



Nov. 5, 2020

Meeting Agenda: Phase 1a

MINNESOTA VACCINE ALLOCATION ADVISORY GROUP

Thank you for agreeing to participate in the upcoming Advisory Group meeting on **Thursday, Nov. 5, from 1 p.m. - 3:30 p.m. (CDT)**.

Meeting Objectives

We will seek to meet the following objectives:

- Update Advisory Group
 - Anticipated Timeline for Federal Process for COVID-19 Vaccine Allocations
- Review Key Distribution Assumptions
- Develop Guidelines for Geographic Distribution
 - Explore Four Scenarios (See Below)
 - Identify Core Principles for Geographic Distribution
- Explore Healthcare Worker Sub-Prioritization
 - Additional Data Requested by Group
 - ACIP Guidance to Date
 - Develop to Key Areas of Inquiry
- Discuss Timeline and Next Steps

Agenda

Welcome (Kris Ehresmann)	1:00 p.m.
Review of Objectives & Agenda (Carlo Cuesta)	1:10 p.m.
Update Advisory Group (Lynn Bahta)	1:15 p.m.
Review Key Distribution Assumptions (Jessica Munroe)	1:35 p.m.

Breakout Groups: Develop Guidelines for Geographic Distribution	1:50 p.m.
(Facilitators: Carlo/Bryn/Rachael/Deb)	
Discussion: Identification of Key Principles	2:15 p.m.
Healthcare Professional Sub-Prioritization	2:45 p.m.
<ul style="list-style-type: none">▪ HCP Data (Ben Christianson, Ashley Fell)▪ ACIP Guidance to Date (Lynn Bahta)▪ Group Discussion	
Discuss Timeline and Next Steps	3:25 p.m.
Adjourn	3:30 p.m.

Breakout Group Discussion Guide – Please Review in Advance

MDH staff have been planning for allocation and distribution of a potential vaccine that prevents against COVID-19. The CDC has provided states with planning assumptions based on the expected vaccine products that will first be available. Four different ways that COVID-19 vaccine could be allocated based on county population are outlined below. MDH staff feel strongly that the geographic distribution of COVID-19 vaccine in Minnesota should ensure that all regions of the state are provided a portion of the initial doses available.

Potential vaccinators will be asked to pre-register and will be allocated doses based on their ability to vaccinate priority populations recommended by the CDC, MDH, and the MDH COVID Vaccine Allocation Advisory Group, as well as ability to meet storage and handling requirements for specific vaccine products. MDH will use randomization to select the order of providers that receive doses.

Please discuss the four scenarios in your breakout group discussion during the meeting. Use the questions below to help guide your discussion. We would like input from the advisory group on what the best strategy or strategies are for Minnesota.

Questions for your group to consider

1. As you review these scenarios, what are the key elements important to helping inform how we distribute the initial allocations of the vaccine geographically?
2. What role, if any, should disease incidence in specific regions play in helping to guide geographic allocations?
3. What role, if any, should the social vulnerability index play in helping to guide geographic allocations?

4. Are there any other indicators, not included in the following scenarios, we should take into consideration?

Distribution Scenarios

Assumptions

- 100 dose package size
- 100,000 doses initially available
- Providers in each county would pre-register and be selected to receive vaccine based on their ability to vaccinate specific priority populations
- The order of providers within a region who receive vaccine may need to be randomized based on the number of doses available

Scenario 1

- Pro rata allocation based on county level population

Scenario 2 (incorporate social vulnerability index)

- Pro rata allocation based on county level population
- Incorporate the Social Vulnerability Index (SVI) score to allocation. Hold 10% of statewide allocation and use pro rata distribution to counties in the highest quartile base on SVI receive additional doses.

Scenario 3 (incorporate transmission of disease)

- Pro rata allocation based on county level population
- Incorporate 5-week COVID-19 case incidence to allocation. Hold 10% of statewide allocation and use pro rata distribution to counties in the highest quartile based on 5-week case incidence received additional doses.

Scenario 4 (incorporate all 3)

- Pro rata allocation based on county level population
- Incorporate 5-week case incidence to allocation
- Incorporate SVI score to allocation

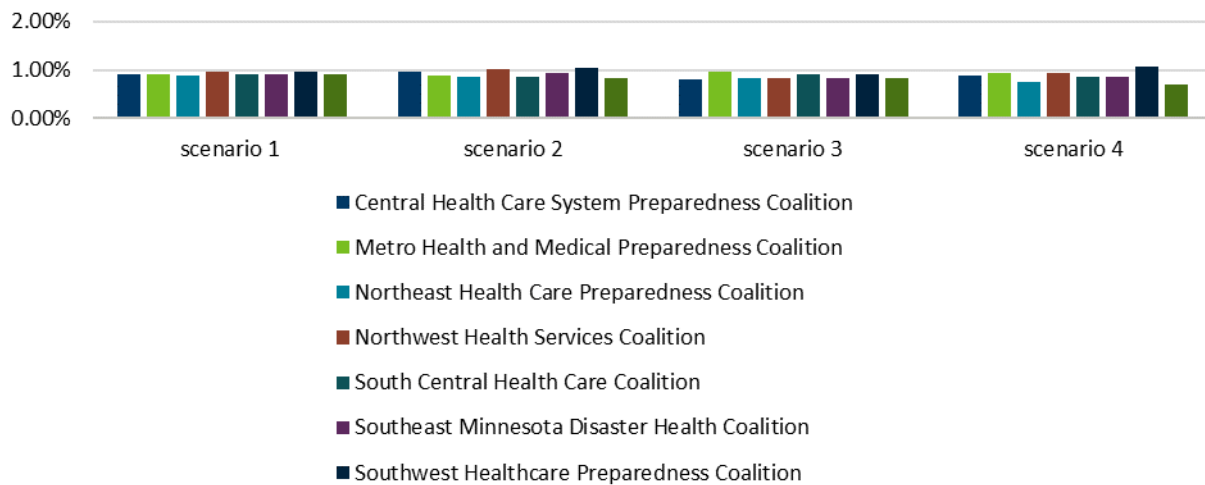
Table 1. Four scenarios for distributing COVID-19 vaccine using a regional approach

These scenarios assume that high-risk health care providers will be the initial priority population for vaccination.

Factors	Scenario 1	Scenario 2	Scenario 3	Scenario 4
County Population	X	X	X	X
SVI		X		X
Five-week case incidence			X	X

The following graphs show the allocations per Regional Health Care Coalition (see them at [Regional Health Care Preparedness Coordinators \(RHPCs\)](http://www.health.state.mn.us/communities/ep/coalitions/rhpc.html) [www.health.state.mn.us/communities/ep/coalitions/rhpc.html]), assuming Minnesota receives an initial allocation from the federal government of 100,000 doses. The data represented here is notional and is only displayed to assist in the small group discussions. The underlying assumptions may change depending on what vaccine products are available.

Percent of Population Vaccination in Regional Health Coalitions, by Allocation Scenario (100,000 doses)

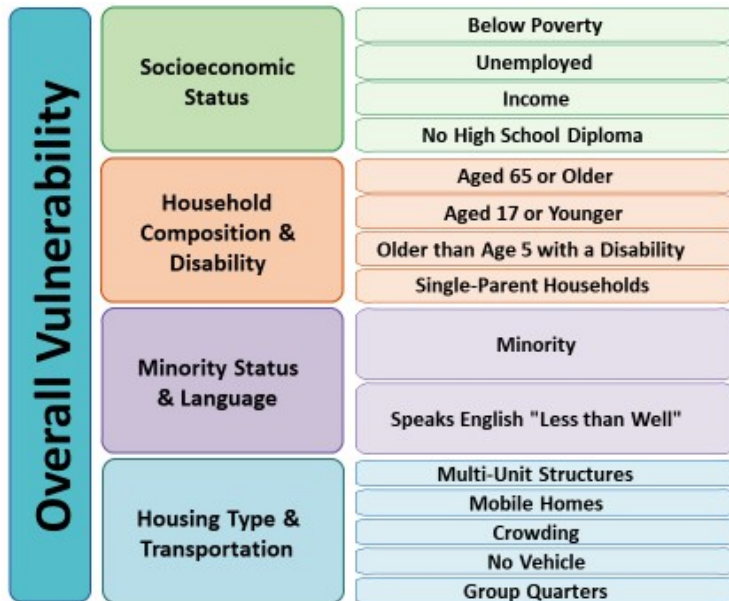


Percent of Population Vaccinated in Regional Health Coalition, by Allocation Scenario (1 million doses)



Appendix A – Social Vulnerability Index

The social vulnerability index indicates the relative vulnerability of every U.S. Census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. SVI ranks the tracts on 15 social factors, including unemployment, minority status, and disability, and further groups them into four related themes. Thus, each tract receives a ranking for each Census variable and for each of the four themes, as well as an overall ranking.



SVI and COVID-19:

[CDC: Association Between Social Vulnerability and a County’s Risk for Becoming a COVID-19 Hotspot — United States, June 1–July 25, 2020 \(www.cdc.gov/mmwr/volumes/69/wr/mm6942a3.htm\)](https://www.cdc.gov/mmwr/volumes/69/wr/mm6942a3.htm): Counties

with greater social vulnerability were more likely to become areas with rapidly increasing COVID-19 incidence (hotspot counties), especially counties with higher percentages of racial and ethnic minority residents and people living in crowded housing conditions, and in less urban areas. Hotspot counties with higher social vulnerability had high and increasing incidence after identification.

[Impact of Social Vulnerability on COVID-19 Incidence and Outcomes in the United States](#)

www.medrxiv.org/content/10.1101/2020.04.10.20060962v2.full.pdf: Social vulnerability is associated with higher COVID-19 case fatality. High social vulnerability and case fatality rates coexist in more than 1 in 4 U.S. counties. These counties should be targeted by public policy interventions to help alleviate the pandemic burden on the most vulnerable population.

SVI Methodology:

[ATSDR: CDC SVI Documentation 2018](#)

www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.html



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