



# Dec. 30, 2020

## 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.\***

**Facilitator:** Welcome! Please use mute button. Use raised hand or chat to ask a question.

## Review Objectives & Agenda

**Advisor 1:** Welcome four new members. Thank you returning members. Grateful for facilitation. We were not expecting ACIP decisions so quickly on Phase 1b. One year ago we received a notification about an unusual pneumonia in China. This was the start of the pandemic. It is remarkable that we have a vaccine in one year. And many are getting vaccinated right now. We are in a good place. Vaccinating Minnesotans. At the beginning of the end of the pandemic. Already looking at a second phase of the vaccination. Guidance you developed is currently in use right now. Vaccinating health care providers, skilled nurse residents moving to assisted living is next. Focus now is how we incorporate ACIP guidance into Phase 1b. Will get together again Jan. 11. Your role is important to make recommendations to advise the governor. We really value your input. We want to remind you that while he reserves the right to make the final decision, he cares very much about your guidance.

Focusing on prioritization today. Lots of parts to this including engagement, communications, identifying gaps, etc. Another group (external vaccination group) is being formed to work with communities and engage with them to successfully vaccinate people. Thank you!

**Facilitator:** Roll call and agenda review.

Organization	Name	Title
Care Providers of Minnesota	Doug Beardsley	Vice President of Member Services
Children's Hospitals and Clinics of Minnesota	Dr. Nneka Sederstrom	Director, Clinical Ethics
DHS Medicaid and MinnesotaCare	Dr. Nathan Chomilo	Medical Director Medicaid & MinnesotaCare
Disability Representative	Karen Herman	Executive Director of Udac inc.

Organization	Name	Title
ICSI Immunizations Workgroup	Lee Mork	Director of Pharmacy for Allina Health Medical Group Clinics
Local Public Health	Christine Lees	Dakota County Disease Prevention and Emergency Preparedness Supervisor
Local Public Health	Kristie Rathmanner	Wright County Public Health Nurse
Mayo Clinic	Dr. Melanie Swift	Medical Director, Mayo Clinic Physician Health Center. Assistant Professor of Medicine
Minnesota Board of Pharmacy	Cody Wiberg	Executive Director
Minnesota COVID Ethics Collaborative	Dr. Debra DeBruin	Interim Director, Associate Professor, Director of Graduate Studies, Center for Bioethics
Minnesota Department of Employment and Economic Development	Maureen Ramirez	Director of the Office of Economic Opportunity
Minnesota Department of Health	Kris Ehresmann	Director, Infectious Disease Epidemiology, Prevention and Control Division
Minnesota Department of Health	Jackie Dionne	American Indian Health Director
Minnesota Department of Health	Danushka Wanduragala	Director COVID-19 Cultural, Faith, and Disability Communities
Minnesota Department of Labor and Industry	Naheeda Hirji-Walji	Director of Public Engagement and Outreach
Minnesota Hospital Association	Abigail Stoffel	Quality and process improvement specialist
Minnesota Medical Association	Dr. Jill Amsberry	Pediatric specialist
MIPAC/MN Council of Health Plans	Patty Graham	Senior Quality Consultant
NorthPoint Health and Wellness Center	Kimberly Spates	Chief Operations Officer
White Earth Tribal Health Director	Pat Butler	Tribal Health Director

## ACIP Phase 1b Recommendations - Lynn Bahta, Minnesota Department of Health

Slide 1 ACIP Interim Allocation Recommendations 1b and 1c

Slide 2 Goals of ACIP Recommendations

Slide 3 Ethical Principles Adopted by ACIP

- Transparency.
- Promote justice.
- Mitigate health inequities.
- Maximize benefits/minimize harm.

Slide 4 Putting it together

- Science.
  - COVID-19 disease burden.
  - Balance of benefits & harms of vaccine.
- Implementation.
  - Values of target group.
  - Feasibility.
- Ethical Principles.
  - Maximize benefits/minimize harms.
  - Promote justice.
  - Mitigate health inequities.

Slide 5 Prioritization: Balancing goals

- Prevent morbidity/mortality.
  - 1a LTC res.
- Preserve societal functioning.
  - Health care workers.

Slide 6 Ethical Principles Considerations

Slide 7 ACIP Meeting Dec. 18-19, 2020

- Which groups should be recommended to receive COVID-19 vaccine in groups 1b and 1c?

Slide 8 Prevention of Morbidity and Mortality

- Persons 75 years and older.
- Persons 64-74 years.
- Adults 18-64 years with medical conditions.

Slide 9 COVID-19 Mortality Rates

- COVID-19 mortality rates are highest in older adults.

Slide 10 Morbidity of COVID-19

- COVID-19 associated hospitalization rates are highest in older adults.

Slide 11 Morbidity of COVID 19

- Risk for COVID-19 associated hospitalization increased with the number of underlying medical conditions.

Slide 12 Preservation of Societal Functioning

- Non-health care essential worker.
  - Frontline essential workers.
    - Work-related duties must be performed on-site and involve being in close proximity to the public or to co-workers.
  - Other essential workers.
    - Work-related duties provide societal critical infrastructure support.

Slide 13 Morbidity and Equity

- Non-Hispanic Black persons disproportionately occupy essential occupation.

Slide 14 Morbidity and Equity

- Racial/ethnic minority groups represent 40% of the total U.S. population, but nearly 60% of COVID-19 cases.

Slide 15 Morbidity and Equity

- Disparities in COVID-19 hospitalization rates among racial and ethnic minority groups occur in both young and older age groups.

Slide 16 Morbidity and Equity

- Occupation: Black persons are more likely to be employed in essential industries and occupations with more exposure to infections.

Slide 17 Applying ethical principles

- Older adults.

Slide 18 Applying ethical principles

- Essential workers.

Slide 19 Applying ethical principles

- Persons 16-64 with high-risk medical conditions.

Slide 20 ACIP Recommendation

- In Phase 1B ACIP recommends vaccine be offered to:
  - Persons 75 years and older.
  - Frontline essential workers (non-health care).

- In Phase 1C ACIP recommends vaccine be offered to:
  - Persons ages 65-74 years and.
  - Persons ages 16-65 high-risk medical conditions.
  - Essential workers not included in 1B.

## ACIP Recommendations for Phase 1b: Q&A

**Advisor 2:** Any discussion at ACIP include 65-75 high-risk medical conditions and how that data looks in comparison to all individuals 75+? Been getting a lot of questions about that group, like dialysis patients?

**Lynn Bahta, Minnesota Department of Health:** Was discussion about this. It may be possible that ACIP go back and revisit 1c again. People ages 65+ with high-risk medical conditions will see a higher risk of severe COVID.

**Advisor 3:** Was wondering if you could provide a breakdown of Minnesotans that fit into these categories? Also geographic and racial breakdowns?

**Ben Christianson, Minnesota Department of Health:** Will have overall estimates in my presentation. Don't have demographics yet. May need to work on this before the next meeting.

**Advisor 2:** One thing that may have been alluded to was transmissibility and reduction of transmissibility? Any information on that?

**Lynn Bahta, Minnesota Department of Health:** No, will have to be learned in the future.

**Advisor 4:** How do you see adults with intellectual and developmental disabilities falling into these phases in terms of vaccination? They do live in congregate settings and are pretty high risk of death as a result of contracting COVID-19. They could fall into phases above that, but have a risk because of living in such a broad living arrangements and could be left out or missed.

**Lynn Bahta, Minnesota Department of Health:** Needs to be discussed with a broader group. Congregate settings are a higher priority, because when you are in a congregate setting, you really can't escape those settings. Can't do the public health measures that are recommended. That alone will increase the risk. Was also listed as a risk factor. Didn't detail out all of the factors, just some of them.

**Advisor 1:** Just to clarify, we do have adults living in congregate settings in Phase 1a, Tier c. they are before 1b.

**Facilitator:** Any other questions, please put in chat.

# Congregate Living Data for Phase 1b - Jennifer Zipprich, Minnesota Department of Health

## Slide 1 Vaccine Prioritization: Group 1b

- Discussion of correctional settings.

## Slide 2 Correctional Settings are High Risk for SARS-CoV-2 Transmission

- Risk of SARS-CoV-2 transmission is higher in indoor environments, enclosed spaces with little opportunity for physical distancing.
- COVID-19 has disproportionately impacted people who are incarcerated or detained in the US. Case rate was 5.5 times higher, and age-adjusted death rate three times higher than overall US population.
- A modeling study of Immigration and Customs Enforcement detention centers predicts that once SARS-CoV-2 enters a facility, 72-100% will be infected within three months.

## Slide 3 Correctional Settings in MN

- State Prison systems.
- County Detention Centers.
- Community based, DOC licensed facilities.
- Federal Bureau of Prisons.

## Slide 4 Correctional Settings: Staff and residents estimates

- 14,196 residents, 9,600 staff.

## Slide 5 Risk of negative societal impact: Equity

- Minorities are disproportionately represented.

## Slide 6 COVID-19 Cases in Correctional Settings 3/2020-12/2020

- 5,898 inmate/resident cases, 1,340 staff cases.

## Slide 7 Risk of Severe Morbidity and Mortality

- Majority of incarcerated or detained persons are young.
- Relevant chronic health conditions of persons incarcerated in MN prisons.
  - 1/3 inmates have chronic health conditions.

## Slide 8 COVID-19 Cases in Correctional Settings 3/2020-12/2020

- Significant increase in COVID-19 cases associated with correctional settings beginning in the late summer/fall.

Slide 9 Facilities with COVID-19 cases by week 3/2020-12/2020

- 181 total correctional settings.
- 119 correctional settings (66%) with COVID-19 cases.

Slide 10 Correctional settings hospitalizations and deaths

- 81 inmates hospitalized, nine deaths.
- 22 staff hospitalized, 0 deaths.

Slide 11 Risk of Negative Societal Impact

- Correctional staff are essential in maintaining safe environment and providing health care to inmates.
- Inmate workers provide laundry, food service, custodial services.
- Inmates support MinnCor Industries which provides a variety of products and services.

Slide 12 Risk of Transmitting Infection to Others

- Correctional settings are not closed systems.
- Risk of transmission to other facilities through movement between correctional settings and other congregate settings.

Slide 13 Risk of transmitting infection to others

- Analysis of COVID-19 cases associated with Cook County Jail found that jail-community cycling was a significant predictor of community cases of COVID-19.
- Data from one large MN adult detention center shows that cycling can be rapid and the volume large.

Slide 14 Other Factors for Consideration

- Impact of COVID-19 on mental health of prisoners.
- Exposed staff may be asked to return to work in settings of severe staff shortages, increasing risk of transmission.
- Use of PPE by staff, availability of PPE, training on PPE use.
- Additional costs with controlling outbreaks can be significant.

Slide 15 Summary

- Correctional settings are high risk for spreading COVID-19.

- Previous estimates show 1/3 of inmates have comorbidity, which increases risk of severe COVID illness.
- Black and Indigenous people disproportionately impacted by incarceration.
- Outbreaks in correctional settings lead to spread in other congregate settings or the community.
- Correctional settings face unique challenges to implementing mitigation strategies or outbreak control.

## Congregate Living Data for Phase 1b: Q&A

**Facilitator:** Questions?

**Advisor 5:** Population has many reasons for prioritization. Interested in jail-community cycling. Would be a challenge on a two-dose series. Have you done any modeling on how that would impact vaccine administration in that setting?

**Jennifer Zipprich, Minnesota Department of Health:** No modeling, but an interesting question. We are concerned about a two-dose series. Any comments on one-dose effectiveness?

**Advisor 5 Follow-up:** Inmates with a longer length of stay could be prioritized? For that reason?

**Jennifer Zipprich, Minnesota Department of Health:** Yes, inmates stay longer in prisons. More likely to complete a two-dose series in that setting. Jails are separated into the intake area and general population area. Intake area may release inmates quicker, general population may be there longer (i.e. awaiting trial) there is some level of uncertainty about how long inmates stay in the facility.

**Advisor 3:** Any data on length of stay in prisons to guide on two doses decisions?

**Advisor 6:** Any opportunity for opt-out for inmates and prisoners? What does that mean for facility? How are they addressing that?

**Advisor 1:** Vaccine is authorized under an EUA, so it cannot be mandated. People have the option to choose not to be vaccinated.

**Facilitator:** Next up is Carrie.

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## Schools and Child Care Data for Phase 1b - Carrie Klumb, Minnesota Department of Health

Slide 1 K-12 Schools and Child Care Populations

- Pre-K-12.
  - Public, private, charter schools.
  - Tier 1 emergency child care.

- Child care.
  - Birth-5 years.
  - Center-based and family child care programs.
  - Some programs also providing care for school-aged children.

#### Slide 2 K-12 Schools Population

- K-12 Schools.
  - >70K educators.
  - 63% work with preK-6 or special ed.
  - 139,144 licensed and unlicensed staff (bus drivers, paras, kitchen staff, etc.).
  - 18.5% of teachers are over the age of 55.
  - Bus drivers, paras, and direct support staff are older and in higher risk groups.

#### Slide 3 Child Care population

- Child care.
  - 43,000 child care workers.
  - Average salary \$11.44/hour or \$23,795.

#### Slide 4 Cases Associated with PreK-12 School Buildings

- Cases attending school while infectious.
- More cases in staff due to community exposure.
- 8,415 cases in students, 12,170 cases in staff.

#### Slide 5 Potential Exposure in Child Care setting

- Certified and Licensed Centers.
- Not including private, in-home.
- 2,948 cases in students, 1,716 cases in staff.

#### Slide 6 Cumulative Hospitalizations and Death

- K-12 Schools.
  - Staff - 123 hospitalized, 14 ICU, 3 deaths.
  - Students – 59 hospitalized, 13 ICU, 0 deaths.
- Child care.
  - Staff – 45 staff hospitalized, 0 ICU, 0 deaths.

- Student – 8 hospitalized, 0 ICU, 0 deaths.

Slide 7 Schools That Have Reported One or More Cases Since 8/2020

- 5,123 PreK-12 schools.
- 2,066 schools reported at least one student/staff case.
- 40% of schools have had at least one case.

Slide 8 Child Care Centers That Have Reported One or More Cases Since 4/2020

- 2,334 licensed child care centers in MN.
- 951 have reported at least one case in student/staff.
- 41% of child care centers reported at least one case.

Slide 9 Risk-based Criteria for Prioritizing Groups

- Risk of Negative Societal Impact.
  - Schools and child care centers help society function. Tier 1 workers depend on schools and child care so they can perform their jobs.
- Risk of Acquiring Infection.
  - No data to show these settings are better or worse than other settings for exposure to the virus.

Slide 10 Risk-based Criteria for Prioritizing Group

- Risk of Severe Morbidity and Mortality.
  - Certain staff fall into higher risk groups, but are not disproportionately represented.
- Risk of transmitting infection to others.
  - 35% of children are asymptomatic.

Slide 11 K-12 Schools and Child Care Essential Services

- Schools provide care for Tier 1 workers' children through emergency child care.
- Children learn best in school.
- Child care provides care for school-aged and younger children of Tier 1 workers.

Slide 12 Risk Mitigation in Schools and Child Care

- Schools and child care are unable to fully implement environmental controls.
- School and child care are a reflection of what is happening in the larger community.

Slide 13 Summary

- K-12 students do better in person.
  - Educational achievement and supports.
  - Socialization.
  - Mental health.
- Schools need adequate staff to operate.
- Many schools have been forced to do distance learning due to staffing gaps.

## Schools and Child Care Data for Phase 1b: Q&A

**Facilitator:** Questions in chat. Did chart cover all cases?

**Advisor 1:** One chat question was: did the numbers in schools include everyone, even if they were in distance learning?

**Carrie Klumb, Minnesota Department of Health:** Curve is only people in building. Larger numbers were from everyone.

**Advisor 1:** Second chat question, are substitute teachers in the employee numbers? How will they be included in vaccinations?

**Carrie Klumb, Minnesota Department of Health:** Got the numbers from MDE. They did not break out substitutes. They only included licensed educators. Will look into that.

**Advisor 1:** When vaccinating schools, will need to work with the districts to identify all of their staff, including those that aren't licensed, even volunteers.

**Advisor 2:** As a pediatrician I support vaccine in school. Any data on uptake? Heard concerns from school administrators that there won't be significant uptake by the staff.

**Carrie Klumb, Minnesota Department of Health:** I do not know that data. Maybe the vaccine team has data?

**Advisor 1:** Initially on a broad scale there was hesitance. As more vaccination is distributed, more people are accepting. But have not seen school-specific data.

**Lynn Bahta, Minnesota Department of Health:** Might depend on area of the state people are in. Have heard hospital staff being reluctant to vaccinate. Need to provide good education. Hesitancy is different from the anti-vaccine hesitancy.

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## Critical Worker Data for Phase 1b – Mateo Frumholtz, Minnesota Department of Health

Slide 1 Clusters by county in MN

- Three or more cases in a 14-day period.
- Virtually every county has a workplace cluster.
- Workplace consultations and resources are offered.

Slide 2 Workplace Clusters, MN, March-May 2020

- Primarily Meat, Food Processing plants.

Slide 3 Workplace Clusters, MN, June-November 2020

- Small business, community spread.

Slide 4 Number of workplace-associated clusters and cases by industry in MN June-December

- Most have been in manufacturing.

Slide 5 Cluster Follow-Up Investigation Findings, MN, September-December

- Community transmission was the main driver of clusters.

Slide 6 Meat and Poultry Processing Plants - National

- COVID disproportional impact on communities of color is likely related to occupational risk.
- In meat and poultry processing facilities 87% of workers with COVID-19 cases were non-white.

Slide 7 Outbreaks in Meat and Poultry Processing Facilities, MN, March-May 2020

- Meat or poultry processing facilities: 19.
- Employees at COVID affected facilities: 15,025.
- Confirmed cases at the facilities: 2,120.
- 85% of the cases were non-white.

Slide 8 Cluster associated cases by race/ethnicity broken down by industry type, MN, March-December 2020

Slide 9 Hospitalization and death among cluster-associated cases by industry type, MN, March-December 2020

Slide 10 Considerations

- Public utilities, manufacturing, distribution, energy, transportation, food, and agriculture are all able to operate under COVID-19 best practices.
  - Most industry workers can wear masks and distance.
- Focus on the industry may be misplaced because by and large people can be at work safely.

- Community transmission is the driving force behind most clusters.

Slide 11 Most vulnerable workers?

- Who is harder to protect within workforce category?
- Seasonal and migrant workers.
- Workers with public interaction.
- Workers who need to work close together.
- Workers who cannot work from home.

Slide 12 Risk-based criteria for consideration

- Risk of acquiring infections.
- Risk of severe morbidity and mortality.
- Risk of negative societal impact.
- Risk of transmitting infections to others.

Slide 13 Conclusions

- Lessons learned for testing.
  - Engagement through workplace not effective.
  - Engagement through community-driven testing initiatives were more impactful.
- These takeaways can help with the vaccination allocation and distribution plan.

## Critical Worker Data for Phase 1b: Q&A

**Advisor 5:** Interesting in paradigm that was laid out rather than listing occupation, looking at population. Looking at contradictions in the CISA lists, called out food and agricultural workers as Frontline Workers, but food service as Other. Looking at the list, like sawmills compared to restaurant workers. Transit is Frontline, but other transit – like desk agents at crowded airports and other transportation workers – are not listed as Frontline. Wondered about your thoughts about the dichotomy?

**Mateo Frumholtz, Minnesota Department of Health:** Questions we were asking ourselves. What jobs are critical? These jobs are absolutely critical to our society functioning. Are those jobs functional right now? Are they getting exposed at work or in the community? Looking at different guidelines either CISA or ACIP – who is harder to protect and who is more vulnerable? Hopefully can look beyond industry and look at the individuals.

**Advisor 5:** Very interesting. Challenge is going to be to translating/interpreting that for vaccine providers so they can be consistent.

**Mateo Frumholtz, Minnesota Department of Health:** Also, with distribution and implementation, it is also a lot easier to just look at the industry rather than at the individual level.

**Advisor 7:** Comment about intersections. Specifically industries like meat packing, the non-English speaking workers. Just a group that isn't highlighted and getting information to this population.

**Advisor 7:** Was the data from worker compensation from OSHA included?

**Mateo Frumholtz, Minnesota Department of Health:** How we classified industries?

**Advisor 7:** When data was being gathered? We get information from worker's comp claims.

**Mateo Frumholtz, Minnesota Department of Health:** We get data from text fields that CICT report. Our team has to go through each report and classify according to the parent codes. Not a perfect overlap. Did look at OSHA classifications.

**Lynn Bahta, Minnesota Department of Health:** As ACIP considered the essential worker, the SVI index with essential workers is extremely high. Workplace may not be the source, other risk factors come into play. How can we help those communities with a lot of disease get vaccinated? Need to include SVI.

**Advisor 6:** What is the responsibility of employers in assisting with vulnerable populations?

**Mateo Frumholtz, Minnesota Department of Health:** We developed best practices for employers to follow. Governor put out guidance, also DLI. MNOSHA looking at MDH guidance, working on enforcement. Have to provide a safe workspace. A lot of prevention. Have provided a lot of guidance to industry. Also have provided CICT guidance. As far as distribution of vaccines, haven't really narrowed it down. Because it is an EUA, they can't mandate vaccine. Think they may be good partners with distribution, since some of these large facilities can store the vaccine and have occupational health nurses that can help administer the vaccine.

**Advisor 8:** Would add that during testing, when there were outbreaks in the workplace, seeing that relationship, how is the information getting there? Still confusion about guidance, looking at all kinds of industries and sectors and workers, there is still some confusion on who is doing what. Example, if is an employee not wearing a mask, who is responsible? What about a customer?

**Advisor 9 (from chat):** Sometimes what we hear from employees doesn't match the employer's preparedness plan or what they described to MDH. Often employees feel the risk of reporting unsafe work practices is too great.

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## Implications of Disparities and Excess Mortality for Phase 1b - JP Leider, University of Minnesota

Slide 1 Decreasing disparities as a core function of the COVID Vaccine Allocation Advisory Group

- Group must consider ameliorating disparities and protecting against deepening inequity.
- Aim of the Presentation.
  - Characterize COVID incidence among critical workers.

- Characterize COVID mortality and excess morbidity.

Slide 2 COVID case trends from occupational data

- MDH has occupational case data on Minnesota cases.
- Coded 33,145 occupational COVID cases provided by MDH.
- Had 25,055 codable cases in MN.

Slide 3 Number of COVID Cases by Week by Critical Worker Status

Slide 4 Percent Over (Under) Representation for Job Families With At Least 500 Occupational Cases

Slide 5 Total COVID-19 Cases by Week by Race/Ethnicity Among Critical Workers

Slide 6 Running Total of Occupational Cases per 100K by Race/Ethnicity (14-64 Only)

Slide 7 MDH's more up to date information is even starker

- Latinx Minnesotans are testing positive for COVID-19 at 3x the rate of white Minnesotans.
- Black Minnesotans are testing positive for COVID-19 at 2x the rate of white Minnesotans.
- Native Hawaiian/OPI Minnesotans are testing positive for COVID-19 at 2x the rate of white Minnesotans.

Slide 8 Highlighting importance of disparities in excess mortality

- While measuring direct mortality impact of COVID-19 is critical, measures of 'excess mortality' should always accompany official estimates.
- Death certificate data used from Minnesota from 2017-19 and 2020 to characterize excess mortality.
- Multidisciplinary team at UMN are looking at this.

Slide 9 Weekly Excess Mortality and COVID Deaths/Cumulative Excess Mortality and COVID Deaths

Slide 10 Cumulative Crude COVID-19 Mortality/Cumulative Age-Adjusted COVID-19 Mortality/  
Cumulative Crude Excess Mortality/Cumulative Age-Adjusted Excess Mortality

Slide 11 Mortality During COVID-19 Pandemic in MN, By Type of Mortality, Race/Ethnicity, and Time Period

Slide 12 COVID and Excess Mortality by Place of Death

Slide 13 Age Distribution on MN COVID Deaths by US/Foreign-born

Slide 16 Discussion

- Critical workers in the COVID occupational data were disproportionately from communities of color.

- Disparities by race/ethnicity and nativity are profound, consistent and worsening.
- Excess mortality is needed to adequately capture mortality impact on COVID pandemic on populace.

## Implications of Disparities and Excess Mortality for Phase 1b: Q&A

**Facilitator:** Questions for JP?

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## Target Group Population Estimates for Phase 1b - Ben Christianson, Minnesota Department of Health

Slide 1 US Census 2019 American Community Survey data

- Just over 1M Minnesotans in 1b category.

## Target Group Population Estimates for Phase: Q&A

**Advisor 10:** Food and Agriculture – does that included an estimate of seasonal and migrant workers?

**Ben Christianson, Minnesota Department of Health:** Would have to go back and look at the codes for what was included.

**Advisor 1:** Some overestimate, some underestimate in some categories. Looking at 1M may be helpful.

**Advisor 9:** Are also H2A workers included in seasonal workers?

**Ben Christianson, Minnesota Department of Health:** Not sure what H2A is.

**Advisor 5:** Question about the Food and Agriculture category. Can we get the codes? Presuming it is not restaurant workers?

**Ben Christianson, Minnesota Department of Health:** Correct, just food and agriculture productions. We do have the codes.

**Advisor 1:** Need workers at more elemental level. Providing food, not serving it.

**Advisor 3:** Is there any ability to see deaths by occupation? And occupations that have more excess mortality than others?

**JP Leider, University of Minnesota:** Excess mortality relies on death certificate occupation data, which is quite poor. Have tried to look at it. There is a field, but not very consistently available. Depends on where the person died and who filled in the certificate.

**Advisor 1:** COVID deaths are based on a number of factors. But also look at positive case results.

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## Discussion

**Facilitator:** Start to explore three questions in the agenda.

**As you consider these presentations, what questions do these raise for you regarding ACIP's target group recommendations?**

**Advisor 2:** Find this phase very overwhelming. Will be difficult to provide answers for the public, especially how decisions were made. Need to provide clear background. Need to prioritize these racial and ethnic disparities. Are concerned about 65-75 range that have high-risk medical conditions.

**Facilitator:** Trajectory of meeting today, digesting all this information, what are the key prioritizations? Will be meeting again on January 11. Really synthesizing the information. Really begin to model a recommendation to go to the governor. Today is for discovery, reflection, and discussion. Encourage everyone to share their perspective.

**Advisor 11:** Job categories are an easy way to get at-risk, but there are some people within the categories that can protect themselves better than others in those settings. Any ability to sub-categorize by some sort of risk rather than job?

**Advisor 3:** Agree, we are going to need some sort of way to categorize. Heard about clinic-based providers who feel they are overlooked because they aren't part of the first wave. Just looking at all the different categories, do you make waves for each category? More risk-based designation that can fall across all these worker categories would be the way to go.

**Advisor 1:** Reminder that we don't have enough vaccine. What will be the impact on society? Looking at schools/child care, group that had less risk based on race/ethnicity, but is a group that impacts our societal functioning. Lack of that group has an equity impact on some of our most vulnerable populations because those kids are less able to navigate the distance learning. Should consider societal impact as well as individual risk.

**Advisor 4:** Was thinking along the lines of school-aged children. Essential workers and their children are being impacted significantly which also hits that social vulnerability area. Covering schools and teachers will go a long way to addressing challenges in essential workers and People of Color, and individuals who cannot stay home when having children in school.

**Advisor 5:** Build questionnaire for patients to self-designate their occupation as a qualifier for vaccination. Electronic tool, or calling in. Wanted to share the point of view of the vaccinating entity and how confused they are. In health care, they don't have population lens, they look very much at the individual. Very biased as to what is in the medical record. Challenging to say we want to have criteria by which we are going to allow or defer someone's vaccination, based on what people claim their job is and us interpreting that. Took the list of frontline essential workers and put it in a question: "Do you fall into any of these groups?" Tried some role playing and discovered it is very hard for an appointment scheduler to ask these questions and get back reliable information. They don't understand it. Example: Do you work in food and agriculture? Answer: I work at Burger King. Oh, that's food. I like the risk-based approach. But it will fall on the clinic to be the arbiter of whether you can control your PPE or not, and

they're not going to be comfortable saying, "Sounds like you can wear PPE" or "Sounds like you can't wear PPE." This is going to be large barrier. Need to have a more concrete tool to use. If we don't have something concrete, it's going to fall to those that advocate most strongly for themselves, and that will lead to more disparity.

**Advisor 1:** Saw that with Phase 1a as well. One thing to consider, focusing on industry is rather imprecise. When we say 75 or older, that is very concrete. When we get to other areas, we should focus on the industry and then do outreach with a more clear message. Will be very difficult for health care providers to be handed a list and then have to sort it out. Or to have someone come in and say "Hi, I work in a meat packing plant." Try for the best way to do things with a little consideration to practical implementation.

**Advisor 5:** Hope MDH pushes for occupational criteria. Seen other states do that, just throw up their hands and say this is too complicated, we're just going with age. Or health conditions. Easier for the public to digest, need to have a strong message push.

**Advisor 11:** Any guidance on how to prioritize needs to be operationalizable. Agree, can't make the vaccinator decide. Possibility of creating a tool. Ethics Collaborative made an attempt for a screening tool for workers to get access to therapeutics. Can JP speak to adapting that tool for vaccines?

**JP Leider, University of Minnesota:** Short answer, should be adaptable. Agree with Advisor 5, there is a lot of potential for confusion by person doing screening, because the nature of the guidance from the governor is very broad, many classifications. Good thing is that the definitions already exist. Advisor 1 made a point, there will be fraud, but asking someone for proof of employment will systematically exclude some classes of people. Will be challenging, regardless.

**Advisor 1:** Always situations where the guidance won't be followed, but there are things we can do operationally that will help to ensure that we have a greater likelihood of reaching the populations we want to reach. But it won't be perfect.

**Advisor 10:** See positives of screening, who will fall through the cracks. Who has the least power, who is the least English proficient? Seen cases where not adequate interpretation is provided. Worried about people with the least power getting access to the vaccine, even though they may have the right to it.

**Facilitator:** Abby question: Who will be operationally responsible for vaccinations in Phase 1b and 1c.

**Advisor 1:** Phase 1b and 1c, vaccinators will be mixed bag. For some people, like our elders, health care or pharmacy setting could be an excellent place to get vaccinated. It's familiar, they have the information, and LPH will also be involved. Some situations could work with employers, but need to make sure it's not a coercion situation, where people feel they have to get the vaccine. Something where we can reach the population. So we are looking at multiple, different settings.

**Advisor 5:** What about a 'Golden Ticket'? Something that could be distributed electronically to employers that they could print off. Employers could give to employees that say they meet the vaccination criteria? In many languages – "You can get vaccinated." How to tell the workers so they are aware and then also take the burden off the vaccinators?

**Facilitator:** A couple of important things – How do we prioritize without just looking at lump sum job categories, prioritize based more on risk that will have the most impact? Let's not get too caught up in the operationalizing it.

**Advisor 11:** Lots of talk about prioritizing risk vs. job. Advisor 1's good point of preserving social functioning. Not simple either/or. Argue we could do both at the same time. Don't think we have to choose.

**Facilitator: What groups do you feel have been left out of ACIP recommendations?**

**Advisor 12:** It's a small group, but the Ombudsmen, Inspectors, surveyors for the LTC facilities in Phase 1a. Some will not go into buildings. Have several articles about horrible things going on in the facility because the facility can't be inspected.

**Advisor 9:** If the decision is based on the job you have, it leaves out the unemployed. About 60% black population applied for unemployment.

**Advisor 13:** Thinking the same thing. Looking at data with race and ethnicity as a risk. Trying to categorize people by their job, and they don't have those jobs anymore. Going to leave a lot of people out. Some that aren't 75, maybe 60 who are now having to take care of their families because others are out of work.

**Advisor 3:** Second Advisor 9's point. How can we include all congregate settings, like Homeless Shelters?

**Advisor 1:** Homeless Team put together a vaccine plan for homeless. There is a plan for that population. Are working on it now. About the unemployed, it is a good point. But when we are vaccinating in the critical work force, because we need them at work or because of the disparate populations they represent. Transportation is in Phase 1c, the broader transportation. Mass transit is called out separately in 1b.

**Facilitator:** Raising good points about the balance.

**Advisor 10:** Hearing so many concerns from disability community. Heard the concerns about those in congregate care. But the one that aren't, the challenges of basic in-home services, specialized care. Hearing about a lot of crisis in that community.

**Advisor 6:** Addressing unemployed in critical positions. Importance of trying to build trust. Also need to work with the employer so employees generate trust.

**Facilitator:** Want to acknowledge Advisor 1, there is no simple answer.

**Advisor 4:** As we look at moving forward, talked a lot about SVI as a driver, need to look beyond easy. Need to look deeper. Prison population for example. They have no choice to be there. They are our wards. Need to honor SVI.

**Facilitator:** Need to look at SVI in a more proactive way or more deeply, or saying it's too simple?

**Advisor 4:** No, you are right. Really look at it from Persons of Color point of view. They are unemployed and are out there. Feel we really need to embrace SVI.

**Advisor 2:** Say want to prioritize SVI, but when put it into practice, I've seen in my community Caucasian physicians finding ways of getting ahead of others who were really meant to get the vaccine. Seen this in Phase 1a, really need to think about how are we going to do this in a way that allows the people who we want to get the vaccine really get the vaccine.

**Advisor 3:** Has there been exploration of care status, specifically Medicaid? Captures many groups we are talking about like essential workers. 40% of Black adults get their health care through Medicaid, 39% of Indigenous adults, 30% of Hispanic adults. Could be a potential way of sub prioritization within these groups. For example, child care. If you are providing child care and are on Medicaid, you would be prioritized over someone who is providing child care but not on Medicaid. Are going to be limits, undocumented or status is unclear. Still struggling with how to prioritize in these big groups.

**Advisor 5** Interesting how HC facility implementing gating systems, and everyone is coming up with their own mechanism. State could ask them to help the state's efforts and starting to prioritize people on Medicaid within this group. Clear message would be actionable by a provider who is trying to figure out a way to do it and not reinvent the wheel.

**Facilitator:** Does that cover the unemployed?

**Advisor 3:** Yes, MN does not have a work requirement to be on Medicaid.

**Advisor 1:** Taking us back to ACIP recommendation. Had an age and then job-based workforce. Are moving away from essential workforce concept, keep in mind how we are framing this. How we are using this to reach those populations we want to reach.

**Advisor 11:** Foundational ethic guidance, two track model: essential worker, general public. Makes sense to do both in tandem. How do you fold the unemployed into the general public track? My question is how wedded do we have to be using age on the General Public side? Is there a way to say those 75+ are being prioritized in Phase 1b in the general public is because of their risk, are there other groups that are roughly the equivalent levels of risk that they should also go at the same time?

**Advisor 1:** When ACIP was considering this, how did age fall out with other risk populations?

**Lynn Bahta, Minnesota Department of Health:** Such a significant increase in incidents with 75 and older. Couldn't reconcile at the meeting someone 64 with several comorbidities vs. someone who was 75 and jogged every day. What drove it was the morbidity and mortality. Just like in nursing home residents where we are seeing this, so we stuck to that age criteria.

**Advisor 9:** Unemployment Insurance System verifies employers, so we would know those that weren't employed based on what industry they are in. Recognize it may put everyone in a category of less risk because they are at home and not working, but getting a vaccine might put them in a position to go back to work or do other things. On Advisor 11's point about the over 75, saw JP's data that was alarming for People of Color.

**Advisor 11:** Is there a way to talk about risk across comparable age groups?

**Advisor 3:** Building on Advisor 5's using Medicaid to sub-prioritize 75+. CMS released data since May showing those on Medicare and Medicaid are at risk of higher rates of COVID infections and hospitalizations. Continue to see higher risk in BIPOC communities. As far as JP's legal part, that supports that there is a lot of risk there.

**In the ACIP recommendation, we have an age determination (i.e., 75 and older) and an occupational determination (i.e., frontline worker) what do you think the key factors and considerations for allocation in MN?**

**Facilitator:** Summarizing so far, block out some of the major points. Blending some of the major strategies, how do we look at the blending of the risk factors (death, infections) along with the societal functionality piece and the blending of that? How do we look through the lens not just through job category but through a risk lens? Appreciated the direction with the unemployed population. Core assumptions that may be made about them that shouldn't be. How do we ensure inclusion there? Really appreciated Advisor 3's point about Medicaid and JP's about do we use Medicaid as a way to help us sub-prioritize? It's all about blending. Not about operationalizing. Also, how do we go deeper into SVI? Do we see any flexibility to reach other age groups that are impacted just as much? Can also look at schools and the impact on societal functionality. Am seeing a lot of schools, schools, schools in the chat, but am wondering if there are other considerations we haven't brought forward yet?

**Advisor 5:** Identified the issue of occupation and occupational risk, does not mesh well with current health care system: don't know people's occupations, not coded consistently, often not populated at all. Not populated in the medical record at all. To keep facility from going path of least resistance. State has to have a very clear message about occupational prioritization and some tools to simplify that eligibility of vaccination based on the occupation.

**Facilitator:** Taken by your talk of tools and a rubric, some way of helping that person.

**Advisor 1:** As we talk prioritization, does it have to be this group first and then this group, or can we provide a background, like with elders, and while we are doing that we are prioritizing educators and child care and then do those and then look at how we are focusing and using the SVI. Bottom line is we don't have enough vaccine, so how do we maximize the vaccine without thinning it so much it is basically meaningless.

**Advisor 5:** Like that. Gives clear direction. Would reduce confusion. Doesn't think it has to be one industry at a time. Will be able to look at the number of vaccine and then open it up to more categories.

**Advisor 3:** Address Advisor 2's questions about leaving out BIPOC communities who are working and are getting insurance through their employers. Issue is we need to find a way to sub-prioritize and don't think this group or any State unfortunately is really ready to rectify structural racism by saying 'Black Minnesotans, Indigenous Minnesotans are going to get priority.' Bunch of legal concerns with that. Need to recognize there is always going to be some BIPOC that are going to be left behind unless we are willing to step out on that ledge. How do we get the most possible? We won't get everyone unless we

are very explicit, saying this is going to be the priority. I don't think we can do that so we need to find the next best path.

**Advisor 12:** I'm concerned about sub-prioritizing those 75+. They have the most deaths. Are probably the most scared. They are staying in their homes afraid to come out. Don't think someone who is 75 and on Medicaid should be prioritized over someone who is 75 and not on Medicare, or has private health insurance. Very hard to defend to the press and others.

**Advisor 11:** Looking at risks caused by structural racism. It's real, we've seen the data. Makes sense to base it on risk. Do it on risk. Will capture more BIPOC. Can we move away from age? If we have a group that is the equivalent of 75+, why can't we do them at the same time rather than make them wait?

**Facilitator:** Need to wrap up now. Jan. 11 is next meeting. Need to synthesize all this information. Appreciate everyone participation. Looking at 1-4:30 p.m. Please pencil it in.

**Advisor 1:** Thanks for everyone's participation. What the team is going to do is look at options, how to incorporate them. Asked Advisor 11/MN Ethics Collaboration to look at more fraught issues. Put together a straw person document for you so we can get to more of the details and guidance people will get. Will be bringing this to the governor as well. Want him to be aware of what our priorities are. Want everyone on the same page. The governor is interested but want to make sure he knows what we are thinking. This is an excellent group that has brought up some really good issues.

**Facilitator:** Thank you for your time and have a great new year. See you Jan. 11.



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