Vaccine Advisory Committee (VAC) Quarterly Meeting

November 12th, 2020

Chair/Facilitator:

Dr. Kathy Lofy	Washington State Department of Health

Members Attending:	**Representing:**
Dr. Amy Person	Washington State Association of Local Public Health Officers
Amy Poel	Urban Indian Health Institute
Anita Alkire	Childcare
Annie Hetzel	Office of Superintendent of Public Instruction
Dr. Beth Harvey	Consultant
Dr. Daniel Moorman	Washington Chapter of the American Academy of Pediatrics
Dr. Ed Marcuse	Consultant
Jean Gowen	Health Care Authority
Dr. Jeff Duchin	Public Health – Seattle/King County
Dr. Jenny Arnold	Washington State Pharmacy Association
Dr. John Dunn	Managed Care
Dr. Linda Eckert	Consultant
Dr. Mary Alison Koehnke	Naturopathic Medicine
Dr. Mary Anderson	Internal Medicine Organization
Dr. Rachel Wood	Washington State Association of Local Public Health Officers
Sarah Murray	Washington State Association of Local Public Health Officers
Dr. Stephen Pearson	Washington Chapter of the American Academy of Pediatrics
Dr. Susan Westerlund	Washington Academy of Family Physicians
Tam Lutz	Northwest Tribal Epidemiology Center
Tara Tumulty	National Association of Pediatric Nurse Practitioners
Tristen Lamb	Washington State Association of Local Public Health Officers
Dr. Usha Rao	Washington Academy of Family Physicians
Wendy Stevens	American Indian Health Commission

Washington State Department of Health Staff and Presenters:

SheAnne Allen	Mary Huynh	Dr. Kathy Bay
Dr. Scott Lindquist	Michele Roberts	Greg Endler
Hannah Febach	Katie Meehan	Blair Hanewall

Topic	Presented Information
Welcome and Introductions **Dr. Kathy Lofy**	VAC Chair, Dr. Kathy Lofy, opened the meeting, allowed time for introductions, and gave an overview of meeting expectations and processes.
Approval of Previous Meeting Minutes **Dr. Kathy Lofy**	Meeting minutes from the October 2020 VAC meeting were approved.
Prioritization and Allocation Guidance Development: Findings from Community Engagement **Katie Meehan**	<u>Focused Engagement</u> Over the last three weeks, the team oversaw focused and broad engagement efforts. Focused efforts were more qualitative in nature and included a mixed methods approach. A total of 90 total key informant interviews, group interviews, community conversations, and focus groups were held with 402 total individuals representing a variety of communities and perspectives. We were intentional to bring groups together based off shared experience, community, or sectors (for example: parents of CSHCN, or people who represent critical infrastructure/essential business sectors.)The team was also intentional in focusing on and centering the experiences of communities disproportionately impacted by COVID-19, such as BIPOC communities. <u>Broad Engagement</u> A more broad, public feedback opportunity was provided using a web-based survey. The survey in English totaled over 17,000 respondents. The in-language surveys vary a bit in terms of response. For these groups, we are using these survey results to supplement what we learn through the qualitative, focused engagement efforts with these respective communities. For the English survey, we are also able to look how people answered different questions based on their job – for example, health care, essential business, first responder, teacher, early learning – as well as if the respondent identifies as being higher risk for COVID-19 because of their race/ethnicity, disability status, or overall health or age. Overall, both the focused & broad engagement efforts aimed to get feedback on how people are feeling about the COVID-19 vaccine and perspectives for how COVID-19 vaccine should be prioritized and allocated in Washington State. A VAC member asked if the team engaged Tribal communities or urban AI/AN: or AIHC delegates in this process and Katie responded that we have a separate plan underway for engaging Tribal Nations, which follows our agency's Government-to-Government process. We did have community members who self-identified as American Indian/Alaska Native throughout these engagement efforts. <u>Proposed Principles of Vaccine Allocation Framework</u> The principles the team used to draft the vaccine allocation framework are: • Maximization of social benefits – to reduce morbidity and mortality to maximize societal benefit (public health and socioeconomic wellbeing) • Equal concern – ensuring everyone is considered and treated as having equal dignity, worth and value • Mitigation of health inequities – mitigating the negative effects of existing health inequities on the transmission of and harms from the novel coronavirus taking into account vulnerabilities due to social, economic, environmental, and structural disparities

- Fairness – using a process based only on relevant non-discriminatory characteristics and employing fair and un-biased process and procedures
- Evidence-based – guided by the best available evidence and models from scientific literature, data, and community voice/wisdom
- Transparency – communicate openly, clearly, accurately, and straightforwardly on culturally appropriate and linguistically accessible channels

Proposed Criteria of Vaccine Allocation Framework:

The criteria the team used to draft the vaccine allocation framework are:

- Risk of acquiring infection: Individuals have higher priority to the extent that they have a greater probability of being in settings where COVID-19 is circulating and exposure to a sufficient dose of the virus
- Risk of severe morbidity and mortality: Individuals have higher priority to the extent that they have a greater probability of severe disease or death if they acquire infection.
- Risk of negative societal impact: Individuals have higher priority to the extent that societal function and other individuals' lives and livelihood depend on them directly and would be imperiled if they fell ill.
- Risk of transmitting disease to others: Individuals have higher priority to the extent that there is a higher probability of their transmitting the disease to others.

Key Findings

When evaluating themes across all engagement efforts, broad and focused, the following themes emerged:

1. **History is impacting community comfort and trust of the future COVID-19 vaccine.**

U.S. and public health history of medical experimentation results in overall distrust of government, pharmaceutical industry, and medical industry. It also results in distrust of vaccine trials and the current vaccine(s) under development. People believe that the initial distribution is a trial. History of systemic and institutionalized racism impacts community response to the government and vaccines. Historical treatment of BIPOC communities in medicine results in distrust of medicine generally and COVID vaccine specifically.

2. **There is a lot of fear about the safety and efficacy of this vaccine.**

People across all communities, groups, and sectors have a lot of questions and concerns about the safety and efficacy of the future COVID-19 vaccine due to increased speed of approval. These same communities, groups, and sectors fear that a vaccine may be mandated by the federal government, state government, or even one's place of employment. This fear is exacerbated for BIPOC communities due to history of medical experimentation. People surveyed in Vietnamese had the lowest numbers reporting "a large amount" or "many" fears about the COVID-19 vaccine and people surveyed in Ukrainian had the highest, with all other language groups having similar results: English (36%), Spanish (40%), Russian (41%), Ukrainian (62%), Vietnamese (20%), simplified Chinese (39%), traditional Chinese (41%).

3. **There is support for prioritizing high risk workers in health care settings, but also a need to widen how we define a high-risk role or environment.**

The high-risk role or environment definition needs to take into consideration that not all health care environments and settings have the same access to personal protective equipment (PPE), and not all workers within a setting have equitable access to PPE. There are other people who work in high risk

	health care settings and environments or with high risk patients, beyond nurses and doctors. Community Health Workers (CHWs), doulas, janitorial staff, caregivers, and aides move through these settings too. Over 90% of all communities and groups who participated in the general feedback survey, interviews, or focus groups--across all language and cultural groups--agreed that high-risk health care workers should receive priority for the COVID-19 vaccine. **4. Prioritization for key groups including farmworkers, the elderly, people with disabilities, BIPOC communities, and people experiencing homelessness should be stronger.** Some groups received strong support for being a higher priority, including farm/agriculture workers, people with disabilities, people experiencing homelessness, and the elderly. However, surveyed individuals were emphasizing the need to think about other individuals who surround high risk groups. Many farm/food processing workers are living in multi-generational households. People with disabilities who have caregivers that may put them at risk. People who are incarcerated may have risk factors that would put them in a different phase of priority--for example, people who are incarcerated and have a disability or comorbidities. Also need to consider the potential of corrections staff getting sick. Lastly, there is a need to think more broadly about "congregate settings." Agricultural workers living in cabins would fall under congregate settings. Individuals with disabilities may also be in congregate living situations. **5. Many essential service sectors feel left out and under-prioritized.** Certain groups are very concerned their front-line workers (or highly impacted people) won't be considered in the first round of vaccinations. Many groups expressed feelings of being left out, forgotten, not supported, or not considered. Non-profits, service, and volunteer organizations do not feel supported or considered as essential. There are critical infrastructure workers in almost every sector that have no alternatives if they get sick, and many could have long-term effects if their work goes undone. Everything from hatchery staff, protecting and maintaining our food supply to data and cyber security teams to utility operators to foster care; so many of these workers feel like they haven't been considered essential. The hospitality industry has by far the highest number of individuals on unemployment in the state and nationwide, and the long-term economic impact on these workers reaches all aspects of their wellness. **6. There is overall support for the principles, criteria, and equity considerations used.** The overwhelming majority of people who participated in engagement activities including the public feedback survey, interviews, and focus groups--across all language and cultural groups--supported the inclusion of the working principles and criteria. <u>Intersectionality and Risk</u> There are some groups that are intersectional in nature and at a higher risk such as: farmworkers living in intergenerational families who are concerned about increasing risk of older adults in their homes, older adults living in multi-family housing are at risk due to reliance on assistance from others and shared use of common areas, people with disabilities may have multiple health conditions, may rely on home health workers who work in multiple settings, community health workers live in their communities, often in multi-generational housing and provide community service so are at risk for themselves and their families, and low-wage workers leaving their children in congregate child care risk exposure at work and via their own children at home. <u>Equity must be woven through & cross-cutting</u> Certain population groups have been prioritized with an aim to mitigate health inequities recognizing

	that specific populations are disproportionately impacted by COVID-19 due to external social factors and systemic inequities. This includes: Black, Indigenous, and People of Color (BIPOC) communities, people with limited English proficiency, people in shared housing, crowded housing, and multi-generational homes, people in poverty and low-wage earners, people with disabilities, and people with access barriers to healthcare. Priority should not be affected by immigration status or healthcare insurance status.
Interim Guidance for Vaccine Allocation & Prioritization **Blair Hanewall**	Before Blair began her presentation, she noted that this guidance is not final and continues to develop. Blair also stated that DOH is committed to sharing this information as clearly and transparently as possible to ensure safe, equitable, and effective introduction of any COVID-19 vaccine to support the health of our community. <u>Phase 1a</u> The objectives of phase 1a are to protect those at the highest risk of exposure and maintain medical surge response capacity. Those who are at a high risk of exposure are workers in sites where direct patient care is being delivered to confirmed or suspected COVID-19 patients, workers exposed to/handling potentially SARS-CoV-2 containing specimens & COVID-19 testing staff, first responders at highest risk of exposure to suspected or confirmed COVID-19 patients, workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity, and workers administering vaccines for phase 1a, 1b, and 1c populations. <u>Questions posed to VAC members about the allocation framework:</u> 1. When to move to the next phase? To determine when we move to the phase, the below bullets are being taken into consideration: • Vaccine coverage trends of prioritized populations – i.e. assessing the vaccine coverage of currently prioritized populations and the uptake trends to estimate projected demand with currently prioritized populations • Vaccine supply – i.e. how much vaccine is currently available in Washington • Vaccine projections – i.e. how much vaccine supply is projected to arrive in Washington State in the coming months based upon information provided by the federal government/CDC • Current scientific data – i.e. current information related to vaccine efficacy and safety and epidemiological context 2. How to prioritize within a phase? The proposed factors to consider within a phase to prioritize are: • Size estimates of prioritized populations • Social vulnerability / equity factors • Epidemic conditions – outbreaks, high transmission areas • Emerging data regarding vaccines • Implementation issues if applicable – high through-put, cold chain capacity, consistent presentation for provider <u>Discussion</u> VAC members were concerned about known distrust about this vaccine and recommended DOH take that into account when planning for phase 1a. One VAC member asked where general primary care providers fit in and suggested that vaccinating primary care providers and pharmacy staff early will help

	them be strong advocates for vaccination. Another VAC member asked where schools fit in. Some discussion occurred around the size estimates of each subgroup in phase 1a. Another VAC member emphasized that all of what was presented was well-detailed but wondered if there will be an any ability for people to dig down and see for themselves where they fall in the phases and Blair responded that yes, once the guidance is finalized and approved, it will be publicly available on the DOH website.

Public Comments:

Public comments were received during the meeting. The comments expressed concerns around whether the state would pursue a mandate for the COVID-19 vaccine, COVID-19 vaccine safety, and tracking and monitoring of adverse events following a COVID-19 vaccination.

As a reminder, the Committee does not respond directly to comments. Members receive comments and take them into consideration during discussions.