



Sept. 29, 2020

Meeting Minutes: Phase 1a

MINNESOTA VACCINE ALLOCATION ADVISORY GROUP

The following is not a word-for-word transcription of the meeting. It is an outline of the conversations had and contributions made by the Advisory Group and meeting presenters. Information and planning assumptions were based on information that was known at the time of the meeting, and assumptions may have changed.

Advisors present:

Organization	Name	Title
MDH	Kris Ehresmann	Director, Infectious Disease Epidemiology, Prevention and Control Division
Minnesota Medical Association	Dr. Jill Amsberry	Pediatric specialist
LeadingAge Minnesota	Kari Everson	Director of Clinical Care & Clinical Consultant
Care Providers of Minnesota	Doug Beardsley	Vice President of Member Services
DHS Medicaid & MinnesotaCare	Dr. Nathan Chomilo	Medical Director Medicaid & MinnesotaCare
Minnesota Hospital Association	Abigail Stoffel	Quality and process improvement specialist
ICSI Immunizations Workgroup	Lee Mork	Director of Pharmacy for Allina Hospitals and Clinics
Minnesota Board of Pharmacy	Cody Wiberg	Executive Director
MIPAC/MN Council of Health Plans	Patty Graham	Senior Quality Consultant
Tribal Health Director	Pat Butler	White Earth Tribal Health Director
Minnesota COVID Ethics Collaborative	Dr. Debra DeBruin	Interim Director, Associate Professor, Director of Graduate Studies, Center for Bioethics
MDH	Jackie Dionne	American Indian Health Director
MDH	Danushka Wanduragala	Director COVID-19 Cultural, Faith, and Disability Communities

Welcome and Review of COVID-19 vaccine landscape (Kris Ehresmann)

Slide 2: Agenda

- Overview of COVID-19 vaccine at the federal level
- Phase 1 approach
- MDH's COVID-19 vaccine response

Slide 3: Operation Warp Speed

MDH would have preferred OWS be called "Operation Safe Speed." The "warp speed" designation has at times conveyed the idea that the operation's goal was "to hurry up and get it done," when the real objective has always been to develop an effective vaccine as safely and efficiently as possible. Safety is our highest priority. No vaccines will be released without ACIP approval.

- Advance development, manufacturing, and distribution of COVID-19:
 - Vaccines
 - Therapeutics
 - Diagnostics
- COVID-19 Vaccine Timeline
 - January 2020 – development of first vaccine based on previous research into SARS and MERS
 - March 2020 – first phase 1 trial began
 - April 2020 - OWS partnership announced
 - July 2020 – first phase 3 trial began
 - Currently four phase 3 trials on-going in US

Slide 4: COVID-19 Vaccine Specifics

This mass-vaccination effort will be infinitely more complex than previous efforts due to specific dosing and storage requirements, and variation of requirements between likely vaccine candidates.

- Varying presentations available, not interchangeable
 - Some will likely require 2 doses (interval of 21 or 28 days):
 - We expect the vaccine(s) will require 2 doses
 - Doses are protocol specific. You can't get the first dose from vaccine A and the second dose from vaccine B.
 - Dosing interval will vary by vaccine
 - Adjuvant may be needed

- Three different vaccine cold chain parameters, stability testing ongoing
 - Refrigerated (2-8C): 1-4 vaccines
 - Frozen (-20C): 1-2 vaccines
 - Ultra-cold (-80C): 1 vaccine
- Distribution:
 - Centralized for most vaccines: MN will be utilizing the same distributor used for the Vaccine for Children Program
 - Ancillary Kits (will include some PPE and Vaccination Supplies): The MDH team is looking to see if additional PPE and supplies are needed.

Slide 5: Current Unknowns “of which there are many”

- Vaccine characteristics – to determine benefits/risk, storage and handling, efficacy, and immunogenicity in certain populations
- Type of approval (licensure or emergency use authorization)
- Actual number of doses initially available
- Vaccine uptake – surveys suggest sizeable proportion of population are hesitant

Slide 6: Emergency Use Authorization (EUA) - will complicate vaccination process

- Extensive consent process at point of care
- No co-administration with other vaccines - patients can not receive the COVID vaccine and the flu vaccine in the same doctor’s visit
- Interval between doses will need to be precise
- Vaccination cannot be mandated or required
- No vaccine information statement (VIS) for vaccines under EUA

Slide 7: Phased Approach

- First phase will have limited doses available
 - Highly targeted administration to priority populations
 - Administration in closed settings as opposed mass vaccination settings
 - The Advisory Group’s input is critical to identify priority populations.
- Phase 2 large number of doses available
 - Initial priority populations will have been vaccinated
 - Able to broaden administration network
 - Commercial sector partner sites (pharmacies, primary care clinics, community clinics)
 - Public health sites (mobile clinics, FQHC’s, target communities)

- Phase 3: Vaccine becomes routinely available. Supply in excess of demand.

Slide 8: Phase 1 - Prioritization

- During phase 1, populations of focus for initial COVID-19 vaccination may include:
 - Phase 1a: Healthcare personnel likely to be exposed or treat people with COVID-19
 - Phase 1b: People at increased risk for severe illness from COVID-19, including those with underlying medical conditions and people 65 years of age and older
 - Phase 1b: Other essential workers
- ACIP will provide more specifics

Slide 10: MDH COVID-19 Vaccine Response - Five Areas

- Vaccine Distribution: provider registration, provider agreement, operationalizing allocation plan, vaccine disposal/return.
- Vaccine Allocation: convening advisory task force, interpretation/implementation of national vaccine recommendations (ACIP, NASEM, NVAC, CDC).
 - Purpose of the Advisory Task Force.
 - Need to interpret federal recommendations down to the local operational level (i.e. injected into the right person's arm).
- Vaccine Partner Education and Outreach: communications and partner engagement, training, material development/web content management, adverse event tracking/reporting.
 - Critical to addressing vaccine hesitancy.
- Local Public Health Vaccine Group: communications, liaison role, SME for local planning.
- Vaccine Data Management: vaccine coverage, summary statistics and other reporting, web content management, modeling, reminder/recall efforts.

Slide 11: COVID-19 Vaccine Planning

- MDH one of five locales for CDC micro-planning site visit
 - State and LPH professionals were given an opportunity to have a dialogue with CDC.
 - Provided input on how vaccine distribution might be implemented
- National plan guidance was released on September 16th and the MDH plan will be due to CDC by October 16th
 - Initial framework - not the final draft
 - New findings will be incorporated as we learn more about the disease and the vaccines.
- Local planning with new group co-led by Emergency Preparedness and IDEPC

Slide 12: COVID-19 Vaccine Allocation and Distribution

- Focus on targeted early phase for vaccine distribution when supply is constrained
- Awaiting priority groups from ACIP, expected October or early November
 - Launching Advisory Group early in order to get a head start on a MN-specific framework.
- MDH allocation advisory group to begin meeting in September
 - Refine priority group
 - Develop guiding principles for MN allocation framework
 - Review written recommendations for public-facing report

Introductions and Review of Objectives & Agenda (Carlo Cuesta):

- Advisory Group introductions
- Review COVID-19 vaccine landscape
- Describe the role of MDH in vaccine allocation and distribution
- Epidemiology of COVID-19 in Minnesota: a brief review
- Process for Federal COVID-19 vaccine recommendations
 - Overview of federal agencies and committees involved in the process
 - Review of September ACIP meeting
 - Review allocation frameworks
- Role of Advisory Group in development of Minnesota's vaccine allocation framework
- Timing and objectives for the next Advisory Group meeting

Role of MDH in vaccine allocation and distribution (Lucy Cosgrove)

- Lucy Cosgrove, MPH, MN Vaccines for Children (VFC) Program Coordinator
- Manages the vaccine distribution process for VFC program - distributes ~\$46 million worth of vaccines to pediatric providers throughout the state every year.

Slide 15: Agenda

- Overview of current vaccine allocation & distribution process
- Lessons learned from 2009 H1N1 Influenza Pandemic
- Next steps
- Q and A

Terminology

- Vaccine Allocations: The CDC or MDH making doses available to distribute to providers
- Vaccine distribution: Creating and filling orders and shipping vaccine doses to providers
- Providers: Any organization with trained vaccinators; e.g. clinics, hospitals, LPH, community vaccinators, pharmacies, etc.

Slide 16: High-Level Vaccine Allocation & Distribution Process

- Process will look similar to our existing framework used to distribute VFC and influenza vaccines
 - Providers enroll with MDH immunization program to register as COVID-19 vaccinators
 - MDH collects provider agreements, provider profile data from providers which will include:
 - Data on patient population
 - Ability to meet storage requirements
 - Once approved, providers enroll in online immunization information system (MIIC)
 - MDH receives daily (or weekly) vaccine allocations from CDC
 - MDH staff distribute doses to enrolled providers across the state
 - Influenza vaccines distribution randomly selected from list of providers
 - COVID likely to be more complex

Slide 17: Initial Phase of COVID-19 Vaccine Distribution

- Supply will be low
- Allocation principles needed to determine equitable process of allocating COVID vaccine to providers across the state
 - Priority group data
 - Geography
- Some federal partners will receive COVID vaccine directly from CDC
 - Some large chain pharmacies
 - Indian Health Services
 - Veteran's Affairs

Slide 19: H1N1 Lessons Learned - Vaccine Allocation and Distribution Strategy

- Vaccine allocation strategy should be based on recommendations from an advisory group with broad representation across healthcare and affected communities
- A pandemic vaccination campaign should be based on established statewide seasonal influenza efforts that are in place every year - leverages the VFC infrastructure

- Vaccine allocation and distribution efforts need to accommodate local needs that are different in metro and urban jurisdictions versus rural jurisdictions in greater Minnesota

Slide 20: H1N1 Lessons Learned - Vaccine Allocation and Distribution

- Ensure process is perceived as fair by both the public and registered vaccine providers
 - Pro rata allocations did not always feel fair
 - Need to determine strategies to communicate about limited resources
- Vaccine supply projections could change constantly
 - Need to adapt to changing supply
 - Need a standardized and flexible methodology that works in a variety of scenarios

Slide 21: H1N1 Lessons Learned Continued

- Careful consideration should be given to the timing for when to shift from vaccination focused on priority groups (and tiers within priority groups) and the general public
 - Waiting too long to make this shift can result in missing an opportunity to capitalize on high interest in the general public for vaccination
- Leveraging and collaborating with large health care systems in the state for vaccine allocation and distribution is key when vaccine availability opens up to a wider group of the general public

Slide 22: H1N1 Lessons Learned - Communication Strategies

- Public communications regarding the estimated number of doses and the timing of when those doses will be available for use should be carefully considered
 - The public's trust is eroded when projections are overly optimistic and there are delays in the availability of the vaccine.
- Effective and coordinated communication strategies are needed for all audiences including healthcare providers, the general public, and special population groups
- Transparency is key in informing all partners of the actions public health is taking and in addressing vaccine hesitancy among potential vaccine recipient

Slide 24: Need for Vaccine Allocation Advisory Group

- Recognize challenges may be different than H1N1
- Looking to Advisory Group for guidance on how to equitably allocate COVID-19 vaccine in early phase of vaccine distribution
- Desire for transparent process
- Input needed early on from diverse group of partners
- Want to build a sense of trust and shared ownership over vaccine allocation policy

Slide 25: Considerations for Initial Priority Groups

- Vaccine likely issued under an Emergency Use Authorization (EUA) which may limit options
- Advisory Committee on Immunization Practices (ACIP) recommendations are still unknown but first phase of vaccine distribution may focus on healthcare workers
 - Initial vaccine supplies may be insufficient to vaccinate entire phase 1a population
 - We will likely need to define prioritized subgroups within healthcare worker population
- How to decide between providers with equal priority populations when supply is low

Slide 26: Next Steps

- Collecting aggregate priority group data
- Awaiting recommendations from ACIP and input from this group moving forward

Q & A:

Q: How do you manage provider distribution of seasonal influenza vaccines? Do you dole it out to the large healthcare systems and let the healthcare system decide? Is it at the clinic level, or at the individual provider level?

A: Influenza allocations are distributed at the health system level or at the clinic level, depending on the preference of the health system. For health systems that prefer a system-wide allocation, they decide how to distribute those doses to clinics in their system.

Redistribution of COVID-19 vaccines is still in discussion.

Q: Will each tribe need to enroll in COVID-19 provider registration even if they are already enrolled as an influenza provider?

A: Yes, there is a separate COVID-19 vaccine provider agreement that all vaccinators will need to complete if they want to provide COVID-19 vaccine.

Q: Network providers usually register as a system. How will that work with COVID?

A: Yes, that will be allowed, but the details have yet to be determined.

Q: Why was H1N1 allocation perceived as unfair?

A: When doses were limited and demand was high, smaller clinics that received pro rata allocations perceived the process as unfair due to the very low number of doses they initially received (e.g. 20 doses). This made vaccination very difficult to implement for smaller clinics during the early phase of distribution.

Epidemiology of COVID-19 in Minnesota: a brief review (Kristin Sweet)

- Kristin reviewed the [MDH Weekly COVID-19 Report for September 24](#).
- The most recent report can be found [here](#).

Overview: COVID-19 cumulative data and cumulative cases by date (p. 3)

- 93,012 confirmed cases (out of 1,895,302 laboratory tests)
- 7,335 Hospitalizations (2,049 ICU Hospitalizations)
- 1,988 Deaths
- 83,862 No longer need isolation

Cumulative Case Rate by County of Residence: Cases per 10,000 people (p. 14)

- Map shows where the largest hotspots have occurred to date based on population.
- Hardest hit areas include:
 - Hennepin, Ramsey and Washington counties
 - South and Southwest counties including Mower, Blue Earth, and Nobles
 - Central MN: Todd, Stearns, and Kandiyohi Counties

Hospitalizations and ICU Hospitalizations - Cumulative by date, and cases by day reported (p. 16)

- 7,335 total hospitalizations, of which 2,049 were ICU hospitalizations
- Daily hospitalizations show a peak back in May.
- Daily hospitalizations stayed relatively flat during the summer, but may be starting to tick up post labor day and with the start of the school year.

Demographics: Age (page 22)

- Age by
 - Proportion of Cases
 - Proportion of Hospitalizations
 - Proportion of ICU Admissions
 - Proportion of Deaths
- Median Age of
 - All cases: 35
 - Non-Hospitalized cases: 34

- Hospitalizations: 59; ICU admissions: 61
- Deaths: 83

Age-Adjusted Race and Ethnicity Rates: Cumulative case rates by race/ethnicity per 100,000 people in MN (p. 26)

- Lets us compare across racial and ethnic groups that have different age distributions in MN. This matters because:
 - Overall distribution of COVID cases skews younger
 - Hence, racial and ethnic groups with a disproportionately younger populations need to be adjusted for age in order to make apples to apples comparisons
- Adjusting for age, hardest hit groups: Hispanic, Black (non-Hispanic), Native Hawaiian/Pacific Islander. White non-Hispanic have the lowest case rate of all race/ethnicities.

Occupational Related Cases: Health Care (p. 32)

- 9,930 cumulative cases among healthcare workers (includes all professions working in a healthcare setting, not just healthcare professionals - e.g. doctors, nurses, lab techs)
- Of those 9,930 cases, 7,986 were most likely the result of occupational exposure.
- 419 healthcare workers hospitalized

Cases Associate with Congregate Care Settings - by date (p. 34)

- 5,263 congregate care staff
- 6,260 congregate care residents

Congregate Care Facility Outbreaks - by date (p. 35)

- Out of 1,803 care facilities
 - 1,072 had 1-2 cases
 - 602 had 3-20 cases
 - 129 had 21 or more cases
- Peaked in May with another bump in August.

Q & A:

Advisor 3: Have you broken down the cases among congregate care staff, and other essential workers, by race in these weekly reports? Or is the Community Resilience & Recovery statistics site still the best place to find that data?

A: No, we haven't broken out the weekly COVID update with that data. The Resilience and Recovery dashboard is still the best place to find that information (Website: <https://mn.gov/covid19/data/data->

[by-race-ethnicity/index.jsp](#)) However, if that info would be helpful with Advisory Group deliberations we can provide it.

Follow up: Yes, if we're charged with identifying and prioritizing sub-populations it would be helpful to know what are the demographics within these essential worker populations.

Process for Federal COVID-19 vaccine recommendations (Lynn Bahta)

- Lynn Bahta, RN, MPH, CPH - Immunization Clinical Consultant

Slide 29: Pathway to Vaccine Recommendations

- Basic research - Phase 1-3 clinical studies
- Phase 3 data sent to FDA for licensure:
 - Reviewed by Vaccines and Related Biological Products Advisory Committee (VRBPAC) for licensure
 - ACIP and subgroups conduct additional review of research and provide recommendations
 - ACIP recommendations go back to CDC for approval
- Phase 4: ongoing surveillance of safety and efficacy data

Slide 30: Overview of U.S. COVID-19 Vaccines

- Over 200 COVID-19 vaccines under development; eight in the U.S.
- Two Phase 3:
 - mRNA-1273 vaccine (Moderna): 25,296 participants enrolled (9/16/2020)
 - Intend to enroll 30,000
 - 28% of participants enrolled are from "diverse communities"
 - BNT162b2 vaccine (Pfizer/BioNtech): 31,928 participants enrolled (9/21/2020)
 - 26% of participants enrolled have "diverse backgrounds"
 - Proposed expansion to 44,000 participants to include additional groups (e.g., pregnant women, immunocompromised, etc.)
- ACIP priority was to include diverse participants in these trials, specifically populations most at risk from the disease.

Slide 31: ACIP Recommendations

- Based on evidence review: Grading of Recommendations, Assessment, Development and Evaluation (GRADE) - What evidence exists and how reliable is it?

- Benefits and harms: Epidemiology of the disease and who will benefit, and how well a vaccine would work on those target populations
- Quality of evidence
- Values: How does the community value prevention?
- Preference of persons affected
- Health economic analysis: Allocation decisions based on the above considerations

Slide 32: Goals of the COVID-19 Vaccine Program

- Ensure safety and effectiveness of COVID-19 vaccines
- Reduce transmission, morbidity, mortality of COVID-19 disease:
 - Efficacy may vary by vaccine candidate for all three metrics
- Help minimize disruption to society and economy, including maintaining healthcare capacity
- Ensure equity in vaccine allocation and distribution

Advisor 3: How is "preference of persons affected" determined?

A: Often done through surveys and polls. Example: New vaccine to prevent Dengue Fever. LPH professionals went out and talked to parents of children who would be targeted for that vaccine. Also could include review of public demand, or review of side effects and tolerability to target population.

Slide 33: ACIP process for COVID-19 vaccine recommendations

- Currently: Weekly workgroup meetings and data review
 - Independent review of phase 3 clinical data by work group. Done in addition to the work by VRBPAC and ACIP.
 - Develop allocation policy options using GRADE – We will know more once we hear if the vaccine will be licensed or released under an EUA.
- When FDA decision is announced – Meeting currently scheduled for October 28
 - ACIP emergency meeting earlier is possible
 - After evidence review, ACIP will make a recommendation and provide allocation guidance
- After an ACIP vote: recommendations submitted to CDC Director
- If accepted, they are published and become official CDC Policy

Slide 34: Vaccine Prioritization and Equity

- ACIP has discussed inclusion of ethics and equity principles as part of the process to identify proposed groups for early COVID-19 vaccination
- Allocation – equity and prioritization models
 - WHO: Strategic Advisory Group of Experts (SAGE)

- Johns Hopkins School of Public Health
- National Academies of Sciences, Engineering and Medicine (NAM)

Slide 35: WHO/SAGE

- Six core values principles:
 - Reciprocity: Those who are on the frontline should be prioritized.
 - Equal respect: Make sure that all needs are being considered when looking at allocation
 - Legitimacy
 - Global equity
 - National equity
- Priority to:
 - Populations with significantly elevated risk of being infected
 - Populations with significantly elevated risk of severe disease/death
- Groups were not ranked

Slide 36: Johns Hopkins - Values/Principles Framework

- Promote the common good:
 - Promote public health
 - Promote economic and social well being
- Treat people fairly and promote equality
 - Address inequities that already exist
 - Prioritize the worst off
 - Reciprocity for those who are at higher risk due to occupation or where they live
- Promote legitimacy, trust, and sense of ownership in pluralistic society
 - Respect diversity of views
 - Engage community

Slide 37: Johns Hopkins - Ranked priority groups

- Tier 1:
 - Those most essential in sustaining the ongoing COVID-19 response
 - Those at greatest risk of severe illness and death, and their caregivers
 - Those most essential to maintaining core societal functions (e.g., utility works, farm workers, teachers, etc.)
- Tier 2

- Those involved in broader health provision
- Those who face greater barriers to access care if they become seriously ill
- Needed to maintain other essential services
- Those whose living or working conditions give them elevated risk of infection

Slide 38: National Academies of Science, Engineering & Medicine (NAM)

- Foundational Principles
 - Maximize benefits
 - Equal regard
 - Mitigate health inequities
 - Fairness
 - Evidence-based
 - Transparency

Slide 39: NAM - Allocation criteria are risk based

- Prioritize according to individuals to the extent of their:
 - Risk of acquiring infection
 - Risk of severe morbidity and mortality
 - Risk of negative societal impact
 - Risk of transmitting disease

Slide 40: COVID-19 vaccine priority group comparison

- WHO did not rank their priority groups
- NAM used a phased approach vs tiers
- Frontline healthcare personnel were in phase 1a and tier 1 respectively

Slide 41: ACIP Work Group Deliberations

- Proposed ethical principles
 - Maximize benefits and minimize harms: Promote public health and the public good, balanced with our obligation to care for persons using the best available science
 - Equity: Reduce rather than increase health inequities. Ensure that everyone has a fair and just opportunity to be as healthy as possible.
 - Justice: Commitment to remove unfair, unjust or avoidable barriers to good health and wellbeing, especially within populations that are disproportionately affected.

- Fairness: Commitment to fair stewardship in the distribution of scarce resources, without exacerbating existing inequities in health outcomes.
- Transparency: Allow for public participation in the creation of framework and decision making. Necessary to build public trust in the process.

Advisor 16: Do you think public health is included under "other healthcare personnel? Thinking about PHNs and LPH staff running immunization clinics.

A: Those details have yet to be determined. It's possible those groups would be included in Tier 1 or 2 based on their importance to maintaining a COVID response. But those specifics haven't been clarified by ACIP at this point.

Slide 42: Goals

- Minimize death and serious disease
- Preserve functioning of society
- Reduce disproportionate burden on those with existing disparities
- Increase equity of opportunity to enjoy health and well-being

Slide 43: Applying ethical principles for COVID-19 allocation

- Phase 1a:
 - Health care personnel (national population ~20 million)
- Phase 1b:
 - Other essential personnel (national population 60-80 million)
 - Persons with high-risk medical conditions (national population greater than 100 million)
 - Older adults 65 years or older (national population ~53 million)
- We don't yet have enough information on risks and benefits

Slide 44: Possible Phase 1 Groups

Slide 45: Next steps for ACIP

- Awaiting key information
 - Vaccine characteristics – to determine benefits/risk; storage and handling; efficacy and immunogenicity by certain populations
 - Type of approval (licensure or emergency authorization)
 - Actual number of doses initially available

Q & A:

Advisor 2: Healthcare workers seem to be repeatedly prioritized. Do we anticipate a need to prioritize within healthcare workers or is supply expected to be enough to cover the entire umbrella of “healthcare workers”?

A: We anticipate that we will need to break down healthcare workers into sub-prioritization groups, because we do not expect to have enough doses for the entire population during the initial phase.

Advisor 2: As we learn more about the virus and its ability to mutate, are there preparations in place to adapt if we see a significant change in the virus?

Lynn Bahta: The proteins being targeted by phase 3 vaccine candidates are stable enough that they don’t anticipate that the vaccine would stop working. The mutation rate appears very slow in comparison to other viruses.

Role of Advisory Group (Carlo Cuesta, Denise Dunn & Ben Christianson)

- Assist with allocation prioritization for the initial phase 1a, when vaccine supply is expected to be constrained
- Create a Minnesota-specific framework for prioritization of sub-groups
- Unknowns:
 - Not sure how detailed federal recommendations will be
 - Regardless of how prescriptive the feds choose to be, we’ll likely need to refine and customize for Minnesota
 - Framework needs to be flexible enough to adapt to multiple scenarios

Advisor 11: If we offer additional guidance, will the feds have a process of approving/disapproving? Or will our framework just be approved by the state?

Lynn Bahta: If the federal recommendations become more prescriptive there may be some contingencies. Where we may have more restrictions is if the vaccine is released under an EUA. Under an EUA we may lose some flexibility.

Advisor 15: I would also add that when MN looks at equity, it’s not always inclusive of racial equity. We need to continue to think about race in the conversation of priorities. When we think about healthcare workers and the different levels of professions. Professionals at the higher end of the higher paid position tend to be white; lower paid professional mostly POC.

Advisor 3: Regarding allocation to large clinic/provider systems, what ability will the state have to enforce this framework is carried out by large systems once they are allocated vaccines? Or is it like other allocation frameworks where it is more guidance than enforcement?

Lynn Bahta: We will need to work with our local jurisdictions partners to identify those providers who represent/serve the prioritized populations and make allocation decisions based on those deliberations.

Jessica Monroe: The provider agreement stipulates that licensed providers follow the ACIP recommendations, which is enforceable. However, the federally mandated provider agreement does not legally obligate providers to follow any additional requirements placed on them by the state.

Advisor 14: Will the outbreak data help determine allocation?

Ben Christianson: This question was addressed at the last ACIP meeting. Given the logistical complexities of vaccine distribution (multiple doses, storage requirements) coupled with the timing limitations for identifying a hotspot, it probably won't be feasible to use outbreak data for allocation decisions. We might consider looking for risk factors that predict hotspots and prioritizing those locations, but vaccination is unlikely to be a useful emergency response for existing hotspots while vaccine remains limited.

Nationally, we do not know whether the outbreak will factor into the allocations that are provided to each state. During H1N1, states were given pro rata allocations, but a final decision has not been made on this yet for COVID-19. We may be able to factor in certain aspects of the outbreak in Minnesota into the Minnesota allocation framework.

Timing and objectives for next meeting (Carlo Cuesta)

- We don't yet have a date for the next meeting. It will be after the next ACIP meeting October 28-30. Earlier if ACIP calls an emergency meeting.
 - Three hours long
 - Developing framework for allocation prioritization
- As more information is released by the CDC, the Steering Committee will synthesize that information so you can review it before our second meeting, likely in November.
- Advisory Group input from the next meeting will be synthesized into a set of draft recommendations that will be reviewed and refined at our third meeting (TBD).

Additional questions and comments from chat:

Advisor 16: LPH could be key to getting vaccines out to at risk communities through community based clinics. Many LPH already work with those groups in their communities.

Advisor 3: To build off of Advisor 16's question and consideration for as this work moves forward -If a vaccine doesn't actually notably decrease mortality (especially in older adults) does it make sense to target the populations that are having higher cases to try and decrease spread overall?

A: This is one consideration that several of the national frameworks have discussed. They seemed to land on focusing the early phases on reducing morbidity and mortality and maintenance on healthcare and emergency services in the early phase, with reduction of transmission as a priority in a later phase. They did acknowledge that the gap in knowledge regarding the vaccine efficacy and effect on mortality will be a barrier in fully assessing this as a strategy. ACIP will likely factor this into their recommendations once more is known about the efficacy data. Depending on how flexible the national guidance is, this may be a strategy that we can consider in Minnesota.



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