940 public safety associations across the state of California. I want to thank you for your continued leadership as our state faces the unprecedented challenges associated with the coronavirus pandemic.

I am writing to formally request that peace officers and other first responders be among the first to receive a vaccine or other medical treatment or protocol that mitigates the effects of COVID-19 as soon as it becomes available.

You know better than most the critical role played by law enforcement in keeping our families and communities safe as our state continues to battle the virus. All first responders remain at significantly higher risk for contracting and even spreading the virus every day in the course of their duties, as they must continue to respond to 911 calls, support the state’s COVID-19 response strategy and interact with often at-risk members of our communities.

Sadly, as I write this letter, over 275 peace officers nationally have died in the line of duty due to COVID-19. Here in California, we have seen at least 11 peace officers die from COVID- 19 in the course of their duties. I am sure this number is higher, but we just don’t know.

PORAC is extremely grateful for all your efforts in getting the federal government to increase the supply of personal protective equipment (PPE), in establishing the coronavirus as a presumptive occupational illness to be covered under workers’ compensation, facilitating expedited testing for officers and other first responders and more. Your management of the state’s response to the pandemic has helped to preserve the lives of countless Californians, including our men and women in law enforcement.

As new vaccines and treatments complete their clinical trials pending United States Food and Drug Administration (FDA) approval before they can be distributed throughout the country, we must ensure that our peace officers and first responders are considered a top priority throughout the state’s own delivery process.

Now more than ever, we need our elected leaders to meet this moment and the needs of our first responders. Even as COVID-19 cases are on the rise and the general public continues to ease their observance of social distancing, mask wearing, social gathering, and curfew regulations, officers continue to risk their own health and safety to educate their communities on these rules for the betterment of all.

With the priority delivery of a vaccine, treatment or other protocol to our peace officers and first responders who are on the frontlines of this pandemic, you, your administration, and the citizens of our great state can have the full confidence that law enforcement and our first responder partners will continue to rise to the occasion and safely support our communities during this unprecedented global health crisis.

**Andrea Gutierrez****, Senior Director, State Government Relations, California Life Sciences Association(CLSA)**

On behalf of the California Life Sciences Association (CLSA), we want to thank you for your strong and aggressive response to the COVID-19 pandemic. Your actions, based on science and facts, have shown careful consideration of California’s diverse regions, and has helped keep health impacts limited while providing regional solutions to front line challenges.

CLSA appreciates the intent behind the establishment of a COVID-19 Vaccine Scientific Safety Review Workgroup to provide California specific guidance for the acquisition and distribution of a vaccine or multiple vaccines. We understand that the Workgroup will be tasked with establishing a system to review safety, prioritization, distribution, and the ultimate administration of vaccines given that supplies are expected to be initially constrained. CLSA agrees it is vital to make certain the vaccine is dispersed equitably and justifiably and to those with the highest risk of becoming infected and/or continuing the spread of COVID-19. Understanding these goals, CLSA would like to request that the Workgroup include input from life sciences industry experts to assure that science and scientists, in consultation with those on the front lines of COVID-19 research and development inform the important decisions being made. With so much uncertainty, we are concerned that even well-intentioned states such as ours undermine the well-established Food and Drug Administration guidelines by hindering a drug’s approval without having access to all the patent-protected information that only the FDA receives as part of the drug development process and application. It would be a great public disservice if actions such as these were to give the impression that the FDA review and approval process was somehow flawed or incomplete and that vaccine safety and efficacy should be questioned by the non-scientific community or the general public. We must trust science, and the integrity of the well-established scientific process. With even more therapeutics in clinical trials, we hope that these same parameters will apply to the Therapeutics Workgroup that your office has also created.

Our Association represents the entire ecosystem of the life sciences industry where many of our members are working tirelessly to discover a vaccine or therapy for the novel Coronavirus. We represent a diverse group of California Universities and private institutions involved with research, testing, and diagnostics-including many that the state of California has partnered with such as Abbott and Verily Life Sciences, and large pharmaceutical companies like Gilead, Genentech, Roche, and Amgen. The life sciences industry is also the second-largest technical employer base to California’s economy, employing almost 350,000 Californians, and is intrinsic to the science behind how we, as a country and global economic partner emerge from this public health crisis. Currently there are over 395 COVID-19 research and development projects in the U.S. with over 30 members of CLSA currently involved in these projects.

We believe that CLSA members can be an excellent resource by informing key administrative officials and the Scientific Safety Review Workgroup on testing, treatment, and COVID-19 vaccine and therapeutic development and the progress that has been made to date. In addition, these experts can inform key decisionmakers about best practices in clinical trials for both vaccines and treatments.

CLSA research institutions and companies have been on the front lines of this battle; rushing to test, combat, and trace this disease. Many are California-based, and all are invested in California leading the way through this pandemic and ensuring we maintain our status as a global leader on the innovation front for the future of our great state.

CLSA requests that their members be given the opportunity to work with the new “Drafting Guidelines Workgroup” to lend additional support and expertise to the already robust cast of leaders.We hope that similar input will be encouraged with the therapeutics workgroup as well.

For your consideration, we are willing to serve as a formal or informal advisory council to the workgroup with the biotech and medical technical expertise critical for success. In addition, our Board of Directors, comprised of leaders and experts within their organizations, are also ready to engage as well.

We look forward to working with you, innovating solutions to move the State forward, and keeping California golden.

**Steve Ferraiuolo, Vice President, West Division, Vitalant**

It was a pleasure (virtually) meeting you a couple of weeks ago as we discussed the state and federal efforts to support our CCP collections. I certainly hope all is well with you and that you had a nice Thanksgiving. As we continue to hear encouraging news about the potentially imminent approval and subsequent initial distribution of a COVID-19 vaccine, I wanted to reach out to you to determine how we might best go about ensuring that blood center personnel are contemplated during discussions about the prioritization of the vaccine distribution. As you can appreciate, our staff play a critical role in supporting the overall healthcare infrastructure, and as such, I am hopeful that at least our front line staff would be considered among the early phases of the roll out and distribution. Thanks very much in advance for your thoughts, continued support, and direction.

**John Wenger, on behalf of Advanced Medical Technology Association (AdvaMed)**

We respectfully request that the state consider certain aspects of the medical device industry workforce in the development of vaccine allocation decisions. Specifically, our workers that perform critical functions alongside health care professionals on the front lines, including industry representatives, technicians or others, should be included in Phase 1 based on their risk of exposure and to ensure continuity of patient care throughout the health care system. Additionally, manufacturing employees throughout the medical product supply chain should be included in Phase 2 or other appropriate phase with other critical manufacturing workers.

As we move closer towards the approval of a COVID-19 vaccine, there must be a transparent and equitable plan for how patients access vaccinations and how that priority is determined. AdvaMed endorses the foundational principles utilized in the National Academies of Sciences, Engineering, and Medicine Framework for Equitable Allocation of COVID-19 Vaccine (“NAS Framework”)—the maximization of benefits, equal regard, mitigation of health inequities, fairness, evidence-based decision-making, and transparency.1 We also strongly support the recommended prioritization schema based on the four identified risk-based allocation criteria—the risk of acquiring infection, risk of severe morbidity and mortality, risk of negative social impact, and risk of transmitting the disease to others.2

As the Committee evaluates and develops recommendations concerning the allocation of COVID-19 vaccines, AdvaMed would be grateful for guidance concerning medical device industry clinical field and manufacturing personnel, who are recognized in the U.S. Department of Homeland Security Cybersecurity & Infrastructure Security Agency (CISA) Guidance3 as essential critical infrastructure healthcare workers.

More specifically, guidance on determining and confirming eligibility for these essential workers to be vaccinated under appropriate allocation phases would help to ensure their health and safety as they endeavor to maintain patient access to needed technology.

# Health Care Industry Representatives (HCIR)

Medical device company representatives are also referred to as Health Care Industry Representatives (“HCIRs”). They are often required to be present in patient care settings to provide technical support concerning the safe and effective application of surgical products and technologies.4 In addition to this technical assistance function, HCIRs “may be involved in the remote calibration or adjustment of medical devices (for example, pacemakers, laser technology) to the surgeons’ and manufacturers’ specifications.”5 Generally, HCIRs must meet certain hospital supplier credentialing requirements to access certain areas of a hospital at the request of a healthcare provider. These credentialing requirements include documentation of vaccinations (or titers showing immunity) for Influenza, Tetanus, Diphtheria, Pertussis, Measles, Mumps, Varicella, and Hepatitis B.6 It is also worth noting that the *American National Standard for Supplier Credentialing in Healthcare* was recently updated to include appropriate Personal Protective Equipment (PPE) use in healthcare provider facilities and a new section concerning Novel Viruses/Communicable Illness.7 HCIRs are not contractors of the hospital; instead, they are employed or retained by medical device companies. This dynamic may complicate a vaccine administrator’s ability to identify and flag HCIRs for prioritized vaccine allocation or to determine and confirm whether an HCIR meets the eligibility requirements for a particular phase of vaccination.

With regard to high-risk health workers identified for allocation Phase 1a of the NAS Framework, AdvaMed endorses the NAS Consensus Study statement that “access should not be defined by professional title, but rather by an individual’s actual risk of exposure to COVID-19.”8 Consistent with that approach, certain medical device company representatives/ HCIRs have an exposure risk to COVID-19 positive patients or their tissues, cells, or biofluids during their work to provide technical support for, calibrate, service, or repair medical devices (including diagnostics). HCIRs required by health care facilities or their job requirements to wear respirators and eye/face protection due to SARS CoV-2 exposure risk should be included among the Phase 1a allocation for High-Risk Health Workers. Some HCIRs support procedures/equipment/technology in the operating room or procedural suite and are required to be present during urgent, non-elective procedures (e.g., trauma, transplant, cardiac) and other medically necessary procedures (e.g., joint replacement). During the pandemic, hospitals have instituted additional COVID-19 access requirements for HCIRs. For example, some hospitals required HCIRs to undergo respirator fit testing and training so that HCIRs will be able to utilize hospital-issued respirators during procedures that these HCIRs support. During crisis capacity operations, some hospitals have required that HCIRs bring in their own respirators and other PPE for the procedures that they support, including gloves, gowns, and face shields. During the current PPE shortage, distributors of NIOSH-approved N95 respirators allocate nearly all of their supply to hospital purchasers. The best-case scenario for medical device manufacturers is to procure non-NIOSH-approved filtering facepieces that have FDA emergency use authorization for use as a respirator during this public health emergency. In these cases, although both the hospital staff and HCIR are in similar proximity to aerosol-generating procedures, some HCIRs do not have equivalent PPE relative to the hospital staff. This dynamic should elevate the prioritization of these HCIRs relative to other high- risk health workers who have access to NIOSH-approved PPE.

Importantly, HCIRs generally work across multiple health care facilities. Some HCIRs cover numerous hospital systems in a region and support procedures in multiple institutions per day. Vaccinating these HCIRs during Phase 1a would decrease the risk for these HCIRs to become vectors between institutions.

# Medical Device Manufacturing/Distribution Personnel

Medical device industry personnel that are physically involved in manufacturing and distributing medical devices and diagnostics should be included among the Phase 2 allocation for Critical Workers in High-Risk Settings. The specialized and environmentally sensitive nature of manufacturing medical devices limits the ability of medical device manufacturers to increase the physical distance between some manufacturing personnel. These are critical workers who are essential to manufacturing and distributing medical devices and diagnostics integral to the treatment of COVID-19 and other patients and are at substantially higher risk of exposure due to their inability to physically distance.

An attestation letter by an HCIR’s employer on company letterhead concerning the nature of their work and exposure risk should be sufficient to confirm eligibility for the HCIR for vaccination during Phase 1a. For medical device industry manufacturing and distribution personnel, an employer attestation on company letterhead concerning the nature of the individual’s work should be sufficient documentation to confirm vaccination eligibility during Phase 2.

AdvaMed appreciates your consideration and looks forward to supporting the state to achieve a transparent and equitable allocation of COVID-19 vaccines. We would be pleased to discuss these issues in greater detail at your convenience. Please do not hesitate to contact us at [fgreaves@advamed.org](mailto:fgreaves@advamed.org) or [mbhatt@advamed.org](mailto:mbhatt@advamed.org).

1. National Academies of Sciences, Engineering, and Medicine. 2020. Framework for Equitable Allocation of COVID-19 Vaccine. Washington, DC: The National Academies Press.<https://doi.org/10.17226/25917>.
2. I.d.
3. U.S. Department of Homeland Security Cybersecurity & Infrastructure Security Agency, Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in COVID-19 Response Version 4.0, Aug. 18, 2020, available at [https://www.cisa.gov/sites/default/files/publications/Version\_4.0\_CISA\_Guidance\_on\_Essential\_Critic](https://www.cisa.gov/sites/default/files/publications/Version_4.0_CISA_Guidance_on_Essential_Critical_Infrastructure_Workers_FINAL%20AUG%2018v3.pdf) [al\_Infrastructure\_Workers\_FINAL%20AUG%2018v3.pdf](https://www.cisa.gov/sites/default/files/publications/Version_4.0_CISA_Guidance_on_Essential_Critical_Infrastructure_Workers_FINAL%20AUG%2018v3.pdf) (Under “Healthcare / Public Health,”

“Vendors and suppliers” and “workers at manufacturers” are specified:

Vendors and suppliers (e.g. imaging, pharmacy, oxygen services, durable medical equipment, etc.).

Workers at manufacturers (including biotechnology companies and those companies that have shifted production to medical supplies), materials and parts suppliers, technicians, logistics and warehouse operators, printers, packagers, distributors of medical products and equipment (including third party logistics providers, and those who test and repair), personal protective equipment (PPE), isolation barriers, medical gases, pharmaceuticals (including materials used in radioactive drugs), dietary supplements, commercial health products, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting or sterilization supplies

1. See Association of periOperative Registered Nurses (AORN), Position Statement on the Role of the Health Care Industry Representative in Perioperative Settings, May 28, 2020, available at<https://aornjournal.onlinelibrary.wiley.com/doi/full/10.1002/aorn.13065>.
2. American College of Surgeons (ACS). Revised Statement on Health Care Industry Representatives in the Operating Room, October 1, 2016, available at [https://www.facs.org/about-acs/statements/91- industry-reps-in-or](https://www.facs.org/about-acs/statements/91-industry-reps-in-or).
3. See American National Standard for Supplier Credentialing in Healthcare, ANSI/NEMA SC 1-2019, Contents and Scope available at [https://webstore.ansi.org/preview- pages/NEMA/preview\_ANSI+NEMA+SC+1-2019.pdf](https://webstore.ansi.org/preview-pages/NEMA/preview_ANSI%2BNEMA%2BSC%2B1-2019.pdf)
4. See MITA and C4UHC Press Release, available at [https://www.medicalimaging.org/wp- content/uploads/2020/05/20.05.05-Final\_MITA-Credentialing-Standard-Release-DRAFT.docx-CLEAN- 002-copy-1.pdf](https://www.medicalimaging.org/wp-content/uploads/2020/05/20.05.05-Final_MITA-Credentialing-Standard-Release-DRAFT.docx-CLEAN-002-copy-1.pdf)
5. National Academies of Sciences, Engineering, and Medicine. 2020. Framework for Equitable Allocation of COVID-19 Vaccine. (p. 107) Washington, DC: The National Academies Press.<https://doi.org/10.17226/25917>. (“The first phase includes a “jumpstart” phase: Phase 1a. Included in Phase 1a would be “frontline” health workers—health professionals who are involved in direct patient care, as well as those working in transport, environmental services, or other health care facility services—who risk exposure to bodily fluids or aerosols. Under conditions of such scarcity, access should not be defined by professional title, but rather by an individual’s actual risk of exposure to COVID-19. The rationale for including “frontline” health workers in the first phase is manifold: their contact with patients with SARS-CoV-2 (despite the use of PPE, which can be limited in some settings); the fact that they work in an essential industry, but may be precluded from performing their professional duties if they are exposed or infected; and the reality that many such workers are potentially important nodes in onward transmission networks, given that many who are in low-wage jobs may also contribute to further transmission due to living in crowded, often multi-generational living situations where social distancing is unrealistic.”)

**Kris Lev-Twombly, President & CEO, California State Alliance of YMCAs**

On behalf of the California State Alliance of YMCAs, I am writing to request that the childcare workforce and child supervision staff, including those providing distance learning and expanded learning supports, be granted rapid access to the COVID-19 vaccination. Ideally, we request that members of this crucial workforce be included in the first tier of the rollout, along with health care workers and assisted living residents.

YMCAs have provided childcare services to children of essential workers since the shelter in place order was implemented in March. Many of the children we serve are the children of medical staff who may be exposed to COVID-19 by their parents or guardians. While children don’t seem to play a prominent role in the transmission of the virus, we have had a number of our childcare staff contract COVID-19, and due to the rules around quarantine, they are unable to staff those programs again for up to two weeks, sometimes longer. That in turn limits our service capacity, which means parents and guardians, who are needed on the front-lines, might need to miss work to care for their children.

The childcare workforce has been deemed essential, and our focus on children who have been most adversely impacted by the pandemic, children of color and those living in poverty, aligns with the state’s high priority on ensuring equity in vaccine rollout. We believe it is smart public health and economic policy to vaccinate the members of our workforce that we have entrusted with the care and supervision of our children. Giving kids a safe play to learn, play and interact is vital to their development, and that is only possible with a steady, healthy childcare and supervision workforce.

We have previously offered our facilities as testing locations and would also be pleased to provide space for vaccination centers. Not only do we have locations across the state, but our close ties to and established trust within our communities could mitigate some of the public’s misgivings about such a new vaccination. If the logistics and storage requirements permit, we hope to partner with you over the next several months in perhaps the most critical public health undertaking California has ever confronted.

If you or your staff have any questions about the services YMCAs have been providing during COVID-19, please don’t hesitate to reach out. I am personally available 24 hours a day, seven days a week. I can be reached at 916.730.0271 and our government relations representative, Christina Marcellus, can be reached at 310.963.2023.

**Sarad Bedy, Executive Director, California Alliance of Boys & Girls Clubs**

On behalf of the California Alliance of Boys & Girls Clubs, I am writing to request that the child supervision staff, including those providing distance learning and expanded learning supports, be granted rapid access to the COVID-19 vaccination. Ideally, we request that members of this crucial workforce be included in the first tier of the rollout, along with health care workers and assisted living residents.

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While children don’t seem to play a prominent role in the transmission of the virus, we have had a number of our supervisory staff contract COVID-19, and due to the rules around quarantine, they are unable to staff those programs again for up to two weeks, sometimes longer. That in turn limits our service capacity, which means parents and guardians, who are needed on the front-lines, might need to miss work to care for their children.

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**Stefan** **Salameh, Air Line Pilots of America (ALPA)**

 I am writing on behalf of the Air Line Pilots of America, ALPA. We represent a majority of the passenger and cargo pilots operating out of California’s largest airports. From the beginning of the CV19 outbreak, our pilots have been at the spearhead of transporting medical supplies and PPE from around the world to the California and the USA. The passenger carriers, such as my employer United, have repurposed many of our long haul aircraft to be used for cargo only flights. Just last week, United Airlines was the first carrier to transport the Pfizer vaccine from its EU production site to the USA.

A concern for the "great lift" about to take place is the safety and reliability of our crew members. Through the last 7 months, many crews have tested positive or been with a crew that tested positive while in the international theatre. This leads to lengthy quarantines and delayed cargo flights. While these delays were manageable with non-perishable medical supplies, they may not be tolerated with cold storage supply chain needed for the CV19 vaccines.

   I ask you consider ALPA to be added to the committee and please provide me with the processes and point of contact to make this happen. We appreciate your time and look forward to transporting this life saving vaccine to California, the US, and the world.

**Julie Khani, American Clinical Laboratory Association**

As the nation prepares for the distribution and administration of COVID-19 vaccines in coming weeks, I am writing to emphasize the critical importance of including laboratory personnel in the category of essential health care workers for prioritized vaccination allocation. The American Clinical Laboratory Association (ACLA) is the national trade association representing leading laboratories that deliver essential diagnostic health information to patients and providers. ACLA members are at the forefront of driving diagnostic innovation to meet the country’s evolving health care needs and provide vital clinical laboratory tests that identify and prevent infectious, acute, and chronic disease. The association’s members also have been a critical component of the response to the COVID-19 pandemic, having performed over 70 million COVID-19 diagnostic and serologic tests to date.

Laboratory professionals are on the frontlines of the COVID-19 response, working around the clock to process tests as quickly as possible and provide critical results to patients, health care providers, and public health agencies. Every day, laboratory personnel including technicians are at risk of direct exposure to the SARS-CoV- 2 virus through handling of patient specimens and processing of tests. As noted in the Advisory Committee on Immunization Practices (ACIP)’s Ethical Principles for Allocating Initial Supplies of COVID-19 Vaccine: “The ability of essential workers, including health care workers and non–health care workers, to remain healthy has a multiplier effect (i.e., their ability to remain healthy helps to protect the health of others or to minimize societal and economic disruption).”1 Without a healthy laboratory workforce, clinical laboratories will be unable to maintain the high volume of testing that is critical to our nation’s COVID-19 public health response and economic recovery.

It is imperative that laboratory personnel who are frontline health care workers have priority access to vaccines in order to continue our collective fight against COVID-19. We applaud ACIP’s initial recommendations that include essential health care workers as one of four prioritized categories for COVID-19 vaccination allocation. In an August 18 guidance, the U.S. Department of Homeland Security Cybersecurity and Infrastructure Security Agency included laboratory personnel, phlebotomists, and diagnostic and therapeutic technicians as examples of

1 Advisory Committee on Immunization Practices’ Ethical Principles for Allocating Initial Supplies of COVID-19 Vaccine (Nov. 27, 2020), *available at* [https://www.cdc.gov/mmwr/volumes/69/wr/ mm6947e3.htm?s\_cid= mm6947e3\_w](https://www.cdc.gov/mmwr/volumes/69/wr/mm6947e3.htm?s_cid=mm6947e3_w)

essential critical infrastructure workers for the COVID-19 pandemic.2 As the laboratory workforce is a critical component of our nation’s response to COVID-19, we strongly urge inclusion of laboratory personnel in the category of essential health care workers for vaccine prioritization.

Thank you for your leadership during these unprecedented times. ACLA remains committed to partnering with you to support our nation’s public health response to COVID-19.

**Tracie Olson, Chief Public Defender, Yolo County**

I am writing to request that public defender clients and public defender staff be offered priority in receiving the COVID-19 vaccine.

Our clients are among the most vulnerable in society. Many are detained in facilities such as jails, juvenile halls, and immigration detention centers, where social distancing is prohibitive and access to necessary sanitary products is sparse. Additionally, many of our clients suffer from underlying health conditions, including physical ailments and mental illness, that make them uniquely susceptible to severe illness and death from the COVID-19 virus. Ensuring the vaccine is offered to our detained population should be a priority in the vaccine distribution plan.

Moreover, public defender staff should be offered priority in receiving the COVID-19 vaccine. The work of public defenders never stopped. Even with the temporary closures of certain courthouses, the responsibility of public defenders to communicate with clients, incarcerated or not, did not stop.

Throughout this pandemic, we have continued to prepare cases, visit clients in jail and other detention facilities, communicate with clients' families, and go to court. We believe that our responsibility to represent our clients to the best of our ability has always superseded the risks to our personal health, and many of us have paid the price by contracting the virus. A Los Angeles Public Defender died from the COVID-19 virus earlier this summer. Allowing us to be vaccinated along with other essential workers would help ensure that clients continue to receive high quality and timely legal representation while keeping us safe in the process.

**Colin Hawley, ARC Strategies for Health Center Partners**

We represent Health Center Partners in San Diego and we had a quick question for your understanding Carol is gone for the week.

In regards to the Advisory Group handling vaccine distribution, we were curious how invitations were sent out? If you aren’t familiar, HCP is a GMC delivery model and we would appreciate a chance to be a part of the discussion if at all possible.

We are aware of CPCA’s participation but we are concerned they might not share pertinent information directly related to HCP’s needs in San Diego.

**Todd Snitchler, President & CEO, Electric Power Supply Association**

I’m writing on behalf of the Electric Power Supply Association (EPSA), the national association representing competitive power suppliers, and the Independent Energy Producers Association (IEPA), our partner association in California. Competitive power suppliers are distinct from regulated utilities though we are a critical piece of the energy supply chain. Our member companies own, operate, and invest in power generation facilities while utilities typically manage the delivery of the electricity that our members produce. EPSA previously contacted your office in March with a letter outlining our member companies’ efforts to ensure that power production would continue during the COVID-19 pandemic; we appreciate your state’s efforts to help us remain reliable during these challenging times.

Attached, please find a letter from me, EPSA’s President and CEO, and IEPA’s CEO Jan Smutny-Jones (copied here), which, given recent announcements concerning COVID-19 vaccine efficacy and likely imminent approval from the federal government, respectfully requests that power plant workers—including contractors and vendors—be prioritized for vaccine distribution. I have also attached a recently sent letter from several energy trade associations and labor unions, including EPSA, which makes a similar request of a host national organizations that represent state and local interests.

As Americans have faced unprecedented disruption during the COVID-19 pandemic, EPSA and IEPA are proud that electricity service has not been among the list of concerns. We appreciate the incredible efforts that you and your administration have made to keep your residents safe and help many businesses continue to operate. We look forward to continuing to work with you as a vaccine nears deployment and offer our assistance in any way to help your state navigate the remainder of the pandemic.

**Nadira Baddeliyanage, Executive Director, and Poul Lemasters, Executive Director, General Counsel, International Cemetery, Cremation and Funeral Association**

In light of the release of the National Academies of Sciences, Engineering, and Medicine (NAS) Framework for the Equitable Allocation of COVID-19 Vaccine, and the drafting of respective State vaccine distribution plans, the International Cemetery, Cremation and Funeral Association (ICCFA) is urging you to utilize the NAS recommendations for vaccine distribution to high-risk health care workers, including those same workers in the deathcare industry. This also follows CISA guidance to states on essential critical workers during COVID-19 response that includes deathcare workers as essential healthcare and public health professionals.

As developing an equitable allocation plan for a COVID-19 vaccine is critical in light of what are expected to be limited resources upon initial approval, prioritization should be given to those at most risk for infection and serious outcomes; in roles considered to be essential for societal functioning; and most at-risk of transmitting coronavirus to others.

Deathcare workers, which include funeral directors, morticians, crematory, funeral home and cemetery workers are all on the front lines in responding to the pandemic. The deathcare profession is handling the COVID-19 deaths in the United States from transporting and refrigerating the deceased, to meeting with family members/loved ones as well as the handling and final disposition of COVID-19 victims, and preparing the deceased for visitations, cremation, funerals, and ultimately burying the deceased.

Within the NAS framework, the highest priority for allocation of the COVID-19 vaccine is targeted to high-risk health workers, first responders, those with underlying conditions, and older adults in overcrowded settings, such as nursing homes. Specifically, under the classification of high-risk workers in health care facilities, the framework lists “morticians, funeral home workers and other death care professionals involved in the handling of bodies,” to receive priority vaccination. In addition, in guidance to states regarding classifying essential critical workers during COVID-19 response, the Department of Homeland Security Cybersecurity and Infrastructure Security Agency (CISA) has defined deathcare workers as essential healthcare and public health professionals.

Every day, deathcare workers risk exposure to the novel coronavirus as they handle remains and interact with the public. Enabling frontline deathcare workers to have access to a COVID-19 vaccine will help safeguard these essential workers so they can continue to provide the timely and effective handling of COVID-19 victims and other deaths. Failure to protect them could further exacerbate the public health hazard. Please make sure to include all deathcare workers as high-risk workers and include them as priority for vaccine distribution.

**Cindy Ehnes, COPE Health Solutions**

POPID’s Vision for Reopening California

# Executive Summary:

COVID-19 virus continues to buffet California, exacting a high human cost and an economic tsunami of nearly unfathomable dimension. POPID, the Pasadena-based technology leader in facial recognition software and artificial intelligence comes forward with a bold proposal for reopening California, combining identity management software (leveraging either facial recognition or QR codes on mobile devices) with existing technology and databases to allow businesses to reopen to real time and provably healthy patrons.

# Background: CA is poised for imminent collapse

Now some 9 months into the nation’s Coronavirus pandemic, California perches on the edge of disaster. Record high unemployment, decreased economic output, and collapsing tax revenues imperil California’s public safety, education, and social safety nets.1

Falling sales and income tax revenues imperil state and local budgets. Soaring unemployment weakens already depleted unemployment insurance reserves as well as inflicting individual and societal psychological trauma.

POPID is a Pasadena-based technology company, a leading and established expert in identity management software and artificial intelligence. Founded in 2016, POPID provides payment and building entry software services to thousands of consumers and businesses in Southern California. The Company is California steeped and proud, with its principal place of business in Pasadena. POPID’s parent company, the Cali Group, is also an owner of other Pasadena start-ups, including Kitchen United and Miso Robotics. The group draws heavily on California Institute of Technology graduates to lead its research and development.

# POPID Technology

1 See e.g., https://californiaforecast.com/covid-19-economic-analysis/; https://[www.latimes.com/business/story/2020-09-30/california-economy-ucla-anderson-forecast](http://www.latimes.com/business/story/2020-09-30/california-economy-ucla-anderson-forecast)

POPID is the developer of the world’s most sophisticated and accurate facial recognition software. POPID also markets cameras capable of interfacing with its software and which are capable of thermal temperature scans. Thus POPID provides technology which can recognize a person who has signed up with POPID, *and* verify the individual has no active fever before allowing entry to a premises.

POPID can be integrated with a databases of presumptively healthy people, i.e., persons who have received a COVID vaccination as reflected in the State’s CAIR2 vaccination database vaccine database once COVID vaccines are available in the next several weeks.

POPID is already working in consultation with the federal Operation Warp Speed vaccine development and distribution program.

# POPID’s vision to Reopen California:

California stands at the abyss. Unless the economy is reopened, the State faces calamity; a private sector unable to generate tax revenues necessarily means the State’s inability to provide criminal justice, education, and social services. Something must be done.

POPID’s vision for Reopening California includes two phases for allowing a demonstrably safe reopening of California.

Phase 1

Individuals who voluntarily choose to do so can sign up for a free POPID account and link their vaccination record to their account. Thus, the individual’s face, or a QR code on his/her phone becomes proof of their presumptively healthy, non-COVID status. Importantly, only POPID hosts the individual’s face image.

Phase I specifically contemplates a pilot project in Pasadena in conjunction with Huntington Hospital, which will soon begin vaccinations on a voluntary basis with its front-line healthcare workers.

Then, Pasadena businesses, e.g., restaurants, stores, health clubs, can voluntarily reopen to persons with *demonstrable* proof of vaccination. Such businesses would install POPID cameras with the POPID software capable of recognizing the individuals who have been vaccinated. As an additional layer of protection, it is recommended businesses install the cameras with thermal temperature scan providing an extra prophylaxis. The end result is an establishment where the doors literally do not open to an individual without proof of vaccination.

POPID’s identity recognition software is critical to such a phased reopening to demonstrably healthy patrons. Facial recognition cannot be borrowed like a piece of paper or card. Moreover, by implementing a phased reopening through the POPID system, this proposal relies on the voluntary participation of consumers and businesses, and can allow for a focused Pasadena pilot.

Phase 2

Phase 2 is identical to Phase 1 except with an expansion to other municipalities and counties seeking to reopen. The results are identical, a business establishment, school, or other public accommodation operating to serve a presumptively healthy public while continuing to stop the spread and protect the vulnerable. California society emerges from a long, dark period of isolation, with a functioning economy, while maintaining a strong focus on public health and infection control.

By allowing businesses to reopen to a healthy population, California can re-establish a stable revenue stream, jobs, and a sense of normalcy critical to the population’s physical and mental health.

# What is Necessary to implement the POPID Vision?

All that is required to get California going again, is to amend the Governor’s Executive Orders to permit businesses with POPID technology to open to patrons with POPID accounts [and negative test results and/or vaccinations], or to amend the Orders to allow local governments to grant such approvals.

Additionally, for Phase 2 only, POPID would need Department of Public Health authorization to link/integrate proof of vaccination records from its CAIR database for those individuals choosing to participate. Equally necessary would be close coordination with the Pasadena Public Health Department to monitor the pilot.

**Julee Malinowski-Ball, PPA for Prolacta Bioscience**

I represent Prolacta Bioscience that is offering to clear freezer space and make it available to the state of California for vaccine storage in the City of Industry/Duarte area. Here is some additional information on the capacity in their -80 C freezer, and I have attached the IOQ report as well. They also have some capacity in their -20 C freezers, and I am working to track down how much additional capacity is there.

Text

Description automatically generated

Prolacta also has a distribution system with dry ice since they ship frozen milk daily. They do have a tissue license from the state and believe that with coordination with the CA Department of Health, they could work with the FDA to handle distribution approval.

**Edward Kissam**

Thank you for the opportunity to submit comments and recommendations regarding California’s vaccination campaign.  I have focused on vaccination strategy oriented to farmworker communities but appreciate your overall efforts to optimize the campaign rollout.  Please see my comments in the attached file.

Please do feel free to get in touch with me with any questions you may have about any of my comments or suggestions. I’d be happy to provide you more details if useful.

I am one of several California members of an advisory committee convened by the National Center for Farmworker Health to provide input to CDC regarding guidance for agricultural workers and employers and will surely be continuing to advocate sound strategy for vaccination efforts.  I’m sure the group wlll be looking to California’s efforts and hoping, as is often the case, that California will be leading the way.

I would like to submit several comments and suggestions relating primarily to vaccination strategy and mounting an effective campaign for farmworker communities. My comments are based on extensive research in California farmworker communities over the past 30 years and substantial engagement in conversing about and writing about effective COVID-19 response in farmworker communities over the past 9 months.

# 1. Multiple CDC-Identified Criteria Suggest High Priority Should Be Given to Vaccinating Farmworkers

A presentation from Dr. K. Dooling during the CDC’s November 23 meeting of the Advisory Committee on Immunization Practices (ACIP) provided a valuable analysis of principles that should guide priorities. In the CDC framework, essential workers deserve priority in vaccination due to their likely risk of contracting COVID-19 in the workplace (burden of disease) while, within the CDC policy frameworks, the other identified groups deserve priority based on the ethical principles of maximizing benefits/minimizing harm, promoting justice, and mitigating health inequalities. The CDC policy framework also takes into account feasibility.

The CDC analysis goes on to note the overlap between three priority groups for vaccination based on these considerations: essential workers, adults 65 or older, and individuals with pre- existing medical conditions. Given the profile of the California farmworker population, the well- reasoned CDC criteria suggest it is necessary to give very high priority to farmworkers because many fall into sub-populations who suffer greater-than-average harm from contracting COVID-

19. Consequently, within the ACIP tiers farmworkers should be placed in Tier 1b.

It is important to understand that California farmworkers deserve high priority not simply because they are essential workers in workplaces where risk of COVID-19 exposure is very high, but, also, because the California farm labor force is aging (less newly-arrived young workers from Mexico in recent years), and because many have co-morbidities.

National Agricultural Worker Survey data show that California farmworkers average 42 years of age (Gabbard 2020). More than one-third are 45 or older—22% in the 45-53 age group, 9% in the 55-64 age group, and 3% in the 65+ group. CDC’s August, 2020 estimates of relative ratio of hospitalization in these age cohorts are 3-5 times higher than for the reference groups of 18-29 year-olds. Relative rates of death for these age groups are 10-90 times higher than for the reference group. Consequently, the impact of COVID-19 as indicated by hospitalization rates and mortality is higher for farmworkers and the related benefits/impact of minimizing harm is greater than generally believed.1

As has also been reported in many publications, e.g. the California Agricultural Worker Health Survey, several co-morbidities associated with worse COVID-19 outcomes (BMI overweight or obese, diabetes, cardiovascular disease) are prevalent in this now-aging farmworker population. Very recent research (July-November, 2020) conducted as part of COVID-19 testing in collaboration with the FQHC showed that 43% of the study sample were obese, 14% were hypertensive, and 13% were diabetic in Monterey County (Eskenazi et al 2020).

# The California Farm Labor Force, Current Farmworkers, and Farmwork as A Way of Life

COVID-19 vaccination policy seems to assume that “essential workers” can be neatly identified via administrative records or vaccinated based on their employment. This approach is understandable (but imperfect) in the case of health care workers. Hospitals or primary care providers have a relatively stable workforce, the industry is heavily regulated, and their employees can be easily identified. That is not the case for farmworkers.

In an analysis I prepared as part of Legal Services Corporation re-authorization of its migrant programs (Kissam and Williams 2014) careful analysis indicated that 6.6% of the farm labor force consisted of women who were not employed were only temporarily out of the labor force because of child-bearing or child care responsibilities. Although they not currently employed in agriculture, it is necessary to consider farmworker women who are temporarily out of the farm labor force to be “farmworkers” because many would soon be returning to farmwork. Similar issues arise with respect to determining whether temporarily disabled farmworkers or those who are unemployed for a protracted period of time should be considered “farmworkers” for the purpose of determining priority for vaccination. In the real-world context of the COVID-19 pandemic their risk of workplace exposure is very high—even if they are currently not in the labor force—because they will soon return to farmwork and, if economically-burdened, as so many currently are due to COVID-19’s disruption of the agricultural production, they may well be re-employed in more marginal working conditions.

What this implies is that implementation of the portion of a vaccination campaign to serve California farmworkers must not have strict, bureaucratic eligibility requirements but, instead, acknowledge the fact that, historically, California has always had a reserve pool of farm labor consisting of unemployed and underemployed farmworkers, as well as seasonal unemployment. Dr. Richard Mines estimates that there are about 650,000 farmworkers in California. I would recommend that planning include allocation of vaccine for this “core” labor force and, also, these more peripheral members of California’s farm labor force and that messaging make clear that they, too, are eligible to be vaccinated in a priority tier of vaccination.

# Pathways of COVID-19 Transmission in Farmworker Communities and the Need for A Strategy Offering Whole-Household Vaccination to Farmworker Households

My analysis of patterns of COVID-19 cumulative incidence in California farmworker communities (Kissam 2020) and analysis by Dr. Richard Mines (Mines and Ward 2020) provide clear-cut statistical evidence that high incidence of COVID-19 among farmworkers stems not only from workplace exposure but, also, from crowded housing. (Papers available on request). My analysis shows cumulative incidence of COVID-19 in farmworker communities to be statistically correlated with household size and, implicitly, with crowded housing. Richard Mines’ analysis shows directly that crowded housing and, particularly, “joint dwellings” (housing conditions where families and non-relatives share housing) are correlated with cumulative incidence of COVID-19 in farmworker communities. Because these “joint dwellings” are often ones where disparate social networks intersect, they are expected to be especially high-risk vis-à-vis COVID-transmission.

Being a farmworker is persistently tied to living in crowded housing and COVID-19 transmission is inevitably extremely high in crowded housing (as shown by research by UCSF, by Dr. Eskenazi’s Monterey County research, and epidemiological analysis of transmission in crowded living quarters on cruise ships, Marine training facilities, prisons, and detention centers). In farmworker households, inevitably, everyone is a “close contact” of everyone else. Even in “complex compounds”, e.g. where some live in converted garages or backyard trailers, bathroom and or cooking facilities are shared, providing opportunities for close contact/viral transmission.

This situation implies that it would make sense to offer vaccination to everyone living in a farmworker household and/or shared living quarters. Including household members in addition to current farmworkers will increase the size of the group eligible for priority vaccination on the basis of their being identified as farmworkers but is justified on ethical grounds and actually improves efficiency in the vaccination campaign.

Although a strategy designed to offer vaccination to everyone in farmworker households increases the number of individuals to be vaccinated in this priority tier reserved for farmworker, it must be recognized that in many farmworker households most or all adults are workers. Consequently, generously and compassionately extending invitations to be vaccinated to the entire household would probably only bring the farmworker tier of individuals eligible for priority vaccination up from 650,000 to about 1 million.

Considerations related to feasibility come into play here too. The National Institutes of Health and many sociologists are concerned about vaccine hesitancy among minority populations and farmworkers. This is a reasonable worry and has some important operational implications for California’s vaccination campaign.

From a cultural perspective it needs to be recognized that the best way to increase vaccine hesitancy among current farmworkers would be to deny their spouses and children an opportunity to be vaccinated while they, themselves, are. The most effective vaccination campaign will be one which promotes whole-household vaccination with messages such as “The family that gets vaccinated together is one that stays healthy and happy” It needs to be recognized also that there are additional compelling reasons to design a vaccination campaign to encourage whole-household vaccination.

One is that such an approach provides the basis for effective messaging (as opposed to a bureaucratic announcement with difficult details eligibility for vaccination resting on meeting a multitude of official requirements).

The other is that vaccination campaigns and outreach targeted to farmworker neighborhoods and communities can facilitate access to vaccination for families who have little free time and difficulties in securing transportation if they do not, themselves, have a car.

These operational considerations are crucial to keep in mind since the success of the national, state, and local vaccination campaigns rests on success in minimizing administrative complexity and speed/ease of implementation.

# A Messaging Campaign to Assure Farmworkers that Vaccination is Free

Somewhere between half and two-thirds of California farmworkers lack legal status and more than one-third lack health insurance. A successful vaccination campaign for California farmworkers will require intensive messaging assuring them that vaccination is available free and with minimal or no paperwork. Current analysis of vaccine hesitancy fails to recognize that a rational reason for hesitancy is that it’s not viable to incur further health care costs.

# A Messaging Campaign and Operational Provisions to Assure Followup After First Shot

Inadequate attention has been given to the challenges of assuring that everyone in a population of working poor return for their second shot (assuming the vaccine is either the Moderna or the Pfizer mRNA one). Extensive messaging will need to explain several aspects of the 2-stage vaccination process—that immunity does not develop immediately after vaccination, that the first shot affords only partial immunity, and that immunization will not be complete until a week or so after the 2nd shot and that, therefore, vaccinated individuals will need to continue to observe social distancing protocols, wear a mask, avoid contact with infected individuals during this period of vulnerability.

# Provisions to Make Vaccination Easily Accessible

There were initially well-founded concerns about the logistics of vaccination using the Pfizer vaccine with its stringent temperature control requirements. Because the Moderna vaccine does not have such stringent temperature control specifications, it will be possible to establish venues for vaccination (including “vaccination fairs”/special events) in venues close to where farmworkers work and live, including vaccination events in local schools, churches, and other immigrant-friendly settings.

1 The CDC analysis of relative risk of hospitalization or death for demographic sub-groups uses slightly different cut points: 40-49 years of age, 50-64, and 65+. However, the overall risk of hospitalization for these older farmworkers is as stated: 3-5 times higher than the reference group.

**James Mittelberger, Chief Medical Officer, Interim CEO, Center for Elders Eduction** Friday, December 4, 2020 1:01 AM

1.       Please prioritize PACE frontline health care providers in the top tier of those to receive vaccinations alongside SNF workers. Our frontline care providers, largely from the most impacted low-income diverse communities  go from one frail participant to another, just like SNF workers and require the same prioritization.

2.       Please include PACE participants in congregate care facilities in the highest tier, alongside SNF patients. All of our PACE patients are frail and require support to survive. It is essential to recognize that our low-income diverse elderly frail patients, living in RCFEs, are in congregate facilities. Even the participants at home are at risk due to the high community risk, which we cannot control

3.       We are able to manage the vaccination of these patients in coordination with our pharmacy.

**Ned Dolejsi, Executive Director, Californi Catholic Conference**,

California Catholic Conference, Catholic Health Care Ministries and   
Catholic Charities Support COVID-19 Vaccinations

The California Catholic Conference affirms that the imminent Pfizer and Moderna COVID-19 vaccines are morally acceptable and commit to working closely with Catholic health care ministries and Catholic Charities to:

* Promote and encourage COVID-19 vaccinations in collaboration with state and local governments and other entities;
* Advocate on behalf of vulnerable populations to ensure that they have access to safe and effective COVID-19 vaccines; and,
* Provide regular and accurate information to parishioners and the community in support of morally acceptable, safe and effective COVID-19 vaccines.

Life has changed this year in ways few of us could have imagined. The COVID-19 pandemic has brought loss of life and livelihood to every community, rich and poor. We mourn for those who have died and for their families, and we offer our prayers and assistance to those struggling with loss of businesses, unemployment, loneliness, anxiety and other traumas brought on by this calamity.

Fortunately, two COVID-19 vaccine candidates will likely be granted emergency use authorization from the U.S. Food and Drug Administration (FDA) before the end of the year, and one or more vaccines will likely become widely available in 2021. While the vaccines are still under review, they have been extensively studied in rigorous clinical trials and early safety and effectiveness findings look promising.

The chairs of the U.S. Catholic Conference of Bishops’ Committees on Doctrine and Pro-Life Activities, the Catholic Health Association and other respected moral theologians have found the early vaccine candidates to be morally acceptable.

We welcome this news and look forward to the distribution of safe and effective vaccines with a sense of relief while recognizing the formidable logistical challenges that lay ahead for vaccine developers, health care providers, governments and others.

All the arch/dioceses in California together with Catholic health care ministries and Catholic Charities support the eradication of disease that disrupts human life. The Pfizer and Moderna vaccines promote health in face of a devastating pandemic that no one expected. We want to reemphasize that the origins of the vaccines are morally acceptable from a Catholic perspective and their advancement fosters the common good. We also affirm that those who are most vulnerable must have a privileged place in their distribution and allocation.

Therefore, California dioceses, various state and local outreach ministries, Catholic health care systems and hospitals offer to assist with this massive undertaking in the following ways:

The California Catholic Conference, Catholic health care systems and Catholic Charities commit to promoting and encouraging COVID-19 vaccinations in the communities we serve.

Dioceses have a special relationship with Catholic health care providers and will work closely with them and rely heavily on their guidance. Many also already work with other providers, such as in bringing health care to farmworkers. These collaborations will be utilized as appropriate and new ones established when they can be helpful. The dioceses and the Catholic health systems will also continue to work with the California governor’s office, the Department of Public Health, and county and local public health agencies.

Our collaboration commits to strong outreach to vulnerable populations such as farmworkers, undocumented individuals and low-wage earners who seek guidance and assistance from our ministries. Much of this work will focus on promoting or establishing, if necessary, safe locations for undocumented individuals and others who may not have regular access to health care, are unsure of the motives behind the vaccination or are not certain where to turn for help.

We commit to providing clear information to parishioners and communities in support of safe and effective vaccines. At a time when misinformation clouds our public discourse it is critical that we focus our efforts on clear, culturally appropriate and effective messaging.

It is also vitally important that we work together in a spirit of solidarity and cooperation. As Pope Francis recently expressed:

*At a time when everything seems to disintegrate and lose consistency, it is good for us to appeal to the “solidity” born of the consciousness that we are responsible for the fragility of others as we strive to build a common future. Solidarity finds concrete expression in service, which can take a variety of forms in an effort to care for others. And service in great part means “caring for vulnerability, for the vulnerable members of our families, our society, our people”… Service always looks to their faces, touches their flesh, senses their closeness and even, in some cases, ‘suffers’ that closeness and tries to help them. Service is never ideological, for we do not serve ideas, we serve people. [115]*

Fratelli tutti, Pope Francis, 2020

Finally, we offer a special thanks to the health care professionals who have and will continue to care for the sick; to essential workers that enable society to continue functioning; for scientists and researchers who brought us to this moment; to teachers and parents struggling to educate children; to workers in ministries finding innovative ways to bring spiritual and corporal resources to congregations; and to everyone who has helped carry the burden of others during this pandemic.

We pray for them as we pray for the world. We still have much work to do, but we now have hope and a path forward rooted in the healing ministry of Jesus Christ. We place our trust and confidence in the providence of God.

**Eric Nunez, President, California Police Chiefs Association**

California has been hard-hit by the pandemic and I know you have been working hard to ensure the safety of our state’s citizens, as well as prepare and plan for a vaccine distribution of historic proportions. We appreciate your leadership during very challenging times.

As President of the California Police Chiefs Association, I wanted to reiterate the importance of law enforcement and all first responders being included in the 1st Tier of COVID vaccine distribution. Our officers are on the front lines and in direct contact with members of the public all day, and the first to rush into dangerous situations. While prioritizing who gets the vaccine as it becomes available is especially challenging, we appreciate law enforcement being included as a priority along with health care workers and the extremely vulnerable. Thank you.

**Chris Lopez, Chair, Board of Supervisors, Monterey County**

On behalf of the County of Monterey, we write you to respectfully request that the State’s farmworker population be prioritized to receive COVID-19 vaccinations to protect our farmworkers who are providing critical and essential services to our community, region, and state.

Monterey County is one of the nation’s top agricultural producers and agriculture is the County’s largest economic and employment sector. A recent study, [*Economic Contributions of Monterey County Agriculture (2020)*,](https://www.co.monterey.ca.us/home/showpublisheddocument?id=95118) shows that in 2018 agriculture contributed a total of $11.7 billion to the county economy. Agriculture also supported 57,503 direct employees, which represented 22.8% of Monterey County’s total employment, or about one out of every five jobs.

According to the [*COVID-19 Farmworker Study*,](http://covid19farmworkerstudy.org/survey/wp-content/uploads/2020/08/EN-COFS-Preliminary-Data-Brief_FINAL.pdf) *“during the current COVID-19 pandemic, all essential workers put themselves at risk when they show up for work in grocery stores, hospitals, packing houses, and agricultural fields. Farmworkers face additional risks because they lack critical social safety net support afforded to other members of society, despite working in one of the most dangerous industries in the country. The COVID-19 pandemic has exacerbated existing vulnerabilities farmworker communities endure in their living, working, and health conditions…”.*

*“The COVID-19 Farmworker Study provides strong evidence that the current pandemic amplifies existing injustices that have long been endured by California farmworkers. Farmworkers and organizations that work with them have powerful and productive suggestions for improving the safety of workplaces and communities. Preliminary findings from data collected through surveys of farmworkers during the pandemic reveals the following:*

1. *Farmworkers experience dramatic loss of work and income during the COVID-19 pandemic.*
2. *Farmworkers lack healthcare access and experience fear using medical services.*
3. *Farmworkers are vigilant about COVID-19 prevention practices outside of the workplace.*
4. *Farmworkers report low numbers of employers providing masks and face coverings.*
5. *Farmworkers have valuable suggestions to improve workplace COVID-19 prevention efforts.*
6. *Farmworkers are systematically excluded from important safety-net programs, which heightens their vulnerabilities and those of their family members.”*

Farmworkers are essential workers and due to nature of the work, are not able to work from home and social distancing at work can be difficult due to machinery constraints. Monterey County data show that our farmworkers are primarily Latinx and our Latinx population is experiencing disparate impacts not only in terms of higher case rates (74%), hospitalizations (83), and fatalities (77%) compared to 61% of population, but also higher food insecurity, overcrowded housing, and loss of income. In a Monterey County study conducted by UC Berkeley in partnership with Clinica de Salud del Valle de Salinas, 57% of farmworkers with COVID-19 infection had symptoms and went to work even though they were told not to, again because of fear of job loss and lack of income replacement options. When asked in the same study, 52% indicated they would be extremely likely to get the vaccine.

For these reasons, we implore you to prioritize agricultural workers in vaccine distribution plans to help reduce the burden of COVID-19 on these essential workers with benefits extending into the household as many live in very overcrowded housing conditions.

On behalf of the County of Monterey, we appreciate your consideration of our request and look forward to working together to keep our communities safe.

**Patrick Welch, California Municipal Utilities Association**

The undersigned organizations, representing the electric, natural gas, and water sector, respectfully urge you to ensure that California’s energy and water Essential Critical Infrastructure Workers – as identified by the State Public Health Officer – are part of the Phase 1-B vaccine distribution of the state’s COVID-19 Vaccination Plan.The Essential Critical Infrastructure Workers critical to keeping the water and power flowing have remained on the job since Day 1 of the COVID-19 crisis to keep the lights on and water flowing across California. For the greater good, these Essential Critical Infrastructure Workers have been putting their personal health at risk every day. Providing them reasonable priority access to the COVID-19 vaccine will help ensure that they can remain on the job to perform their critical functions while protecting the health and safety of themselves and those around them.

Collectively, our organizations, member organizations, and Essential Critical Infrastructure Workers provide electricity, natural gas, and water to nearly every Californian. We recognize the seriousness of the decisions that must be made when it comes to prioritizing what appears to be a safe and efficacious vaccination for COVID-19. We understand that there are myriad priorities and metrics to consider, including complex coordination with federal and local government partners. We also recognize the importance of ensuring California’s healthcare workforce is prioritized in receiving the vaccine.

The Interim Draft of the California Department of Public Health’s COVID-19 Vaccination Plan, dated 10/16/2020, provides that people at increased risk for severe illness or death from COVID-19 and other essential workers, may receive the vaccine in Phase 1-B of the three-phase approach to vaccine allocation. The Interim Draft does not define what are considered “other essential workers,” but does recognize that the state is currently identifying and estimating the critical populations for Phase 1.

The State Public Health Officer, in accordance with Executive Order N-33-20, has designated certain utility employees as Essential Critical Infrastructure Workers.1 These Essential Critical Infrastructure Workers perform work at critical infrastructure locations (such as water treatment plants and power plants) to keep electric and water infrastructure operating in neighborhoods, making necessary repairs to utility lines, and in the field carrying out wildfire prevention activities such as vegetation management and inspections for safe operations.

To reduce the risk of COVID-19 transmission, our organizations, member organizations, and Essential Critical Infrastructure Workers, have changed the way they work. For example, utilities are using staggered shifts or smaller teams of Essential Critical Infrastructure Workers. However, due to the nature of the work, there are times when these employees need to be in close proximity to each other, making vaccination – and PPE – highly important to the job. For example, Essential Critical Infrastructure Workers in grid control rooms often work in open floor plan environments with no walls or separation between desks, and the work requires frequent consultation between employees. Some work activities also require Essential Critical Infrastructure Workers to be in the community conducting field work, often in teams, which increases their potential exposure to the virus.

It is for these reasons that we respectfully request the Governor’s COVID-19 Vaccine Task Force Drafting Guidelines Workgroup ensure that energy and water Essential Critical Infrastructure Workers as identified by the State Public Health Officer, be specifically included in Phase 1-B of the state’s vaccination plan. Thank you for your consideration of our input and request. Our organizations and member organizations are committed to serving their communities and stand ready to work with you to inform the state’s vaccination plan. Please contact Patrick Welch at (916) 827-7113 or [pwelch@cmua.org](mailto:pwelch@cmua.org) to get in touch with our organizations.

**Jay Pea, Save Standard Time**

Thank you for your work in addressing COVID-19 in California. As an additional step that is easy, inexpensive, and necessary to take, please advise Governor Newsom to cancel California’s upcoming clock change to Daylight Saving Time (DST) and to restore permanent Standard Time in the state as soon as possible. Permanent Standard Time is recommended by thousands of scientists and doctors to improve sleep, mood, and immunity.  
  
UCLA Chancellor Gene Block PhD called for this same measure last year: <https://newsroom.ucla.edu/stories/who-wants-to-go-to-work-in-the-dark>  
  
The American Academy of Sleep Medicine called for it this year: <https://aasm.org/american-academy-of-sleep-medicine-calls-for-elimination-of-daylight-saving-time/>  
  
Please find attached a brief letter with citations detailing the many reasons permanent Standard Time can help defeat COVID-19. Feel free to let me know at any time if I can help on this matter further in any way.

**Samantha Beard, National Cattlemen’s Beef Association, National Pork Producers Council, and North American Meat Institute**

For the reasons discussed below the National Cattlemen’s Beef Association, National Pork Producers Council, and the North American Meat Institute (the organizations) respectfully request that workers in the meat and poultry industry, including United States Department of Agriculture meat and poultry inspectors, and livestock producers be given very high priority regarding the distribution and administration of COVID-19 vaccines.

Earlier this year the Department of Homeland Security identified food manufacturing as a critical infrastructure sector, which included meat and poultry workers and livestock producers.1 Those people have been on the front lines ensuring Americans have access to safe, nutritious, and affordable food.

The challenges packing plants and their producer suppliers in particular faced in the early stages of the pandemic were unprecedented and yet were endured. The meat industry is resilient and the supply chain remains intact.

Critical components of that resilience are the programs and protocols packers implemented in the spring and summer, programs that have proven effective in limiting the spread of the virus even while the curve nationally has been soaring in the opposite direction. Those programs and protocols, coupled with the education programs packers will undertake to explain the importance and safety of vaccination, put meatpacking facilities in an ideal position to administer the vaccine to many people in an orderly and efficient fashion.

The undersigned organizations acknowledge and support the Centers for Disease Control’s Advisory Committee on Immunization Practices recent recommendation administering the vaccine first to health care workers and certain other high-risk individuals. But prioritizing thereafter meat industry workers and their livestock suppliers addresses an industry that is part of the critical infrastructure and necessary to ensure the animals are harvested and processed. Such prioritization would allow the utilization of an existing system to deliver the vaccine to a significant and important part of the workforce.

The Committee on Equitable Allocation of Vaccine for the Novel Coronavirus, part of the National Academies of Sciences, Engineering, and Medicine, got it right when it concluded that people in the population group that includes meat and poultry workers “need to be provided the vaccine, and special efforts must be made to reach these workers in ways that encourage them to be vaccinated.”2

The systems are in place. The workers are part of the critical infrastructure and the State of California depends on these people to supply and process livestock so agricultural communities can thrive. For these reasons we respectfully request that, as you plan for the distribution of the vaccine, meatpacking workers, USDA inspectors, and livestock producers be given high priority to receive vaccinations.

1 Cybersecurity & Infrastructure Security Agency. [https://www.cisa.gov/identifying-critical-](https://www.cisa.gov/identifying-critical-infrastructure-during-covid-19) [infrastructure-during-covid-19.](https://www.cisa.gov/identifying-critical-infrastructure-during-covid-19)

2 *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*, p. 67.

**Darrin Greenlee, Blood Centers of California**

The Blood Centers of California (BCC) is an alliance of 11 non-profit blood centers located throughout the state. BCC member centers supply more than 1.4 million units of blood and blood products representing over 90% of products needed by California’s hospitals, physicians and patients. Our mission is to provide safe, high quality, and readily available blood and blood components for Californians.

We write, on behalf of all Californians, to join AABB, America’s Blood Centers, and the American Red Cross to support the CDC’s definition of “healthcare personnel” and the recommendation by the Advisory Committee on Immunization Practice (ACIP) to prioritize healthcare personnel, including blood center employees, for the purpose of allocating the COVID-19 vaccine.

Throughout the current COVID-19 pandemic, blood center employees across the state have continued to work every day with uncompromised and selfless commitment to ensure a safe and adequate blood supply remains available to Californians. Simply put, these individuals serve a critical role in service to patients needing blood and blood products including the collection of convalescent plasma used specifically to treat COVID-19 patients. The need for our ability to continue this service to the state without compromise by protecting these workers at the earliest possible opportunity is unquestionable.

To ensure a safe and robust blood supply remains available throughout the pandemic, it is essential that blood centers’ personnel be considered healthcare personnel for the purpose of the vaccine allocation in the state of California.

**Norma Groot, Farm Bureau Monterey**

Monterey County Farm Bureau represents family farmers and ranchers in the interest of protecting and promoting agriculture throughout our County. Since 1917, Farm Bureau strives to improve the ability of those engaged in production agriculture to provide a reliable supply of food and fiber through responsible stewardship of our local resources,

Since the start of the COVID-19 pandemic last March, our organization has been actively involved in farmworker health and safety issues, to maintain not only the health and well being of our valued employees, but also to keep critical food supply chains moving forward for retail and commercial food services.

Farmworkers play a critical role in the growing and harvesting of the 150 different crops produced here in Monterey County, mostly fresh food products such as leafy greens, vegetables, and berries. The Salinas Valley, known as the "Salad Bowl of the World" supplies a vast majority of these crops to our nation's dinner tables each year.

Taking a pro-active stance developing practices and workplace rules that protect our farmworkers was mission critical to keeping· our food supply secure. Indeed, Monterey County was the first in our state to develop and issue a Farmworker Advisory Document that detailed necessary guidance to both employers and employees. This document served as a template for many other counties in our state, as well as across the nation.

Our crops cannot be mechanically harvested. Thus, we are dependent on over 57,500 individual farmworkers to grow and harvest our crops each year. Any shortage of farmworker labor means that crops are left in the field unharvested; such is the reality of producing fresh food products that have a short window of harvest for optimal market quality.

On behalf of the Board of Directors of Monterey County Farm Bureau, we request that due consideration be given to prioritizing our farmworkers for any and all COVID-19 vaccines made available in the State of California.

Farmworkers are the first responders of our food supply; we need to protect them as much as possible to ensure own collective food security.

**Susie Fishenfeld**, **PACE**

I am writing to request inclusion of Programs of All-Inclusive Care for the Elderly (PACE) staff and the participants we serve in the populations prioritized for distribution of the COVID-19 vaccines.  PACE serves individuals who are 55 or older who meet our state’s criteria for needing a nursing home level of care but are able to live in the community with the support of the PACE program.  Brandman Centers for Senior Care operates a PACE program in Los Angeles County.

Like their nursing facility resident counterparts, PACE participants are at significant risk of severe illness and death from COVID-19 given their advanced age and health status. In its most recent recommendations, the Advisory Committee on Immunization Practices (ACIP) clearly recognized the vulnerability of frail elderly and disabled residents of nursing homes, assisted living facilities, and other congregate settings to severe complications of COVID-19. Equally as vulnerable are similarly frail elderly and disabled individuals in the community. For PACE organizations, having access to the COVID-19 vaccine is of utmost importance. PACE participants and staff (and perhaps family caregivers of PACE participants) qualify as critical populations for whom early access to the vaccine is extremely important. The National PACE Association and its members are prepared to take appropriate and necessary steps to ensure that access to the vaccine for PACE participants and staff is consistent with their needs.  Notably, PACE organizations operate PACE centers where the vaccine could be administered in a centralized location to our population of frail older adults.  Further, PACE organizations provide transportation services to enable our older adults to receive the vaccine at our centralized PACE center location.

We look forward to working with you to provide access to the vaccine to our highly vulnerable population and staff.  Please contact me if I can provide any additional information.

**David Shoultz, Phillips**

On behalf of Philips and the company’s nearly 1,800 employees in California, I request that the State consider certain medical device industry workers in Phase 1a of vaccination distribution. Many of these workers, like technicians and industry representatives, also have an increased risk of COVID-19 exposure because they perform critical functions alongside health care professionals in healthcare settings. They endeavor to maintain patient access to needed technology. In addition, medical device manufacturing workers should also be vaccinated in the appropriate phase with other critical manufacturing workers.

As the State determines its COVID-19 vaccination strategy, Philips urges guidance to determine and confirm eligibility for medical device industry clinical field and manufacturing personnel; they are both considered essential critical infrastructure healthcare workers by the U.S. Department of Homeland Security Cybersecurity & Infrastructure Security Agency (CISA) Guidance.1 Having a clear plan would help ensure these workers’ health and safety.

# Health Care Industry Representatives (HCIR)

Medical device company representatives are also referred to as Health Care Industry Representatives (“HCIRs”). They are often present in patient care settings to provide technical support concerning the safe and effective application of surgical products and technologies.2 In addition to this technical assistance function, HCIRs “may be involved in the remote calibration or adjustment of medical devices (for example, pacemakers, laser technology) to the surgeons’ and manufacturers’ specifications.”3

Generally, HCIRs must meet certain hospital supplier credentialing requirements to access certain areas of a hospital. These credentialing requirements include documentation of vaccinations (or titers showing immunity) for Influenza, Tetanus, Diphtheria, Pertussis, Measles, Mumps, Varicella, and Hepatitis B.4 It is also worth noting that the *American National Standard for Supplier Credentialing in Healthcare* was recently updated to include appropriate Personal Protective Equipment (PPE) use in healthcare provider facilities and a new section concerning Novel Viruses/Communicable Illness.5 HCIRs are not contractors of the hospital; instead, they are employed or retained by medical device companies. This dynamic may complicate a vaccine administrator’s ability to identify and flag HCIRs for prioritized vaccine allocation or to determine and confirm whether an HCIR meets the eligibility requirements for a particular phase of vaccination.

With regard to high-risk health workers identified for allocation Phase 1a of the National Academy of Sciences (NAS) Framework, Philips endorses the NAS Consensus Study statement that “access should not be defined by professional title, but rather by an individual’s actual risk of exposure to COVID-19.”6 Consistent with that approach, certain medical device company representatives/ HCIRs have an exposure risk to COVID-19 positive patients or their tissues, cells, or biofluids during their work to provide technical support for, calibrate, service, or repair medical devices (including diagnostics). HCIRs required by health care facilities or their job requirements to wear respirators and eye/face protection due to SARS CoV-2 exposure risk should be included among the Phase 1a allocation for High-Risk Health Workers. Some HCIRs support procedures/equipment/technology in the operating room or procedural suite and are required to be present during urgent, non-elective procedures (e.g., trauma, transplant, cardiac) and other medically necessary procedures (e.g., joint replacement).

During the pandemic, hospitals have instituted additional COVID-19 access requirements for HCIRs. For example, some hospitals require HCIRs to undergo respirator fit testing and training so that HCIRs will be able to utilize hospital-issued respirators during procedures that these HCIRs support. During crisis capacity operations, some hospitals have required HCIRs to bring their own respirators and other PPE for the procedures that they support, including gloves, gowns, and face shields. During the current PPE shortage, distributors of NIOSH-approved N95 respirators allocate nearly all of their supply to hospital purchasers. The best-case scenario for medical device manufacturers is to procure non-NIOSH-approved filtering facepieces that have FDA emergency use authorization for use as a respirator during this public health emergency. In these cases, although both the hospital staff and HCIR are in similar proximity to aerosol- generating procedures, some HCIRs do not have equivalent PPE relative to the hospital staff.

This dynamic should elevate the prioritization of these HCIRs relative to other high-risk health workers who have access to NIOSH-approved PPE.

Importantly, HCIRs generally work across multiple health care facilities. Some HCIRs cover numerous hospital systems in a region and support procedures in multiple institutions per day. Vaccinating these HCIRs during Phase 1a would decrease the risk for these HCIRs to become vectors between institutions.

# Medical Device Manufacturing/Distribution Personnel

Medical device industry personnel that manufacture and distribute medical devices and diagnostics should be included among the vaccination phase when other critical workers are vaccinated. The specialized and environmentally sensitive nature of manufacturing medical devices limits the ability to increase the physical distance between some manufacturing personnel. These are critical workers who are essential to manufacturing and distributing medical devices and diagnostics integral to the treatment of COVID-19 and other patients and are at substantially higher risk of exposure due to their inability to physically distance.

An attestation letter by an HCIR’s employer on company letterhead concerning the nature of their work and exposure risk should be sufficient to confirm eligibility for the HCIR for vaccination during Phase 1a. For medical device industry manufacturing and distribution personnel, an employer attestation on company letterhead concerning the nature of the individual’s work should be sufficient documentation to confirm vaccination eligibility during Phase 2.

1. U.S. Department of Homeland Security Cybersecurity & Infrastructure Security Agency, *Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in COVID-19 Response Version 4.0*, Aug. 18, 2020, available at [https://www.cisa.gov/sites/default/files/publications/Version\_4.0\_CISA\_Guidance\_on\_Essential\_Critical\_Infra structure\_Workers\_FINAL%20AUG%2018v3.pdf](https://www.cisa.gov/sites/default/files/publications/Version_4.0_CISA_Guidance_on_Essential_Critical_Infrastructure_Workers_FINAL%20AUG%2018v3.pdf) (Under “Healthcare / Public Health,” “Vendors and

suppliers” and “workers at manufacturers” are specified:

Vendors and suppliers (e.g. imaging, pharmacy, oxygen services, durable medical equipment, etc.).

Workers at manufacturers (including biotechnology companies and those companies that have shifted production to medical supplies), materials and parts suppliers, technicians, logistics and warehouse operators, printers, packagers, distributors of medical products and equipment (including third party logistics providers, and those who test and repair), personal protective equipment (PPE), isolation barriers, medical gases, pharmaceuticals (including materials used in radioactive drugs), dietary supplements, commercial health products, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting or sterilization supplies

1. See Association of periOperative Registered Nurses (AORN), Position Statement on the Role of the Health Care Industry Representative in Perioperative Settings, May 28, 2020, available at [https://aornjournal.onlinelibrary.wiley.com/doi/full/10.1002/aorn.13065.](https://aornjournal.onlinelibrary.wiley.com/doi/full/10.1002/aorn.13065)American College of Surgeons (ACS). Revised Statement on Health Care Industry Representatives in the Operating Room, October 1, 2016, available at [https://www.facs.org/about-acs/statements/91-industry-reps-in- or.](https://www.facs.org/about-acs/statements/91-industry-reps-in-or)
2. *See* American National Standard for Supplier Credentialing in Healthcare, ANSI/NEMA SC 1-2019, Contents and Scope available at [https://webstore.ansi.org/preview-pages/NEMA/preview\_ANSI+NEMA+SC+1-2019.pdf](https://webstore.ansi.org/preview-pages/NEMA/preview_ANSI%2BNEMA%2BSC%2B1-2019.pdf)
3. See MITA and C4UHC Press Release, available at [https://www.medicalimaging.org/wp- content/uploads/2020/05/20.05.05-Final\_MITA-Credentialing-Standard-Release-DRAFT.docx-CLEAN-002- copy-1.pdf](https://www.medicalimaging.org/wp-content/uploads/2020/05/20.05.05-Final_MITA-Credentialing-Standard-Release-DRAFT.docx-CLEAN-002-copy-1.pdf)
4. National Academies of Sciences, Engineering, and Medicine. 2020. *Framework for Equitable Allocation of COVID-19 Vaccine.* (p. 107) Washington, DC: The National Academies Press. [https://doi.org/10.17226/25917.](https://doi.org/10.17226/25917) (“The first phase includes a “jumpstart” phase: Phase 1a. Included in Phase 1a would be “frontline” health workers—health professionals who are involved in direct patient care, as well as those working in transport, environmental services, or other health care facility services—who risk exposure to bodily fluids or aerosols.

Under conditions of such scarcity, access should not be defined by professional title, but rather by an

individual’s actual risk of exposure to COVID-19. The rationale for including “frontline” health workers in the first phase is manifold: their contact with patients with SARS-CoV-2 (despite the use of PPE, which can be limited in some settings); the fact that they work in an essential industry, but may be precluded from performing their professional duties if they are exposed or infected; and the reality that many such workers are potentially important nodes in onward transmission networks, given that many who are in low-wage jobs may also contribute to further transmission due to living in crowded, often multi-generational living situations where social distancing is unrealistic.”)

**Maria Elena Durazo and Robert Rivas, California Latino Legislative Caucus**

On behalf of the CA Latino Legislative Caucus, we write to thank you for your work to ensure an equitable distribution of a COVID-19 vaccine and for including farmworkers in Phase 1 of the Vaccination Plan.

Given the extraordinary role that farmworkers play in our state and the health challenges they face in the commission of their work we request that farmworkers be prioritized in Phase 1B of your vaccine rollout.

Farmworkers are the backbone of our state’s $50 billion agriculture industry and, notwithstanding their vulnerability to COVID-19, have not stopped working during the pandemic. Whether due to overcrowded and multigenerational housing, the lack of health insurance or protective equipment, and/or absence of safe space to quarantine, farmworkers are at higher-risk of contracting COVID-19. Additionally, 97% of the state’s agricultural industry workers are Latino. The Latino community has been disproportionally impacted by COVID-19 infections and deaths. Protecting our farmworkers benefits all of our residents by helping prevent labor shortages, keeping the food supply strong, and improving public health by minimizing the number of agriculture-related COVID-19 cases. Prioritizing farmworkers in the Vaccination Plan is also helpful to farmers and growers, who depend on farmworker labor to meet the demand of California’s massive agricultural industry.

COVID-19 outbreaks amongst agricultural employees have become far too common. Nationwide, at least 145,000 farmworkers have tested positive. A forthcoming statewide report estimates that 15,774 of those cases come from right here in California. The largest outbreak in the state happened at a Foster Farms plant in Merced County, where 392 employees tested positive for COVID-19. Sadly, these numbers likely underestimate the breadth of the problem since they exclude temporary and foreign labor.

These troubling statistics demonstrate the urgent need to prioritize farmworkers in Phase 1 of the preliminary three-phase rollout that you have presented. Specifically, we request that you prioritize farmworkers in the ‘essential workers’ category, 1-B, right behind healthcare professionals that are at higher risk of COVID-19 exposure (1-A). Further, the Vaccination Plan should have a farmworker specific component developed by agriculture data experts, community outreach experts, and community-based organizations. When the pandemic first hit, language and cultural barriers limited the effectiveness of educational outreach to the farmworker community. To avoid similar problems and ensure the successful distribution of a COVID-19 vaccine we must have a rollout that is culturally and linguistically sensitive to the needs of our diverse labor force. Lastly, the Vaccination Plan must include undocumented immigrants who are often afraid to seek government aid if it may jeopardize their residency in the country. All farmworkers must be equipped with the tools necessary to make their own personal and informed decision when a vaccine is available.

Thank you for your consideration of this request. We trust that you will take the appropriate action to prioritize farmworkers in Phase 1 of the Vaccination Plan not only to protect our food supply but also the essential workers that support it. Please do not hesitate to contact us should you have any questions or need additional information.

**Brian Pacheco, Fresno County Board of Supervisors, District 1**

As we begin the vaccination stages for COVID-19 in the weeks and months ahead, I encourage you to keep California's hardworking production agriculture workforce in mind.

Our first priority, of course, is ensuring that all essential healthcare workers are provided vaccinations, but I urge you to consider our state' s essential agricultural workforce as the next highest priority. As you are aware, farmworkers frequently work in close proximity to one another and go home to multi-generational and multi-family living arrangements in small spaces where family members have health conditions that make them vulnerable to COVID-19.

In Fresno County, that workforce is more than 90,000 strong, feeding the nation and the world. Fresno County produced $7.7 billion in agricultural commodities in 2019, more than any other county in America and - you should beproud to know - that seven of the top 10 agricultural counties in America in 2019 were in California.

Again, I am in full support of healthcare workers being first in line, but please seriously consider our essential workers who produce more food than anyone else in the world, the California farmworker.

**Caroline Krauskopf**

I am a parent of two California public school students — one in 8th grade and one in 12th.  Both have been at home doing all online learning since last March.  And it’s been really tough on them, despite having good Internet connectivity and their own computers.  Even with these privileges, they are struggling with anxiety and isolation, as well as diminished academic performance and overall decreased educational attainment.  And they’re the lucky ones!

Many of our state’s most vulnerable youngsters are suffering now — from learning loss, mental health issues, hunger and homelessness, and abuse — because their schools remain closed.  This current approach has one clear result:  increasing inequity in California.

Re-opening schools is urgently critical for California.  Children and families are in crisis, especially the most disadvantaged.  The economy will not be able to recover if parents cannot go to work because they are looking after their children and serving as teachers and homework monitors.  This is particularly significant for women who have been forced to leave the labor force in unprecedented numbers and are suffering huge economic losses.  And children must begin to recapture their lost months of learning as soon as possible to avoid irreversible damage to their future wellbeing.

There are no data to support keeping schools shuttered, especially for elementary grades.  Data from California, the United States, and internationally reveal that schools implementing appropriate COVID-19 safety precautions have very low within-school transmission rates and they are not sources of community spread.  Across schools in many diverse settings, cases that have been reported are largely due to community transmission, such as the parent of a student being exposed at his/her workplace.  Well-regulated, supervised school settings are safe — this has been demonstrated across the globe.  For example, New York City’s schools had extremely low positivity rates this fall, and there was wide agreement from everyone from the president of the teachers’ union to public health officials that schools were safer than they had anticipated.

Yet many public schools in California remain firmly closed, often due to demands for rigorous protections or guarantees of “safety.”  With several vaccine candidates on the near horizon, these demands could soon be met.  BUT only if public school teachers are among the early priority groups for vaccination.

Prioritizing public school teachers for early COVID-19 vaccination will importantly meet the National Academy of Science goal to “reduce negative societal impact” at both macro and micro levels.  Large swaths of working age persons will be able to return to work which will have significant positive impacts not only on the economy, but also on individuals' physical and mental well-being.  Children will be able to return to learning and have access to school lunches, nurses, and other services.

Public schools truly are foundational to our society — it is imperative that we restore their functioning.  Therefore, please move public school teachers to Phase 1b of the COVID-19 Vaccine NASEM Prioritization.

Thank you for your serious consideration of this important matter.

**Brittney Barsotti, California News Publishers Association**

Re: Inclusion of News Media Representatives for Vaccinations with Other Essential Workers

The California News Publishers Association (CNPA) represents daily and weekly newspapers, ethnic and community publications and online news outlets throughout California. We respectfully urge that members of the news media be expressly included in the phase of the COVID-19 vaccine that includes the essential and critical infrastructure workforce.

Over the last few months, California news organizations have worked on the front lines of the COVID-19 pandemic, risking their health and safety to report, produce, and deliver the information Californians rely on for a deeper understanding of the pandemic and to help them make well-informed decisions about their health and safety. Those who gather the news, and those responsible for publishing and printing the news, should be vaccinated as soon as possible with other essential workers to ensure that Californians can continue to have the news delivered to their doorstep.

Both the U.S. Department of Homeland of Homeland Security’s Cybersecurity and Infrastructure Security Agency and the California State Public Health Officer reaffirmed the importance of newspapers as essential businesses by declaring workers who support news media are critical infrastructure workers in the communications sector who may continue their operations during the COVID-19 crisis. We appreciate that the role of news organizations was affirmed in the Executive Order that stated Essential Critical Infrastructure Workers are necessary to “protect communities, while ensuring continuity of functions critical to public health and safety, as well as economic and national security.” The recent curfew and stay-at-home orders also have acknowledged that essential critical infrastructure workers may continue to perform their responsibilities.

CNPA respectfully urges that the state prioritize the workers who support news media for vaccination in the phase of distribution to essential workers so that these workers can safely gather the news, report and publish critical information to communities, including those who depend on print editions. *See* [https://covid19.ca.gov/essential-workforce/](https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcovid19.ca.gov%2Fessential-workforce%2F&data=04%7C01%7Cjeff.glasser%40latimes.com%7C008c8937050745bf07cf08d88d872440%7Ca42080b34dd948b4bf44d70d3bbaf5d2%7C0%7C0%7C637414958849626942%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=UgLmWRvvuaO9BnCkf5xSfURC4J0bOVzsK3JQxe8Tljs%3D&reserved=0) and *See* <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/limited-stay-at-home-order.aspx> (“workers who support radio, television, and media service, including, but not limited to front line news reporters, studio, and technicians for newsgathering, reporting, and publishing news” are critical infrastructure workers in the communications sector who may continue their work during the COVID-19 crisis).

Thank you for your consideration. We look forward to working with you to facilitate and expedite this critical request.

**Denny Chen, Justice in Aging**

Justice in Aging, on behalf of the undersigned aging and disability advocacy organizations, writes to thank the Administration for your continuing efforts—through the state’s COVID response, the Master Plan for Aging process, and other avenues—to build a state that is committed to valuing the lives of older adults and people with disabilities. We write today to ask that the state maintain its commitment to older adults and people with disabilities in its COVID-19 vaccination allocation and distribution plan.

We are pleased that many aging and disability organizations were named to the state’s Community Vaccine Advisory Committee (CVAC), and we request that the steps laid out below be taken to ensure that the needs of older adults and people with disabilities are prioritized in the vaccine distribution process. With older adults constituting nearly 75% of COVID-19 deaths in California, we urge you to prioritize older adults in the planning and the implementation process.1 Below we identify four steps we believe are necessary to the overall success of the state’s vaccine rollout and critical in prioritizing the needs of older adults—especially older adults of color—who have been most impacted and are most at risk.

Define Settings and Prioritize Facilities in Phase 1-A to Protect the Most At-Risk Older Californians

We applaud the state to include residents of congregate settings in Phase 1-A with frontline medical workers as recommended by the CVAC and the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP), and which is also in line with the National Academies of Sciences, Engineering, and Medicine’s (NASEM) framework for equitable allocation.2

In doing so, the state must define “congregate settings” broadly. The state has already indicated it will prioritize those most impacted and at risk in its plan, which requires defining congregate settings to include not only skilled nursing facilities but also assisted living facilities, affordable senior housing residences, group homes, mental health residential facilities, and jails and prisons. All workers in these settings should also be included.

Given a recent report from the California Health Care Foundation indicating that disproportionately higher rates of COVID-19 cases occur in nursing facilities with at least 2% of Black residents and 26% of

Latinx residents, we further recommend the state elevate the priority of these facilities in particular.3 The vaccine should go first to the settings where there is the highest demonstrated risk.

Include High-Risk Older Adults and People with Disabilities in the Community in Phase 1-B

We strongly recommend that the state include high-risk older adults and people with disabilities who reside in the community in Phase 1-B with the state’s other essential workers. We encourage the state to define this category as individuals who use home and community-based services (HCBS), including individuals who privately pay for them, many of whom would be in a nursing facility without these vital community supports. If that group is too large, we encourage prioritizing those on Medicaid HCBS.

Focusing on HCBS users would operationalize California’s draft plan, reflective of ACIP’s initial considerations, and be even more specific than NASEM’s Phase 1-B recommendation.2,4

Older adults have been asked to shelter in place and have given up either partially or entirely many of the necessary services and programs that keep them happy, healthy, and in the community. The longer they languish without appropriate in-person services and supports and while waiting for a vaccine, the more likely they will face institutionalization. California must take all necessary steps to ensure that the pandemic does not result in unnecessary increased institutionalization of the state’s older adults.

Conduct Outreach to Older Adults and People with Disabilities Recognizing the Intersectionality of Their Lived Experiences

We urge the state to act swiftly to conduct targeted outreach to older adults and people with disabilities that recognizes the intersectionality and historic injustices of their lived experiences. Both ACIP and NASEM list transparency—fostered through public participation or community engagement—as part of their foundational principles.2,4 Although the CVAC remains an important forum to provide feedback and input on the plan, relying on the committee members themselves to conduct outreach is insufficient.

With shipments of a vaccine arriving as early as mid-December, we recommend the state critically consider the legitimate distrust certain communities of older adults feel toward medical providers or government action as a result of systemic racism or other historic injustice. Efforts to develop an equitable vaccine distribution plan coupled with distrust of the vaccine among older adults of color, who are also high-risk, requires continual targeted outreach to these communities. Recommendations 4 and 5 from NASEM respond to this distrust built from historic medical exploitation and other racial injustices.2

Following in other states’ footsteps, California could assemble mini-focus groups with older adults to better understand their concerns and work with them to get feedback on outreach and educational materials. At a minimum, materials must be translated in the state’s threshold languages, and the state should consider tailored but consistent messaging for certain communities of older adults when shown to be more effective and culturally resonant. Continual engagement with older adults—and particularly older adults of color—will promote not only equity in distribution but also equitable uptake.

Prepare to Collect and Release Intersectional Data

California has been a leader in combatting health disparities and championing health equity. We have appreciated efforts to date to release state-level COVID-19 infection, death, and race and equity data. Similarly, as California focuses on vaccination efforts, we request that the state make public the real-time monitoring of who is getting the vaccine—disaggregated by race, age, disability other protected characteristics—and in what settings. Data should also be presented in an intersectional manner (e.g. race and age, race and setting). This level of data collection will allow the state to more readily address COVID-19 disparities among California’s older adults and other communities. This effort would also be reflective of the CDC’s COVID-19 Response Health Equity Strategy and NASEM’s Recommendation 2 regarding the promotion of equity through monitoring and evaluation.4,5 Specifically for congregate settings, we urge the state to put in place specific data sharing requirements with CVS and Walgreens, who will be distributing the vaccine in these settings, so that the state has a clear understanding of who within these settings is getting vaccinated.

California undoubtedly faces a challenging winter with respect to the state’s transmission rates and difficult decisions to create a fair and equitable vaccine distribution and allocation plan for all. By prioritizing and committing to the needs of older adults and people with disabilities in the plan, the state is prioritizing the needs of those most impacted and at-risk, dramatically reducing the deaths from COVID-19, and potentially marking a significant victory in the state’s fight against the virus.

**Michael Arnold,** **CA Dialysis Council**

On behalf of the CA Dialysis Council, we were very happy to see that dialysis centers were included in Tier 1 of Phase 1A for the distribution of the COVID-19 vaccine.

Attached is an [article](https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0242182) which supports this decision. Note the conclusion of the study:

“This study provides quantitative estimates of the contribution of pre-existing clinical phenotypes to COVID-19 hospitalization and highlights kidney disorders as the strongest factors associated with hospitalization in an integrated US healthcare system.”

Just thought you might be interested in seeing this.

**Jack Kenney, Mitchell International**

I am Associate General Counsel at Mitchell International based in San Diego and its subsidiary, Genex Services.  Mitchell has thousands of nurse field case managers around the United States and hundreds in California.  These nurse field case managers work with workers compensation claimants in coordinating the injured workers care and treatment to help them get back to work.  The case managers meet directly with the injured workers and their medical providers, including by meeting with medical providers in their facilities.  Mitchell performs these services on behalf of workers compensation insurers and payors.

Will there be a mechanism and process through which companies can request to have certain of their employees be included in one of the priority tiers for the purpose of having priority access to that tier for the eligible employees?  We believe our nurses fall under the Tier 2 criteria.

Tier 1:

Acute care, psychiatric and correctional facility hospitals.

Skilled nursing facilities, assisted living facilities, and similar settings for older or medically vulnerable.

Paramedics, EMTs, and others providing emergency medical services.

Dialysis centers.

Tier 2:

Intermediate care facilities.

Home health care and in-home supportive services.

Community health workers.

Public health field staff.

Primary care clinics.

Tier 3:

Specialty clinics.

Laboratory workers.

Dental and health clinics.

Pharmacy staff not working in settings at higher tiers

**San Francisco Board of Supervisors**

[Urging Prioritization of Public-School Educators for COVID-19 Vaccine Access]

Resolution urging Governor Newsom and the California Department of Public Health to prioritize California public school educators for phase one COVID-19 vaccine access.

WHEREAS, As of Monday November 30, 2020, the California Department of Public Health has reported at least 1,198,934 confirmed COVID-19 cases in California, and a total of 19,121 deaths in the state; and

WHEREAS, In the early stages of the pandemic, local and state public health orders required the closure of public schools across the state to slow the spread of coronavirus in the community; and

WHEREAS, Despite the unprecedented nature of the public health crisis, school districts and educators across the state stepped up and adapted to the significant challenges caused by school closures by shifting towards new online distance learning formats; and

WHEREAS, Even with innovative distance learning measures put in place, COVID-19 school disruptions have had an adverse effect on K-12 learning, especially among low-income students and students of color; and

WHEREAS, While schools have been closed for nearly 9 months, state officials have failed to prioritize enough resources to support safe school reopening as a part of the state’s COVID recovery efforts and many school districts remain closed with no clear timelines or commitments for reopening in the near future; and

WHEREAS, Public school enrollment has begun to decline across the state and country, with many families being forced to leave public school districts to enroll in private and independent schools systems that have managed to reopen schools with government authorization and safety protocols in place; and

WHEREAS, School closures have had extreme ramifications on student achievement including cutting student learning time, limiting the ability of educators to provide their usual level of support, diminishing opportunities for students to develop their social and emotional skills, and increasing rates of anxiety, depression, obesity, and other serious health conditions among students; and

WHEREAS, These educational consequences from school closures are exponentially worse at understaffed and underfunded schools across the state that traditionally serve large populations of students of color and their families, who were already facing stark achievement gaps prior to the COVID crisis; and

WHEREAS, The disproportionate health and economic impacts of COVID-19 on Black, Latino, Asian and Pacific Islander, and Native American families, including higher rates of job loss and COVID-19 infections compounded by limited access to technology and reliable internet access, have only exacerbated the educational challenges that students of color have had to endure during this crisis; and

WHEREAS, To not act with greater urgency to resolve these disruptions to the public education system, then the severe learning deficits caused by school closures could have lasting impacts on our students including persistent behavioral and academic challenges, grade repetition, and increases in school truancy, suspension, expulsion, and dropouts rates longer term; and

WHEREAS, For many working families, the continued closure of schools has forced many parents and caregivers to make an impossible choice between leaving their jobs and foregoing their family’s income, or leaving their children home alone without the care or supervision of an adult; and

WHEREAS, There is general agreement among parents, educators, school administrators, and public health professionals that schools should be able to reopen as long as the rates of COVID-19 transmission remain low in the general population, and there is adequate school testing, screening, monitoring, sanitation, personal protective equipment, and emergency response protocols in place to ensure that educators and students can safely return to an in-person school setting; and

WHEREAS, Providing vaccines to all school site personnel, including teachers, paraprofessionals, janitors, and other support staff, will be key to reopening schools safety and efficiently; and

WHEREAS, Several pharmaceutical companies have released recent reports showing promising results that vaccines protecting against the COVID-19 virus may become available to priority populations as early as December 2020 following authorization from the U.S. Food and Drug Administration; and

WHEREAS, According to the National Institutes of Health, there are enough vaccines available to vaccinate up to 20 million people in the United States in December and those doses are likely to be distributed based on state conditions and population size; and

WHEREAS, Because initial vaccine supply will be limited, California state health officials are developing a phased distribution plan in partnership with the U.S. Centers for Disease Control and Prevention that will establish the priority populations for vaccination; and

WHEREAS, The state has indicated that health care workers and first responders who are likely to treat or be exposed to COVID-19 patients are expected to be the first phase of vaccine recipients, and these workers are being divided into subgroups in case of a shortage in the first rounds; and

WHEREAS, The definition of an essential worker in the distribution guidance is still being developed by state health officials; and

WHEREAS, Public School educators are arguably among the most essential workers in the society as they not only provide an education, but also serve to protect children from hunger and other social ills, give children purpose, set them up for success as citizens, and inspire them to succeed in life; and

WHEREAS, While educators are generally considered essential workers, it is still unclear where educators will fall in the state’s priority ranking, which will be decided in the coming weeks; and

WHEREAS, European countries like France have prioritized keeping schools open citing their commitments to minimize the academic harm of school closures, while the United States has prioritized reopening bars and retail establishments as schools have remained closed; and

WHEREAS, Education is the cornerstone of democracy, and at a time when democratic institutions are under attack, there is a moral obligation to protect the integrity of educational institutions by ensuring that they are well resourced and equipped to overcome the current and future challenges presented by the COVID-19 health crisis; now, therefore, be it,

RESOLVED, That the San Francisco Board of Supervisors urges Governor Newsom, the California Department of Public Health, and all other state health officials to prioritize the recovery of our public education system by providing teachers and school support staff with vaccines immediately after health care professionals so that we can safely reopen schools and get students back into the classroom as soon as possible; and be it,

FURTHER RESOLVED, That the San Francisco Board of Supervisors urges Governor Newsom, the California Department of Public Health, and all other state health officials to ensure that the costs of COVID-19 vaccines for all educators and school support staff be subsidized by our state and federal government to ensure equitable and timely access to these vaccines; and be it,

FURTHER RESOLVED, That the San Francisco Board of Supervisors hereby directs the Clerk of the Board to transmit copies to the Honorable Governor Gavin Newsom and to the California Department of Public Health with a request to take all actions necessary to achieve the objectives of this Resolution.

**Christopher Gresens, MD and Steve Ferraiuolo, Vitalant**

On behalf of Vitalant, we request that the vaccination plan for the State of California specifically include blood center personnel in the prioritization of “healthcare personnel” for Phase 1-A allocation of the COVID-19 vaccine, as now recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practice (ACIP).

Vitalant is the nation’s largest independent, non-profit blood service provider focused on providing lifesaving blood products and comprehensive transfusion medicine services for approximately 900 hospitals and their patients across the United States, including locations in California. Vitalant also provides plasma-derived therapeutic biologicals and offers specialty laboratory and therapeutic procedures through its therapeutic apheresis, hemophilia treatment center, hemostasis & thrombosis clinic, and stem cell reinfusion service to support patients with cancer, autoimmune diseases, and bleeding disorders, among other conditions.

Vitalant’s personnel have either been on the front line of patient care in hospitals or outpatient treatment centers or work directly with the public every day to ensure not only a safe and adequate blood supply for patient care, but also to support the nation’s response to COVID-19. Since April 2020, Vitalant’s personnel have actively collected, tested, processed and distributed approximately 50,000 units of COVID-19 convalescent plasma–a widely administered treatment option for use in hospitalized patients diagnosed with COVID-19. Vitalant wants to ensure that its ability to manage lifesaving blood products continues unabated. Access to the vaccines for our staff on the front lines will be critical to ensuring there is no disruption to patient care.

As presented during ACIP’s December 1, 2020 meeting, the definition of “healthcare personnel” by the CDC includes a reference to the Department of Homeland Security’s (DHS) “*Advisory Memorandum on Ensuring Essential Critical Infrastructure Workers Ability to Work During the COVID-19 Response*,” dated August 18, 2020. The DHS Advisory Memorandum specifies that “Donors of blood, bone marrow, blood stem cell, or plasma, and the workers of the organizations that operate and manage related activities” are part of Healthcare/Public Health’s “essential critical infrastructure workforce.” This approach is also set forth in the CDC’s October 29, 2020 *“COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations,”* in defining healthcare personneland isconsistent with the 2018 CDC “*Updated Planning Guidance on Allocating and Targeting Pandemic Influenza Vaccine During an Influenza Pandemic*,” which provides that “blood donation facilities” be classified in Tier 1 for vaccination priority. We support both ACIP’s and CDC’s earlier recommendation to prioritize healthcare personnel, including our blood center personnel, for allocation of the COVID-19 vaccine and encourage the State of California to specifically adopt this recommendation.

It is also important to note that Vitalant is uniquely positioned to store all available vaccines and our licensed health care providers can administer the vaccines to our personnel. Vitalant is developing a sub-prioritization plan to ensure those working in hospital settings or public-facing settings are given higher priority.

We look forward to engaging in a meaningful dialogue with you to ensure optimal vaccine administration to blood center personnel critical to the national healthcare delivery system.