STAY SAFE MN

Jan. 11, 2021
Meeting Minutes: Phase 1b

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.

Welcome

Facilitator: Welcome everyone.

Advisor 1: Thank you everyone for meeting today. We are discussing really challenging issues. At the last meeting we were discussing the vaccine as a light at the end of the tunnel. Over the last few weeks, it feels more like an oncoming train. We are at a very important next step, and a very challenging one. I want to acknowledge the challenges and thank our team for all their hard work. In the process of moving forward, what we have seen at national level is a lack of consistency. When we recall the H1N1 pandemic, there were two really significant lessons learned. First, over-promising and under-delivering, and that ball was dropped at the federal level with the promise of 20,000,000 dose by the end of the year. The second lesson was the value of consistency across states. Inconsistency creates challenges when neighbor states are doing things differently than what you are recommending. In both cases we are experiencing a lot more challenges. This makes the conversation regarding Phase 1b that much more challenging. I realize it has been a constantly moving target. We are working with the governor's office, because he ultimately makes the decision about how to allocate or prioritize within the various phases. We checked in with the Governor this afternoon so that the straw document we share with you today is consistent with our discussions, but also fits with the Governor's thinking. Allocating scarce resources is a challenging thing and is very difficult. I want to acknowledge that and thank you for your feedback and thoughts. Thank you for being with us.

Facilitator: Meeting instructions and housekeeping.

Roll Call

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

Organization	Name	Title
Care Providers of Minnesota	Doug Beardsley	Vice President of Member Services
DHS Medicaid and 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 Health Medical Group 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
Local Public Health	Christine Lees	Dakota County Disease Prevention and Emergency Preparedness Supervisor
Local Public Health	Kristie Rathmanner	Wright County Public Health Nurse
Health Equity Advisory and Leadership Council	Therese Genis	Health East Community Health and Wellbeing Strategist
Disability Representative	Karen Herman	Executive Director of Udac inc.
Mayo Clinic	Dr. Melanie Swift	Medical Director, Mayo Clinic Physician Health Center. Assistant Professor of Medicine
Children's Hospitals and Clinics of Minnesota	Dr. Nneka Sederstrom	Director, Clinical Ethics
NorthPoint Health and Wellness Center	Kimberly Spates	Chief Operations Officer
Minnesota Department of Employment and Economic Development	Maureen Ramirez	Director of the Office of Economic Opportunity
Minnesota Department of Labor and Industry	Naheeda Hirji-Walji	Director of Public Engagement and Outreach

Facilitator: Review of meeting agenda.

Updates from MN COVID Ethics Collaborative (MCEC) – Presented by Advisor 11

Slide 1 Overview

- The commissioner approached the collaborative to discuss a couple of questions.
- MCEC met on Tuesday, Jan. 5 to provide input on vaccine allocation planning.
- Issues considered.

- Possible prioritization for populations in prisons and jails.
- Considerations regarding the 75+ priority group.

Slide 2 Prisons and Jails

- MDH staff provided background on vaccine allocation and Phase 1b.
- Jennifer Zipprich provided background information at the MCEC meeting last week.

Slide 3 Prisons – Ethical Considerations

- Strong support for prioritizing prison population in Phase 1b.
  - Concern about risks and difficulty mitigating risks.
  - MCEC moral and legal obligations to protect those who cannot protect themselves.
    - Recognize obligation to provide health care.
  - Prison sentences are loss of privacy and freedom.
    - Cannot compound their sentences by failing to address health and safety.

Slide 4 Prisons - Logistical and Political Considerations

- Size of population was small enough that addition of this group to Phase 1b would not delay vaccinating other groups.
- Maybe politically unpopular, but we cannot allocate resources because “some people have greater social value than others.”

Slide 5 Jails

- Considerations regarding jail populations are more mixed.
  - Concern about the risk of the setting contributes to community spread.
  - Concern about obligations to similar prisoners.
  - Stays are shorter, which mitigates risk.
    - However, some stays are much longer – those convicted but sentenced to less than one year often serve sentences in jails, not prisons.
  - Concern about lack of infrastructure to vaccinate.
  - Difficulty predicting need of vaccines. Doses might be thawed but not given.
  - Length of stay raised concern about second shot.
    - Some members felt this would be a manageable operational issue.

Slide 6 Recommendation

- Prioritize prison population and only those in jails who are convicted and serving sentences, but not awaiting trial.

Slide 7 Considerations regarding 75+ Priority Group

- JP Leider presented his data to the group at the last meeting.

Slide 8 Understanding Risk

- Are there groups <75 years old that have comparable risk to 75+ who are prioritized in Phase 1b?
  - It would be ideal to compare outcomes among specific groups (hospitalization data).
  - Death certificates are helpful, but do not capture Latino and Native American burden.

Slide 9 Among 75+ substantial heterogeneity (see table)

- Excess mortality is much higher within the 75+ BIPOC population than the 75+ White population, especially among men.

Slide 10 Comparing risk

- Age standardized COVID-19 mortality.
  - American Indian, M, 65-74 (+17%).
  - Asian/PI, M, 65-74 (+13%).
  - Black, M, 65-74, (+52%).
- Age standardized excess mortality.
  - Black, F, 65-74 (+23%).
  - Black, M 65-74 (+130%).
  - Latino, M, 55-64 (+23%).

Slide 11 Summarize Discussion

- Overwhelming support for prioritizing those at comparable risk to 75+ age group.
- Discussion centered on how to operationalize.
  - Directly based on race, given racial/ethnic disparities.
    - What about disparities related to SES?
    - Very unlikely to survive legal challenge.
  - Identify specific groups of comorbidities (independent or combined) that produce comparable risks to 75+ group.
  - If necessary, and data is hard to come by, use proxy such as 2+ comorbidities.
    - There is some worry that this would not be sufficiently evidenced-based.

Slide 12 Recommendation

- Phase 1b prioritize groups who are at comparable risk to 75+.
- MDH should determine how best to operationalize this, given considerations outlined by MCEC.

Updates from MN COVID Ethics Collaborative (MCEC) – Q&A

Facilitator: Questions or comments?

Advisor 4: Very thoughtfully done. Questions about comorbidities. What about Down Syndrome? Would this be a category to consider?

Advisor 11: Would certainly be a consideration. Very important to respond to concerns of the disability community. Acknowledge that disability contributes to severe illness. MCEC needs to make sure people are similarly situated, to determine level of risk. People with comparable risk should get prioritized at the same time.

Facilitator: Advisor 21 from chat: Can incarcerated people decline the vaccine?

Advisor 11: The vaccines are approved under an Emergency Use Authorization (EUA). As such it cannot be mandated. Inmates have the right to decline the vaccine.

Advisor 3: Did MCEC look at zip code data, Social Vulnerability Index (SVI), or census track data to target the at-risk populations without incurring legal challenge? Worried that comorbidities are the result of structural racism and are not getting upstream enough.

Advisor 11: Acknowledge comorbidities are the result of structural racism. MCEC endorsed using SVI to allocate in the past. Was not discussed at last meeting about using it. Could be raised in the future.

Advisor 16: Speak about the considered logistical, practical considerations when considering sub-prioritizing these groups. In practice, with each level of granularity, there is a corresponding slowness in reaching them. Was there discussion about this?

Advisor 11: Often there is MCEC discussion about challenges of promoting fairness versus efficiency. People felt strongly about the idea that similar risk should be similarly prioritized. Operationally this would be more burdensome and problematic. Want to give MDH some latitude to find a way that was not unduly burdensome. Trying to find a balance. Looking through public comments there were a lot of comments along the lines of "I am younger than 75 but feel I am at the same level of risk, so why am I not being prioritized?"

Subject Matter Expert 1: There is a challenge in balancing efficiency and equity. Can we more expeditiously handle some of the equity issues, while not making those efforts subject to legal challenges? Any type of response is better than nothing.

Facilitator: Advisor 1 in chat: There are a limited number of doses available.

Advisor 5: From the perspective of providers (vaccinators), state priorities and recommendations must be very explicit and publicly available. Health care providers are getting a lot of arguments, complaints, and patient dissatisfaction, and local politics are really tough on health care providers that are just trying to administer the vaccine and follow MDH guidance. It needs to be said that this is a state public health

requirement, not the individual's or health care provider's decision. That is the perception of the patients – that the vaccinator is withholding the vaccine from them.

Facilitator: We will be raising the communications pieces later.

Advisor 3: Were there concerns about the legality of using Medicaid eligibility data, or any public assistance data, since people on this were clearly suffering more? What would be clearer for health care providers to point to, so that the public to wrap their head around. Any discussion about this?

Advisor 11: No there was not. But there was a recognition about sub-prioritizing among the 75+ population. From JP's data there was a lot of heterogeneity of risk in that population. It may be possible to sub-prioritize. I did raise this issue with MDH. It was a very active discussion. Does seem worth thinking about.

Facilitator: Thank you for questions and comments. Will turn it over to Ben Christianson.

Key Principles from Phase 1a – Ben Christianson, Minnesota Department of Health

Slide 1 Key Ethical Principles

- Maximize benefit/minimize harm: Protect the population's health by reducing mortality and serious morbidity.
- Promote justice: Respect people and groups and promote solidarity and mutual responsibility.
- Mitigate health inequities: Strive for fairness and protect against systematic unfairness and inequity.
- Promote transparency: Respond to needs respectfully, fairly, effectively, and efficiently in ways that are accountable, transparent, and worthy of trust.

Slide 2 Social Vulnerability Index (see figure)

- Counties with greater social vulnerability had rapid increase in COVID cases.
- SVI is associated with higher COVID-19 fatalities.
- Phase 1a Allocation: 15% of doses allocated based on SVI. 85% pro rata allocated based on priority population.

Slide 3 Updated Geographic Allocation Scenarios

Slide 4 Updated geographic scenarios 75+

- Pro rata distribution to all regions based on 75+ population.
- Pro rata distribution to all regions based on total population residing in vulnerable census tracks.
  - Scenario 1 – 85% based on priority population, 15% hold back for SVI.
  - Scenario 2 – 75% based on priority population, 25% hold back for SVI.

- Scenario 3 – 60% based on priority population, 40% hold back for SVI.

Slide 5 Percent of 75+ Population Immunized with first dose, by allocation scenario and region (100,000 doses) – see chart

- Visual is at regional level, but data is at county level.
- Scenarios 2 and 3 provide most benefit to North West and Metro regions.

Slide 6 Medicare/Medicaid Dual Eligible Beneficiaries, Age 75+

- DHS provided the number of people 75+ who are Medicare/Medicaid dual eligible by county.
- Total in the state are 38,045. About 10% of 75+ population.
- Data from CMS shows hospitalization disparity for dual eligibility population is significant.
- One way to sub-prioritize within 75+ age group.

Slide 7 Additional Data Source for Consideration

- Free/Reduced Lunch Program (FRLP) eligibility data
  - Students cannot be vaccinated, but vaccinating the staff would facilitate in-person learning.
- School districts with high percentage of students receiving special education.
  - Have a lot of one-on-on support staff.
- Child Care Assistance Program (CCAP) data. Child care with a higher proportion of families eligible for CCAP.
  - Could pick put child care that is serving families eligible for these programs and prioritize them.

Key Principles from Phase 1a – Q&A

Facilitator: Advisor 12 from chat: How were doses held back for SVI distributed in Phase 1a? How would SVI eligibility be determined?

Ben Christianson: "Held back" is the wrong term. All doses were allocated as soon as we got them. 15% of doses were allocated to regions that had a higher SVI ranking (i.e., the region contained a disproportionate number of vulnerable census tracks). This increased the number of vaccine doses available to vulnerable regions, but they were not earmarked for specific individuals. The hospital and health care providers in those areas got more because they were serving those vulnerable populations. Would be the same in Phase 1b. Proposed by National Academies and CDC.

Advisor 5: Will there be separate allocations for 75+ and health care workers, or just one allocation for both?

Ben Christianson: Might need to have the vaccine distribution experts weigh in here. My understanding is that it is two allocations, because of the different vaccinators. 75+ may be vaccinated in medical homes and community pharmacies, whereas essential workers would be vaccinated by local public health and/or with a public/private partnership. Would try to split it up.

Facilitator: from chat: Do we know how many doses were administered in Phase 1a from the 15% SVI holdback?

Ben Christianson: 15% of the overall doses but does not guarantee those doses were getting to the community. Mostly because Phase 1a was health care providers, so it was a more indirect benefit.

Facilitator: Advisor 6 from chat: Is there race/ethnicity data to accompany those potential subgroup breakout options?

Ben Christianson: Yes, for FRLP race/ethnicity data is very correlated at the school district level. Not sure about CCAP program. Advisor 3 mentioned there might be race/ethnicity data with dual eligibility information.

Utilization of Social Vulnerability Index – Advisor Discussion

Facilitator: Should SVI percentage be increased in Phase 1b?

Advisor 14: Looking at scenario 1, the range of difference in allocation by region it is 4%. But when you get all the way over to scenario 3 you are talking about a 20% difference. I get uncomfortable looking at the differences. It seems almost unfair.

Advisor 3: We should also be uncomfortable with the impact COVID-19 has had on these more vulnerable regions. The difference in allocation is intended to get help to those communities that have been disproportionately impacted.

Advisor 5: I would like to hear the communications plan and distribution plan regarding inventory. If uptake is low in areas where we want it to be high, and vaccine is just sitting on a shelf, what is the plan? More communication? Do we reallocate vaccine to areas with higher uptake? What happens to regional allocations in subsequent weeks?

Subject Matter Expert 2: We will keep a close eye on doses administered compared to doses shipped. We will not continue to send doses where they are not being used. We are trying to tightly manage the supply.

Advisor 5: If we are using SVI, we need to also look at ways to drive up demand. Otherwise, what is the point?

Subject Matter Expert 2: Whole section of the response working on engagement and communications with communities of focus. Needs to be a large effort to address vaccine hesitancy by ensuring that vaccination opportunities are available with trusted providers serving these communities.

Advisor 5: From a provider viewpoint, we are doing all we can just to get the vaccines out. Having vaccinators also responsible for outreach messaging is overextending what they can do. Need more community groups at the table to drive that demand and reduce hesitancy.

Subject Matter Expert 3: Cultural/Faith/Disability Branch has community liaisons with communities of color and diverse ethnicities. Develop communication venues where those choosing to get vaccinated have access and know where to go. We are also developing informational forums to address hesitancy generated by historical trauma and current racial and systemic inequalities. We might not be able to address all hesitancy, but addressing misinformation, and acknowledging the distrust and fears might help reduce the hesitancy. Also a plan has been developed with the governor's office that communication and education are available to all communities, particularly our communities of focus.

Advisor 2: Not to belabor the point, but this is similar to conversations we had in the Phase 1a. Areas with higher social vulnerability are receiving more doses, but we do not see a corresponding uptake in vaccinations. Moreover, because of systemic disparities in these regions, the people we are trying to vaccinate do not have a seat at the table. The individuals that do have a seat at the table are making local allocation decisions in their best interests. For example, we have heard that health care providers are vaccinating spouses of health care workers because they have excess doses. I just want to remind everyone about the ethical principles. How this plays out is more important than just looking at numbers.

Advisor 12: Do we have any feedback, anecdotal or actual, that the 15% vaccination had an impact on communities of focus?

Ben Christianson: We are looking at MIIC trying to link to other data sources to look at race and ethnicity and uptake. Not quite there yet.

Advisor 12: That is disappointing. I would he hesitant on increasing 15% if we do not know if it had any effect.

Advisor 11: For Phase 1a we are targeting health care workers, part of allocation is based on SVI, trying to get doses to communities that have higher levels of vulnerable populations. We knew it was not the actual population, but health care workers that served them. Now are looking at vaccinating members of the general public. Even though we do not have data from Phase 1a, I would expect allocations in Phase 1b will have more of an impact since we are targeting at-risk populations directly.

Advisor 3: Looking at the website public comments regarding equity. The vaccine provider application collected no data regarding equity concerns. No place for clinics to state how they were going to equitably distribute the vaccine. We need stronger guidance on equity.

Advisor 16: I want to bring up the concept of looking at the practicality of the logistics and distribution. Tactics at local public health level are very important. Our ability to reach communities that are high risk is about what is happening on the ground, getting the registration links out. We should have this discussion at the local level. And our ability to reach these populations efficiently and effectively impacts SVI communities as well.

Facilitator: Very good input from everyone.

Advisor 5: Health care facilities respond to feedback in terms of data. MIIC has zip code level data regarding vulnerability. Maybe we could use a zip code vaccination rate to determine if we are

adequately reaching our target populations? I had a call with the regional coalition about how there is going to be a shift in how allocations are done by health care system rather than regional coalitions. Need to keep coalitions strong. Regional coalitions are the best way to reach populations.

Facilitator: Advisor 9 from chat: Sounds like SVI is only half the problem. The regions or sites that do not administer so quickly get penalized in the next weeks. It does not seem worth it to be given the preference in the first round.

Facilitator: Seeing a desire for equitable distribution, and SVI may be a means of advancing it. Questions about implementation come into play. As we go deeper into these conversations, implementation becomes more and more a question about how these things get operationalized and what the impact is.

Advisor 6: I want to add, we have always had a strong desire to work toward equity, and things get all stressed out when it comes to logistics. I urge us to continue to drive and push it. I would encourage us to increase it, if we stumble while we are doing, at least we are still doing. Do not worry about getting it right out of the gate. Just acknowledge that our desire matches our intentions.

Facilitator: Advisor 11 from chat: It should be increased.

Facilitator: Advisor 14 from chat: What about applying SVI to administrations, not allocations?

Facilitator: Advisor 11 from chat: need to get more to populations in need.

Advisor 3: Agree. One other thing: this is unprecedented. Other pandemics may come. We are setting a precedent for how we respond in the future. We need to build capacity to be more equitable in the future. I agree with Advisor 6, we might stumble, but it should not hold us back.

Facilitator: Advisor 2 from chat: Agree we should increase the percentage, encourage distribution group to parallel.

Facilitator: Advisor 7 from chat: Agree we should increase percentage allocation by SVI especially if we are struggling to get them out to these SVI populations. Need to put even more of an emphasis on this.

Advisor 5: If we start to have significant discrepancies in allocation by region, it will be difficult to defend politically if we do not have data showing that these vulnerable groups are getting the intended vaccine. It could be that wealthy people within these higher vulnerability regions are the ones accessing these allocations. Need to have a metric that proves the vaccine is getting into the right arms.

Facilitator: Should the additional data sources be recommended for prioritization?

Advisor 9: Question about Medicare/Aid about immigrants undocumented worker, does it leave them out?

Ben Christianson: I am not an expert in Medicare/Medicaid, but Advisor 3 said there would be some groups left out if this was used.

Advisor 3: If you are undocumented, you are not eligible for Medicaid in MN, except for emergency Medicaid.

Advisor 19: I worked at DHS and teach an online course about Medicaid. The undocumented are only eligible for emergency Medicaid. Not eligible for Medicare at all. Even for documented individuals, states can make them wait five years before they are enrolled into Medicaid.

Advisor 9: With the priority on food and agriculture workers who are undocumented, I do not want to set up another barrier to vaccinating this population.

Facilitator: Advisor 11 from chat: Will data be used for sub-prioritization regarding allocation across the state?

Ben Christianson: Not for the state level, but more for individual allocations. One question for health care providers in the group – would this be an indicator that is readily available? We have discussed that as the prioritization criteria gets more complex it gets more difficult to implement. It is intended as a statewide recommendation but implemented at the clinic level.

Facilitator: Advisor 16 from chat: Would we rely on self-reporting? I run immunization clinics which are completely self-reported. People cycle on or off Medicaid all the time.

Advisor 2: Clarifying questions, are we talking about sub-prioritizing 75+?

Ben Christianson: Yes, for dual eligible Medicare/Medicaid within this age-based group.

Advisor 2: Do we need to sub-prioritize this age group?

Ben Christianson: We would like to. This age group is about 380K+. Not everyone will be able to get vaccinated in the first week.

Advisor 1: Some of the groups that we are considering for sub-prioritization, could instead be targeted through communications. Look at age groups, and then look at comorbidities as guidance for outreach.

Advisor 2: When people hear sub-prioritization, they think the vaccine is not currently available for them. Then when it is their turn in line, they are not ready for the vaccine. I would be concerned about sub-prioritizing this group.

Facilitator: Advisor 5 in chat: Target outreach to populations but allow hospitals to vaccinate all patients that fall within the Phase 1b.

Advisor 1: We struggle to find the balance between the efficiency of our vaccination efforts, with the need to get the vaccine to the right people. So, if we can find an approach that accomplishes both, that would be great.

Advisor 3: I could be convinced that targeted outreach could work. But I do not know how this is different from what is being done now. Our system is currently structured so that those with societal advantages know how to navigate the system and will get the doses. We have been doing targeted

outreach for decades and these communities are still falling behind. What is the teeth to this idea of outreach? Will vaccine providers be required to prove they conducted targeted outreach? Is there going to be accountability to MDH? Otherwise, this seems like a work around the hard work of sub-prioritization.

Advisor 1: There are several ways to address that. We can target our allocations to locations and providers that serve those at-risk populations. But I hear you 100%. We need to address this issue.

Advisor 5: We also had outreach problems during H1N1. After the first month, we had vaccines sitting on shelves because no one was coming in. Once you turn people away, it is harder to get them back. I like the idea of sticking with broad CDC phases, then doing some engineering for a more targeted communications strategy.

Facilitator: Advisor 14 from chat: Outreach does not equate to administration. Repeated outreach needs to come from MDH.

Facilitator: Advisor 9 from chat: Do not want efficiency to be a reason to take away doses from communities who are at high risk.

Facilitator: Subject Matter Expert 3 from chat: Talks of using testing outreach model so vaccination outreach is specific for communities.

Advisor 10: I lead the Culture/Faith/Disability branch. We have done a lot of community outreach with regard to COVID testing. This includes contracts with diverse organizations and diverse media. They also have COVID community connectors. These are organizations that are really embedded with their communities. They have hotlines, have helped to stand up community testing sites, and reduce other barriers to testing. There are pieces of these efforts we can apply to vaccination roll-out. But until we get to having community vaccination sites, I am worried about the handoff. Can we just tell people about the vaccine, and the need to connect them with the vaccine? We need to flesh out administration along with outreach.

Facilitator: Advisor 1 from chat: Have a team that is specifically focusing on communities of focus to do outreach and get vaccines to those communities.

Advisor 12: Need someone to explain how we operationalize this SVI for Phase 1b? A geographic area gets a certain number of vaccines for Phase 1b. Local vaccinator opens the high school gym, invites police, first responders, teachers, etc. If the first two people in line are white, is the vaccinator supposed to say, “We are supposed to vaccinate people of color first?” Or is it first-come-first served, but we will still vaccinate more at-risk people because there are more slots in line since that area has 15% more vaccines? Not sure it is safe for vaccinator to make those decisions.

Ben Christianson: SVI is used in the latter way. We are not turning away individuals. SVI is used as a regional indicator, not an individual indicator. Area only gets more doses.

Advisor 16: With trying to reach seniors who are 75+ and on Medicare and Medicaid, we know where they live. They are subsidized by our CDAs. We really want to vaccinate those groups. This is where it

becomes very important to communicate with the cultural and ethnic groups who serve these populations. That how the word gets out. Otherwise, they will not come to the community sites.

Facilitator: Break time. Please come back at 3 p.m.

COVID-19 Vaccine: Phase 1b Sub-Prioritization – Advisor 1

Slide 1 Phase 1 Vaccination

- Proposed interim Phase 1 sequence:
  - Phase 1a: Health care personnel & long-term care facility residents.
  - Phase 1b: Frontline essential workers & persons 75+ year old.
  - Phase 1c: Other essential workers, adults 65+, and adults with high-risk medical conditions.

Slide 2 Prioritization Themes: Balancing Goals

- Prevention of morbidity and mortality.
  - Consideration for expanding the age group to those 65+.
  - Include inmates.
  - Other essential frontline workers.
- Preservation of societal function.
  - Child care and pre-K-12 workers.
  - First responders (law enforcement and firefighters).
  - Corrections staff.
  - Other essential frontline workers.

Slide 3 Phase 1b Population Estimates – see table

- Adding 65+ adds around 600K more people.

Slide 4 Scenario #1 65+, 2 tiers

- Priority 1: 65+, E-12, child care.
- Priority 2: First responders, corrections staff and inmates, Food and Agriculture, USPS, public transit, grocery store workers, and manufacturing.

Slide 5 Minnesota Deaths by Race/Ethnicity (to-date) – see table

- 65+ population makes up 89% COVID deaths.
- 1 in 200 in 65+ have died of COVID.

Slide 6 Hospitalizations, ICU Admissions and Deaths by Age and Race/Ethnicity – see table

Slide 7 Risk-based Criteria for Prioritizing E-12, Child Care

- Risk of Negative Societal Impact.
  - Tier 1 workers depend on school, child care to continue to treat those with COVID and provide essential services.
- Risk of Acquiring Infection.
  - School and child care data do not show that schools transmit the virus.
- Risk of Severe Morbidity and Mortality.
  - Certain staff fall into higher risk groups, but we do not have the data to target those populations.
- Risk of Transmitting Infection to Others.
  - 35% of children are asymptomatic.

Slide 8 Additional Requests for Consideration

- Judicial system is grinding to a halt.
- Civil liberties are at risk by slow roll out.

Slide 9 Additional Request for Consideration

- ACIP split out Mass Public Transit (1b) from broader transportation (1c).
- Mass Public Transit was seen as essential to get frontline workers to work.
- Air travel caries a low risk of COVID-19 transmission*.
  - *Pombal R, Hosegood I, Powell D. Risk of COVID-19 During Air Travel. *JAMA.* 2020;324(17):1798. doi:10.1001/jama.2020.19108. https://jamanetwork.com/journals/jama/fullarticle/2771435.

Slide 10 Summary of Justification

- Data shows these are mostly at-risk or essential workers: 65+, child care workers, E-12, first responders and corrections staff and inmates.
- Workers in Food and Agriculture, USPS, Public transit workers, grocery store workers and workers in manufacturing provide essential services that must be performed on site and involved in being in close proximity to the public or coworkers.

Slide 11 Phase 1b First Priority

- 65+, child care, school aged care and Head Start, E-12 schools.

Slide 12 Phase 1b Second Priority

- Food and Agriculture, First Responders, Correctional settings, USPS, Public Transit workers, Grocery stores, Manufacturing.

Slide 13 Sub-prioritization Principles for Frontline Essential Workers

- Groups of workers that are critical to maintaining core societal functions.
- Groups of workers with unavoidable higher risk of exposure.
- Groups of workers impacted by health disparities.
- Groups of workers who are likely to transmit infections outside of work.

Slide 14 Additional Clinical Considerations of Phase 1b Populations

- Underlying medical conditions.
  - Prioritize those with underlying medical conditions.
  - CDC list of conditions that ARE associated with severe illness.
  - CDC list of conditions that MIGHT BE associated with severe illness.
- Offer vaccine by descending age.
- People who have not tested positive for COVID in the past 90 days may be prioritized over those who have recently tested positive.

COVID-19 Vaccine: Phase 1b Sub-Prioritization – Q&A

Facilitator: Advisor 3 from chat: Are the percentages all deaths or percentages of individuals within communities that are hospitalized/have died?

Advisor 1: Looking at individuals in the community.

Facilitator: Advisor 5 from chat: Regarding Judicial staff population. Are those all the people necessary to run the court, or just judges?

Advisor 1: They prioritized their staff that were needed to run the courts.

Advisor 11: If we just blanket 65+, it works against equity. Ethnic groups within that age range have a much harder time accessing vaccines. Seems like there is an argument to sub-prioritize 65+.

Facilitator: To summarize: if we are going to add 65+, we need to think about sub-prioritization because size impacts equitable distribution of vaccine.

Subject Matter Expert 1: Given that a larger percentage of the 65-74 aged population is white, it is meaningful that death rates for that group are significantly less than the 75+ group. However, there are particular groups within the 65-74 age range that are at higher risk, mainly people of color. If we are going to include the 65-74 group without sub-prioritization, I would suggest making 75+ priority 1, and 65-74 priority 2. But if we do that there will not enough vaccine to go around.

Facilitator: Advisor 3 from chat: I do not see how we can include 65+ without sub-prioritization.

Facilitator: Advisor 5 from chat: Was inclusion of 65-74 with underlying medical conditions considered? Looking at ACIP recommendations for 1c, 65+ and those with high-risk health conditions, could be

provided to those with conditions rather than everyone in 65+. Seems like a lot of people to add, many of them privileged. Maybe more palatable to start with adults 65-74 with comorbidities.

Advisor 1: Important we bring back our thoughts to the Governor.

Facilitator: Doing some synthesis here: 65-74 age range adds a huge population. Is there an ability to sub-prioritize? Can we use comorbidities? How to implement? Comment from Subject Matter Expert 1, go 75+ in Priority 1 and then 65+ in Priority 2? Advisor 12 agrees, says 75+, then 65+ with health conditions.

Facilitator: Looking at first set of priorities in Phase 1b, are there any other comments or questions?

Advisor 16: Issues with community mental health, seeing the effort to vaccinate child care to create stability in the community is very important; it affects the mental health of many people. Focusing on how to reach this group as fast as we can. This is a key component for community health.

Advisor 3: In my review of public comments, top two things were schools and prisons. Surprising that after our recommendations that prisons were given second priority. Especially based on the small size of the population. Recommend that prisons be in first wave of phase 1b.

Advisor 13: Agree with the comment about the individuals in jails. Would it mitigate the request from the judicial branch? If inmates are being vaccinated, would that help the judicial branch? I have a question about need to understand in Phase 1. Who is vaccinated? How has it gone? Did it follow the process?

Advisor 1: Phase 1a things have gone pretty well. Health care systems are not following the guidance as written. They have interpreted it more broadly. For example, Tier 1 is acute care providing care to COVID patients (COVID unit, COVID ICU, Emergency Room, etc.). Tier 2 is acute care, not clinics. Health care systems expanded well beyond that to all staff. Have to acknowledge, there are some parts that work well and others that have not?

Advisor 13: Any data on age, race, ethnicity for vaccinations?

Advisor 1: We do have some data on the website based on age, but we do not have it on race/ethnicity. We will look into this.

Advisor 13: I thought we were on a timeline to get recommendations back to the Governor. We need to understand the timeframe. To me it all comes back to people of color and how we get the vaccine to them and doing it in a way that makes us feel okay about doing it.

Advisor 1: Currently reporting administering 147,000 vaccines –27,000 for ages 18-49, 42,000 for ages 50-60, 18,000 in 65+. Will put a link in the chat.

Facilitator: We are trying to gather as much input as possible. Recognize there is a lot to process. But also, in this environment we are moving very quickly.

Advisor 4: Thank you for the presentation. Really support schools as part of this. Prisons should be considered as well. Both address some of the social vulnerability. Tremendous support for the schools. Judicial is important, but not as urgent as other populations. Not impressed with letters from airlines, banks, etc. Essential workers need their children in school. 65+ will have people slipping in that they do not need the vaccine. We need to pay special attention to the SVI.

Facilitator: Advisor 12 in the chat: By the end of week, all nursing home staff and residents will receive their first dose.

JP Leider: Expanding to 65+, needs to be sub-prioritization. Otherwise, it is a numbers game. More people who do not need the vaccine will get it before the populations we are targeting. Unless you put in some kind of constraints, people will get in that are going to be prioritized in 1c anyway. We need to have concrete sub-priorities.

Advisor 2: Support child care and teachers. Have high-risk population in the area. Many families need children in school for nutrition and mental wellbeing. We need to get children in schools.

Facilitator: Any more comments regarding the draft recommendations?

Facilitator: Advisor 1 in chat: We cannot vaccinate children, but getting them in schools will benefit them.

Advisor 14: Getting back to school component. According to data, risk of transmission is low. Not as bad as some frontline workers. Police, corrections staff have higher risk.

Advisor 16: The reason behind teachers – child care is more similar to health care providers. Risk is not to morbidity/mortality, but to workforce stability. If we cannot staff schools, that is what will shut them down. Same with nurses in ICU. Transmission is very low, but we need to provide services to those impacted by COVID.

Advisor 1: We were not totally looking at risk, but we were looking at societal functions.

Advisor 5: Vaccinating teachers is great. Not logical to say it does not exempt them from quarantine post exposure. Do not know if the vaccine protects from transmission. As long as there are high community transmission rates, we will still have teachers in quarantine.

Advisor 1: Are a number of teachers pushing back about need to be in classroom without PPE? They are very fearful. It is absolutely right that we do not have data about asymptomatic transmission after vaccinations.

Advisor 11: I am trying to think about the straw proposal. Would first vaccinate 65+, school and child care workers and then move down. This worries me. 65+ is a very large group. I have concerns about preserving an essential workforce. A lot of essential workers are BIPOC. It looks to me like we are losing on trying to promote risk mitigation and societal benefits and losing on equity if we put 65+ in the second tier.

Advisor 1: Yes, totally agree. Another challenge is the lack of vaccine. Even when we do 65+ and schools, it will take a quite a while due to lack of vaccine. Including 65+ is a challenging proposition and it undermines equity. Are we getting an appropriate amount of vaccine from the federal government? Vaccine allocation is based on populations.

Facilitator: Advisor 9 in chat: Food and Agriculture workers are pushing back about having risk on the job site.

Facilitator: Advisor 3 in chat: I am hearing that parents are fearful of children bringing COVID back from school. Vaccinating teachers will not solve this. Can we prioritize schools by free lunch and special education? That would be an ideal start.

Advisor 16: Is it more of a communication issue regarding parents' fear of transmission from sending their children back? Transmission was zero at school. All transmissions were from extracurricular activities. Happening in sports, other activities with close contact. Risk is quite low from classroom only.

Advisor 1: Absolutely right. Will pull articles and put them in the chat.

Subject Matter Expert 1: General questions. It might take a while to work through priority groups. What is the plan? Is it random? As we move to bigger populations what are the equity plans?

Advisor 1: We do not have enough vaccine. Maybe we can randomize or target where the vaccine goes. Health care settings serving the most vulnerable populations. We need to think granularly to address equity. Some states are a disaster. Anyone at any time. We do not want to do that. There is pressure on the health care system to use doses the minute they get them. Need to have plan with our partners to reach the targets populations and community of focus.

Facilitator: Advisor 21 in chat: Since vaccines are limited, would school staff with preexisting conditions be prioritized?

Advisor 1: That is very challenging. Looking a free lunch, and special education, again to sub-prioritize by age, will add to the complexity.

Facilitator: Any other questions?

Facilitator: Advisor 14 in chat: Are schools using school nurses to vaccinate staff? Just a logistics question.

Facilitator: Advisor 20 in chat: Any lessons learned from testing that we can use for communities we want to target with vaccinations?

Advisor 1: Advisor 10 referred earlier to grants to community partners regarding testing. We want to build on that when it comes to vaccinations. We need to recognize vaccination is different from testing. We need to adapt it.

Advisor 10: it will look different than testing. Especially as we go through priority phases. Might be different if we had community vaccinations sites. We will need to be very targeted. Might need more partners.

Facilitator: Advisor 13 in chat: Target populations are going to places they trust.

Advisor 16: I am seeing lots of questions about school planning. A lot underway with LPH to partner with clinics. Also work to partner with school nurses to provide shots. Technical issues around their license and a medical provider to write standing orders. Lots of planning to use school nurses, but there are some barriers.

Facilitator: Sensing that 65-74 piece, there is some concern, can we sub-prioritize this? Comorbidities? Maybe a second priority? Some clarification in chat regarding first responders. How many have been vaccinated? Why are some not first priority? A lot of time talking about impact of E-12. Also, the societal impact this has. Also, a consideration of timing. If we add more and more, can we allocate effectively? Does it impact equity? If we get too granular, does it slow it down? I heard about district courts and the judicial system.

Facilitator: Advisor 1 in chat: Many First responders have been included in Phase 1a.

Facilitator: Subject Matter Expert 1 in chat: Restricting Phase 1b to mass transit seems appropriate.

Facilitator: Advisor 1, do you have anything else you would like to say about the input?

Advisor 1: Thank you all for your input. I appreciate all your comments. You had concerns and you remained true to yourselves. I appreciate that you verbalized this.

Facilitator: Advisor 19 what did you put in chat?

Advisor 19: School nurses having to understand orders. Due to federal guidance under the PREP act, pharmacists can order vaccines themselves. I do not know if there are enough pharmacists to assist schools. The National Association of Chain Drug Stores wanted pharmacist utilized in Phase 1b.

Facilitator: Looking at getting input regarding communications prior to finalization.

Advisor 5: I brought up last time the difficulties for vaccinators to identify these different occupational groups. Can we give guidance about how occupational groups will be identified and verified?

Advisor 12: I was surprised with the number of public comments by dentists who wanted to be prioritized when they were already prioritized. We need to do a better job with other groups so they know the process and the procedures and when they are eligible and how they will get access.

Advisor 5: We do not have a plan in our region to vaccinate them. I think that is part of the regional coalition's job to decide how to divvy this up.

Facilitator: Next steps – we have quite a bit of information. Advisor 1 stated in chat there is a website where the minutes and guidance are posted. Those pieces are there. MDH is trying to make them as

clear as possible. We need to go into synthesis phase. Regarding getting back together, please bear with us. We may need to reconvene again. Clarity about getting back together may be sooner rather than later. When a final recommendation is made, I will make sure you get it.

Advisor 1: Very appreciative of the conversation. Grateful for the advocacy and points you made. I will reach out to communications, so it is easy to understand. I will convey back the concerns and commitment about racial justice and equity. Also convey you want to prioritize within the 65+ age group. Will let the Governor's office know you are very committed. Next steps will refine the guidance. Have to share it with the Governor's office for approval. Will let you know what the plan is. We are on the same page as you. Thank you!

Facilitator: Thank you for all your expertise.

End of Meeting